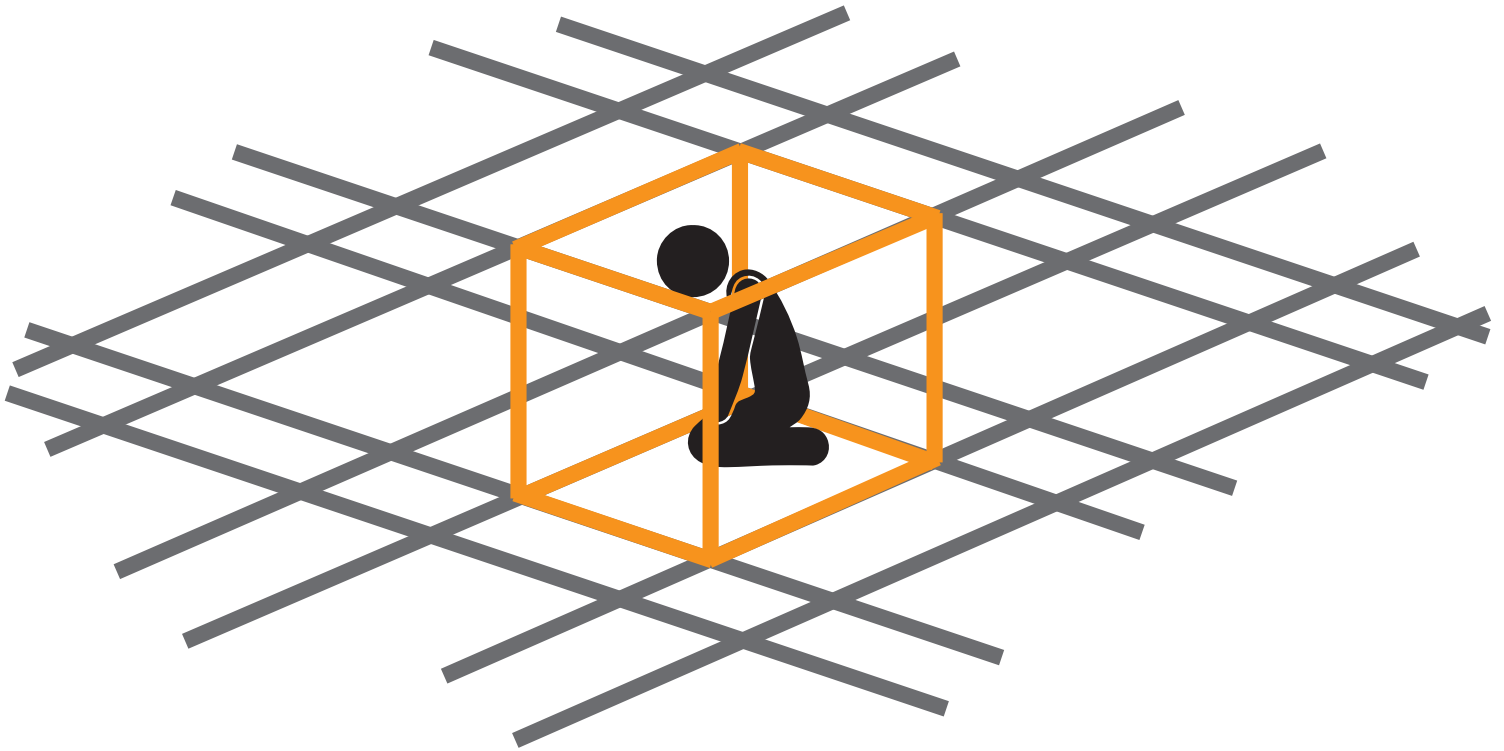


'A SECRET PUNISHMENT'

- THE MISUSE OF SEGREGATION IN IMMIGRATION DETENTION



Medical Justice

The cases referenced in this research have been Medical Justice clients or their details are in the public domain. Medical Justice is the only organisation in the UK to send independent volunteer clinicians in to all the Immigration Removal Centres across the UK. The doctors document detainees' scars of torture and challenge instances of medical mistreatment. We receive over 1000 referrals from detainees each year and have gathered a sizeable, unique and growing medical evidence base. We help detainees to access competent lawyers who properly harness the strength of the medical evidence we generate. Evidence from our casework is the platform for our research into systemic failures in healthcare provision, the harm caused to detainees by these shortcomings, as well as the toxic effect of immigration detention itself on the health of detainees. We and others use our research to secure lasting change to the detention regime through policy work, strategic litigation and by raising awareness of the conditions inside places of immigration detention.

**If you would like to make a donation, our preferred method is via our JustGiving page (<https://www.justgiving.com/medicaljustice>), or alternatively our bank details are:
CAF Account - Sort Code: 40-52-40 Account number: 00021167**

Company Registration No. 6073571
Registered charity No. 1132072
General enquiries: info@medicaljustice.org.uk
Phone: 020 7561 7498
Fax: 08450 529370
Website: <http://www.medicaljustice.org.uk/>

Written by Kristine Harris for Medical Justice

We would like to acknowledge the brave contributions of all the Medical Justice clients and volunteers who have made this work possible. Without the volunteers' dedication and the clients' courage in speaking out about their experiences, segregation would remain a hidden world. We would also like to thank Sharon Shalev for allowing us to make use of parts of her research. And last, but not least, to thank all who proofread and commented on draft versions of this report. Any mistakes in the report are entirely the author's.

Illustrations on pages 52, 59, 84 & 89 adapted from the Noun Project (<https://thenounproject.com/>)

'A Secret Punishment – The misuse of segregation in immigration detention' is published in 2015 by Medical Justice.

Copyright © Medical Justice 2015

'A SECRET PUNISHMENT'

THE MISUSE OF SEGREGATION IN IMMIGRATION DETENTION

"I believe that very few men are capable of estimating the immense amount of torture and agony which this dreadful punishment... inflicts upon the sufferers; and in guessing at it myself, and in reasoning from what I have seen written upon their faces, and what to my certain knowledge they feel within, I am only the more convinced that there is a depth of terrible endurance in it which none but the sufferers themselves can fathom, and which no man has a right to inflict upon his fellow-creature. I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any torture of the body: and because its ghastly signs and tokens are not so palpable to the eye and sense of touch as scars upon the flesh; because its wounds are not upon the surface, and it extorts few cries that human ears can hear; therefore I the more denounce it, as a secret punishment which slumbering humanity is not roused up to stay."

–Charles Dickens on the use of solitary confinement–

**OCTOBER 2015
MEDICAL JUSTICE**

EXECUTIVE SUMMARY

Segregation is one of the most severe and dangerous sanctions that can be imposed on detainees - its devastating impact on mental and physical health is widely recognised. Yet, there has been surprisingly little scrutiny of its use in Immigration Removal Centres (IRCs).

Drawing on case studies from Medical Justice's work in IRCs, this report sheds light on the solitary and secretive world of segregation. Medical Justice sends independent doctors into IRCs to document evidence of torture and to challenge instances of medical mistreatment. Our research demonstrates that despite repeated damning critique from HM Inspectorates of Prisons (HMIP) and Independent Monitoring Boards (IMB), the over use and misuse of segregation continues in IRCs across the UK

Every year more than 30,000 detainees are locked up in IRCs without a time-limit. These detainees are not detained as part of any criminal sentence but are held for administrative convenience. Most detainees are held in centres outsourced to private companies, some are detained for years, and there is little public insight into what happens behind these locked doors. This is often doubly true of the closed segregation units.

Every year between 1200 and 4800 detainees are segregated in IRCs, a very high proportion compared to other countries. There is little central monitoring of the use of segregation so reported numbers vary significantly, with a four-fold discrepancy in rates provided by Home Office and those reported by HMIP. In addition, there are no guidelines governing the use of segregation in detention and no independent oversight of the process.

The great majority of instances of segregation are in accordance with Detention Centre Rules, which allows for the segregation of violent detainees or detainees who constitute a risk to the safety or security of the centre. However, our research also found relatively widespread use of segregation which contravened the Detention Centre Rules:

- The unlawful use of segregation as a form of punishment for detainees who are held without the benefit of automatic judicial oversight and without access to adjudication processes;
- The use of segregation to manage detainees with mental health disorders that cannot be satisfactorily managed in detention. Behaviour rooted in on-going and untreated mental health issues is often mistaken as confrontational behaviour and managed through the use of segregation;
- The use of segregation to manage detainees at risk of self-harm, despite segregation being an entirely unsuited environment for vulnerable detainees in crisis;
- And the indiscriminate use of segregation as a means of aiding in removal processes in the absence of individual risk assessments.

Some detainees are inappropriately segregated for months and even years, with one detainee being segregated more or less continuously for 22 months. One detainee was only removed to psychiatric

hospital following 80 days in segregation whilst another was segregated more than 8 times during her 800 days in detention.

Detainees are frequently segregated without proper authorisation. Some are held in conditions of de facto segregation in units which are given innocent sounding names like the Care and Support Unit or the Assessment and Integration Unit, without being subject to the safeguards and monitoring provided by the Detention Centre Rules. A schizophrenic detainee died alone in segregation, whilst an age disputed child was segregated for 9 days until the trauma of the situation caused him to stop eating. Inappropriate force has been used on detainees to remove them to segregation including assaults with riot shields and one detainee was repeatedly handcuffed and segregated to stop her self-harming.

Some detainees may have been held in segregation as part of past torture which means that re-exposure to this environment could be extremely traumatising. Despite the horrific experiences many of the case studies in this report have lived through in their countries of origin, and on the journey to the UK, it was the trauma of segregation experienced in the UK they could not bear to relive or discuss.

Medical Justice believes that the conditions of detention, including segregation, are so detrimental to the health and wellbeing of those detained that the only way to remedy this situation is to close IRCs. The use of segregation in immigration detention is disproportionately retributory for a low risk population detained for administrative purposes. The over-reliance on, and misuse of, segregation in immigration detention reflects the abdication of the state and its private contractors of their moral and legal obligation to treat those in their custody humanely.

Medical Justice believes that segregation is inappropriate in immigration detention and that the Detention Centre rules should be changed to reflect this fact. We are particularly concerned about prolonged segregation, the use of segregation as punishment, segregation of the mentally ill or those at risk of self-harm.

Medical Justice, 2015

FOREWORD

“The Royal College of Psychiatrists Working Group on Asylum Mental Health welcomes the publication of “A Secret Punishment - the Misuse of Segregation in Detention” which highlights the overuse and misuse of segregation in immigration detention. We are particularly concerned about the use of segregation to manage detainees with mental ill health. The use of segregation for such individuals is a wholly inappropriate form of management and fails to comply with Home Office policy specifying that patients with severe mental ill health that cannot be satisfactorily managed should not be in detention in the first place, making segregation of such individuals doubly wrong.

Poor screening processes, inadequate healthcare and the failure of vital safeguards mean that vulnerable people with mental health difficulties can have long stays in detention where their mental health is allowed to deteriorate sometimes to the point of requiring hospitalization. During this process of deterioration their behaviour often becomes more challenging. This is often seen as disruptive or antagonistic behavior leading to segregation of the detainee which is wholly inappropriate and likely to lead to further deterioration of their mental health. Segregation in detention is also frequently used to manage detainees at risk of self-harm, removing such vulnerable persons in crisis from social contact with peers can contribute to the risk of further self-harming behaviour.

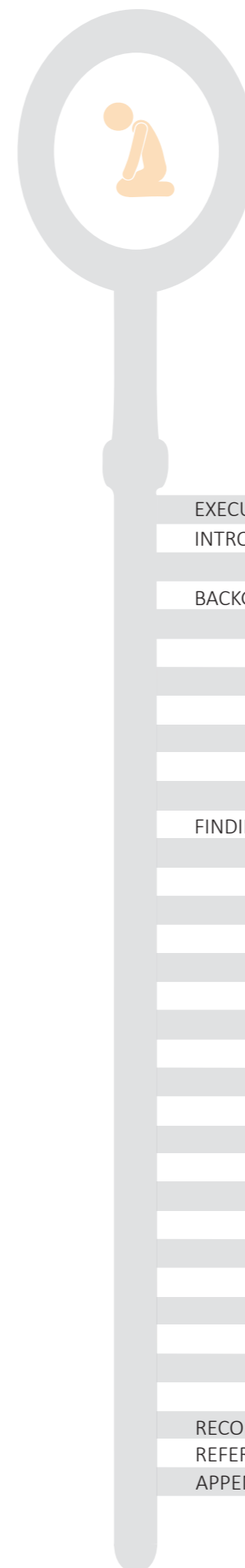
Within the NHS all segregation of psychiatric patients must abide by the Mental Health Code of Practice 2015 and it is imperative that all segregated patients must be afforded the same procedural safeguards that they would were they to be detained under the Mental Health Act. Current best practice in NHS mental health services is focused not just on the symptoms of mental health disorder but on recovery, relapse prevention and successful reintegration into society. The inappropriate use of segregation in IRCs for those with mental health disorders runs entirely counter to this philosophy.

The group believes that the procedures for identifying vulnerable individuals need to be improved and safeguards for those who become vulnerable whilst in detention must be strengthened. Staff need to be trained in recognizing the signs of mental ill health, and in particular those working in the segregation units need specialized training. Proper governance on the use of segregation is vital to ensure that misuse does not occur, any guidelines must apply to all IRC’s to ensure parity across all centres. The guidelines should be published and data pertaining to the use of segregation made publicly available. Segregation under Rule 40 and Rule 42 should not be used for the management of detainees with mental ill health, for vulnerable detainees in crisis or those at risk of self-harm or suicidal behaviour.

In conclusion, the working group endorses the recommendations of Medical Justice’s report that overuse or misuse of segregation in immigration detention must end.”

**Dr Jane Mounty,
on behalf of the Royal College of Psychiatrists Working Group on Asylum Mental Health**

CONTENT



EXECUTIVE SUMMARY	p.1
INTRODUCTION	p.5
Segregation defined	p.10
BACKGROUND	p.11
Immigration detention in the UK	p.11
A brief history of segregation	p.13
The health effects of segregation	p.15
International use of segregation in immigration detention	p.20
International legal framework	p.22
National legal framework	p.25
Comparison to prisons	p.28
FINDINGS	p.31
Methodology	p.31
A prison within a prison- experience of segregation	p.33
The use of segregation	p.37
The misuse of segregation	p.41
Overuse of segregation	p.41
Held longer than necessary	p.41
Segregated when no longer violent	p.43
Segregation unit used as healthcare facility	p.44
Lack of proper authorisation	p.44
Poor governance	p.45
Poor monitoring and record keeping	p.46
Inappropriate use of force	p.47
Age disputed cases kept in segregation	p.49
Deaths	p.50
The merry-go-round	p.51
The use of segregation as punishment	p.54
The use of segregation to manage detainees with mental health issues	p.61
The use of segregation to manage risk of self-harm	p.75
The use of segregation to aid in removal	p.85
Segregation by any other name	p.90
RECOMMENDATION	p.95
REFERENCES	p.99
APPENDICES	p.108

INTRODUCTION

The use of segregation within prisons and other detention facilities has been a controversial practice ever since it first gained popularity in the late 19th century. Despite on-going criticisms and concerns over the negative impact on the mental and physical health of those subject to segregation, the practice is still widely used in prisons and detention centres in the UK and cross the world. All international standards stress that segregation should only be used as the absolute last resort, when all other options have been exhausted and, then, only for as short a time as possible. Yet, as this report will illustrate, this is not the case when it comes to the use of segregation in Immigration Removal Centres (IRCs) in the UK.

Segregation, or the practice of locking individuals in cells for up to 23 hours a day and limiting their access to meaningful activities and empathetic social interaction has been found to lead to increased rates of anxiety, social withdrawal, perceptual disorders, hallucinations and suicidal thoughts after relatively short periods of segregation. This is particularly true for those with pre-existing mental health conditions or other vulnerabilities. The UN Special Rapporteur on Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment has called for a ban on segregation that exceeds 15 days as after this point the negative effects are more likely to become permanent^[1].

Every year in the UK over 30,000 people are detained in IRCs across the country under immigration powers. Those held in IRCs are held for administrative convenience rather than as part of any criminal sentence. It is therefore questionable to what extent the use of segregation is appropriate for this population at all.

One might expect that application of severe restrictions such as segregation would be tightly controlled and regulated by the Secretary of State. Whilst the legal framework for the use of segregation is set out in the Detention Centre Rules 2001, there are no publically available guidelines on how these rules should be applied and monitored in individual IRCs.

The only independent oversight comes in the form of inspection reports from HM Inspector of Prisons (HMIP) and the annual reports of the Independent Monitoring Boards (IMB) in each IRC. HMIP have criticised the use of segregation across the board since their earliest inspection reports in 2006 through to their most recent reports in 2015. In some cases the same establishments have been reprimanded year on year by the HMIP but abuses continue to occur.

In most instances immigration detainees are segregated for short periods of time and in accordance with the Detention Centre Rules. However, in some cases segregation is being misused e.g. as a form of punishment or to manage vulnerable detainees. In addition, there is evidence that forms of de-facto segregation has been in place within IRCs. Detainees in these small group isolation units are subject to limitations and restrictions similar to segregation but are not subject to the same safeguards.

It is with these instances that this report will concern itself. By drawing on case studies from a number of Medical Justice clients who have been subject to inappropriate segregation practices the report will explore the misuse of segregation and scrutinise the dangers of this practice when applied to a population not subject to the same judicial frameworks as prisoners.

There is a common misconception that segregation is a necessary tool used to manage the 'worst of the worst' who cannot be safely located anywhere else in IRCs. However, when investigating the use of segregation in IRCs it becomes apparent that rather than the 'worst of the worst' segregation often houses the 'most vulnerable of vulnerable' detainees. These vulnerable detainees end up being housed in bleak and austere segregation units in cells that are often unfurnished except for a plinth bed and a metal toilet. This environment is totally unsuited for the housing of vulnerable detainees and the forced isolation provides little support for these individuals. The use of segregation in immigration detention is doubly problematic as those detained should be held in the most relaxed environment possible and should not be subject to disciplinary or punitive measures. The use of segregation does not fit in with the stated intention of immigration detention and the effect on those individuals subject to inappropriate segregation can be devastating.

Overview

The reports begins with an outline of the history of segregation, an overview of the academic findings on the health impact of the use of segregation and the relevant international and national legal framework governing the use of segregation. There has been very little research carried out on the use of segregation in immigration detention but the report summarises the relevant findings from other countries to provide an international context. This contextual information is intended to arm the reader with a good background understanding of segregation and to serve as reference material for interested parties.

The second half of the report delves into the specific findings of the use and misuse of segregation in immigration detention in the UK based on Medical Justice research and casework.

There is very little information available on frequency and length of segregation in IRCs. The Home Office only started collecting information

on the use of segregation in 2014 and even now they only collect the most basic of information; number of detainees segregated and total number of days of segregation. There is no central monitoring of the potential equality impact of segregation or any independent monitoring to ensure that segregation is not misused in IRCs. In 2014 the Home Office reported that roughly 1200 detainees were segregated, approximately 4% of detainees. HMIP carries out user surveys during their inspections which have found that on average 16% of detainees (roughly 4800) report having spent a night in segregation during the last 6 months. It is not clear what lies behind this fourfold discrepancy but it seems likely the Home Office are underreporting rates of segregation. This is particularly worrying as even 4% constitutes a very high rate of segregation for a detained population. The only comparable data on the use of segregation in immigration detention comes from the US^[2] and the Netherlands^[3] where rates of segregation in immigration detention are closer to 1%. The high rates are indicative of a systemic overuse of segregation and this has been one of the most frequent criticisms levelled by HMIP at IRCs during inspections.

There are no time limits on detention or on periods of segregation. For detainees this uncertainty means that detention is experienced as indefinite as is their isolation in segregation. This can have a profound psychological effect on detainees as they linger in isolation cut off from the rest of the world and their peers.

Facilities in segregation are very basic and meaningful activity and social interaction is kept to a minimum. There have also been reports of a lack of heating in segregation cells with detainees being left without blankets in cold cells for days. Others report that the lights were kept on 24 hours a day, such as in the case study of Zachariah, which may constitute conditions of torture in segregation^[4].

Detainees report an atmosphere of fear and control in the segregation unit and that removal to segregation is frequently used as a threat to get detainees to comply with directives from

custodial staff. One detainee described how staff would taunt him with repeated segregation after he was transferred out of segregation by asking him *“Do you want to go back there again? Do you need a refresher?”* (Detainee Harmondsworth).

Whilst another described the fear and powerlessness of being held in segregation unit: *“whether you are screaming, no one knows (...) officers can do anything. Managers are all the way on the other side...”* (Detainee Yarl’s Wood).

Drawing on criticisms from official inspectorates the report outlines an overview of some of the most common misuses of segregation. The lack of independent oversight, monitoring and public insight into the use of segregation means that this is a realm hidden from scrutiny and often the only insight we have is from inspection reports, anecdotal mentions in fatal incident reports and the testimony of detainees themselves. Collating these morsels of information provides a picture of a frightening and under-regulated world where abuses of segregation are common.

Medical Justice sees cases where victims of torture, who should not be in detention in the first place, are placed in segregation and re-traumatised. For some, segregation may even have played a part in their original experience of torture. We also see cases where the very ill, both physically and mentally, are placed in segregation as a form of informal in-patient facility. This happens despite the fact that custodial staff working in segregation have no medical training. This is particularly worrying in IRCs where the segregation unit is not always staffed. So that ill and vulnerable detainees find themselves alone with two locked doors between themselves and any medical attention. In the last few years there has been at least one death of a severely ill detainee who died alone in segregation. The coroner found that he died of natural causes but that neglect contributed to his death.

In the last 3 years there have been 5 High Court findings of *‘inhuman and degrading treatment’* in breach of Article 3 of the European Convention on Human Rights in immigration detention in the UK. 3 out of 5 of these cases involved mentally

ill detainees being placed in segregation, 3 were clients of Medical Justice. In addition there are likely to be a number of similar cases which were settled out of court. There has also been frequent use of de facto segregation across IRCs. *“Detainees with mental health or behavioural problems had see-sawed between a healthcare ward and being in segregated accommodation, removed from association”*^(5:7). For the detainee themselves the distinction between the various regimes may not be clear and both are likely to be experienced as segregation. However, de facto segregation regimes are not subject to the same safeguards, monitoring or paperwork as segregation under Rule 40 and 42. As a result it may be very difficult for detainees to demonstrate that they were in fact subjected to segregation.

Segregation is an inappropriate environment for most adults and the negative health effects are well documented. Children, who should not be in detention in the first place, but who end up in this situation due to their age being disputed by the Home Office, are sometimes segregated for their own protection.

Inappropriate use of force is often applied to transfer detainees in or out of the segregation unit, even in cases where detainees are compliant. There is also evidence of what has been dubbed the ‘merry-go-round’ of segregation where detainees are transferred from the segregation unit in one IRC straight into the segregation unit in another. One detainee was transferred a total of 8 times during the 22 months he was held in continuous segregation. Another detainee was transferred out of segregation unit of one IRC shortly before an announced inspection following an email from the Home Office manager at Brook House stating *“my concern at this point is that due to the timeframes involved in this process he is more than likely going to be sitting in RFA [Removal From Association] when the HMCIP [Her Majesty’s Chief Inspector of Prisons] inspectors come to visit us on 15th March. He will most probably be sleeping in the toilet area in his room, where he normally is, and the question may be asked as to why he is not in more appropriate accommodation i.e. a healthcare bed at one of*

our other Centres and he has remained in RFA since December.” The detainee in question was transferred to the segregation unit of another IRC on the 7th of March, one week prior to the scheduled inspection.

These are all in themselves extremely concerning failings in application and governance of segregation which may have devastating and lasting health impact on detainees and must be addressed. Many of the case studies reported in this dossier are still not able to live and work independently in the community after release.

Over the last few years Medical Justice cases as well as cases in the public domain have brought the misuse of segregation in 4 primary areas to our attention. The abuses are ongoing and shocking:

1. The use of segregation as a form of punishment
2. The use of segregation to manage detainees with mental health issues
3. The use of segregation to manage detainees at risk of self-harm
4. The indiscriminate use of segregation to aid in removal

1. The use of segregation as a form of punishment

Home Office policy stipulates that segregation may be used when it appears in the interest of safety or security (Rule 40) or to manage actively violent detainees (Rule 42). These are intended as short term measures to manage an on-going risk. Yet, Medical Justice sees segregation used as a form of punishment, sometimes hours after the incident has ended. Using segregation as a form of punishment is not a way to manage risk but to administer sanctions on individuals who are held for administrative convenience and who have not been subject to regular, automatic judicial oversight. In a prison context segregation is frequently used as punishment for disciplinary infractions. However, the prison

setting is governed by fixed prison rules with pre-determined punishments for infractions and an adjudication process through which the prisoner can challenge these sanctions. None of these frameworks exist in the immigration detention setting and there are no adjudication processes available to detainees. The use of segregation as a form of punishment is unlawful and disproportionate in a detention setting.

2. The use of segregation to manage detainees with mental health issues

According to Home Office policy vulnerable detainees, such as those suffering from a mental health condition which cannot be satisfactorily managed in detention, should only be considered suitable for detention in very exceptional circumstances. In reality the screening processes are insufficient and mentally ill detainees often end up inappropriately detained. In addition, the existing safeguards in IRCs, such as the initial health screening, monthly detention reviews and Rule 35, often fail to identify these vulnerable individuals. Despite reported high rates of mental health disorders among asylum seekers and migrants, the mental health provision in IRCs fails to meet the needs of the detained population and falls short of that provided in the community. As a result IRCs end up detaining individuals with mental health issues that cannot be satisfactorily managed in detention. Their behaviour, which is often rooted in ongoing mental health disorders, is interpreted as ‘behavioural issues’ which are managed through the use of segregation. Segregation is an entirely inappropriate and non-therapeutic environment which only contributes to the continued deterioration of the detainee’s mental health and wellbeing. The mental health of individuals is frequently allowed to deteriorate to the point where they require sectioning in a secure psychiatric facility under the Mental Health Act.

3. The use of segregation to manage detainees at risk of self-harm

Segregation in IRCs is frequently used to manage detainees considered to be at risk of self-harm or suicide despite the fact that this practice has been repeatedly criticised by HMIP and other observers. Segregation provides a stark environment where detainees are removed from the natural support network of their fellow detainees and placed in an environment where there are few distractions from their thought pattern and little opportunity for emotional release through social interactions. Detainees at risk of self-harm are in a vulnerable situation and are therefore less able to deal with the conditions of segregation which only seems to increase their vulnerability and may leave them even more susceptible to self-harm. Segregation is an entirely unsuited environment for vulnerable detainees in crisis.

4. The indiscriminate use of segregation to aid in removal

Lastly, segregation is often used in the nights leading up to the proposed removal or deportation of a detainee to their country of origin. Detainees who often fear for their own life if forced to return may resist removal through violence or acts of self-harm. Segregation is then used as a means of managing this risk to the detainee and the centre staff. However, Medical Justice sees frequent examples of situations where segregation is used as a blanket policy on detainees who are complying with instructions and in the absence of an individual risk assessment. As an indiscriminate policy applied to certain groups of detainees it may become a discriminatory practice which disadvantages certain groups and increases stress in an already very stressful situation. As access to phones and faxes is limited, being placed in segregation may compromise a detainee's ability to communicate with their legal representatives and mount a legal challenge to their removal. It also hinders

their ability to contact friends and family in their country of origin to make arrangements for their return.

The European Court of Human Rights has recognised that *“solitary confinement is one of the most serious measures which can be imposed within a prison”*^[6]. Home Office policy stipulates that segregation must be used in extreme moderation and only in exceptional circumstances when all other options have been exhausted. Clearly this is not happening in IRCs at the moment. The use of segregation on immigration detainees held for administrative convenience needs to be re-examined as it is ill suited to the stated purpose of detention. Some prisons in the UK, both open and closed, manage without segregation units and report that this has contributed to a positive atmosphere in the facilities^[7]. Thus it is clearly possible to operate a secure setting without resorting to this most draconian of measures.

Medical Justice believes that the conditions of detention, including segregation, are so detrimental to the health and wellbeing of those detained that the only way to remedy this situation is to close IRCs. Medical Justice believes that all segregation in immigration detention is inappropriate and calls for the publication of strict guidelines governing the use of segregation, for improved safeguards to ensure vulnerable detainees are not inappropriately detained, mandatory health screening prior to segregation and stringent independent monitoring of the use of segregation.

We are particularly concerned about the use of prolonged segregation, the use of segregation as punishment, segregation of the mentally ill or those at risk of self-harm.

Segregation defined

Segregation, single separation, removal from association, temporary confinement, solitary confinement, isolation. The practice of separating detainees from the rest of the detained population, limiting their interactions with others and subjecting them to a severely restricted regime is known by many names and is currently in use across all IRCs in the UK. Colloquially, amongst detainees themselves, segregation is usually referred to as being taken to *‘the block’* or by the names of the units in each detention centre – such as the much dreaded Kingfisher Unit at Yarl's Wood IRC. According to Home Office policy, detainees held under Rule 40 or Rule 42 of the Detention Centre Rules are termed as being held in Removal From Association (40) and Temporary Confinement (42).

There is no universally accepted definition of solitary confinement. However, the UN Special Rapporteur on Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment relies on the Istanbul Statement on the Use and Effects of Solitary Confinement which defines solitary confinement as the *“physical isolation of individuals who are confined to their cells for 22 to 24 hours a day. In many jurisdictions, prisoners held in solitary confinement are allowed out of*

their cells for one hour of solitary exercise a day. Meaningful contact with other people is typically reduced to a minimum. The reduction in stimuli is not only quantitative but also qualitative. The available stimuli and the occasional social contacts are seldom freely chosen, generally monotonous, and often not empathetic.”^[1-8]

In this report we will use the term **‘segregation’** which encompasses, but is not restricted to, the concept of solitary confinement. The term segregation will be used to describe officially recognised separation under Rules 40 and 42 but also any practice which resembles these in that they involve the separation of individuals from the rest of the detained population and where the individual is subject to a limited regime.

Segregation has many names and takes on many forms. In most cases prisoners or detainees are held in specially designed units with basic facilities. However, the standard and regime of these facilities vary considerably between different IRCs. As a rule, segregation involves detainees being locked in these units for more than 23 hours a day being let out only briefly to exercise, to smoke or to shower. Interactions with others are kept to a minimum.

BACKGROUND

DETENTION CONTEXT IN THE UK

Every year more than 30,000 people in the UK are held in immigration detention under immigration powers. Those detained under these powers are not detained as part of any criminal sentence but are held for administrative convenience. Detention is optional. The decision to detain can be taken by a relatively junior caseworker at the Home Office and is not subject to automatic judicial oversight. At any given time between 3500 and 4500 individuals may be held in immigration detention facilities and prisons under immigration powers across the UK.

Home Office policy stipulates that the *“purpose of detention centres shall be to provide for the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression.”*^[8]

However, the intention implied in the wording of these policies is not reflected in the lived reality in IRCs. Most IRCs are either converted prisons or have been built to Category B prison standards. The prison-like environment and overly security conscious attitude of staff in the centres have been frequently criticised by HM Inspector of Prisons^[9] and others as inappropriate for a detainee population and failing to provide humane accommodation in a relaxed regime. Instead, detainees are locked in their cells overnight in

many IRCs and are subject to prison-like conditions including the inappropriate use of punitive incentive schemes and the high use of segregation.

Further, Home Office policy specifies that detention *“must be used sparingly, and for the shortest period necessary (...) there is a presumption in favour of temporary admission or release and, wherever possible, alternatives to detention are used.”*^[10]

Though the majority of detainees held under immigration powers are held for less than 29 days a significant number are held for much longer and some are detained for months and even years^[11]. In addition, the UK is the only European country not to have a limit on how long someone can be held in immigration detention^[12]. As a result detainees do not know how long they will be detained for and the indefinite and uncertain nature of detention can have a negative psychological impact on detainees. Statistics from the first Quarter of 2015 show that, of those detained, only 50% were removed from the UK whilst the rest were released back into the community bringing into question the decision to detain these individuals in the first place and whether alternatives to detention are used effectively. Home Office statistics indicate that 44% of detainees have claimed asylum^[11].

There are 10 Immigration removal centres in the UK, 2 Short Term Holding Facilities and 1 Pre-Departure Accommodation. The daily operation of 10 out of 13 of these facilities has been outsourced by the Home Office to private profit

making companies. SERCO and G4S are infamous outsourcing companies who are involved in the operation of immigration detention and private prisons across the world. Both companies have been involved in controversies around operating standards at their facilities. Over the last few years there have been 5 rulings by the UK High Court finding that conditions in IRCs operated by these companies constituted ‘inhuman and degrading treatment’ in breach of Article 3 of the European Human Rights Act. Mitie is a relative newcomer to the field and the only major domestic company involved in immigration detention.

In September 2014 the commissioning of healthcare in IRCs in England was transferred from the Home Office to NHS England. As part of a tender process, healthcare services in 4 out of 12 centres are now provided directly by NHS Trusts whilst the rest are provided by private companies.

IRC	Location	Centre Operator	Healthcare Provider	Total Capacity
Yarl's Wood	Bedford	SERCO	G4S Forensic and Medical Services (UK) Ltd	408 (314 Female, 38 Male STHF, 56 Family unit adult only)
Brook House	Gatwick	G4S	G4S Forensic and Medical Services (UK) Ltd	448 (Male)
Tinsley House	Gatwick	G4S	G4S Forensic and Medical Services (UK) Ltd	154 (120 Male, 34 Family unit incl. children))
Morton Hall	Lincolnshire	HM Prison Service	Nottinghamshire Healthcare NHS Foundation Trust	392 (Male)
Dover	Dover	HM Prison Service	Integrated Care24	401 (Male)
The Verne	Weymouth	HM Prison Service	Dorset Healthcare University Foundation Trust	580 (Male)
Colnbrook	Heathrow	Mitie	Central and North West London NHS Foundation Trust	408 (381 Male, 27 Female STHF)
Harmondsworth	Heathrow	Mitie	Central and North West London NHS Foundation Trust	661 (Male)
Campsfield House	Oxford	Mitie	The Practice PLC	276 (Male)
Dungavel	Near Glasgow	GEO Group UK Ltd	Med-Co Secure Healthcare Services Ltd	249 (235 Male, 14 Female STHF)
Pennine House STHF	Manchester	TASCOR	Tascor Medical Services	32 (Male)
Larne House STHF	Northern Ireland	TASCOR	Tascor Medical Services	19 (Male)
departure Accommodation	Gatwick	G4S / Barnardo's	G4S Forensic and Medical Services (UK) Ltd	44 (Families incl. children)

THE HISTORY OF SEGREGATION

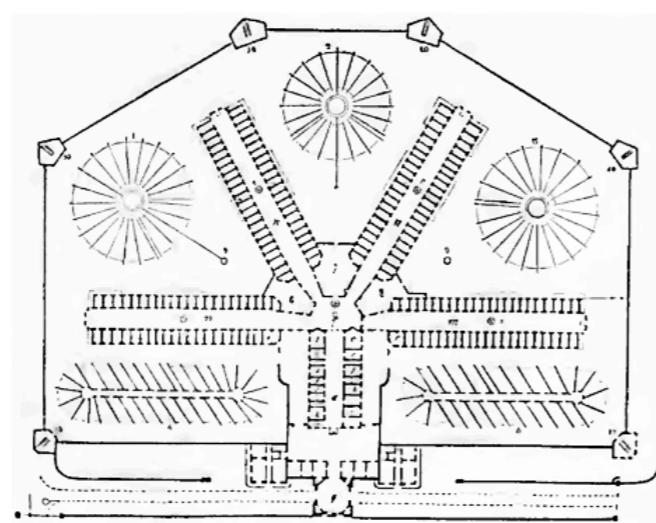
The routine use of solitary confinement was first systematically implemented in the Pennsylvania prison system in the 19th Century. One of the first prisons to experiment with social isolation was the Quaker-run Walnut Street Jail in Pennsylvania. Solitary confinement was introduced partly as a rejection of the violent corporeal punishments of the day such as flogging, placement in the pillory stocks, transportation to the colonies, or irregularly imposed hanging. The jail was run on a humanist idea that prisoners should be rehabilitated and not merely punished and the focus of punishment shifted from the criminal's body to their soul.

"Thrown into solitude he reflects. Placed alone, in view of his crime, he learns to hate it; and if his soul be not yet surfeited with crime, and thus have lost all taste for anything better, it is in solitude, where remorse will come to assail him." (Beaumont & Toqueville 1833)^[13: p.22]

This revolutionary idea gained in popularity and by 1829 the Eastern State Penitentiary was built. It was the first prison to be established according to the 'segregation principle' where all prisoners were kept in separate cells in the belief that a prisoner locked in total silence and isolation, with nothing to distract them but the Bible, would spend the time in quiet contemplation, prayer, introspection and paying 'penance' for their crimes. It was hoped that such 'penance' would lead to rehabilitation of the offender as *"the reflection that it gives rise to and the remorse that cannot fail to follow, solitude must be a positive instrument of reform"* ^[14: p.237] leading to offenders becoming better people and better citizens of the state.

The practice soon spread to other prisons in the US and gained popularity around the world, not least in Germany, France, Scandinavia and the UK.

In 1842 Pentonville prison in London was built according to the 'Pennsylvania model'. However, already by 1850 it had become apparent that 32 out of every 1000 prisoners in Pentonville suffered serious mental health breakdowns and had to be removed from their cell compared to only 5.8 out of every 1000 prisoner in prisons that did not rely on solitary confinement^[15]. Similar numbers were reported from other countries such as Germany^[16] and the US^[17] with reports of high rates of psychotic illness, hallucinations and dementia.



Plan of Pentonville Prison with rows of solitary cells (Source: Project Gutenberg)

The conditions in these solitary prisons were harsh and, after a visit to solitary confinement in Pennsylvania, Charles Dickens wrote the following assessment:

"I believe that very few men are capable of estimating the immense amount of torture and agony which this dreadful punishment (...) inflicts upon the sufferers; (...) and which no man has a right to inflict upon his fellow-creature. I hold this slow and daily tampering with the mysteries of the brain, to be immeasurably worse than any torture of the body."

–Charles Dickens^[18]–

SEPTEMBER 24, 1859.]



town on the high-road, still a long way from Paris.

[Illustration - Darnay in his cell at La Force prison after his second arrest in Paris. - A Tale of Two Cities by Charles Dickens, illustration by John McLenan]

A 1939 study on Problems in Prison Psychology by Wilson and Pescor concluded that the inmates in Pennsylvania model prisons 'went insane instead of being reformed'^[19]. The recognition of the devastating effect of solitary confinement on the mental health of prisoners played a major part in solitary confinement falling from favour and the discontinuation of the practice as a primary penitentiary principle. However, the idea of solitary confinement had taken hold in prison

operations and some form of segregation or other is utilised in most prison systems around the world.

The use of solitary confinement has continued for prisoners on remand in the Scandinavian countries where prisoners are routinely placed in solitary confinement pending their trial in order to protect the integrity of any on-going investigation^[20], a practice which has been frequently criticised by international human rights bodies^[21]. Perhaps the most extensive use of solitary confinement can once again be found in the US where there has been a resurgence in its use since the beginning of the 1980s. Rising crime rates and changes in sentencing policy led to a skyrocketing of the prison population with subsequent overcrowding and increasing rates of violence inside of prisons all contributed to the emergence and growth of so called 'supermax' prisons where prisoners are routinely kept in segregation for months and even years^[22]. With the increase in 'supermax' prisons came growing evidence of the negative impact of such incarceration on the mental and physical health of prisoners^[23]. There is today a growing condemnation of the use of solitary confinement in the US prison system^[24] and a growing movement to limit the use of such incarceration^[25, 26].



Cell Block D, Alcatraz. Creative Commons Licence: [paloma. elena](#)

THE HEALTH EFFECTS OF SEGREGATION

“There is unequivocal evidence that solitary confinement has a profound impact on health and wellbeing, particularly for those with pre-existing mental health disorders, and that it may also actively cause mental illness. The extent of psychological damage varies and will depend on individual factors (e.g. personal background and pre-existing health problems), environmental factors (e.g. physical conditions and provisions), regime (e.g. time out of cell, degree of human contact), the context of isolation (e.g. punishment, own protection, voluntary/ non voluntary, political/criminal) and its duration. Notwithstanding variations in individual tolerance and environmental and contextual factors, there is remarkable consistency in research findings on the health effects of solitary confinement throughout the decades” (Shalev 2008)^[27:10].

Health care in immigration removal centres

The Home Office’s Detention Operating Standards stipulate 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”^[28 p.34]*. However this is not the case for many detainees. Medical Justice has seen hundreds of cases where failing healthcare provision in IRCs causes harm to some of the most vulnerable detainees. Many detainees with complex health needs find it difficult to access healthcare and this is further exacerbated by short consultations, late-night screenings, poor use of interpreters, poor clinical assessments, and lack of adherence to clinical protocols^[29].

Research from across the world shows that migrants, due to pre and post migration stressors,

have high rates of mental disorders^[30, 31]. In addition, being held in immigration detention has been shown to be detrimental to the mental health of detainees and in particular for those with pre-existing mental health conditions^[32]. Despite this increased need, the provisions for mental health care in IRCs is less than that offered in the community^[12]. Home Office statistics indicate that as many as 43% of those held in IRCs have claimed asylum^[11]. This is significant as asylum seekers are more likely to have a history of trauma and other vulnerabilities which makes them more susceptible to the negative health impact of segregation.

Indefinite detention is harmful to the health of detainees and some are detained for years^[12]. In addition, Medical Justice research has demonstrated that detainees are harmed by improper use of segregation, instances of medical mistreatment, excessive use of restraints, injuries caused during removal, and inappropriate treatment of hunger strikers^[33-35]. The last few years has seen 5 High Court rulings of ‘inhuman and degrading’ treatment of detainees in breach of Article 3 of the European Human Rights Convention^[36-40] and two inquest verdicts of ‘neglect contributing to death’^[41, 42]. The cases seen by Medical Justice are, we strongly suspect, only the tip of the iceberg and reflect systemic failings that affect thousands of detainees each year.

Home Office Guidelines stipulate that those *“suffering from serious mental illness which cannot be satisfactorily managed within detention”^[10]* should only be considered suitable for detention in very exceptional circumstances. However, individuals with unmanaged mental health issues are still detained. Contrary to this policy Medical Justice frequently sees torture victims^[29], pregnant women^[43], very sick, disabled

or elderly people detained against policy. We also see cases where detention has exacerbated existing mental health conditions, sometimes to the point of requiring hospitalisation, and has even led to detainees developing new mental illness.

A HMIP inspection report from Harmondsworth IRC stated that the provision of healthcare within the detention centre gives *“cause for significant concern”^[44 p.6]*. The only HMIP themed report into healthcare at an IRC found that though *“basic healthcare provision was usually adequate for those detainees who stayed for only a short time(...) However, 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.”^[45 p.5]*

Since these inspections were carried out the commissioning of healthcare has transferred to NHS England. While the Home Office retains ultimate responsibility for all services provided in IRCs, the direct responsibility for, and oversight of, healthcare providers now falls to NHS England. We had hoped that the transfer of commissioning would lead to improved services, however, the most recent joint Care Quality Commission/HMIP inspection of Yarl’s Wood IRC revealed that of *“all the areas in the centre, health care had declined most severely. G4S Justice Health had provided health services since September 2014. There were severe staff shortages and women were overwhelmingly negative about access, quality of care and delayed medication. Local governance was poor. Care planning for women with complex needs was so poor it put them at risk. The available mental health care did not meet women’s needs and this made it particularly unacceptable that a number of women with enduring mental health needs had been detained. The small enhanced care unit was located in health care and was used to isolate women. It was effectively used as an inpatient unit although it was not commissioned, resourced or registered to be so.”^[46:7]*

It is clear that many of those held in immigration detention are extremely vulnerable and that many are not receiving the care they need. For reasons that will be discussed in detail later, many of those placed in segregation in IRCs are amongst the most vulnerable of vulnerable detainees. In addition to this vulnerability, segregation itself can lead to negative physical and mental health outcomes.

Health effects of segregation

The negative mental and physical health effects of segregation are well established. Research from the 19th century penitentiaries through psychological experiments in the 1960’s and 70’s to modern observations from segregation units and high security prisons are strikingly similar in their findings. Almost all report a negative impact on mental and physical health^[23].

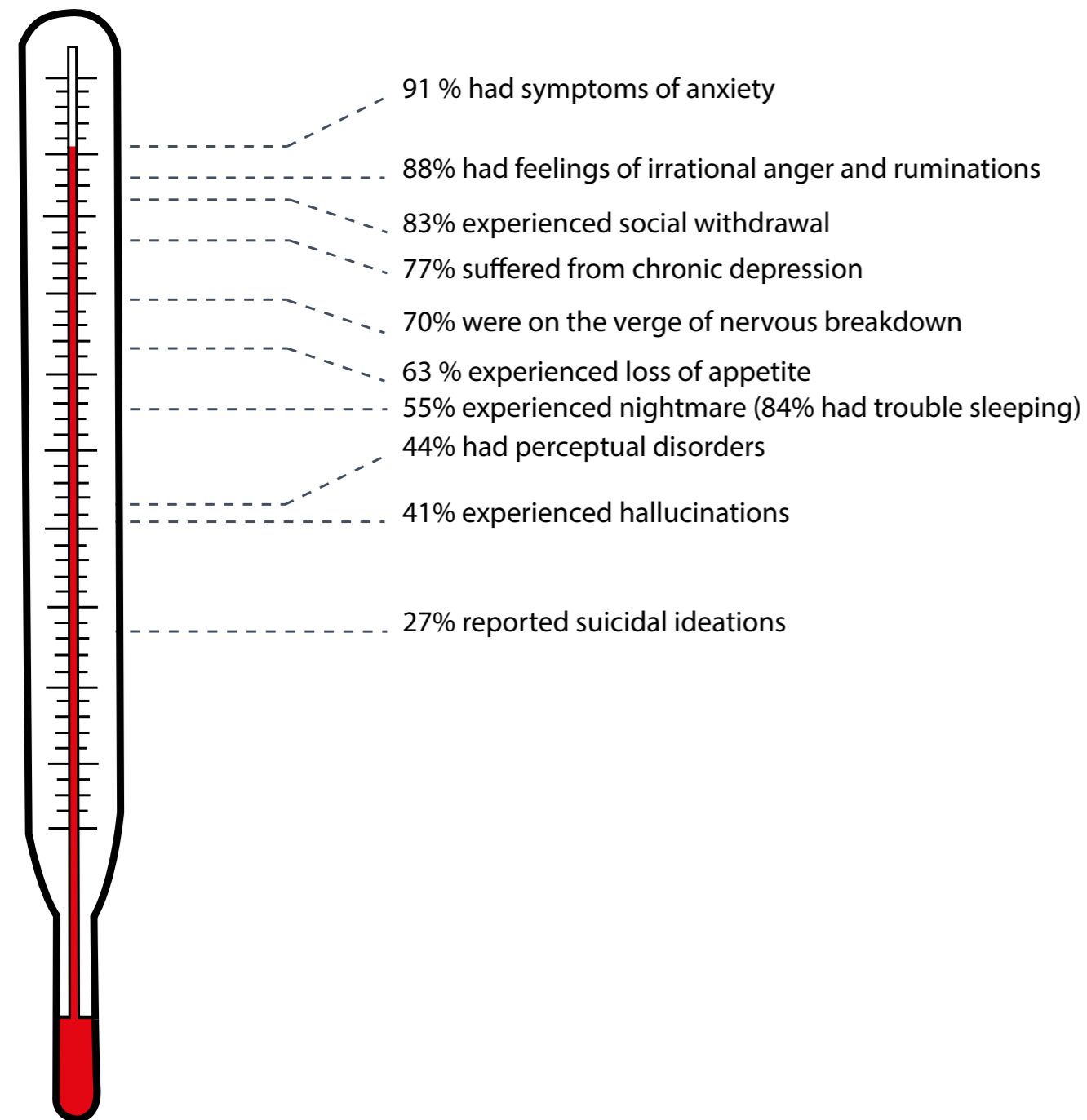
In 1977 a Council of Europe study of long-term isolation of prisoners identified a set of emotional, cognitive, social and psychological problems in prisoners that was so specific that they termed it *‘separation syndrome’^[27]*. In 1983 these effects were further elaborated on by Stuart Grassian who produced detailed clinical descriptions of the psychological effects of isolation based on in-depth psychiatric assessments of prisoners held in a solitary confinement block in a US prison. He identified perceptual changes, affective disturbances, difficulty with thinking, concentration and memory, disturbances of thought content, and problems with impulse control^[47] as the most pervasive effects..

A 1993 study of 100 randomly selected prisoners at the infamous Pelican Bay prison in the US, where prisoners are kept in strict segregation, found many of the same symptoms as those identified by Grassian a decade earlier^[48]. *“Specifically, a high percentage of prisoners in the present study reported suffering from heightened anxiety (91%), hyper-responsivity to external stimuli (86%), difficulty with concentration and memory (84%), confused thought processes (84%), wide mood and emotional swings (71%), aggressive fantasies (61%), perceptual distortions (44%),*

and hallucinations (41%). Moreover, fully 34% of the sample experienced all eight of these symptoms, and more than half (56%) experienced at least five of them."^[49:137]

The most common physical and mental effects of solitary confinement and segregation

reported in the academic literature range from mild disturbances to more severe forms of psychopathology. Summary of the most common health consequences are outlined in the table on the following page.



Thermometer showing Haney's findings of psychological effect of solitary confinement

HEALTH CONSEQUENCES OF SOLITARY CONFINEMENT

– summary of research findings and medical literature on the health effects of solitary confinement

The below table is reproduced from Shalev (2008:15-16) with authors permission

PHYSIOLOGICAL EFFECTS

- Heart palpitations (awareness of strong and/or rapid heartbeat while at rest)
- Diaphoresis (sudden excessive sweating)
- Insomnia
- Back and other joint pains
- Deterioration of eyesight
- Poor appetite, weight loss and sometimes diarrhoea
- Lethargy, weakness
- Tremulousness (shaking)
- Feeling cold
- Aggravation of pre-existing medical problems.

PSYCHOLOGICAL EFFECTS

Anxiety, ranging from feelings of tension to full blown panic attacks

- Persistent low level of stress
- Irritability or anxiousness
- Fear of impending death
- Panic attacks

Depression, varying from low mood to clinical depression

- Emotional flatness/blunting – loss of ability to have any 'feelings'
- Emotional lability (mood swings)
- Hopelessness
- Social withdrawal; loss of initiation of activity or ideas; apathy; lethargy
- Major depression

Anger, ranging from irritability to full blown rage

- Irritability and hostility,
- Poor impulse control
- Outbursts of physical and verbal violence against others, self and objects
- Unprovoked anger, sometimes manifesting as rage

Cognitive disturbances, ranging from lack of concentration to confusional states

- Short attention span
- Poor concentration
- Poor memory
- Confused thought processes; disorientation.

Perceptual distortions, ranging from hypersensitivity to hallucinations

- Hypersensitivity to noises and smells
- Distortions of sensation (e.g. walls closing in)
- Disorientation in time and space
- Depersonalisation/derealisation
- Hallucinations affecting all five senses, visual, auditory, tactile, olfactory and gustatory (e.g. hallucinations of objects or people appearing in the cell, or hearing voices when no-one is actually speaking).

Paranoia and Psychosis, ranging from obsessional thoughts to full blown psychosis

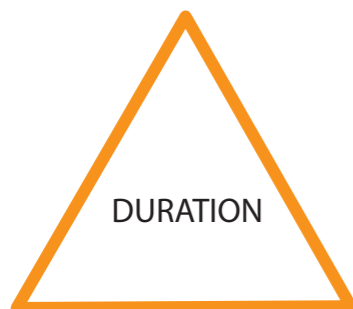
- Recurrent and persistent thoughts (ruminations) often of a violent and vengeful character (e.g. directed against prison staff)
- Paranoid ideas – often persecutory
- Psychotic episodes or states: psychotic depression, schizophrenia.

How does segregation affect health?

“Because most immigration detainees have committed no crimes and are not dangerous to society, they often cannot understand why they are being held in facilities that are identical to jails. While this deprivation of liberty alone is enough to inflict psychological damage, the further deprivation of liberty inherent in segregation and solitary confinement might be reasonably expected to compound the psychological stress of detention.”(Physicians for Human Rights 2012)
[50:13]

In her seminal work, *A Sourcebook on Solitary Confinement*^[27], Sharon Shalev discusses four main factors that contribute to the negative effects of solitary confinement on the individual:

↓ ACTIVITY / STIMULATION



SOCIAL ISOLATION LACK OF CONTROL

Social isolation: Placing someone in segregation removes the detainee from meaningful and sympathetic contact. *“Social contact is crucial for forming perceptions, concepts, interpreting reality and providing support”*^[27:18] Paradoxically, enforced social isolation may lead to further social withdrawal after release from segregation. It may also lead to a reduced ability to participate meaningfully in their on-going legal and immigration case as well as to integrate into society in the UK or in their country of origin after release. Many of the cases referred to in this report are still not well enough to live and work independently despite gaining their refugee status in the UK.

Reduced activity and stimulation: The experience of segregation seems designed to enhance monotony and to reduce sensory stimulation. The segregation regime in most IRCs is basic or very poor, with meaningful activity reduced to an absolute minimum. Detainees are often locked in their cells for 23 hours a day with little social interaction with anyone but staff in the unit. In some IRCs detainees mobile phones are taken off them further reducing their access to contact and support.

Lack of control: In segregation every aspect of a detainee’s life is controlled by the staff on the unit who control access to even the most basic of needs, such as showering, exercise, food and social contact. As one detainee put it *“They put the meanest officers in the segregation unit (...) You can call the officers but they will ignore you. If you are hungry, don’t bother asking. They will give you food when they feel like it. Make us beg for water”* (detainee at Harmondsworth).

“[C]ontrary to the aims of enforcing calm and control on a prisoner, solitary confinement can produce further irritability and even violent outbursts”^[27:20]. Violence which may be directed at staff or the detainee themselves through acts of self-harm. In situations where a detainee does become more docile this may be a pathological reaction to the loss of control experienced as a loss of the capacity to exercise personal autonomy. Again this may make the detainee less able to adjust to outside society either in the UK or in their country of origin upon release/removal^[27].

and duration of confinement: Most studies have found that the longer the segregation the more severe the negative effects. However, the effects may set in almost immediately in some individuals. The UN Special Rapporteur on Torture and Other Cruel, Inhuman and Degrading Treatment or Punishment, Juan Mendez, has called for a ban on solitary confinement in excess of 15 days as research has found this is the point at which the sequelae of isolation is more likely to become permanent with some being unable to regain the necessary social skills to lead a ‘normal’ life and resume a social interactions^[1]. Research has also

found that prior knowledge of the duration of segregation may be vital to a detainee’s ability to endure the isolation. Indefinite segregation and lack of understanding of the reasons behind the segregation *“promotes a sense of helplessness. Finite sentences imposed for acknowledged acts seem less prone to inspire panic”*^[51:250 quoted in Shalev (2008)]

The effects of segregation on the individual are dependent on the detainee, their background, the context of segregation, the duration of

segregation and the conditions of confinement. Though some may experience the negative effects of segregation almost immediately, especially if the segregation does not have a set time limit, the research finds that the longer someone is segregated the more profound the impact and the more likely that the negative effects will be permanent.

INTERNATIONAL COMPARISON OF THE USE OF SEGREGATION IN IMMIGRATION DETENTION

“While the mental health effects of solitary confinement among the criminally convicted have been studied, much less information exists regarding the psychological effects of segregation and solitary confinement on individuals in immigration detention. Many non-citizens in detention survived persecution and torture in their countries of origin. Others have survived human trafficking, domestic violence, sexual assault, and other crimes(...). They are alone and terrified, unsure if they will be deported, and they frequently suffer from severe anxiety, depression, and Post-Traumatic Stress Disorder (PTSD). Without treatment, many detainees experience deteriorating psychological states during their weeks, months, or years in detention.”(Physicians for Human Rights 2012)^[50:13]

There is very little research on the use of segregation in immigration detention nationally or internationally. What little research we have been able to find comes from the US, Canada and the Netherlands.

Research from North America:

Research from Canada found that segregation is being used as a means of controlling detainees, e.g. *“if a detainee fights or argues with a guard, goes on a hunger strike, attempts selfharm, or engages in other “disruptive” behaviour, he can be segregated”*^[52:37]. Studies in the US have found that the *“use of disciplinary ‘segregation’ is widely abused. Segregation is often used disproportionately in response to minor offenses.”*^[53] Several groups have documented the use of segregation in response to detainees asking for mental health services, for minor disciplinary infractions, for arguments with other detainees, or for questioning their rights or immigration status. Research by Physicians for Human Rights^[50] in the US have found that solitary confinement in immigration detention is often used as a control mechanisms to stop what was seen as undesirable behaviour— one detainee was placed in solitary confinement after helping other detainees to file complaints about detention. They also found that detainees

were placed in segregation when mentally ill and that people who identify as gay, lesbian bisexual or transgender (LGBT) were assigned to solitary confinement^[2, 54] because staff were “unwilling to deal with the their unique circumstances and /or because staff thinks of solitary confinement as a ‘protective’ status for vulnerable populations”^[50:9]. Despite an acknowledgement that the use of solitary confinement as a protective measure constitutes punitive measures it is still being used in immigration detention across the US as a means of ‘protective custody’ for LGBT detainees^[54]. The American Civil Liberties Union of Arizona even documented cases where LGBT detainees were placed in solitary confinement in response to being sexually assaulted by fellow detainees.^[55]

According to official statistics from Immigration and Customs Enforcement only about 1% of immigration detainees in the US are placed in segregation, this translates to over 300 detainees daily^[2]. This statistic does not tally with previous research carried out by Dr Allen Keller who “interviewed about 70 immigration detainees a decade or so ago, roughly a quarter said they had been put in solitary at some point and about 40 percent said they had been threatened with it.”^[2] Whatever the correct statistic, the fact remains that “this practice is nonetheless startling because those detainees are being held on civil, not criminal, charges. As such, they are not supposed to be punished; they are simply detained to ensure they appear for administrative hearings.”^[2] In addition, due to poor decision making to justify detention, many of those segregated are detainees who should not have been detained in the first place and more needs to be done to call attention to the punitive practices applied to a population that is supposed to be detained administratively.^[56]

A study carried out by the American Civil Liberties Union (ACLU) found that increasing criminalisation of immigration has led to a situation where half the federal prosecutions were for illegally crossing the border into the US. Non-citizen prisoners are put into special low custody facilities operated by private profit making companies. ACLU found that these companies were contracted to keep the facilities full at all times and that contracts specified that all facilities must be built with 10%

of cells as dedicated segregation cells. In addition, the contractors are paid an ‘incremental unit price’ for additional prisoners above the 90% quota up to 115% capacity. So, in fact, the company is paid extra for holding more prisoners than the facility was built for and 10% of these will ‘necessarily’ be held in segregation as a result of the prison design and the contract. Further, medical understaffing and extreme cost cutting increases risks to all prisoners but in particular those held in segregation.^[57]

Research from the Netherlands:

Research carried out by the National Ombudsman found that though there should be no element of punishment in immigration detention, immigration detainees were nonetheless subject to the same security measures and disciplinary punishments (including segregation) as prisoners. “In several respects there was not even adherence to the principle that detention conditions under administrative law should not be worse than those under criminal law. Points of concern include (...) the repeated placing of people in segregation (...) The Ombudsman takes the view that the current embodiment of immigration detention imposes restrictions for which there is no clear need based on the purpose of the detention”^[58:34]

A 2015 study by Amnesty and other NGOs found that despite governments commitment to reducing the use of segregation in immigration detention the numbers have remained fairly stable, with 1.2 to 1.3 % of the detainee population placed in segregation annually. Though this is a rather small percentage it translated to hundreds of detainees annually who may suffer the negative health impact of segregation. Common complaints amongst detainees in segregation was the use of force while being placed in segregation, being threatened with segregation by staff, poor access to reading material like books and magazines and the cells being cold. Detainees were placed in segregation as a disciplinary measure, to prevent suicide, for hunger strikes, and to manage mental health problems.^[3]

LEGAL FRAMEWORK

Segregation is one of the most restrictive and harsh measures that may be utilised against someone in a secure setting. As a result there are a number of international legal frameworks which seek to ensure that a decision to segregate an individual is taken in accordance with legal guidelines.

In general, these frameworks set broad guidelines for segregation stipulating that the decision to segregate:

- must not be taken lightly
- must not be arbitrary
- must be for the shortest possible time
- must be taken by a competent body
- must be in accordance with the law and due process
- must be justified in writing
- must be substantially and regularly reviewed by independent body
- must be appealable by detainee
- must be subject to judicial oversight

International legal framework

The use of solitary confinement has been regulated through several international human rights directives.

Firstly, though not directly addressed in the **Declaration of Human Rights**^[59] from 1948 it did provide a basis for subsequent laws. Prisoner protection was further formulated in the Geneva Conventions^[60] of 1949 which, though explicitly directed at the treatment of prisoners of war, it was argued that no State should treat its prisoners of war better than its civilian population and therefore served to set out the basic definitions and principles for future international prison standards.

In 1966 the **UN Convention on Civil and Political Rights (ICCPR)**^[61] included

ARTICLE 7 “No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment”

Where the term cruel, inhuman and degrading treatment or punishment “should be interpreted so as to extend the widest possible protection against abuses, whether physical or mental, including the holding of a detained or imprisoned person in conditions which deprive him, temporarily or permanently, of the use of any of his natural senses, such as sight or hearing, or of his awareness of place and the passing of time”^[62]

ARTICLE 10 “All persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person... the penitentiary system shall comprise treatment of prisoners the essential aim of which shall be their reformation and social rehabilitation”

Together these two articles set out a general protection for persons held in any form of detention or imprisonment from any form of ill-treatment: where

“Article 10, paragraph 1, imposes on States parties a positive obligation towards persons who are particularly vulnerable because of their status as persons deprived of liberty, and complements for them the ban on torture or other cruel, inhuman or degrading treatment or punishment contained in article 7 of the Covenant. Thus, not only may persons deprived of their liberty not be subjected to treatment that is contrary to article 7,(...) but neither may they be subjected to any hardship

or constraint other than that resulting from the deprivation of liberty; respect for the dignity of such persons must be guaranteed under the same conditions as for that of free persons. Persons deprived of their liberty enjoy all the rights set forth in the Covenant, subject to the restrictions that are unavoidable in a closed environment. (...) Treating all persons deprived of their liberty with humanity and with respect for their dignity is a fundamental and universally applicable rule. Consequently, the application of this rule, as a minimum, cannot be dependent on the material resources available in the State party. This rule must be applied without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status.”^[63]

The UN Standard Minimum Rules (SMR) for the Treatment of Prisoners was first established in 1955 and set out good practice in the treatment of prisoners. The rules specify that prisons should be used *as* punishment and not *for* punishment and stipulated that “[d]iscipline and order shall be maintained with firmness, but with no more restriction than is necessary for safe custody and well-ordered community life”^[64:6]

A subsequent revision of the rules in 1977, introduced the prohibition on the use of close confinement and placement in dark cells specifically and states that “[p]unishment by close confinement ...shall never be inflicted unless the medical officer has examined the prisoner and certified in writing that he is fit to sustain it”^[64:5].

The SMR is currently undergoing another revision which will introduce a number of changes. Amongst these is a provision that relates to the use of solitary confinement and which has been dubbed the Mandela Rules. This revision sets out the provision that solitary confinement “shall be used only in exceptional cases as a last resort for as short a time as possible and subject to independent review”. The rules also prohibit indefinite solitary confinement and prolonged solitary confinement — defined as more than 15 consecutive days — as well as the solitary confinement of people with mental or physical disabilities where isolation would exacerbate their conditions.”^[65]

In 1990, the so-called **UN Basic Principles for the Treatment of Prisoners** were more direct, stating that ‘Efforts addressed to the abolition of solitary confinement as a punishment, or to the restriction of its use, should be undertaken and encouraged’ (principle 7)^[66].

The **UN Committee Against Torture (CAT)** has criticized isolation practices in different parts of the world^[67] and has, for example, recommended that “the use of solitary confinement be abolished, particularly during pre-trial detention, or at least that it should be strictly and specifically regulated by law (maximum duration, etc.) and that judicial supervision should be introduced”^[68]

European Convention on Human Rights (ECHR) does not address the use of solitary confinement directly but echoes the Human Rights Conventions Article 7 in its own Article 3 which enshrines the prohibition of torture and inhuman and degrading treatment as an absolute right.

European Prison Rules of 2006: States that “[s]olitary confinement shall be imposed as a punishment only in exceptional cases and for a specified period of time, which shall be as short as possible.”^[69]

European Committee for the Prevention of Torture (CPT) has stated that solitary confinement can amount to inhuman and degrading treatment and thereby violate Article 3 of the European Human Rights Convention. The CPT has also, like the CAT, criticized isolation practices in several countries and recommended reforms that either abolish or limit the use of solitary confinement except in exceptional circumstances.

Most of the international human rights frameworks direct themselves mainly at prisons and the treatment of prisoners. However, CPT has specified that the European Prison Rules, with its limitations on solitary confinement, should apply equally to immigration detainees. The CPT further argues, in relation to immigration detainees, that the “purpose of deprivation of liberty of irregular migrants is thus significantly different from that of persons held in prison either on remand or as convicted offenders [And] Conditions of detention for irregular migrants

should reflect the nature of their deprivation of liberty, with limited restrictions in place and a varied regime of activities. For example, detained irregular migrants should have every opportunity to remain in meaningful contact with the outside world (including frequent opportunities to make telephone calls and receive visits) and should be restricted in their freedom of movement within the detention facility as little as possible.”^[70:70-1] Clearly the use of solitary confinement should be even more strictly controlled and restricted than when applied to prisoners in order to reflect the nature of their deprivation of liberty – i.e. that immigration detainees are held for administrative convenience and not as part of a criminal sentence.

The Istanbul Statement on the Use and Effects of Solitary Confinement: is an attempt at drawing together international human rights standards and academic research in order to formulate more in-depth guidelines for the use of solitary confinement. The statement was adopted on 9th of December 2007 at the International Psychological Trauma Symposium in Istanbul and is signed by a number of prominent international experts in the field of solitary confinement, prisons and torture representing numerous national and international institutions.

The Istanbul Statement recommends that solitary confinement should be absolutely prohibited in the following circumstances: For death row and life-sentenced prisoners by virtue of their sentence; for mentally ill prisoners; for children under the age of 18; for the purpose of applying psychological pressure on prisoners. In addition, the statement recommends that solitary confinement should only be used in very exceptional cases, for as short a time as possible and only as a last resort. The statement argues that in situations where solitary confinement is used efforts must be taken to raise the level of meaningful social contact, either by raising level of staff contact, allowing participation in social activities with other prisoners, increasing number of visits with volunteers, religious personnel or in depth conversations with mental health professionals as well as creating opportunities for maintaining and developing relations with the outside world and especially family and friends. ^[71]

Segregation as torture

International human rights standards provide a basic framework for the use of solitary confinement which, if adhered to, can help states avoid the worst kinds of abuses in this area. However, it only provides a basic framework and further limitations and safeguards must be set down in national law to ensure that it does not maintain practices that have been shown to be damaging to the health of those subjected to them.

In 1992 the UN Human Rights Committee concluded that “prolonged solitary confinement of the detained or imprisoned person may amount to acts prohibited by article 7 [- ‘No one shall be subjected to torture or cruel, inhuman or degrading treatment or punishment’]”^[72]

This analysis has been taken up by two separate UN Special Rapporteurs on Torture. In 2008 the then Special Rapporteur, Manfred Nowak, “expressed concern at the use of solitary confinement (...). In the opinion of the Special Rapporteur the prolonged isolation of detainees may amount to cruel, inhuman or degrading treatment or punishment and, in certain instances, may amount to torture.”^[73:18] And he stressed that “the use of solitary confinement should be kept to a minimum, used in very exceptional cases, for as short a time as possible, and only as a last resort.”^[73:21]

The current Special Rapporteur on Torture, Juan Mendez, also concludes that segregation may amount to torture in certain circumstances but goes even further in his condemnation. He argues that prolonged segregation of prisoners can never be justified as a form of punishment or disciplinary measure as “it imposes severe mental pain and suffering beyond any reasonable retribution for criminal behaviour” ^[1:20]. It follows that the use of segregation for immigration detainees who are not held as part of criminal sentence must be further protected from unreasonable retribution. He does not go as far as to call for an outright ban on the use of solitary confinement but lists a number of recommendations and limits which should be put in place:

- “A prisoner or detainee should **never be kept in solitary confinement for longer than 15 days**, the limit between “solitary confinement” and “prolonged solitary confinement,” at which point some of the harmful psychological effects of solitary confinement can become irreversible.
- If solitary confinement is to be used, it must be **only in exceptional circumstances**; its duration must be **as short as possible**, and **for a definite term** that is communicated to the detainee.
- Solitary confinement should only be imposed **as a last resort**, where less restrictive measures could not be employed for disciplinary purposes.
- While it may be necessary to segregate detainees with mental disabilities from the general population, solitary confinement should **never be used on the mentally ill**.
- Qualified medical and mental health personnel who are independent from and accountable to an outside authority must regularly **review the medical and mental health condition** of detainees in solitary confinement, both **at the initiation of solitary confinement and on a daily basis thereafter**.^[50:25, emphasis added]

UK legal framework

The legal framework for the use of segregation in the UK is set down in the Detention Centre Rules (2001)^[8] under Rule 40, Removal From Association, and Rule 42, Temporary Confinement. Some further provisions are set out in the Home Office Operating Standards Manual for Immigration Removal Centres^[28] and in the Detention Centre Rules Guidance^[74]. Lastly, HMIP Inspection Expectations^[75] describes the standards against which establishments are inspected and assessed. The information in these sources is summarised in the table on the following page and more detail is given in Appendix 1. However, the guidance in these documents only serves to set out the most basic of frameworks. No further guidance or service orders on the use of segregation in immigration removal centres is publically available.

DETENTION CENTRE RULES 2001

“Removal from association

40.—

1. Where it appears necessary in the interests of security or safety that a detained person should not associate with other detained persons, either generally or for particular purposes, the Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may arrange for the detained person’s removal from association accordingly.
2. In cases of urgency, the manager of a contracted-out detention centre may assume the responsibility of the Secretary of State under paragraph (1) but shall notify the Secretary of State as soon as possible after making the necessary arrangements.
3. A detained person shall not be removed under this rule for a period of more than 24 hours without the authority of the Secretary of State.
4. An authority under paragraph (3) shall be for a period not exceeding 14 days.
5. Notice of removal from association under this rule shall be given without delay to a member of the visiting committee, the medical practitioner and the manager of religious affairs.
6. Where a detained person has been removed from association he shall be given written reasons for such removal within 2 hours of that removal.
7. The manager may arrange at his discretion for such a detained person as aforesaid to resume association with other detained persons, and shall do so if in any case the medical practitioner so advises on medical grounds.
8. Particulars of every case of removal from association shall be recorded by the manager in a manner to be directed by the Secretary of State.
9. The manager, the medical practitioner and (at a contracted-out detention centre) an officer of the Secretary of State shall visit all detained persons who have been removed from association at least once each day for so long as they remain so removed.

Temporary confinement

42.—

1. The Secretary of State (in the case of a contracted-out detention centre) or the manager (in the case of a directly managed detention centre) may order a refractory or violent detained person to be confined temporarily in special accommodation, but a detained person shall not be so confined as a punishment, or after he has ceased to be refractory or violent.
2. In cases of urgency, the manager of a contracted-out detention centre may assume the responsibility of the Secretary of State under paragraph (1) above but shall notify the Secretary of State as soon as possible after giving the relevant order.
3. A detained person shall not be confined in special accommodation for longer than 24 hours without a direction in writing given by an officer of the Secretary of State (not being an officer of a detention centre).
4. The direction shall state the grounds for the confinement and the time during which it may continue (not exceeding 3 days).
5. A copy of the direction shall be given to the detained person before the 27th hour of the confinement.
6. Notice of the direction shall be given without delay to a member of the visiting committee, the medical practitioner and the manager of religious affairs.
7. Particulars of every case of temporary confinement shall be recorded by the manager in a manner to be directed by the Secretary of State.
8. The manager, the medical practitioner and (at a contracted-out detention centre) an officer of the Secretary of State shall visit all detained persons in temporary confinement at least once each day for as long as they remain so confined.”(Detention Centre Rule 2001:12-13)

HM INSPECTOR OF PRISONS INSPECTION EXPECTATIONS:

Sets out the inspection criteria on which IRCs are assessed

“18. Detainees are held safely and decently in the separation unit for the shortest possible period and for legitimate reasons only.

- Detainees are separated with the proper authorisation and for reasons of security or safety only, not for punishment or in relation to the management of self-harm or mental illness.
- Detainees are given the reasons for single separation, in writing and in a language they understand, within two hours.
- Further authorisation follows established procedures and is effectively monitored and independently reviewed.
- Those in single separation are allowed access to religious ministers, books, education staff, phones, exercise, social and legal visitors and a daily shower.
- Detainees kept separated are monitored daily for their physical, emotional and mental wellbeing. Staff keep accurate records of the behaviour of detainees to ensure continuity of care.”

Detention Services Operating Standards manual for Immigration Service Removal Centres

Specify that

“The use of removal from association must achieve the correct balance between the need to maintain safety and security and the need to show due regard for the dignity of the individual. Procedures must comply with the requirement of Rule 40.”

“Temporary confinement of refractory or violent detainees must achieve the correct balance between the requirement to maintain order and discipline whilst having due regard for the individual and in particular the need to prevent self-harm.”

Detention Services Order 2/2002 - Guidance on the Detention Centre Rules 2001

Rule 40: Removal from Association

- “Any decision to remove a detainee from associating with other detainees (or to temporary confinement) **is not one which should be taken lightly** and must be taken on the basis that it appears necessary in the interests of security or safety that the detainee should not associate with other detainees, either generally or for specific purposes. (...)”
- “It is important that where a decision to remove a detainee from association has been taken that that decision should be **reviewed at regular intervals**.
- “Removal can be authorised for periods up to 14 days but **should be for the shortest time possible** and may be subject to review by the contract monitor (in a contracted-out centre) or the removal centre manager (in a directly managed centre). It is therefore very important to record details on form **RCF 1** of the time at which removal from association began and ended if we are to be in a position to show that periods of detention were lawful.”
- “Provision for the recording of information relating to visits is contained in form **RCF 1**. These visits are an absolute requirement if the wellbeing of a detainee is to be properly safeguarded and an assessment as to whether the original reasons for removing the detainee still apply.”

Rule 42: Temporary confinement

- “Temporary confinement may be authorised for periods up to three (3) days. If the detainee’s behaviour ceases to give rise for concern a decision must be taken to cease the period of temporary confinement. The reason for this must be recorded on form **RCF 3**.”
- “No person should be kept in temporary confinement for any longer than necessary nor should the period go beyond 24 hours without a direction by the head of the detention operations or Immigration Service senior on-call officer (in the case of contracted-out centres) or from the Prison Service area manager (in the case of a directly managed centre).”
- “Details of all such visits must be recorded in form **RCF 3** together with any other relevant information. Again it is vital that start and end times are recorded so that it can be demonstrated that the periods in temporary confinement were lawful.”

For full details of Detention Services Operating Standards manual for Immigration Service Removal Centres and Detention Services Order 2/2002 - Guidance on the Detention Centre Rules 2001 please see Appendix 1.

COMPARISON TO PRISON FRAMEWORK

The use of segregation in UK prisons is subject to detailed guidance through Prison Service Order 1700^[76]. The service order came into effect in 2006 following a growing recognition of problems with the segregation processes and very high death rates amongst segregated prisoners. The Prison and Probation Ombudsman (PPO) recognised that “[t]hose prisoners who are the most ‘difficult’ are often the most vulnerable”^[76:4] and as a result any service order would need to ensure that these vulnerabilities were addressed and balanced up against control and security concerns of prison staff. The importance of treating prisoners as individuals and taking into account their personal circumstances when making decisions was also recognised, especially following on from the judgment of the European Court of Human Rights in Keenan v. the United Kingdom, which found that his rights under Article 3, torture and inhuman treatment, of the EHRC had been breached by the conditions in segregation. *The judgement found that the “lack of effective monitoring of Mark Keenan’s condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk. The belated imposition on him of a serious disciplinary punishment [segregation] (...) is not compatible with the standard of treatment required in respect of a mentally ill person. It must be regarded as constituting inhuman and degrading treatment and punishment within the meaning of Article 3 of the Convention.”*^[77:§116]

The PSO 1700 guidelines stipulate that segregation should only be used as a last resort and that prisoners at risk of self-harm and suicide should only be placed in segregation when no other suitable location can be found and all other options have been tried and found unsuitable. In addition, it is expected that segregation unit staff focus on helping prisoners manage their behaviour and

problems rather than simply focus on segregation as punishment. For this purpose the service order recommends that a designated officer be assigned to each prisoner and that this officer should try to engage the prisoner in purposeful dialogue which should be recorded in the daily history sheet which sets out details of staff efforts and the mood/demeanour of the prisoner at least three times a day. In order to aid in this PSO 1700 stipulates that staff working in segregation units should have been trained in: basic control & restraint (including de-escalation and interpersonal-communication skills), race awareness/diversity, mental health awareness, and suicide prevention as a minimum.

Prisoners are usually segregated for the Good Order and Discipline (GoOD) of a prison, for their own protection, to prevent prisoners associating with other particular prisoners (e.g. in cases of bullying) or whilst they are awaiting adjudication.

Prisoners can initially be placed in segregation for a preliminary period, not exceeding 72 hours, on the authority of the Prison Governor. All segregated prisoners must be seen by a registered nurse or doctor within 2 hours of being segregated for an Initial Health Screening which aims to determine if there are any apparent clinical reasons to advise against the use of Special Accommodation.

After 72 hours, continued segregation must be authorised by the Secretary of State. In the past this has been taken to mean the Prison Governor but this has recently been ruled unlawful in a landmark case^[78] so procedures will need to change. The continued segregation of a prisoner should be reviewed by a Segregation Review Board which comprises of a chair (usually the prison Governor), healthcare staff and/or mental health in-reach team, segregation officer, chaplain, psychologist and the prisoner themselves. The board should meet within the first 72 hours of segregation to

review the initial decision to segregate. Following this the board should meet every 14 days to assess the prisoner's behaviour since being segregated, assess the appropriateness of ongoing segregation, and any concerns that may have come to light about how the prisoner is coping with segregation (e.g. mental health / self-harm concerns). Similarly to IRCs, daily visits are required by a number of staff and officials including a competent manager, member of IMB, healthcare staff, Chaplain, self-harm and suicide prevention officer if the prisoner is on an open management plan.

“Challenging prisoners, particularly those suffering from mental health issues, may also have significant vulnerabilities which may be worsened by segregation. Staff may naturally be focused on the challenging behaviour rather than the vulnerabilities, so to help counter any threat to a prisoner's wellbeing, PSO 1700, Segregation, specifies that an Initial Segregation Health Screen must be conducted within the first two hours of a prisoner being placed in segregation. The primary purpose of this screen is to assess a prisoner's ability to cope with the effects of being segregated. If the decision is made to segregate a prisoner, regular Segregation Review Boards should then take place throughout the period that the prisoner continues to be segregated. These should be multi-disciplinary, attended by both prison and healthcare staff. (...) It is important that decisions are not based simply on a prisoner's current demeanour and their assurance that they are coping. An outwardly positive persona can mask underlying problems and does not always represent a true picture of an individual's mental health state and coping abilities. (...) A decision of whether to approve a prisoner as fit for segregation should take into consideration any current suicide and self-harm risks which have been identified, but also their full mental health history, and any other factors that might make segregation particularly difficult for them.” (Prison and Probation Ombudsman 2015)^[79:3-4]

Difference between prison and IRCs

Prisoners are frequently segregated for breach of

prison rules. These rules are widely publicised and the consequences of breaking the rules are clearly set out. As those held in immigration detention are held for administrative convenience they should not normally be subject to punitive measures. In addition, the rules of the detention centre are not always clearly set out. In some centres detainees are made to sign a concordat when entering the centre though this is frequently only available in English and the significance of this document is not always clear to detainees. In addition, there is no clear guidance on the consequences of breaching these rules. Thus, detainees often end up in segregation without necessarily understanding why they are segregated. A detainee will be handed a written justification for their segregation within hours of being segregated but this is usually only given in English and has repeatedly been criticised by HMIP for being insufficient, incomplete and unsatisfactory. As there are no guidelines on the length and nature of segregation available to detainees the segregation itself is experienced as indefinite as there is no defined timescale for particular indiscretions.

PSO 1700 set out a strict procedure for the segregation of a prisoner and the expected follow up of that prisoner. In IRCs, there is no comparable detailed guidance (at least not available for public review). As we have seen in previous chapters there is guidance on what authority is required and at which juncture. However, the wording of the Detention Centre Rules is modelled on the Prison Centre Rules so the lawfulness of current arrangements depends on to what extent the ruling in *Bourgass v SSJ* applies to the mechanisms in the detention setting. There is no equivalent to PSO 1700 in effect in IRCs and no publically available DSO governing the use of segregation or the framework for appropriate follow up.

As discussed above, PSO 1700 sets out a requirement for all prisoners under segregation to be reviewed by a registered nurse or doctor within 2 hours of the decision to segregate to ensure that there are no clinical contraindications to segregations. No such safeguards are in place in immigration detention where a detainee may be segregated for lengthy periods of time without necessarily receiving a thorough health screen.

Daily visits by healthcare staff are carried out in segregation but these have been criticised for being cursory at best. This is particularly worrying in light of the known weaknesses in the decisions to detain and the failure of major safeguards such as Rule 35 which mean that vulnerable detainees are frequently detained inappropriately and may not be picked up by the safeguards. Without an initial health screening by a registered nurse or doctor there is a great risk that these vulnerable detainees may end up in segregation which is a totally inappropriate environment.

PSO 1700 sets out a detailed review plan for continued segregation by the Segregation Review Board, a multidisciplinary panel of senior prison officials and health professionals, tasked with reviewing the appropriateness of continued segregation and the impact of segregation on a prisoner's health. No such equivalent exists in most IRCs. Ideally, there would be additional independent oversight of the process by a body external to the prison and detention removal centre. In addition, prisoners attend the review

board which gives them an, if somewhat limited, opportunity to address their segregation and the reasons behind this. For prisoners in adjudication there are provisions for bringing in legal counsel. For detainees in IRCs there is no pathway for involvement in the process of reviewing the decision to continue segregation.

PSO 1700 sets out the specific training that staff working in segregation units would need to have undergone as a minimum before working in the unit. No such specific training is required for guards working in segregation units in IRCs. This is especially worrying in relation to the use of segregation to manage detainees with mental health issues and those at risk of self-harm and suicide.

There have been criticism of the prison guidelines and the extent to which they are implemented in reality, but at the very least they set out a standard to which the institutions can be held responsible when reviewing the progress of segregation of individuals.

FINDINGS

METHODOLOGY

For those subject to the misuse of segregation the effects can be both immediate and lingering. Several of the cases included in this report are still struggling with significant after effects of detention and segregation with ongoing mental health issues.

When embarking on this research we realised that statistical sampling would not yield the insight we were looking for as segregation is too frequently used. Though segregation is problematically applied to a population held for administrative convenience, the majority of instances of segregation comply with Home Office policy. The horrors of segregation come to light in the cases where segregation is misused. Where it is abused as a form of punishment, as a means of managing mentally ill detainees, as a means of preventing self-harm or when exercised without the appropriate safeguards or outside of the Detention Centre Rules.

There is very limited information on the use of segregation in IRCs, both in terms of the frequency and duration of segregation. There are no guidelines governing the use of segregation. Most statistics are collected locally in each centre and details of segregation are retained purely in individual detainee's detention records. Very little information is centrally recorded or monitored and none of this information is published annually or quarterly for the public to review.

The data for this research comes from three primary sources:

1. From Freedom of Information Act (FOIA) requests for information from various sources

2. From detailed records obtained as part of Medical Justice's ongoing casework and summarised in case studies: including medical records, legal documents and Home Office files.
3. And from published materials: including Home Office policy, HMIP inspection reports, IMB annual reports, academic studies and international research.

FOIA:

As stated, it is very unclear what information is collected and collated locally and centrally on the use of segregation in IRCs. We submitted a number of FOIA requests to the Home Office seeking to clarify the extent of the use of segregation under rule 40 and 42 across the detention estate. The requests queried the number of instances of segregation, the number of segregation exceeding 14 days (which would require the authorisation of the Secretary of State), the number of detainees segregated and any characteristics recorded (such as age, gender, nationality etc) and as well as a list of the 20 longest periods of segregation and their duration. As segregation is one of the harshest restrictions that can be imposed on populations in secure environments it would be reasonable to assume that there would be thorough oversight and review from central authorities.

However, the FOIA requests were turned down on the grounds that, as the information was held in individual detainee files, it would exceed the maximum expenditure (£600) to provide this

information. Another batch of requests were submitted limiting the range of years in question and breaking down the areas of interest into separate requests. Again, the request was turned down on the grounds of exceeding the expenditure. So, clearly this was not information being routine collected and reviewed by the Home Office. Even the request for the number of instances of segregation in excess of 14 days, which requires the explicit authority of the Secretary of State could not be provided.

It is not possible to access the information held in locally in most IRCs as the operation of the majority of centres is outsourced to private companies who are not covered by the Freedom of Information Act despite providing public services at the expense of the public purse. As all detainees held in segregation must be visited daily by members of the IMB we placed FOIA requests with IMBs at all IRCs and received a response from the IMB secretariat who were unable to provide the information as *"the data in your request is owned (...) by Home Office Immigration Enforcement and handled by the Contractor or the Prison Service depending on who runs the establishment. IMBs have access to it, but it is not theirs to disclose."*

In the belief that there must be some central monitoring of segregation data we submitted a FOIA to determine *"what information and statistics is centrally collated/collected on the number or instances of, the number of detainees involved and demographics of those removed from association under Rule 40 and placed in temporary confinement under Rule 42 of the detention centre rules in immigration removal centres & b) and, more specifically, on those held for more than 24 hours under Rule 40 and 42 requiring the authority of the Secretary of State."*

And received this response from the Home Office: *"For both Rules 40 and 42 we centrally collate the number of individuals held under each rule and the total number of days the individuals were collectively held for. Further information would be recorded on individual case files."*

So we submitted a request for the above information going back to 2010 or as far back

as records were kept and was provided with information from 2014 and informed that information was not collected prior to this. No data seems to be held on cases requiring the authority of the Secretary of State. The information received is summarised in the subsequent chapter.

Case studies:

All case studies in the report have been Medical Justice clients or their details are in the public domain. Based on our ongoing case work we identified suitable case studies where segregation had been misused according to the Detention Centre Rules, some for prolonged periods and some for only a few hours. A number of these ex-detainees could not be contacted, some had been removed from the country, some declined to participate in the study and some were still too unwell to be able to give consent to participate in the study.

The majority of ex-detainees contacted would only agree to be part of the study on the condition that they would not have to speak of their traumatic experience in detention and segregation. Despite the horrific experiences that many of these individuals have lived through in their own countries of origin, and on the journey to the UK, it was the trauma of segregation they could not bear to relive or discuss. In order to avoid further traumatising, the majority of case studies of survivors of misuse of segregation are based on relevant court records, medical records and Home Office files. There is therefore a noticeable absence of the voices of segregated detainees themselves with certain exceptions.

All case studies have been anonymised except for the death of Mr Dalrymple where the name is already in the public domain. Medical Justice cases have been given pseudonyms and cases in the public domain are referred to by their initials to protect the identity of clients.

Published materials:

This study draws heavily on the seminal work of Dr Sharon Shalev's 2008 'Sourcebook on solitary confinement'^[27] for background information on the use and effect of solitary confinement. A wider search on information of the history and effect of segregation was carried out and though most academic studies of segregation are drawn from the prison setting, many of the findings still apply to immigration detention despite not being directly

transferable. Very few studies have been published that deal directly with segregation in immigration detention.

Other sources of information on segregation are the announced and unannounced inspection reports of HMIP as single separation and safety is one of the key areas inspected upon. In addition, Independent Monitoring Boards (IMB) annual reports also tend to address the use of segregation in IRCs.

"A PRISON WITHIN A PRISON". THE EXPERIENCE OF SEGREGATION

"Being held in solitary confinement is, for most prisoners, a stressful experience with potentially harmful health effects. The prisoner is socially isolated from others, his human contacts reduced to superficial transactions with staff and infrequent contact with family and friends. He is almost completely dependent on prison staff – even more than is usual in the prison setting – for the provision of all his basic needs, and his few movements are tightly controlled and closely observed. Confined to a small sparsely furnished cell with little or no view of the outside world and with limited access to fresh air and natural light, he lives in an environment with little stimulation and few opportunities to occupy himself." (Shalev 2008)^[27:9]

and contain the 'worst of the worst'. However, research shows that this is not the most frequent usage for such punitive measures which are in fact often doled out for rather arbitrary infractions. As a result those found in segregation are not the 'worst of the worst' nor are they necessarily cases for which other options would not be appropriate.^[80]

In effect, since segregation is often used to manage those with mental health issues, those at risk of self harm, and those so afraid to be return to their country of origin that they are willing to resist removal in any way possible – it is often the 'most vulnerable of the vulnerable' that are found in segregation units in immigration detention. And even those who may not appear at first to be vulnerable may in fact become vulnerable as a result of being segregated

Officially, most segregation under Rule 40 and 42 in immigration detention are used because the detainee was disruptive, non-compliant

or abusive to staff, physically violent towards other detainees or at risk from other detainees. Before being placed in segregation all other options should have been exhausted as all interventions should favour de-escalation and the least invasive measures possible - especially in immigration detention where punitive measures are inappropriate. Placing someone in segregation and isolating them from social interaction and support is the most extreme intervention available in the system and should be used sparingly, if at all.

The only information on reason for segregation that is publically available was published by the IMB at Dover who provide a detailed breakdown for the years 2009, 2010, 2011. Though this does not provide us with enough information for meaningful analysis, it does provide an interesting glimpse into the reasons behind the use of segregation^[81, 82].

Reasons for Segregation Dover IMB			
	2009	2010	2011
Age dispute	11	3	13
Arson	1	0	0
Assault on detainee	13	6	3
Assault on staff	7	6	7
Att. Abscond/escape	9	8	1
Bullying	2	5	0
Dirty Protest	0	0	0
Disruptive	21	13	4
Drugs	28	17	13
Fights	31	53	34
Good order or discipline	5	22	27
Incitement	5	7	1
Investigation	66	27	3
Lodged/medical	19	11	6
Non-compliant	11	8	10
Not suitable for DIRC	5	1	0
Own protection	11	5	4
Refuse to locate	35	34	15
Refused transfer/deportation	28	11	20
Serving prisoner	3	0	2
Theft	2	2	0
Threat to others	10	7	2
Threats to staff & inappropriate behaviour	38	26	3
Unauthorised article/weapon	3	8	4
Self harm/constant supervision			13
Total	364	280	185

What does segregation look like on a day to day basis?

According to the Detention Centre Rules a detainee can be segregated if it is deemed necessary to limit their association with other detainees for the safety and security of the centre. However, as will be discussed in more detail later on segregation is often misused for inappropriate and unlawful purposes.

When a detainee is taken to segregation they will be segregated either under rule 40 – Removal from Association, or Rule 42 – Temporary Confinement. The conditions of temporary confinement are generally more restricted with detainees placed in very basic cell often without furniture beyond a plinth bed.

The decision to place a detainee in segregation should be taken by the Secretary of State (in a contracted out centre) or by the manager (in a directly managed centre). In urgent cases the manager of a contracted out centre may assume the authority of the Secretary of State but must inform the Secretary of State as soon as possible. In addition, the Independent Monitoring Board, the medical practitioner and the manager of religious affairs must be informed so they can arrange to visit the detainee. The centre manager, an officer of the Secretary of State, a member of the IMB and the medical practitioner must visit the detainee once a day for the duration of the segregation and this must be recorded in a manner prescribed by the Secretary of State. The purpose of these visits is to assess the continued segregation of the detainee and to assess their medical suitability for continued segregation. There have been frequent criticisms of both the nature and recording of these visits. During the inquest into the death of a detainee in segregation an independent GP expert in the case stated that the daily medical visits to segregation were not "fit for purpose" as detainees were only seen for a few seconds. He described the system as the 'alive or dead round' as that was all it was capable of assessing^[83]. Still, the Home Office and the Detention Centre staff rely on these rounds to inform them of any medical problems.

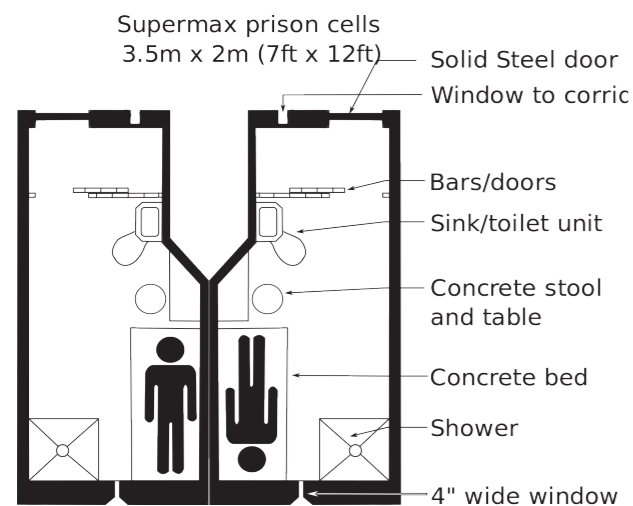
Who is segregated and why?

There has long been a misconception that solitary confinement and other such punishments used in prisons are necessary measures to control

A written reason for segregation must be given to the detainee within 2 hours of being placed in segregation. This is usually only provided in English and there is currently no requirement for such explanations to be translated into the detainee's own language. It is considered good practice to try to communicate the reasons for segregation to a detainee in a manner they can understand. However, this often does not happen.

If segregation exceed a 24 hour period authorisation must be given by the Secretary of State. Such authorisation cannot exceed 14 days for removal from association and 3 days for temporary confinement but the authority can be renewed for consecutive periods. According to Home Office policy segregation should only ever be used for the shortest possible period of time and under the least restrictive regime possible. Temporary confinement should only be used for as long as the detainee remains violent or refractory.

Regime whilst in segregation



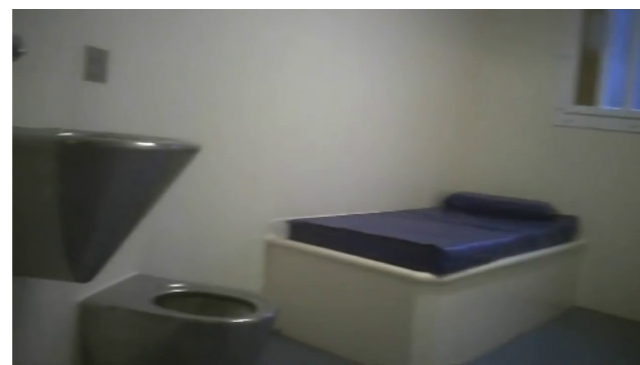
ADX prison cell Creative Commons Licence Richard-59

According to Home Office policy detainees should only be segregated in rooms that have been designated for this purpose and been certified as complying with basic requirements (Detention Centre Rules 15)^[8]. There is quite

a bit of variety between different IRCs both in terms of the standard of segregation rooms as well as the regime detainees have access to whilst segregated. Still, the broad strokes of the regime in segregation are similar.

In most cases a detainees will be locked in a segregation cell by themselves for 23 hours a day and only let out to use the showers, to smoke or to exercise. Exercise is usually taken in solitude, with detainees either taken to a special yard or taken at times when other detainees are not utilising the outdoor facilities. Exercise yards for segregated detainees have been described as stark and even 'cage like'^[84]. Social interactions are kept to a minimum and the regime has been described as 'impoverished'^[85].

The cells themselves are very basic. The facilities in segregation cells vary from IRC to IRC but in general they provide very limited facilities. Most segregation cells tend to be unfurnished except for a plinth bed with mattress and cell toilet. They have been described variously as 'stark and depressing'^[86], 'bleak and austere'^[87], 'unfurnished'^[88], 'bare, containing just a shelf table and built-in locker, with no television'^[86] and no chair'^[89]. In some centres there had been attempts to soften the décor of the segregation cells with furnishings or by painting murals on the cell wall. Despite these efforts it remains a stark and un-therapeutic environment^[87]. Some inspection reports have raised the issue of poor ventilation and dirty rooms, toilets and shower facilities^[84, 90].



Kingfisher Unit Yarl's Wood IRC Source: Channel 4

One detainee described the facilities such: *"It is a horrible place, below basic. There is nothing in the room. Like a dungeon"* (Detainee at Harmondsworth)

Cells designated for the use for removal from association should, but in some centres do not, contain basic furnishing such as a table and chair where the detainee can eat their meals. All meals are served through the cell door and taken in the cell^[85]. Detainees have access to a library cart with books and some basic personal items but very few activities beyond this^[91]. *"Nearly all detainees spent most of the day locked in their rooms with nothing meaningful to do."*^[92:69] Detainees will have visits from religious leaders but are generally not allowed to participate in communal worship. Whilst in segregation detainees are generally not allowed to continue their work duties or take part in education activities. In some centres detainees' mobile phones are routinely removed whilst they are kept in segregation despite this practice being repeatedly criticised by HMIP.^[46, 86, 90, 93-95] Lack of access to mobile phone means detainees have limited access to legal representatives and support from the community whilst they remain in segregation. This can hamper their ability to mount a legal challenge, both to their continued segregation and to participate meaningfully in their on-going immigration case. In the case of those scheduled for removal it limits their ability to make practical arrangements for their return, to connect with support organisations and to communicate with any friends of family in their country of origin.

Those held in Temporary Confinement under Rule 42 are subject to even more restrictive conditions. Cells designated for the use under Rule 42 are often bare cells with no movable furniture and only a plinth bed made of concrete and a fixed toilet. This means that detainees have to eat their meals sitting on the bed as there is no table or chair available. Such strip facilities should only be used after a risk assessment has deemed it necessary in individual case but they are routinely used for segregation under Rule 42. This practice has been criticised by HMIP. In some centres there is no practical difference between

segregation under Rule 40 and 42 in terms of facilities, as rooms are used interchangeably^[87]. Whilst in other centres those on Rule 40 were permitted to have their doors unlocked during the day^[46, 96].

In 2014 the Harmondsworth IMB raised concerns about the 'fabric of Elm (the segregation unit), even for short occupations. For example, the IMB has heard from detainees that their cells were unheated'^[96:17]. The lack of heating in the segregation unit at Harmondsworth is something that was also raised in relation to the death of Prince Ofofu in 2012 as discussed in a later chapter. The HMIP inspection of Yarl's Wood in 2015 raised concerns about the appropriateness of male staff supervising women in segregation, in particular when only partly dressed. There are also concerns about the frequent transfers of detainees between segregation units and the use of de facto segregation.

Social interactions are kept to a minimum and often detainees only see the guards that bring them food or escort them for exercise. Detainees held in segregation still have the right to receive visitors. In some centres the doors to the rooms of those segregated under Rule 40 are left unlocked and there is some opportunity to associate with others held in the segregation unit but no association beyond this group. Such association may or may not be beneficial as many of those held in segregation may be particularly vulnerable individuals who may not form mutually supportive relationships.

THE USE OF SEGREGATION

In prison systems around the world the state's rationale for the use of segregation of prisoners usually falls into one of 5 justifications:

1. To punish an individual (as part of a sentence or as part of a disciplinary regime);
2. To protect vulnerable individuals;
3. To facilitate prison management of certain individuals;
4. To protect or promote national security;
5. To facilitate pre-charge or pre-trial investigations. ^[1]

The majority of academic research and knowledge comes from the use of segregation within the prison system. However, as immigration detention facilities and protocols are modelled closely on prisons, segregation plays a part in immigration detention regimes as well. The application of segregation within

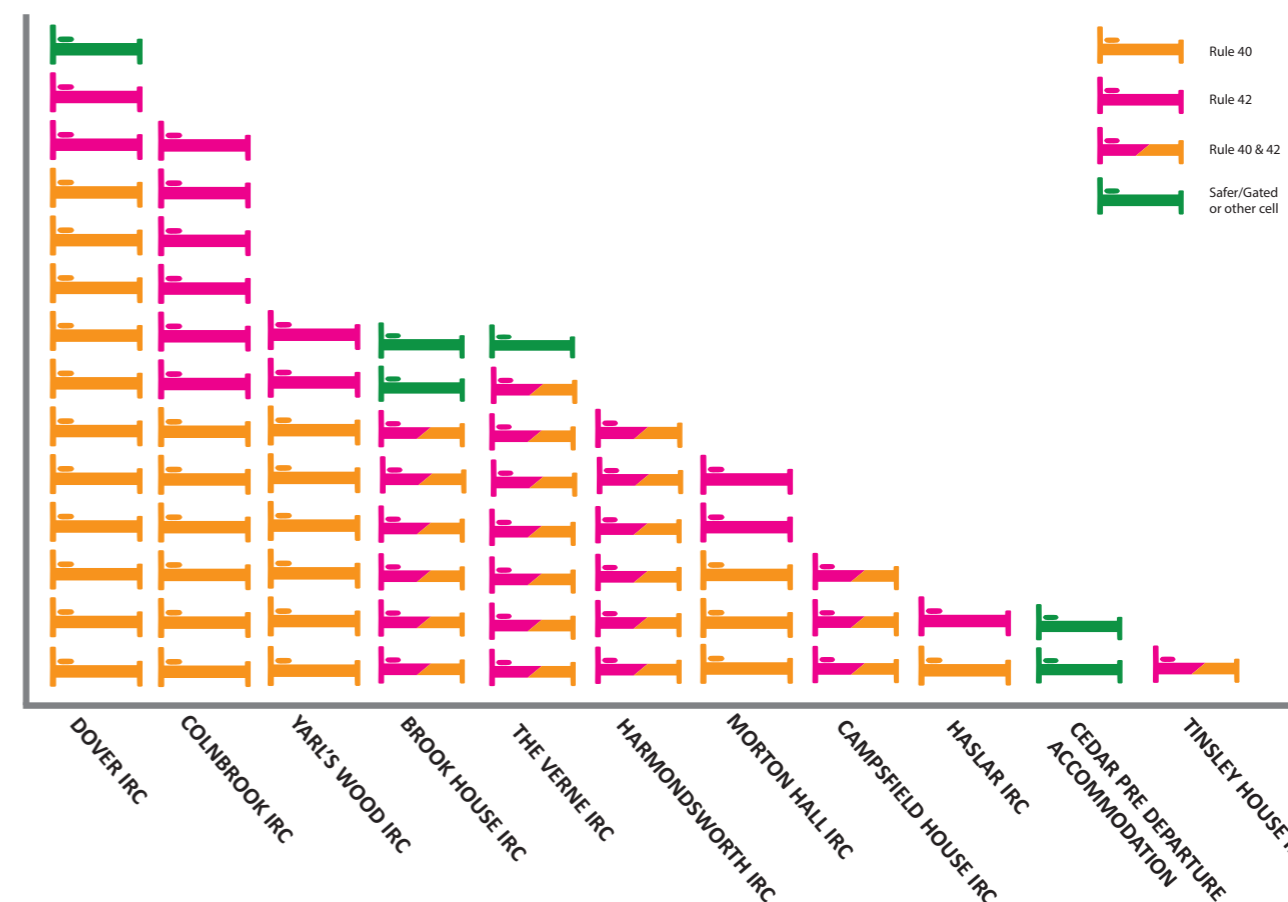
immigration detention focuses mainly on the three first reasons: punishment, protection and management. In the UK detention policy prohibits the use of segregation as punishment as there is no system of adjudication but as will be discussed later segregation is still used as punishment.

Up until 2014 no data on the use of segregation was centrally collected. After 2014 the Home Office records the number of days and the number of detainees segregated under Rule 40 and Rule 42, but as we shall see below this data appears to be inconsistent with other observations and inconsistently recorded between centres. Data on the use of segregation is not routinely published but is available through FOIA request. The lack of routine and robust data collection and analysis of the use of segregation is one of the recurring criticisms in HMIP inspections.

Below is an outline of the dedicated segregation facilities at each IRC:

IRC	Location Opened	Total Capacity	Segregation capacity	Segregation Unit Name
Yarl's Wood	Bedford	408	2 Rule 42, 6 Rule 40	Kingfisher
Brook House	Gatwick	448	Eden Wing 11 room for departure wing + 2 constant watch rooms for people at risk of self harming. CSU 6 rooms for Rule 40/42	Eden 'E' Wing + CSU (Care and Separation Unit)
Tinsley House	Gatwick	119	1	Room 12 two specialist behaviour management apartments
Cedars	Gatwick	44	2	—Orchid for the care of vulnerable individuals, and Lavender for the management of individuals presenting challenging behaviour
Morton Hall	Lincolnshire	392	4 Rule 40, 1 Rule 42	Segregation Unit
Dover	Dover	401	11 Rule 40, 1 Rule 42, 1 gated cell to prevent self harm and suicides	Hythe
The Verne	Weymouth	580	8 cells including gated constant watch room	
Haslar	Gosport	197	1 Rule 40, 1 Rule 42, 1 three-bedded suite named a care suit	Special Accommodation Unit (SAU) NOW CLOSED
Colnbrook	Heathrow	408	6 Rule 40, 6 Rule 42	Elm House
Harmondsworth	Heathrow	661	6 used for 40 & 42	
Campsfield House	Oxford	276	3 (dual 40/42 use)	
Dungavel	Nr Glasgow	249	???	Secure Unit

Segregation capacity across the immigration removal centres in the UK:



HMIP survey question: "Have you spent a night in the segregation unit in the last six months?"

	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Brook House IRC						25%	15%	15%	15%		
Campsfield House IRC					13%					8%	
Colnbrook IRC	40%		40%	27%		31%			23%		
Dover IRC						22%				15%	
Dungavel IRC		12%				4%					13%
Harmondsworth IRC		27%		21%		17%	19%		13%		
Haslar IRC	24%				3%					11%	
Morton Hall IRC									17%		
Tinsley House IRC							16%	12%		10%	
Yarl's Wood IRC							6%		6%		8%
The Verne IRC											12%

HMIP inspections carry out standardized surveys as part of their inspections. One of the questions asked is “Have you spent a night in the segregation unit in the last six months?” Over the years the average segregation rate across centers has been around 16%. This has come down slightly in the last three years to 13% but does not reflect all centers (see table above). There is also considerable variation between centers with markedly higher rates at Colnbrook and lower rates at Yarl’s Wood.

However, these self-reported rates do not tally with the rates reported by the Home Office who recorded that 1049 detainees were held in segregation under Rule 40 and 127 under Rule 42 in 2014. At the same time the Home Office recorded that during the same period 30,365 detainees entered IRCs^[11]. This amounts to approximately 4% of detainees being segregated over the last year. It is not clear what explains this discrepancy.

It is however clear that there is great variance in how data is collected between different IRCs and that there is poor correlation between the data collected by independent inspectorates like HMIP and that reported by the Home Office. The Detention Centre Rules stipulates that particulars of every case of removal from association/temporary confinement “shall be recorded by the manager in a manner to be directed by the Secretary of State”^[8]. No such guidance is publically available to review and, as evidenced by the variance in data collected at the different IRCs there is no consistent method of handling data collection and analysis.

7 HMIP inspections were carried out in 2014 and 2015 which cover parts of the same period as that reported on by the Home Office. If we analyze these two sets of data side by side we find that:

- Home Office records indicate only 7 people were detained at Haslar IRC – whilst HMIP report from Feb 2014 indicate 11 % reported being segregated and 50 detainees segregated in 2013^[95]. Unless there has been a drastic shift in segregation practices this does not seem to correspond.

- Home Office records from Yarl’s Wood IRC indicate 62 detainees segregated under Rule 40 and 14 under Rule 42 in 2014. Yarl’s Wood IMB records for 2014 indicate 66 segregated under Rule 40 and 19 under Rule 42. These records match quite well but it is still surprising that the numbers do not match for an indicator as straight forward as whether or not someone was held under Rule 40/42.
- Home Office records from Dover IRC indicate that 25 detainees held under Rule 40 and 1 detainee under Rule 42 in 2014. However, the records indicate almost all those held under Rule 40 were segregated in December 2014. HMIP carried out an inspection in March 2014 and found that in the last 6 months there had been 80 cases of segregation under Rule 40 and 4 under Rule 42. These numbers do not seem to tally at all with those provided by the Home Office. Indicates an annual rate of segregation in excess of 160. If we assume 1/3 of the cases reported in the last 6 months fell in 2014 this would still constitute 27 cases whilst Home Office records shows no use of R40 in Jan, Feb or March of 2014.
- Home Office records for Tinsley House IRC indicate 29 detainees were held under Rule 40 and 1 under Rule 42. HMIP carried out an inspection of Tinsley House in December 2014 and found that Rule 40 had been used 26 times in the last 11 months and Rule 42 only once. Allowing for the additional month these numbers seem to correlate well with Home Office records.
- Home Office records for Campsfield House IRC indicate 16 detainees were segregated under Rule 40 and 23 under Rule 42 (though the majority of these were segregated in December 2014). HMIP inspection carried out in August found 10 instances of segregation in the previous 6 months which would indicate an annual rate of approximately 20. This would correlate with Home Office statistics if we disregard the anomalous increase in December.
- Home Office records for the Verne indicate 75 detainees were segregated under Rule

40 and none under Rule 42 since the centre opened in late September 2014. HMIP inspection from March 2015 found that 128 detainees were segregated under Rule 40 and 3 under Rule 42 in the last 6 months. This corresponds well with Home Office records assuming half of these occurred in 2014.

- Home Office records for Dungavel indicate 75 detainees were segregated under Rule 40 and 3 under Rule 42 in 2014. HMIP inspection completed in February 2015 found that 53 were detained under Rule 40 and 3 under Rule 42 in the last six months. This would indicate an annual rate of 106 and 6 detainees segregated, assuming rates remain relatively stable, which is much higher than that indicated in the Home Office records.

It is very difficult to draw conclusions from this data. In the absence of regularly published data on the use of segregation it is difficult to say anything about trends or accuracy. However, it is clear from the above analysis that reporting is variable and that there are great variances between centers in how well the data reported correlates with that reported by independent inspectors. There is also variance in how the data is reported which may account for some of these discrepancies. Some centers report decimalized data indicating they count the hours not just days that detainees are held in segregation. This is particularly important as segregation often last shorter than a day. Other centers seem to count days and quarter days whilst others only report on whole days in detention. There needs to be clear and firm guidance on how to record and report on the use of segregation so that data is transparent and comparable between centers. This guidance, as indicated in the Detention Centre Rules, should come from the Secretary of State.

Inconsistent recording and interpretation means there is no compatible data between centers. For example, HMIP reported that at Haslar IRC “Rule 40 (removal in the interests of security or safety) was widely interpreted to cover detainees separated in their own interests, and rule 42

(temporary confinement) for those posing risk of harm to others. This was incorrect, and resulted in misleading statistics, which could suggest a higher level of violence than had occurred.”^[97:52]

Rule 40		Q1	Q2	Q3	Q4	Total
Brook House	Days	139.5	145.5	59.25	69.75	414
	Individuals	57	96	37	52	242
Colnbrook	Days	142	158	139	158	597
	Individuals	62	70	67	74	273
Campsfield	Days	2	2	5	12.5	21.5
	Individuals	2	2	3	9	16
Dungavel	Days	14	27	32	33	106
	Individuals	12	19	22	22	75
Dover	Days	0	0	0	29.25	29.25
	Individuals	0	0	0	25	25
Harmondsworth	Days	49	93	174	113	429
	Individuals	44	87	72	54	257
Haslar	Days	0	0	0	7	7
	Individuals	0	0	0	7	7
Morton Hall	Days	8	0	0	0	8
	Individuals	8	0	0	0	8
Tinsley House	Days	3.27	3.25	2	11.15	19.67
	Individuals	4	11	4	10	29
The Verne	Days	0	0	0	218	218
	Individuals	0	0	0	75	75
Yarl's Wood	Days	82.7	16.75	36	47	182.45
	Individuals	15	12	5	30	62
Subtotal days		440.47	445.5	447.25	698.65	2031.87
Subtotal individuals		204	297	210	358	1069
Total Days						2031.87
Total Individuals						1069

Rule 42		Q1	Q2	Q3	Q4	Total
Brook House	Days	2.25	7.1	0.75	2.25	12.35
	Individuals	7	6	3	5	21
Colnbrook	Days	23	31	22	0	76
	Individuals	13	15	11	0	39
Campsfield	Days	1	3	2	24	30
	Individuals	1	3	3	16	23
Dungavel	Days	1	2	0	0	3
	Individuals	1	2	0	0	3
Dover	Days	0	0	1	0	1
	Individuals	0	0	1	0	1
Harmondsworth	Days	3	7	16	3	29
	Individuals	2	4	15	3	24
Haslar	Days	0	0	0	0	0
	Individuals	0	0	0	0	0
Morton Hall	Days	1	0	0	0	1
	Individuals	1	0	0	0	1
Tinsley House	Days	0	0	0	0.25	0.25
	Individuals	0	0	0	1	1
The Verne	Days	0	0	0	0	0
	Individuals	0	0	0	0	0
Yarl's Wood	Days	28.75	0.25	1.75	4	34.75
	Individuals	4	1	2	7	14
Subtotal days		60	50.35	43.5	33.5	187.35
Subtotal individuals		29	31	35	32	127
Total Days						187.35
Total Individuals						127

Full details of FOI response and monthly breakdown in Appendix 2

THE MISUSE OF SEGREGATION

“It can be difficult to judge the appropriateness of use of RFA or TC in individual cases where the removal occurs as a result of a spontaneous incident (...)The question of whether the detainee has presented a threat to security and safety of the Centre or of other detainees is a matter of judgment for the manager at the time” However, steps should be taken to ensure detainees are only removed from association *“if they genuinely pose a threat to safety and security, and not simply as a result of being non-compliant; secondly, to ensure that every emphasis is placed on diffusing situations without the use of these measures.”* (HMIP Yarl’s Wood 2011)^[98:11]

As was seen in the previous chapters segregation is widely used across IRCs in the UK though rates, conditions and regimes vary widely. Segregation in itself is a controversial practice and what role it needs to play in settings of administrative detention can be legitimately questioned. However, under current policies detainees can be segregated where *“it appears necessary in the interests of security or safety that a detained person should not associate with other detained persons, either generally or for particular purposes”*. In many cases segregation is correctly applied for the shortest possible time and in the least restrictive regime possible. However, in some cases segregation is inappropriately applied and misused to the detriment of the health and wellbeing of vulnerable detainees. The worst abuses are seen in relation to mental health, self-harm, removals and punishment. Each of these will be dealt with in detail in the coming chapters.

However, segregation fails in a number of related areas which contribute to the inappropriate use of detention and the failure of safeguards and processes.

Overuse of segregation

“Separation was being used excessively and not in line with the Detention Centre Rules”(HMIP Harmondsworth 2013)^[89:5]

Detainees held under immigration powers are held for administrative convenience and not as part of any criminal sentence. Those detainees that are deemed too dangerous or disruptive for IRCs on account of their individual risk assessments will not be transferred to IRCs but will continue to be held in prison under Immigration powers. Also, as there is no adjudication system in place segregation should not be used to punish or to maintain discipline. This means that one would expect to see very low levels of segregation across IRCs yet this is not the case. As we saw in the previous chapter roughly 16% of detainees report that they have spent a night in segregation in the last 6 months. HMIP frequently criticise the overuse of segregation in their inspections of IRCs.^[91, 92, 99]

Detainees held longer than necessary in segregation

“It appeared – and some staff concurred with this view – that a night in the separation unit was used as a standard ‘cooling-off’ period. This was contrary to Rule 40 of the Detention Centre rules (removal from association in the interests of security or safety) which only allow separation to manage clear and immediate risk. Twenty-five per cent of those separated in the previous 12 months had been returned to normal location at exactly 10.30am, which was a further sign of a routine element in the length of separation.”(HMIP Harmondsworth 2013)^[89:29]

Segregation should only be used for the shortest possible period of time in the interest of security and safety. Therefore, detainees should be removed from segregation as soon the risk has passed in each individual case.

However, HMIP often found that *“[d]etainees spent too long in separation without evidence of continuing risk”*^[89:13]. There is also evidence that the length of segregation is governed by bureaucratic or logistic considerations rather than individual assessments of risk. As in the example above where most detainees had been moved back to normal location at exactly 10:30am indicating a change in shift or other practical consideration. The inspector noted that there was *“high use of separation and detainees were not allowed back to normal location at the earliest possible time. Most uses were over a single night, with a move to the induction unit on the following day. The length of separation was not on the basis of ongoing risk in every case and in many cases the unit was used effectively as a ‘cooling off’ facility, contrary to Detention Centre Rules.”*^[89:17].

Other inspections have noted that there is a tendency for detainees to be moved back to normal location just before the 24 hour mark when special authorisation from the Secretary of State would be required which *“suggested they could have been moved earlier.”*^[100, 101]

During a 2015 inspection of Yarl’s Wood the HMIP commented that *“[s]ingle separation was sometimes used for too long and we questioned whether it was appropriate for some of the vulnerable women held.”*^[46:33] Indicating that there had been no improvement and segregation is still being used for prolonged periods of time.

Both IMB reports and HMIP inspections frequently raise concerns over detainees that have been held for prolonged periods in segregations, to list but a few:

- *“one detainee with mental health or behavioural problems was in the segregation unit at Harmondsworth or other IRCs for a virtually continuous period of **22 months.**”*^[102:5]
emphasis added

- One detainee at Yarl’s Wood was held for more than 12 days under rule 40 before being transferred to HMP Holloway. *“This is an unacceptably long period and we do not understand the delay in finding her a prison place.”*^[103:12]
- A HMIP inspection of Brook House noted that *“during this period a detainee had been taken to a psychiatric institution after more than 80 days in separation for disturbed and disruptive behaviour”*^[99:59]
- *“We were extremely concerned by the case of a Mr A, who appeared to have physical or mental health issues causing him to have severe tantrums, who had been placed on Rule 40 from 27th August until 22nd December, when he was transferred to Colnbrook IRC.”*(IMB Harmondsworth 2011)^[104:15]

Prolonged segregation was clearly an issue in several of the case studies reported later in the report with HA being segregated virtually continuously for almost 9 months.

Reported averages in annual reports and inspections often mask individual instances of detainees being held for prolonged periods of time. The IMB at Colnbrook noted that though the average time spent under Rule 40 was around 2 days this masked a significant number of detainees being held for much longer and indicated that during 5 months of the previous year there had been detainees held in segregation for longer than 14 days requiring the authorisation of the Secretary of State.^[105]

In addition, repeated segregation is an ongoing issue indicating a failure to deal with underlying issues - e.g. IMB at Yarl’s Wood reported the case of a clearly mentally ill woman who had been segregated on 8 separate occasions due to behaviour which should have been properly understood as a symptom of her mental health issues^[106].

Detainees segregated under Rule 42 when no longer violent or refractory.

According to the Detention Centre Rules segregation under Rule 42- Temporary Confinement – should only be used when a detainee is violent or refractory and should be used for the shortest possible amount of time. “[A] detained person shall not be so confined as a punishment, or after he has ceased to be refractory or violent”^[8]. The conditions under Rule 42 Temporary Confinement are usually more restrictive than under Rule 40 with a more limited regime, additional restrictions and a very bare room. Segregation under Rule 42 should be used sparingly, it should not be used as punishment nor continue to be used after the detainee has de-escalated and ceased to be violent. However, there is ample evidence that both are happening regularly in IRCs across the UK and is criticised in more than a dozen inspection reports over the last few years:

Prolonged segregation under Rule 42:

- Home Office statistics shows that in March 2014 3 detainees were kept in segregation under Rule 42 for a total of 22.25 days (see Appendix 2)– it is not clear if they were all kept for equal amounts of time but in either case this would be a very long time for someone to remain violent and refractory.
- HMIP inspection at Brook House found that “[t]emporary confinement under Rule 42 had been used 83 times in the previous six months, for an average of 22.35 hours. In some cases, detainees had been placed in [Temporary Confinement] for passive non-compliance.”^[99] 22.35 hours seems extremely long for the average detainee to remain violent.
- “Some incident reports and Rule 42 records indicated that detainees had continued to be held under Rule 42 after they had become compliant. A detainee located to the Rule 42 unit at 1pm was not relocated to the Rule 40 unit until 11am the following morning, despite

being compliant for the whole period.”(HMIP Colnbrook 2008)^[91:59]

- “In a number of cases, people had been held in temporary confinement when not recorded as actively violent or refractory, and the average time they spent in these conditions was too long.”^[98:11] “The average length of time spent in temporary confinement was seven and a half hours, indicating use beyond the period when a detainee was actively violent or recalcitrant. It had recently been used for a passively non-compliant detainee, for another who had not offered physical resistance and a third who was recorded as ‘speaking very loudly and aggressively to staff’. It was also clear that detainees remained in these conditions after they had become calm and compliant; for example, a detainee had been put in this type of cell at 3pm, was not recorded as offering any violence or resistance, ‘appeared calmer’ at 4.40pm but had not been moved to a normal separation cell until 9pm.”(HMIP Yarl’s Wood 2011)^[98:53]

- HMIP inspection of Harmondsworth indicated that the average length of confinement on Rule 42 was 17 hours “much longer than is normal for a measure designed to address actively violent or refractory behaviour”^[89:30]

Punishment/Inappropriate use of segregation under Rule 42

- “We also came across an example of a detainee who had pushed past an officer and then been persuaded to return to his room, who was later moved to the Rule 42 unit because of his earlier behaviour.” (HMIP Colnbrook 2008)^[91:59]
- IMB at Yarl’s Wood reported concerns about a case where “a detainee[was] placed into TC because she would not walk from the legal corridor back to her unit. This detainee was passively non-compliant and could not be described as violent or refractory, yet she was carried off the legal corridor and taken into [Temporary Confinement].”^[107:13]
- Even when moved from Rule 42 after not being violent anymore this did not always make a massive difference – “Most detainees

were usually moved from Rule 42 (temporary confinement) to Rule 40 (removal from association in the interests of security or safety) status within a day, and soon after they had ceased to be refractory or violent. However, this was not always the case and there was no substantive difference between the conditions under Rule 42 and Rule 40”(HMIP Colnbrook 2010)^[92:18]

Segregation unit used as healthcare facility

“Detainees were frequently located in the RFA [Removal From Association, Rule 40] unit for observation and monitoring at the request of health care staff. It was inappropriate for detainees to be subject to a solitary regime because of their medical condition. In non-medical cases, no certification of fitness to detain was provided by a health care professional in advance of separation”(HMIP Brook House 2010)^[99:60]

Segregation is ‘not conducive to recovery’^[108] and the segregation of detainees with health issues might delay access to needed treatment. Often the detainees are left to the supervision of the staff at the separation unit who lack medical training. The segregation unit is often some way away from the main healthcare unit and in some instances in a different building altogether. The segregation unit might not be immediately accessible to medical staff. In some centres, like Tinsley House the segregation unit may not even be staffed at all times. Healthcare staff make daily visit to the segregation unit but the rounds a very brief and have been described as the ‘alive or dead’ round by some medical professionals.

In addition most segregation units offer an inappropriately stark environment with limited access to meaningful engagement for someone who is suffering from ill health. The 2014 HMIP report from Tinsley House recorded the use of Room 12 (Segregation Unit) to isolate a man suffering from TB but noted that this was not appropriate as the centre needed to create a much more therapeutic environment for detainees in crisis.^[87]

The practice of using the segregation unit to house those suffering from physical illness has been criticised by HMIP who found that in some cases the segregation unit was being used as a modified inpatient facility which is not appropriate and for which it is not certified.^[99] Clearly there is a need for a contingency in the case of infectious disease but this should not be the unnecessarily stark and punitive environment of the segregation unit.

Lack of proper authorisation of segregation

“We were not confident that approval of removal from association (Rule 40) beyond the 24-hour period was always based on a thorough examination of the facts by Home Office staff. Some documentation had been signed by centre staff on behalf of immigration staff, which was inappropriate.”(HMIP Brook House 2013)^[85:28]

Proper monitoring and oversight is crucial for ensuring that segregation is lawful and in accordance with due process. The Detention Centre Rules stipulate that written authority must be provided by the Secretary of State for segregation beyond 24 hours and that all segregated detainees should receive a copy of the reasons for their segregation within 2 hours. Yet this is far from always the case: “The initial 24-hour period of separation was generally authorised by a GEO manager rather than a Home Office manager, which would be acceptable only in cases of urgency. In only a few cases were Home Office signatures present on the authorisation forms held in the separation unit.”^[89:30]

HMIP frequently finds that proper authorisation is lacking for segregation beyond 24 hours^[88, 99, 109, 110], that proper justification for removal is missing^[85], segregation had been authorised by centre staff rather than Home Office staff^[87], that recording was incomplete and that first line managers authorised separation rather than senior managers^[46, 99, 111, 112]. The lack of proper authority and incomplete paperwork is of great concern. It potentially makes the segregation of individual detainees unlawful but it also removes some of the safeguards built

into the system and hinders proper oversight of the process.

Authorisation by the Secretary of State is meant to provide an additional layer of safeguarding of detainees interests by ensuring that segregation is in accordance with the Detention centre rules. However, HMIP has found that in some centres *“authorisation by the UK Border Agency manager was not always based on a sufficiently thorough examination of the facts. (...) we saw examples where UKBA managers had been over-reliant on staff accounts of incidents and had not always interviewed detainees before authorising separation.”*^[113:25]. Unless there is a proper review of the facts of the case, with an opportunity for a detainee to give their version of events, then the added authorisation becomes a rubber stamping exercise and loses its intended function as an additional safeguard.

“In three cases, a period of less than 24 hours under Rule 42 temporary confinement had been immediately followed by a period of removal from association under Rule 40. UKBA staff had taken the view that authorisation for continued separation was not required unless any single period of separation under one of the rules had exceeded 24 hours. This was an artificial distinction and could lead to long periods of separation without the requirement to provide adequate justification. However, the principles underlying the relevant Detention Service Order clearly demand that authorisation be given by a UKBA manager for any holding of a detainee in the separation unit for a continuous period exceeding 24 hours. In two further cases, vulnerable detainees had inappropriately been kept in separation for more than 24 hours, primarily for their own safety, and UKBA authorisation beyond 24 hours was not recorded in one of these cases.”(HMIP Campsfield House 2009)^[114:50-1]

Authority following BOURGASS V SSJ. Who should authorise segregation?

As we have seen above proper authorisation is sometimes missing from segregation paperwork, bringing into question how robust the review processes and safeguards of segregation are in practice. In addition there has been a recent

judgement in the supreme court which challenged authorisation of segregation in prisons.

According to PSO 1700, anything in excess of 72 hours of segregation must be authorised by an officer of the Secretary of State. PSO 1700 (a non statutory guidance) has interpreted this as being a senior prison officer, or ‘operations manager’ in the form of the head of the Segregation Review Board, usually the prison Governor. However, the Supreme Court found in the judgement of *Bourgass V SSJ*^[78] that this was not in accordance with the intentions of the prison rules as the Governor could not be seen as an official of the Secretary of State and as such could not authorise continued segregation. The Judge found that the clear intention of the rules was for the authorisation to provide independent oversight of the process by an authority independent to the prison.

The wording of the Detention Centre Rule 40 (3) *“A detained person shall not be removed under this rule for a period of more than 24 hours without the authority of the Secretary of State”* and 42 (3) *“A detained person shall not be confined in special accommodation for longer than 24 hours without a direction in writing given by an officer of the Secretary of State (not being an officer of a detention centre)”* are both similar in nature to that in use in prisons. As outlined in *Bourgass V SSJ* the law makes it clear that in order to protect prisoners, decisions to continue segregation beyond an initial period should be taken independently of local management by the Secretary of State.

Poor governance of segregation

“Although separation was justified and authorised properly, formal governance was generally weak. A distinct separation strategy set out expected working practices and the aims of the unit but had not been implemented. Separation management meetings did not take place, and the analysis of information on how many times the unit was used and the length of time detainees spent there had

not been adequately developed.”(HMIP Haslar 2014)^[95:26]

For the purposes of this research a FOIA request was made to the Home Office asking for sight of any guidance or policy related to segregation. The Home Office replied that this information would not be released as the information was to be published within 2 months. 6 months later the information is still not public which means that there is currently no publically available guidance on the use of segregation in IRCs and there are indications that it is practiced differently from IRC to IRC.

There are indications that some individual IRCs have policies in place ^[84] in the form of strategy documents but that the overall Governance structure of the use of segregation is very poor. HMIP has found that staff working in the segregation unit have a poor understanding of proper procedures for segregation under Rule 40/42 in many IRCs. HMIP commented during an inspection of Tinsley House that *“all detainees under segregation rules 40 and 42 would be placed in cell 12. There were no protocols for use of the cell, particularly for detainees on removal from association, and managers and staff we spoke to were not clear about the conditions governing its use”*^[115:52]. Worryingly detainees are segregated under Rule 40/42 of the Detention Centre Rules at CEDARS Pre-Departure Facility despite the fact that this facility does not come under the purview of the Detention Centre rules. In fact, there are currently no rules for the operation of Pre-Departure Accommodation or Short Term holding Facilities. Which means that there is no policy framework for the segregation of detainees at this facility. HMIP has questioned the practice and pointed out that the *“governance of this separation was unclear. Detention Centre Rule 40 documentation was completed, but this had no jurisdiction in Cedars.”*^[116:25]

Poor monitoring and record keeping

“Isolation is problematic both from a human rights and a medical perspective – especially in immigration detention. Human right standards

impose strict requirements on the use of isolation. It may only be applied in exceptional circumstances, if it is absolutely necessary, proportionate and non-discriminatory. Moreover, such cases require consistently good accountability.”(Amnesty 2015)^[3:2]

Monitoring and ongoing analysis of trends in the use of segregation is vital to ensuring that segregation is absolutely necessary, proportionate and non-discriminatory. However, data has only been centrally collated since 2014. Prior to this there has been no central collection of numbers and duration of segregation under Rule 40 and Rule 42. This data has exclusively been held at individual IRCs. Individual IRCs have frequently been criticised by HMIP for either having incomplete records, for not routinely collecting the data required or, more frequently, for not analysing and following up on this data in a meaningful way^[46, 88, 95, 99, 117]. This has profound implications for the monitoring and preventing equality and diversity impact of segregation as well as monitoring excessive use, misuse or prolonged periods of segregation.

In the absence of an overarching framework and guidelines such as those provided by PSO 1700 in prisons, the issue of coherent monitoring is further compounded by inconsistency in the way segregation is recorded and measured at different IRCs.

“The increase in separation, and in violent incidents, appeared to be linked to the higher number of people with mental health problems and the increase in ex-prisoners; we were assured that this explained the increase in use of temporary confinement, but not removal from association. No systematic data were analysed to examine these concerns.”(HMIP Yarls Wood 2015)^[46:17]

Equality issues and the use of segregation:

The lack of systematic analysis of data on the use of segregation opens up the possibility of discriminatory practices. There is no available data on the ethnicity, age, sexuality, nationality or other characteristic of those held in segregation so no definitive statement can be made about whether or not the usage is in fact discriminatory. According to the detention centre rules such

monitoring records should be kept by all IRCs but as many of these are private providers and this information cannot be accessed through Freedom of Information Requests. The information is thus not publically available. As discussed above HMIP frequently criticise the lack of on-going analysis and monitoring in their inspection reports. No data on the equality and diversity of segregation usage at IRCs is centrally collected or monitored by the Home Office.

Analysis from prisons have demonstrated that there is often innate inequalities in who is subject to segregation – BME prisoners are disproportionately more likely to be segregated^[118, 119] and in 2011 HMIP reported “that prisoners from a black or minority ethnic background, foreign nationals, Muslim prisoners and those under the age of 21 were more likely to report having spent time in the segregation or care and separation unit in the last six months”^[120:25] There is also growing concern about the number of detainees and prisoners with mental health problems held in segregation and the punitive and discriminatory nature of this practice. One prison IMB termed the practice a “warehousing of the mentally vulnerable”^[7]

Poor monitoring and analysis of data, as well as lack of public insight into this analysis, means it is impossible to determine whether or not this is also the case in IRCs. Some HMIP data indicates that Muslims and the disabled are over represented in segregation units. A HMIP inspection of Colnbrook IRC found that 41% of those who considered themselves to have a disability had spent a night in segregation in the last six months compared to only 27% of those who did not consider themselves to have a disability.^[92] Similarly, the 2015 HMIP inspection of Yarl’s Wood found considerably higher rates of segregation of those who consider themselves to have a disability 17% as compared to 7% of those who did not – which is more than double the rate. This could be partly explained by the lack of suitable facilities for disabled detainees in some IRCs. A HMIP inspection at Brook House found that “It was not uncommon for new arrivals requiring a single or ground-floor room to be located initially in the separation unit in the absence of more suitable short-term accommodation. A detainee had recently arrived with two sprained ankles. He

had been located in the separation unit because ‘no disabled or ground floor beds were available’”^[99:60]. Though he was moved to a residential unit the following day this usage is highly inappropriate and discriminatory.

Equally worrying trends have been identified in regards to Muslims with a HMIP inspection of Harmondsworth finding that “[t]here was little local analysis of any patterns or trends in separation, although our survey showed that this might be fruitful; for example, 16% of Muslims (the majority faith group) said that they had spent a night in the separation unit in the previous six months, against 9% of non-Muslims”^[89:29].

The only publically available ongoing analysis of trends in terms of nationality comes from Campsfield IMB who have provided a breakdown in their annual report since 2009. The reports note that there is a disproportionate number of Iraqis and Afghans segregated but that this is due to the fact that “these groups are prone to dissent as they are very hostile to removal and therefore tend to be more non-compliant than other groups” and again in 2012 the IMB reports that Afghans are over-represented. “Examination of the group shows that over half placed in RFA were from Afghanistan and were non-compliant mainly in respect of removal directions and immigration issues; this is understandable” the generalisations seem problematic and have not been explored in enough detail. The language seems somewhat victim blaming and does not recognise the potentially very legitimate fear than many Iraqis and Afghan’s might feel at the prospect of return to their country of origin. Secondly, if the IMB sees their response as ‘understandable’ may this also be the case for the staff at Campsfield House IRC who may be segregating this group pre-emptively on the expectation that they will be non-compliant rather than on the basis of individual risk assessments. Segregation should be used to manage risk to the centre’s security and not to ensure that detainees are removed.

Inappropriate use of force

Use of force is sometimes necessary in relation

to moving detainees to segregation particularly in cases where a detainee is being violent or refractory. The IMB at Brook House raised concerns over the high use of segregation at the facility and in particular about “how many occasions force was necessary to place men in their rooms (under Rule 40 and 42)”^[121:15]. The IMB went on to report that force was necessary in more than 10% of cases in order to place individuals in segregation.

Bearing in mind that many detainees placed in segregation are exhibiting behaviour that is symptomatic of a mental health disorder the experience of force in that situation may be extremely stressful^[122] and especially for detainees with mental health issues^[123]. There is also evidence that force is used inappropriately to move vulnerable detainees at risk of self-harm to the segregation unit^[97, 109] thus risking causing further traumatisation and destabilisation of detainees in crisis. In such cases the use of force might serve to escalate the situation rather than defuse it.

There is evidence that suggests that the excessive restrictions and oppressive environment of segregation units in themselves lead to escalations of violence^[124]. Indeed, one IRC found that 36% of all use of force had involved detainees under Rule 40 or 42^[125] whilst another found that almost half the incidents of use of force had been in the segregation unit^[126]. The IMB at Harmondsworth reported that instances of segregation and use of force tended to have arisen in the parts of the facility with the most prison like and restricted facilities^[104]. Which seems to indicate that segregation is poorly equipped to defuse situations and that the use of segregation may in fact contribute to escalating levels of violence in a facility. In addition, there is not always enough evidence that proper de-escalation procedures have been followed in order to avoid having to place individuals in segregation^[111] or to use force in order to place them in segregation: “We saw examples where detainees had been separated for minor incidents caused by anger or frustration due to their personal circumstances, without evidence that staff had tried to de-escalate the situation.”^[92:68]

Further, staff used unprofessional language^[101], inappropriate use of control and restraint gear^[127],

and giving unclear instructions to detainees thus causing further distress, e.g HMIP report an incident where a detainee “was asked to bring his knees to his chest during a forced full strip search while he was on the floor, so he could be helped to stand up, but this was not explained to him, and he was clearly scared when he shouted, ‘what are you going to do to me?’”^[101:63]

Violence used on compliant detainees.

- A HMIP inspection of Campsfield House in 2014 found that “a detainee complied with his move to the separation unit until he reached the threshold of the unit where he stopped. Rather than guiding the detainee by his arms, full control and restraint locks were used risking injury to staff and the detainee.”^[93:26]
- And the HMIP inspection of Tinsley House in 2012 again reported an instance of inappropriate and unnecessary use of force on a compliant detainee in crisis. “A detainee refused food at the centre and was placed on an ACDT, and subsequently on constant watch. It was decided to transfer him to the segregation unit at Brook House where he could be more easily observed. He refused to move but was not violent or refractory nor did he pose a threat to the safety and security of the centre. Three DCOs in full personal protection equipment entered the detainee’s room to put him in handcuffs which he passively resisted. He was forced to the ground and staff again tried to place him in handcuffs which the detainee continued to resist. Staff stopped using force and the detainee remained passive and unrestrained on the ground with his eyes shut before force was reapplied. The remainder of the incident was not video recorded. Documentation showed that the man had been taken to the segregation cell in Tinsley House before going to Brook House, from where he was released.”^[128:25] The instance demonstrated the consequences of the failure to use proper de-escalation techniques and to give the detainee the opportunity to indicate that he/she is willing to comply with instructions.

Use of excessive force and unauthorised techniques

- *“A detainee had become distressed and tried to self-harm by placing a cord around his neck and hitting himself. Staff restrained the detainee to prevent further harm and moved him to the cool-down room where he remained passive. Two officers sat beside the detainee and, according to logs, held his arms for 2 hours 20 minutes, first in the cool-down room and then in the Lavender suite, despite compliant behaviour. He was allowed to speak to his wife on the telephone while held in Lavender, but was not reunited with her until the family’s removal more than 12 hours later. Given his compliance, there should have been some attempt to reunite them earlier and it was not clear why this was not done”*(HMIP CEDARS 2014)^[129:27]
- During an inspection of Brook House in 2010 HMIP noted that *“on a recent occasion a detainee had been moved from RFA (Rule 40) to temporary confinement (Rule 42) after urinating through his door. The officer’s own record read: ‘I entered first with the shield. A was standing up by the table and I hit him with the shield ...’. Another officer in the team had recorded that ‘(Officer N) used the shield to hold the detainee against the table in the room. Detainee folded his arms behind the shield’. The name of a medical practitioner present at the incident was entered on the record, but there was no comment. There was no recorded assessment by any manager, although the name of a team leader was typed on the form. (...) On the same day, the first officer had been involved in a further incident with another detainee, who had thrown excrement at three officers who entered his room with the lunch meal. The officer recorded: ‘I entered with the shield, D was sitting on the bed so I pinned him to the bed while Officers A and B got locks on his arms.’ Another officer recorded ‘We entered room, Mr N using shield to hold detainee in place on the bed...’ The names of a nurse and team leader were entered on the record, with no comment or assessment. These uses of a full-length Perspex shield as a weapon were clearly illegitimate as recorded.”*^[99:59]

- Very similar inappropriate use of force is still being reported from other IRCs with HMIP finding that during a recent inspection of Yarl’s Wood in 2015 *“[o]ne incident caused us significant concern. A group of seven women had gathered in a room in a non-violent attempt to prevent a removal - they all sat on a bed. Centre staff felt under pressure to effect removal by a deadline and decided to use force after several efforts to persuade the women to leave the room had failed. Staff used personal protective equipment, including helmets and shields, because of intelligence that the women may have had weapons. The video showed an officer advancing on the women with his shield. Some of them raised their legs to push the shield away and he then used excessive force by repeatedly striking the bottom edge of his shield down on the outstretched legs of at least two women, effectively using it as a weapon, and causing injuries to the women’s legs. The officer was suspended while an investigation took place. (...) There were weaknesses in the overall management of the incident; staff were not prepared for seven women to be taken to the separation unit at the same time, and the control and restraint teams were backed up waiting to enter the unit. As a result, some women were subjected to unnecessary and lengthy waits under full restraint.”*^[46:33]

Age disputed cases kept in segregation

“We were particularly concerned about the detention of those who claimed to be children, but whose ages were disputed. They were held in segregation, to keep them away from adults, in what amounted to solitary confinement and without care plans, while awaiting social service assessments. One such detainee, held for nine days, had not eaten for two days. Though the centre was not responsible for the delays in assessments, these were wholly unacceptable conditions in which to detain children (...)”^[130:5] (...) *“Potential minors spent too long waiting for social services assessments. Much of this time was spent in the separation unit, often locked in a rule 40*

cell, which was inappropriate. We saw evidence of the deterioration in mental wellbeing of one such individual.”(HMIP Dover 2009)^[130:10]

Home Office policy stipulates that children under 18 should not be held in IRCs. In cases where a detainee’s age is in dispute they should receive an age assessment as soon as possible. The Home Office does not report on how many cases of age disputed detainees have been held in detention. However, statistics show that in the last 2 years 45 detainees who have later been shown to be children have been detained in IRCs and Short-Term Holding Facilities alongside an adult population. In addition, IMB reports and HMIP inspections make frequent mention of age disputed cases being placed in segregation ‘for their own protection’^[131] and that they are often held in these conditions for far too long. The segregation unit is a totally inappropriate environment for minors^[97, 127] and may lead to deterioration of the mental and physical wellbeing e.g. *“[o]ne detainee who said he was 15 had been in separation for nine days when we met him. During this time, he had become withdrawn and unengaged and had refused all food for the previous two days. He had no care plan, a limited regime and was locked behind his door in a separation cell for most of the time for no clear reason.”*^[130:27]

“Eight detainees whose age was disputed had been in the centre in the year to date. All had been assessed by social services and one was confirmed as minor. He had been taken to the separation unit, which was not an appropriate environment for a child.”(HMIP Brook House 2011)^[126:12]

Deaths in segregation

“Solitary confinement is widely viewed as the most dangerous way to detain people, and roughly half of prison suicides occur when people are segregated in this way. Deprived of meaningful human contact, otherwise healthy prisoners often become deeply troubled. Paranoia, depression, memory loss and self-mutilation are not uncommon”(Urbina & Rentz 2013)^[2]

There has been no specific investigation into the reasons for deaths in segregation units in IRCs. The PPO reports high rates of self-inflicted deaths in segregation units in prisons. 50% of these deaths affected prisoners who had been assessed as at risk of suicide but were still held in segregation. Self-inflicted deaths in segregation accounted for 9% of all self-inflicted deaths in prisons^[79].

In IRCs there have been two deaths of detainees in segregation units since 2012.

Brian Dalrymple died in 2012 whilst held in segregation at Colnbrook where he had been transferred after 6 weeks in Harmondsworth IRC, much of which was spent in segregation. The case of Dalrymple will be discussed in greater detail later in the report. However, it is important to note that during his detention at Harmondsworth he went for 9 days without seeing a doctor despite the awareness that he suffered from severe and possibly life threatening hypertension and was refusing medication. Brian Dalrymple suffered from severe mental health issues but did not receive a mental health assessment during the 6 weeks he was held in detention. *“The man’s psychiatric condition deteriorated significantly whilst in detention, with the emergence of behavioural problems, abuse and threatening behaviour. As a result, he was removed from normal location and placed into segregation. Staff did not explore any possible medical reasons for his deteriorating behaviour.”*^[41:5] The Coroner returned a ruling of ‘neglect contributed to death’.

Another death that followed soon after a period of segregation was the death of Prince Ofose at Harmondsworth IRC. The case is still being considered by the Crown Prosecution Service and little is known about the case pending a formal inquest or criminal proceedings. However, shortly after his death a group of Ghanaian detainees issued a statement stating that he had been held in the segregation unit, naked and without heating for 24 hours before he died. The post mortem could not establish how he died so ruled it a death from ‘sudden adult death syndrome’.

The ‘merry-go-round’ of segregation

“In cases of men with mental health or behavioural problems the Board has concerns about the level of care the Centre is able to offer. Such patients are, occasionally, moved from Centre to Centre but this does not satisfactorily address the problems these men are suffering.”(IMB Brook House 2011)^[132:6-7]

In prisons the process of ‘managing’ difficult prisoners from prison to prison, especially from segregation unit to segregation unit, were dubbed the ‘merry-go-round’ or ‘sale or return’ policy, the very names indicating a lack of individual management and care. The practice was ostensibly stopped in 2006 with the implementation of PSO1700 aimed at increasing personal care and management of prisoners held in segregation^[133] though others argue that “it is only a small number of prisoners who find themselves in long term segregation. A number of those however, end up **trapped in the system** and are transferred between segregation units across the detention estate”^[7:4.13 emphasis added] However, the practice of managing difficult and self-harming detainees by transferring them between segregation units in different centres seems to persist in IRCs, as can be seen in the below examples:

IMB at Harmondsworth report that a *“detainee was in fact in segregated accommodation, in Harmondsworth and other IRC’s, for 22 months and was moved between IRCs 8 times.”*^[102:14]

HMIP inspection of Dover IRC found that in *“a sample of 100 cases of RFA [Rule 40], around a third of detainees had been held for more than 24 hours, with an average stay of 2.5 days during the six months before the inspection. Approximately 35% of the sample had subsequently been transferred out to another centre”*^[127:51].

In addition, the case study of HA in this report demonstrates that he was repeatedly moved from centre to centre as none felt they could deal with his bizarre behaviour. In total he was moved 8 times until he was finally transferred to a psychiatric facility. This includes one move which appears to have been motivated by an upcoming announced inspection by HMIP and the need to transfer him before his segregation raised uncomfortable questions with the inspectors. As soon as his mental health stabilised he was again transferred back from the psychiatric facility to immigration detention, contrary to medical advice, where his mental health again deteriorated.

CASESTUDY - MALIK

Segregation continued for weeks with little justification. No evidence of meaningful engagement.

Malik had substance abuse issues and a serious ongoing health condition when entering detention. He was detained for over 9 months during which time he was segregated on 9 or 10 occasions. He describes how during his time in detention his ‘mind was gone, was broken’ as he struggled with ongoing mental health issues.

He was frequently taken to external hospital appointments for treatment for his ongoing condition. On one occasion he was transported in double handcuffs, both ankles and wrists cuffed. Malik says the handcuffs were fitted so tightly that his hands went blue. He says the cuffs were hurting him and that staff were intentionally twisting the cuffs to cause him pain. After returning to the detention centre he asked the guards to photograph the injuries he had sustained to his wrists but no photos were taken that same day. On the way back from the hospital Malik became agitated and demanded that cuffs be removed. He threatened staff with physical violence. As a result he was taken to segregation.

Malik says he was sometimes taken to hospital appointments in single handcuffs and sometimes in double. He did not want to go in double handcuffs and requested that he be allowed to attend appointment in single handcuffs. His request was refused as staff said he was a potential danger to the public. He was informed he would have to go in double handcuffs. Malik refused to go in double handcuffs and as a result he did not receive his treatment which put his health at great risk. He grew increasingly frustrated, stating that he had gone in single handcuffs before and had not been a danger to the public then. Again his request was refused. Malik complained that two officers in particular were bullying him and using the double handcuffs as a way of demeaning him and making him ‘feel like a dog’. Again, the complaint was not upheld. Malik grew increasingly frustrate.

The next time Malik was due to attend a hospital appointment and the guards went to put him in double handcuffs he refused to comply. He

threatened the staff with violence and threatened to burn down the IRC. As a result he was taken to segregation where he remained for 14 days. Segregation records state that Malik refused to move back to the assigned wing. Malik himself says that officers came into the segregation cell without saying anything, just looked at him and then filed a report saying he refused to move. The Rule 40 segregation authorisation records, a sample of which can be seen on the next page, shows that segregation was continued again and again without any indication of attempts to address Malik’s behaviour or the roots of this behaviour. There is no indication of meaningful engagement – just, ‘segregation continued for another 24 hours’.

Obviously a threat to burn down the IRC can be a serious threat to safety and security. However, it must also be understood in the context of the events leading up to the event, with Malik’s deteriorating mental health and his increasing levels of frustration. He had made complaints about the use of restraints and about the bullying by two particular officers but felt these were not taken seriously and that his concerns were not being listened to or respected. Though initial segregation to deal with his immediate threat may have been understandable there is no indication that this threat level was maintained or that his frustration was addressed in such a way as to resolve the situation, instead segregation was continued for 14 days contributing to his increasing frustration.



Rule 40 authorisation for justification of Maliks continued segregation

THE USE OF SEGREGATION AS PUNISHMENT

23/09

██████████ it has been reported that following a failed Hospital visit you made threats to a staff member that you would burn down the centre.
For the safety and security of the centre an initial 24 hours Rule 40 has been authorised

24/09

██████████, due to the level of the threats you made towards the safety and security of all those who live and work within Harmondsworth you will remain on Rule 40.

A further 24hrs

25/09

██████████, today you have stated that you will not move to any unit but Beech House. You are not going to Beech House due to the threats you made against it.

A further 24hrs RFA have been authorized.

26/09

██████████ you have refused to move to any other unit apart from Beech house, you also made threats regarding setting fire to yourself due to this non-compliant behaviour a further period of 24hrs RFA rule 40 has been authorized.

27/09

██████████ you have refused to return to normal location therefore a further period of 24hrs RFA rule 40 has been authorized.

28/09

██████████ you continue to relocate to normal location from rule 40 therefore a further period of 24hrs RFA rule 40 has been authorized.

29/09

██████████ you continue to refuse to relocate to normal location therefore a further period of 24hrs RFA rule 40 has been authorized.

30/09

██████████ you will remain in Elm House for an extended period of 24hrs. This will allow staff to continue to monitor your behavior prior to a move to normal association.

01/10

██████████, you will remain on Rule 40 for a further period of 24 hrs.

Tomorrow we will try and resolve your situation and move you back to more suitable surroundings.

02/10

██████████ you were placed onto Rule 40 following threats made to the head of residence, since your initial stay you have made a number of refusals to leave the unit and return to the houseblock. Stating your preference at staying on Beech House in order to complete an integration and return to normal location a re-integration plan must be completed and signed off by your unit manager

A further period of 24 hours RFA has been granted

03/10

██████████, today you have been offered the opportunity to move to Fir House as part of an integration plan, to which you have been refused.

24hrs have been authorized.

“This is a punishment room”
- (detainee Harmondsworth)



THE USE OF SEGREGATION AS PUNISHMENT

“It was clear from the pattern of usage that separation was frequently used as a form of punishment for those who infringed certain rules, and this was acknowledged by managers and staff. Non-compliant detainees were removed from association for one, two or three days as a punishment and not because of assessed risk and therefore not in strict accordance with the Detention Centre Rules.”(HMIP Brook House 2010) [99:59]

Under the Detention Centre Rules detainees can be segregated to ensure the safety and security of the facility. Segregation should not be used as a form of punishment or a disciplinary measure. The Guidance to the Detention Centre Rules stipulate that *“[t]here are no adjudication procedures and it is therefore not possible to take disciplinary action.”*[74] HMIP’s inspection criteria echo this concern and goes on to specify that *“Detainees are separated (...) for reasons of security or safety only, not for punishment”*[75].

Unlike in prisons where prisoners have access to adjudication processes and therefore have the opportunity to answer to the alleged violations no such mechanisms exists within immigration detention. In accordance with the Detention centre rules detainees should be given the reasons for their segregation within 2 hours of being taken to segregation. However, there is no direct mechanism by which a detainee may contest these reasons or, indeed, contest their segregation. Access to funded legal representation is limited to extreme circumstances where the amount of compensation that is to be expected justifies the expense. The process of launching a judicial review may take so long that a detainee who is segregated for a few days will generally be released from segregation by the time they get a case of the ground. Also, those who are stuck in segregation for months tend to be unable to access lawyers because of the mental

health and the conditions of their segregation. Often officers description of a sequence of events are favoured over that of the detainee and in some cases HMIP found that *“UKBA managers had been over-reliant on staff accounts of incidents and had not always interviewed detainees before authorising separation”*[113:25].

Despite this, segregation continues to be used as a form of punishment in IRCs and is used *“on a daily basis as a punitive response to disruptive or non-compliant behaviour and not on the basis of assessed risk of harm in concordance with the Detention Centre Rules.”*[99:11] HMIP specifies that the use of segregation as a form of punishment is *“possibly unlawful”*[86:61] as it fails to comply with Home Office policy as outlined above.

The use of segregation as a form of punishment is particularly worrying in the context of poor assessment and treatment of mental health disorders where behaviour which may be an expression of deteriorating mental health is misinterpreted as behavioural issues. Segregation is potentially damaging to the health of detainees and in particular for those who have underlying mental health issues. The safeguards that ought to be in place to ensure that those with mental health issues are not detained, such as Rule 35 of the Detention Centre Rules, have been shown to be ineffectual[134]. Therefore the most vulnerable easily end up being punished for their vulnerability without even the benefit of judicial oversight or access to mechanisms of adjudication.

HMIP inspections have repeatedly highlighted the use of segregation punishment as an on-going and problematic issue: at Colnbrook they came across *“an example of a detainee who had pushed past an officer and then been persuaded to return to his room, who was later moved to the Rule 42 unit because of his earlier behaviour. (...)We noted an*

incident where a detainee had been aggressive towards a member of staff and had damaged a notice board. The situation was calmed by another detainee custody officer and the detainee returned to his room at 2.45pm. Despite no further issues arising, he was removed onto Rule 40 at 6.15pm. We could find no reason for the detainee to be moved, except to punish his earlier poor behaviour. There were also some occasions when detainees appeared to have been held on Rule 40 for several days, with no apparent reason for the extended separation. These examples appeared to indicate that separation was sometimes used to punish poor behaviour by detainees, which is not the intention of separation as set out in the Detention Centre Rules. This view was supported by discussions with some staff and managers, who felt that they had no other sanctions they could use to deter bad behaviour. Detainees also told us that separation was used to punish poor behaviour.”[135:59-60]

Though this criticism comes from 2007 the same practices were still in use during the next inspection 3 years later when HMIP noted that the recommendation to eliminate the use of segregation as a form of punishment had not been met and found that *“detainees had been held on Rule 40 for several days, with little apparent reason for the extended separation. It was clear from discussions with UKBA staff, Serco managers and staff that separation was sometimes used to punish poor behaviour by detainees because they felt they had no other means to deter poor behaviour.”*[92:18]

Similar practices were found at other IRCs across the country with segregation being used as an ‘unofficial sanction’ for non-compliance rather than as a strategy for managing specific risk factors or as a ‘cooling-off’ facility when a detainee is being non-compliant and obstructive, even when there is no risk of harm to staff or detainees[97]. Including at Yarl’s Wood IRC which primarily detains women: *“During the inspection, a detainee was placed in the separation unit after an uncharacteristic outburst (involving lunging at an officer) following the receipt of bad news. She was held in the unit long after she had calmed down, which was said to be intended to underline to staff and detainees that such behaviour was not acceptable. It was therefore in practice a form of unofficial punishment.*

Supervising staff in the separation unit had no knowledge of why the woman was there, and had no written background information.”[136:73] During the inspection of the facility in 2013 HMIP were still finding that *“separation had clearly been used as punishment which was unacceptable”*[111:14].

This practice not only contravenes Home Office policy and might, as the HMIP stated, be ‘possibly unlawful’ it also has the potential to cause severe persistent harm to vulnerable detainees.

Frequent reports by ex-detainees that segregation is used as a threat to ensure compliant behaviour with statements such as *“do as I say or you will be placed in Kingfisher”* reported by a number of women held at Yarl’s Wood.[137, 138] This type of usage can also be seen in the case of George below but it is especially worrying in this case as it is combined with ongoing mental health issues and a clear lack of understanding of the experience of mental health amongst custodial staff.

Another case where segregation was clearly used as a form of punishment can be seen in the case of Mr B below – where he was compliant and calm throughout but was none-the-less placed in segregation as a punishment for failure to comply with the process of obtaining Emergency Travel Documents.

Worryingly, there are reports that segregation is being used inappropriately as a precautionary measure: *“Elm was not only used to prevent self-harm ahead of planned deportation (...) but also as a precautionary measure to ensure compliance of difficult detainees with a history of threatening behaviour.”*[96:18]

Segregation used against non-violent protest

Segregation should only be used to ensure the safety and security of the centre and not simply as a result of being non-compliant. This becomes complicated when segregation is used as a means of controlling non-violent protest by detainees within the centre. The IMB at Yarl’s Wood reports that

“following the protest in October, five detainees involved in the protest were temporarily confined for longer periods, varying between 14 hours (one detainee), 19 hours (one detainee) 21 hours and 23 hours (one detainee each). The IMB was present when those involved in the protest were removed to TC and observed that it was a peaceful process, and no force was necessary.”^[122:15] However, as the protest was non-violent and no force was necessary it is difficult to understand why the detainees needed to remain in TC for such a long time (up to 23 hours) unless it was intended as a means of sending a message to other detainees that this type of action was undesirable at the centre and would lead to consequences. The Detention centre Rules are very clear that detainees should only be held under Rule 42 for as long as they remain violent or refractory. There is no indication that the protesters were later removed from the IRC and relocated to prison if there was concern over continued unrest and instigation.

Other similar incidences have been reported from Yarl’s Wood, where detainees were recently segregated for non-violent protest in the form of wearing a t-shirt demanding ‘freedom’ in a case that was widely reported in the media^[139]. In 2015 HMIP reported on the inappropriate use of force on women engaged in a peaceful protest in order to remove them to segregation.^[46]

Segregation used as part of incentive scheme and as an inappropriate sanction

“There was confusion about the incentives scheme and evidence of inappropriate sanctions. It was not officially in use pending a national UKBA review. However, breaches of rules still resulted in warnings from some staff and sometimes resulted in a night in separation. Those separated for behavioural reasons were often inappropriately barred from access to work for a subsequent period.”^[99:13] Further, “detainees separated under Rule 40 for harmful or non-compliant behaviour were usually excluded from access to paid work for a variable period, according to the individual circumstances. This punitive link between separation and

deprivation of work was not appropriate.”(HMIP Brook House 2010)^[99]

“The creation of an enhanced wing and use of a prison-style three-level rewards scheme were not appropriate for a detainee population. Detainees on the basic level were locked up for most of the day, with limited access to activities, and also had their mobile phones removed. Separation was used as a punishment under the scheme, which was inappropriate for a detainee rewards scheme. Detainees had little understanding of how the rewards scheme worked.”(HMIP Brook House 2011)^[126:14]

It is not clear that detainees would necessarily be aware of or able to understand the centre rules, so utilising segregation as a means of punishing detainees for breaching these rules seems inappropriate. HMIP report from Brook House in 2011 records that all detainees are given a ‘house rules and compact’ booklet that contains some illustrated information about the facilities. The booklet is available in English only. Detainees had to sign a separate ‘rules of behaviour’ compact, which was also only available in English.^[126]

CASE STUDY - GEORGE

Inappropriate detention of the mentally ill combined with lack of understanding of mental illness leads to the most vulnerable being punished for their vulnerability

When George entered detention he was already presenting with severe but manageable mental health issues. The initial health screening notes state that he was “un-cooperative due to (...) mental illness”.

Throughout his detention the medical records make frequent reference to his psychotic symptoms, his bizarre ideas, paranoia and visual hallucinations. He repeatedly self-harmed by attempting to jump off staircases, cutting himself, and tying his neck with the cord of a mobile phone charger. After 9 months in detention he was found unresponsive with a ligature tied around his neck.

George’s ongoing and deteriorating mental health issues meant that he found the daily regime of detention extremely difficult to deal with. He frequently self-harmed and the self-harming episodes were often preceded by stressful situations in detention which his mental health disorder made it difficult to deal with. He reported using self-harming as a coping mechanism. One of the psychiatrist reports summarised it thus: “For someone with [mental health issues], the continuing inability to have so little control over their environment is extremely stressful. [George] is now profoundly depressed and psychotic. Continued detention will, in my opinion, lead to further deterioration.”

He was seen by an IRC consultant psychiatrist who prescribed medication but he found it very difficult to adhere to the medication regime due to his ongoing mental health issues. Eventually he stopped taking the medication as he felt it was not working. Medical Justice arranged for him to be seen by independent psychiatrists on two separate occasions 6 months apart and both concluded that continued detention was detrimental to his mental health and recommended that his care be transferred to external psychiatric services. George was assessed by a consultant IRC psychiatrist who concluded that he was unsuited for detention, that continued detention was clearly detrimental

to his mental health and that his care should be transferred to a psychiatric facility.

A Rule 35 (1) report was submitted to the Home Office stating that George is ‘likely to be injuriously affected by continued detention or any conditions of detention’. However, the Home Office replied that it could not rely on the psychiatrist’s opinion as the report was handwritten.

As George’s mental health deteriorated his behaviour became increasingly difficult to manage. As a result, the decision was made to continue his detention with continued management of his condition. In response IRC staff met to establish a care plan for George. The plan states that George’s behaviour has become ‘increasingly unmanageable’. It recognises his severe mental health issues and his need for hospital care. Yet, it proceeds to set out a number of actions which failed to make suitable accommodations for his mental health issues and seem to introduce punitive measures. The report stipulates that “if [George’s] behaviour continues [he] will be relocated to [the segregation unit]” thus setting out punitive measures to address behaviour which is clearly rooted in mental health issues.

Despite George’s mental illness being apparent from the outset he was inappropriately detained. Several psychiatric reports made it clear that the conditions of detention were detrimental to his mental health. The Rule 35 safeguard failed to get him released to the community where he could access the care he clearly needed. Unable to manage his deteriorating condition and increasingly difficult behaviour in detention the staff threatened him with segregation as a punitive measure. This demonstrates a complete lack of understanding of mental illness and a lack of suitable management of such conditions.

After 16 months in detention George’s mental health had deteriorated to such an extent that he was transferred to a psychiatric hospital under Section 48 of the Mental Health Act. George continues to require ongoing psychiatric care and supported living even now, 2 years after his release from detention.

CASE STUDY - MR B

Blurring the lines between the function of IRCs and the Home Office. Using segregation to punish non-compliance with immigration processes.

During the initial health screening at the IRC Mr B informed the health care staff about ongoing conditions such as asthma, epilepsy, stomach and back problems. There is note on file stating: "He denies any self-harm and suicidal ideation." Mr B also informed the healthcare staff that he was a victim of torture but no Rule 35 report was completed to trigger a review of his detention. Victims of torture should be considered unsuited for detention absent exceptional circumstances.

4 months after begin detained Mr B was informed that he would be moved to the Short Term Holding Facility so that he could attend a face to face interview with embassy officials to secure Emergency Travel Documents. Mr B refused to relocate and as a result was placed in segregation under Rule 40. A 'Maintenance of Security and Safety Notice' indicated that: "[Mr B] was relocated from Bravo Unit to the Secure Unit due to non-compliance as he refused to relocate to STHF as internal move for a pending (...) High Commission review. [Mr B] complied with staff during relocation process". The following day, whilst removed from association under Rule 40, Mr B was seen by a doctor who recorded that he "feels low in mood" and notes that he had not seen the mental health nurse despite a referral being made two weeks earlier. Mr B's medical records make repeated references to his low mood and depression.

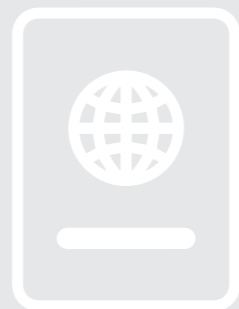
6 weeks after the segregation incident Mr B's medical records make reference to him expressing psychotic experiences. He hears voices telling him that he is detained and that he should kill himself so that he may be free. He sees people chasing and shooting him with guns and machetes. Mr B reports having difficulty sleeping as he is disturbed by the people who are after him, who are trying to kill him and take away his wife.

Prior to detention Mr B had been getting a lot of help from his wife with regards to his mental health problems. She used to talk to him and take him for long walks in the park when he was very disturbed psychologically. However, detention has separated

him from her and he feels isolated. The experience of segregation increased isolation and may have been contributing factor in his deteriorating mental health.

The decision to remove Mr B from association under Rule 40 was not in accordance with the Detention Centre Rules. The noted justification indicates that he was removed from association purely because he had refused to comply with a requirement to move to the short term holding facility for the proposed of an Emergency Travel Document interview. It clearly states that he was compliant during the relocation process and there is nothing to indicate that segregation was necessary for the maintenance of security or safety. Mr B was placed in segregation not because he constituted a danger to the safety and security of the centre but as a punishment for non-compliance with the immigration process. Actions such as these have been criticised in the past as blurring the role of Immigration Removal Centres and that of the Home Office. The role of the IRC should be to "a neutral custodian, not to punish detainees for their lack of compliance with the Home Office]." ^[114:50]

The power to remove from association does not exist to enable IRCs to effectively penalise an individual who refuses to comply with a requirement to attend an Emergency Travel Document interview. The Detention Centre Rules do not create a form of adjudication process equivalent to that which exists under the Prison rules so it is not appropriate to utilise this as a punitive sanction. The power under Rule 40 exists to ensure that safety and security can be maintained within detention centres. It is therefore oppressive and an abuse of power to use the power under Rule 40 to punish an individual. Mr B continues to struggle with serious mental health issues post release from detention.



CASE STUDY - MISS R

Segregation under both Rule 40 and Rule 42 used to punish those who have been involved in peaceful protest. Ends in 15 day segregation before transfer to prison.

Miss R is a survivor of sectarian violence in her country of origin where she saw parts of her family killed in front of her. As a result of these experiences she was diagnosed as suffering from PTSD as early as 2005. She is lesbian and fears for her safety if returned to her country of origin.

She was detained at Yarl's Wood IRC in December 2011. Whilst in detention she reports being 'bullied' by guards and other detainees as a result of being lesbian. She was detained with a number of detainees from her own country of origin where homosexuality is against the law and not accepted by the community. She made formal complaints about her treatment at the hands of guards and of other detainees. Eventually she found support amongst other detained lesbians.

In September 2012 she started an online petition together with 4 others to highlight the abuse they felt they were being subjected to at the hands of other detainees and religious leaders. The petition garnered significant support with more than 800 signatories.

On the 19th of October 2012 she staged a non-violent sit in protest at Yarl's Wood to protest their treatment and demand their release from detention. Miss R was singled out as an instigator of the protest and placed in segregation under Rule 42 despite not being violent. On the 24th of October 2012 Rule 40 form states "We have been asked to accept [Miss R] overnight on 24.10.2012 when on Friday the 25.10.2012 she will be transferred to another centre. [Miss R] was involved in a protest at Yarl's Wood on the 19.10.2012 all intelligence gathered lead to [Miss R] being one of the main ring leaders, which therefore lead to her being placed into the prison estate. We do have other residents who were active players still residing in the centre and due to [Miss B] being influential and her manipulative behaviours, which she clearly demonstrated on the day of the incident and leading up to the incident it is only appropriate that

we place her into kingfisher under rule 40 for the night"

Miss R was kept in segregation for a total of 14-15 days before being moved to prison, this was done despite the IRCs awareness of her ongoing mental health issues. She had been diagnosed with PTSD in 2005 and medical notes make reference to her experiencing psychotic depression, hearing voices and having thoughts of self-harm. Miss R said "her mental health deteriorated considerably following her period of solitary confinement and her transfer back to HMP Styal, to the extent that 'I nearly lost my life'. She explained that the voices she had been hearing became louder. She had given in to their instructions to kill herself and tried to tie a ligature round her neck. Following this 'I was told I was unconscious for 30 minutes. I lost my pulse. The doctor told me it was a near miss'."

Miss R was released on bail in February 2013. Following release her psychiatric problems continued and shortly after she was hospitalised for several months. She continues to experience dissociative episodes, flashbacks, auditory hallucinations and severe depressive episodes with psychotic features for which she is receiving community mental health support.

It is difficult to understand why it would take so long to secure a place for her and why she would need to remain in segregation for such a long time despite not being violent unless it was intended as communicating a message to other detainees that such behaviour was not tolerated. Clearly others involved in the protest remained at the IRC and were not considered a threat to safety and security.



THE USE OF SEGREGATION TO MANAGE MENTAL HEALTH



“The most likely location to find the severely mentally ill is the segregation unit” - (IMB Harmondsworth 2012)^[102:5]

THE USE OF SEGREGATION TO MANAGE MENTAL HEALTH

Detainees with mental health issues should not be placed in segregation

“There is consensus amongst observers, experts and, increasingly, the courts, that the mentally ill and those at risk of self harm should not be held in solitary confinement (...) **“For these inmates, placing them in [isolation] is the mental equivalent of putting an asthmatic in a place with little air to breath”** (Madrid v. Gomez judgement, 1995). (...) Thus, those suffering from mental illness must not be placed in solitary confinement and under no circumstances should the use of solitary confinement serve as a substitute for appropriate mental health care” (Shalev 2008)^[27:30 emphasis added].

The academic literature has demonstrated the negative effect that segregation can have on a detainees’ mental health and in particular on those with pre-existing vulnerabilities^[27]. Thus, segregation should not be used for the management of detainees with mental health issues other than in exceptional circumstances. As we will see below, IMB reports and HMIP inspections from IRCs across the UK continue to highlight the continuing inappropriate use of segregation to manage detainees with mental health issues.

This is particularly worrying as segregation is not a therapeutic environment^[102] and healthcare provision within segregation units falls short of those provided in the community. “[A]s some of these women were ultimately transferred to secure hospital conditions, the separation unit was not an appropriately therapeutic environment. One woman reported: ‘I was restrained a few times before I was sectioned

“Solitary confinement harms prisoners who are not previously mentally ill and tends to worsen the mental health of those who are.” (Istanbul Statement 2009)^[71]

“It is bizarre that if you’re paranoid and hallucinating, they stick you in a hole” (International human Rights Programme 2015)^[52:83]

Detainees with mental health issues should not be segregated in the first place. As discussed in previous chapters segregation can cause tremendous harm to the mental health of detainees and in particular those who have pre-existing mental health disorders. According to Home Office policy detainees with mental health issues should not be considered suitable for detention except in exceptional circumstances^[10]. However, insufficient screening processes means that many are not identified and end up inappropriately detained^[140]. Safeguards within IRCs designed to identify and release these individuals do not work as intended^[141] and the provision of mental health services in IRCs falls far short of those offered in the community^[142]. Mentally ill detainees are often placed in segregation as a result of the IRC’s inability to appropriately deal with their challenging behaviour, which is often a symptom of their deteriorating mental health. Failure to satisfactorily manage detainees’ mental health leads to segregation of these vulnerable detainees which only exacerbates the problem and often leads to the detainee deteriorating to the point where they need to be sectioned in a mental health facility. This familiar pattern in IRCs represents a failure on the part of the Home Office and its subcontractors to safeguard the most vulnerable individuals in society and may cause irreversible harm to the mental and physical wellbeing of vulnerable detainees^[1].

under the mental health act and I remember being carried away in only a nightdress. I felt my right to dignity and respect was violated^[146:34].

Reviewing the use of segregation in immigration detention in the United States the Department of Homeland Security issued the following recommendations:

- *“Segregation is never an appropriate setting for long-term placement of mentally ill detainees.*
- *Segregation often exacerbates mental illness and is counterproductive to the goal of stabilizing a detainee.*
- *Segregation is not a good environment for those with mental health concerns because detainees reported increased levels of depression and anxiety when held in a short stay unit.*
- *It is not possible to make segregation into a therapeutic setting in which mentally ill detainee’s condition would improve.*^[108]

Yet, in the UK detainees with mental health issues are often routinely held in segregation unit, *“many men arrive with apparent mental health issues or behavioural problems. These men are often in considerable distress and are, perhaps, facing their first time in detention. They are generally held in the Care and Separation unit and, if necessary, moved on to a secure mental health unit elsewhere.”*^[143:7-8]. However, segregation units are not an appropriate alternative to more suitable arrangement such as release to the community where the person can access the specialist mental health care they need or transfer to a psychiatric facility where more suitable care and accommodation can be provided^[84]. IMB and HMIP reports are littered with references to the detention and segregation of those with mental health issues e.g.: Current thinking in mental health care has very much turned against the use of segregation as a form of restraint or treatment alternative. The focus has now shifted to the importance of mental healthcare being provided in the least restrictive environment possible and with the involvement

of the patients support mechanisms. Good mental health care means providing healthcare in a least restrictive environment with avoidance of inhuman treatment. Outcomes are better when a person with a mental disorder is treated in the least restrictive environment.

“There is also an accepted moral imperative (codified in both the Mental Health Act and the Capacity Act) that treatment should be provided in the least restrictive setting possible. Most people who would until recently have been admitted into psychiatric hospital for long periods were not admitted anymore or only admitted very briefly.” (Royal College of Psychiatrists 2013)^[145]

There are strict limitations on the use of segregation in mental health care which reflects the recognition of the harm caused by locking individuals up in a non-therapeutic environment^[146]. Yet, detainees remain locked in segregation in IRCs whilst awaiting transfer to mental health facilities who would not subject them to the same treatment. At best it is a form of warehousing of vulnerable individuals, at worst it is leading to deterioration in their conditions and contributing to the need to be transferred to a mental health facility in the first place.

“Our concern about the care of those with mental health needs remains the same as last year. Detainees with significant mental health needs sometimes languish at Harmondsworth because external beds cannot be found for them or because their needs, while significant, do not warrant their being sectioned under the Mental Health Act. This is distressing for them, for staff and for other detainees.” (IMB Harmondsworth 2009)^[147:17]

Detainees with mental health issues should not be detained

“The Board would yet again question the quality of the initial decisions to detain, and the amount and quality of the screening which takes place prior to detention. An increasing number of detainees have arrived suffering severe mental

health problems to the extent of requiring sectioning under the Mental Health Act. These detainees are effectively then ‘stuck’ in detention until the authorities argue over responsibility or a suitable alternative can be found. We saw one resident who was detained for 8 months exhibiting increasingly disturbed behaviour (...) HOIE’s own guidelines state that people should only be brought into detention for the shortest possible time and where there is a realistic expectation that a removal can be effected. These figures show that these are not being followed.” (IMB Yarl’s Wood 2014)^[148:17]

Home Office policy Enforcement Instructions and Guidance (EIG) 55.10 sets out several groups of people who should not normally be considered suitable for detention except in exceptional circumstances. One of these groups is “[t]hose suffering from serious mental illness which cannot be satisfactorily managed within detention”^[10]. Despite this those suffering from mental health disorders continue to be detained in the absence of exceptional circumstances and in contravention of Home Office policy.

Yarl’s Wood IMB reported in 2014 that a small number of detainees with severe mental health problems were held at the IRC because there was *‘nowhere else considered safe for the vulnerable women’* which cannot be seen as an adequate reason to place people in detention. Of these, one was held for 15 days in segregation before being moved to a secure mental health facility^[148]. Also the IMB reported the case of a woman who was detained for over 800 days, during which time she displayed signs of severe mental health issues and was segregated on no less than 8 occasions. Segregation has repeatedly been found to be one of the most dangerous places to hold a detainee so cannot be seen as an appropriate solution to such situations.

It is not justified to detain a person with a mental disorder for the reason of administrative convenience because the severity of his/her mental illness is such that detention is more likely to have an adverse impact of their wellbeing and underlying risks. *“For many of these detainees, segregation had been a component of*

*“Mr A, who appeared to have physical or mental health issues causing him to have severe tantrums, who was placed on Rule 40. The full picture has now emerged following our letters to the Minister and a report by UKBA’s Professional Standards Unit. This detainee was in fact in segregated accommodation, in Harmondsworth and other IRC’s, for 22 months and was moved between IRCs 8 times. His was a difficult case because he refused all the help that was offered. **However, this help was offered in the context of living in the segregation unit rather than in anything approaching a therapeutic environment.** This European detainee was eventually returned to his home country”* (IMB Harmondsworth 2012)^[5:14 emphasis added].

“Numbers of detainees placed in the segregation unit (Elm) have decreased again, but there remain occasions where men are held in the area for considerable periods. Three examples: Mr A, who exhibited disturbing behaviour (with an apparent sexual fixation), was held in Elm from 22nd December 2012 until late January 2013, before being removed from the country. Mr B was in Elm from 20th June until late July, then being transferred to Colnbrook IRC. He neglected his personal hygiene and communication with him was difficult as he apparently spoke only an unusual village dialect. GEO did what they could to try and arrange appropriate interpreting services.

Mr C was in Elm for nearly 4 weeks from 11th October and eventually spent some time on the healthcare ward before his deportation on 22nd November. He was also difficult to communicate with, as although his command of English was very good his statements were illogical and incoherent” (IMB Harmondsworth 2013)^[144:13].

their original torture experiences and now was applied as a means to control behaviour and address mental health concerns”^[149:487].

“Each year we observe more women with acute mental health problems being detained when they are clearly not fit for detention. Quite apart from the effect on the individual, there is an effect on the service to other detainees, with Healthcare staff spending hours trying to arrange other accommodation for them, and officers trying to manage them on the residential units or in the separation unit.” (IMB Yarl’s Wood 2014)^[148:12]

“Forgotten World” – Mental Health care in immigration detention

“At our inspection of Harmondsworth we found that detainees’ mental health needs were under-identified, and staff described the inpatients department as a **‘forgotten world’**. There had been no mental health needs assessment, no staff training in mental health awareness and there was no counselling service, despite increasing numbers of detainees with high anxiety.” (HMIP Annual Report 2012-13)^[9:67 emphasis added]

Healthcare in IRCs, and especially mental health care, has been found to fall short of that provided in the community with staff referring to the healthcare as the *‘forgotten world’* where individuals linger inappropriately and indefinitely. Despite high rates of mental disorders among detainees^[30, 31] – in particular anxiety, depression, self-harm and PTSD - the provision of mental health services in detention is inferior to that in the community. Current NHS mental health service is focused not just on the treatment of symptoms of mental disorder but on the recovery, relapse prevention and the successful reintegration in society of sufferers^[145]. None of these conditions can be easily fulfilled in the immigration detention setting which is characterised by fear and uncertainty^[150] and has been shown to have a deleterious effect on mental health and recovery rates^[32]. The Royal

College of Psychiatrists Working Group on Asylum Seekers position paper on detention of people with mental disorders argued that “[w]e believe it is likely that any person with mental disorder would deteriorate to a level of ‘serious mental illness’ in the conditions of detention, which would also be associated with an increased level of emotional suffering.”^[145 p.6] It can never be appropriate to utilise detention as an alternative or equivalent to hospital as detention is not a therapeutic environment. Rather, it adds another layer of stressors: loss of liberty, uncertainty over deportation, unpredictable events, social isolation, fear of abuse by staff, riots, forceful removal, hunger strikes, self-harm, the indefinite period of detention, a culture of disbelief, and the absence of specialist psychiatric service. “The very fact of detention (which, unlike imprisonment, has no punitive or retributive function) mitigates against successful treatment of mental illness”^[145 p.6]

Even with transfer of commissioning to NHS England in September 2014 the provision of healthcare does not appear to have improved at IRCs. In fact, the HMIP inspection of Yarl’s Wood in April 2015 found that healthcare at the facility had declined drastically since the last inspection. The Care Quality Commission reported that “[h]ealthcare provision did not ensure that patients received care and treatment comparable to that provided in the wider community. They were not assured of access to support, care and treatment for low level mental health needs”^[46:34]

The fact that detainees’ mental health needs continue not to be met in detention makes it particularly galling that those with mental health issues continue to be detained^[46]. “Registered mental health nurses attended the ward round and separation unit daily to provide support. There was no access to psychological therapies or groups. There was fortnightly psychiatrist input and a counsellor saw six English-speaking clients weekly. Self-help materials were available only in English”^[89:49]. Those with mental health issues who are detained quite often end up in the segregation unit which has been demonstrated to be detrimental to health and well-being^[27]. In addition, though detainees are seen by

healthcare staff daily when in segregation, the quality of these consultations has been questioned^[83] and it could be argued that access to healthcare is limited as a result^[132].

In the words of one detainee: “Instead of helping us they locked us up. We need support, we need mental health help but they just put us in ‘the block’ with a metal toilet. They just threatened us with the block”^[138]

The IMB at Harmondsworth raised concerns about a clearly disturbed detainee that had been held in segregation for more than 10 months. In the very same report the IMB raises concerns over the level of healthcare provision at the centre in particular the uncaring attitude of some of the healthcare staff and the inadequacy of the mental health service provision for the population. Clearly this man would not have been getting the care he needed and, should therefore have been released from detention so he could access the care he needed rather than left to linger in segregation for 10 months^[151].

During an inspection at Tinsley House IRC HMIP found that systems for referring detainees with mental health issues were inadequate and that there was little use of recognised assessment tools or structured care planning^[128]. At Harmondsworth HMIP found that “[t]here was no formal care planning and links between health care and segregation staff were underdeveloped. The centre lacked a multidisciplinary team approach to case management and a structured regime with appropriate interventions.”^[152:71] Similar concerns have also been raised by the IMB at The Verne IRC who are concerned about the unsuitability of the ex-segregation unit as a Care and Separation Unit (CSU) for those seriously ill with mental health problems. “It is often two to three weeks before mental health detainees can be assessed and relocated to more suitable accommodation; in one instance a detainee was kept in CSU for 51 days before a secure bed in a mental health facility could be found.”^[153:12]

In the absence of effective safeguards. Decision to detain, Rule 35 and monthly reviews

The safeguard built into EIG 55.10 should prevent those with mental health issues from being detained in the first place but Medical Justice continues to see detainees inappropriately detained due to poor decision making during the initial decision to detain vulnerable individuals. Both the initial screening and the ongoing monitoring is inadequate.

Once in detention a detainee’s continued detention is reviewed by the Home Office caseworker on a monthly basis to ensure that the decision to detain is still appropriate. However, in most cases caseworkers have never met the detainee in question and will base their decision on information received from the detention centre. Monthly detention reviews have been shown to be formulaic, pay little attention to the amount of time already spent in detention and often fails to mention important developments in a detainee’s case such as deteriorating mental health and periods of segregation^[38].

Another safeguard should really be found in the complaints process. However, Medical Justice research, *Biased and Unjust*, has demonstrated that the complaints process is inadequate. There is a lack of understanding of how it works amongst detainees, insufficient investigations of complaints and as well as strong barriers to submitting complaints as detainees fear of reprisals for submitting complaints. As a result, the complaints process is not an effective means of redress for detainees nor an effective safeguard^[154].

Lastly, Rule 35 of the Detention Centre rules should function as a safeguard for detainees by triggering a review of their detention if a doctor has concerns that (1) a detainee’s “health is likely to be injuriously affected by continued detention or any conditions of detention”^[155]; (2) “they suspect of having suicidal intentions”;

or (3) “they are concerned may have been the victim of torture “ they must fill in a Rule 35 report and submit this to the Home Office so that the detainee’s continued detention may be reviewed. However, very few Rule 35 (1) reports are submitted and very few of these lead to the release of the detainee^[156]. Medical Justice research, *the Second Torture*^[29], demonstrated that Rule 35 had failed to protect victims of torture in 49 out of 50 cases and documented criticisms of systemic Rule 35 failures by organisations, inspectorates and damning court judgements. The Home Offices own internal audits has shown that Rule 35 reports rarely lead to the timely releases of detainees^[157] and the process as a whole has been shown to not work as intended and to fail to provide for the adequate safeguarding of detainees^[141].

‘Bad behaviour’ masking mental health issues

Detainees with mental health disorder are “particularly likely to present with high levels of anxiety and/or agitation. This may be misunderstood as challenging behaviour, leading to a vicious circle of increasingly restrictive containment and worsening behaviour.”^[145]

Staff at IRCs lack adequate training in recognising and dealing with mental health issues. As was seen in the case study of George, even when mental illness is recognised, staff are not qualified to manage such conditions. As a result, behaviour that is rooted in mental health issues is often misunderstood as difficult behaviour and dealt with through the segregation of detainees under Rule 40/42 rather than addressing underlying causes and ensuring that the detainee has access to mental health treatment. The IMB at Yarl’s Wood found that “[a] small number of detainees have been in TC on more than one occasion. We are concerned that detainees with perceived and identified mental health issues end up in TC because of their behaviour.”^[148:13]

Since segregation is frequently used for the management of detainees with mental health

problems that cannot be satisfactorily managed in detention many detainees with mental health issues end up in segregation. And once placed in segregation their mental health further deteriorates due to being placed in such an extremely un-therapeutic and restrictive environment. Knowledge of the fact that many with mental health issues end up in segregation may deter detainees from raising mental health concerns with medical staff.

One common such behavioural situation arises around the notion of ‘dirty protests’ where detainees or prisoners self-neglect, refuse to wash or use urine or faeces as projectiles. There is no publically available protocol for how to deal with a dirty protest in an IRC. What is clear from the examples we have seen is that a dirty protest is usually dealt with as a behavioural issue rather than as a symptom of an underlying mental health issue. In prisons, PSO 1700 recognises that dirty protest “may be undertaken as a protest, they may also be as a result of mental health problems.”^[76:55] And goes on to specify that “[e]very effort should be made to ascertain the reasons for the protest. Appropriate encouragement should be given to the prisoner to withdraw the threat or end the protest.”^[76:56] Interestingly, it argues that “[a]ll closed establishments must have in place a written policy for managing prisoners on dirty protest. Under the Human Rights Act 1998 it is necessary to have a justifiable and proportionate response to dealing with dirty protests.”^[76:55] If there is any such policy in place in IRCs it is not publicly available. As such, the lack of such a policy possibly place IRCs in breach of the Human Rights Act 1998.

Segregation often leads to sectioning under the Mental Health Act

“individuals in solitary confinement are forced into an environment that increases their risk of hospitalisation...for psychiatric reasons” (Sestfot et al 1998)^[158:105 quoted in Shalev (2008)]

“a detainee presented with extremely challenging and disturbed behaviour, being placed in Removal from Association (RFA) and Temporary Confinement (TC) on a total of eight occasions from May to October. She had a prolonged period of assessment, but ultimately she was admitted to a secure in-patient facility.” (IMB Yarl’s Wood 2012)^[122:12-3]

Detainees with mental health issues left in segregation will often deteriorate to the point of requiring sectioning under the Mental Health Act. Often there is considerable delay whilst arranging for transfer to a secure psychiatric facility and in the meantime detainees are left to linger in segregation cells^[84]. “It is also inappropriate for detainees (who are not prisoners) whose illness is so severe that they really do require hospitalisation, but who are willing to be admitted and treated to be admitted under Mental Health Act Section 47/48 provisions. This is clearly not the least restrictive option that meets their mental health care needs. Where compulsory assessment and /or treatment is necessary, the most appropriate option will normally be release from immigration detention and admission on Sections 2 or 3 of the Mental Health Act, since such hospital detention is subject to appeal and also enables appropriate discharge planning, including day leave, as well as continuity care once hospital admission is no longer necessary.”^[145]

Many of these detainees should not have been detained in the first place under EIG 55.10 and the majority should have been picked up by safeguards such as Rule 35 (1) to be released into the community where they could access the care they needed. Failure to identify and safeguard detainees with mental health issues has led to 5 High Court rulings of inhuman and degrading treatment in breach of Article 3 or the EHRC in the last 3 years, 3 of these spent significant time in segregation before being transferred to a psychiatric facility. This is a tragic and avoidable situation.

“A lack of bed capacity in mental health units does not make it right for detainees to be held in a segregation unit awaiting a hospital

place. The cases of two detainees who were accommodated in 2012 in the segregation unit (one for 2 months, one for 5 months) and who were eventually transferred to hospital should be of great concern to the Minister” (IMB Harmondsworth 2012)^[5:14]

Lastly, following cuts to legal aid a growing number of detainees do not have legal representation and may therefore find themselves without an advocate or anyone to object to their segregation^[159]. There are practical barriers to detainees in segregation signing up to legal surgeries as the sign-up sheet is kept in the library or welfare unit to which segregated detainees generally do not have access. Even if access is arranged there may be delays and difficulties in accessing legal visits^[12].

There are particular challenges in accessing legal representation “for detainees who are in health care. Those who are disabled and those who have been segregated – often they’re segregated because of mental health problems, risk to others, risk to themselves.”^[12] For immigration detainees, deteriorating mental health often leads to the loss of capacity to engage in ongoing legal challenges and immigration process. Even for those who are lucky enough to have a solicitor representing them they may lose the ability to instruct that solicitor after a period in segregation. Medical Justice has seen many cases where loss of mental capacity has led to the detainees’ case being transferred to the official solicitor or litigation friend. This means that the detainee has, perversely, been allowed to deteriorate to a point where they are unable to take part in the administrative process which landed them in detention in the first place. As such, what was perhaps intended as a practical solution to the issue dealing with problematic behaviour has instead created a “level of restriction that, instead of solving administrative problems, becomes both a mental health issue and a further problem for the prison administration” ^[160:92 quoted in Shalev (2008)].

CASE STUDY - DALRYMPLE

Segregation used to manage 'bad behaviour' rooted in mental illness ends in tragic death.

Brian Dalrymple suffered from schizophrenia and severe hypertension (dangerously high blood pressure). He came to Britain for a two-week holiday on 14 June 2011. Immigration officials at Heathrow airport were suspicious at his lack of luggage and odd behaviour, and detained him in Harmondsworth IRC pending removal back to the US. No attempts were made to trace his medical records. Even when Mr Dalrymple refused the hypertensive medication which he so desperately required, and exhibited increasingly bizarre behaviour in detention, no psychiatric assessment was carried out during the full six weeks that Brian remained detained. Brian Dalrymple died isolated and alone in a single cell at Colnbrook IRC on the 31st of July 2011. The Coroner ruled that neglect contributed to his death from natural causes.

On the 15th of July 2011 Mr Dalrymple was seen by Dr Hamid at Harmondsworth who referred him to hospital with extremely high blood pressure. Mr Dalrymple discharged himself against medical advice and told Dr Hamid that he would control his blood pressure through spiritual means. However, this failed to raise concerns about Mr Dalrymple's mental health or prompt a referral for a psychiatric assessment. Despite his dangerously high blood pressure Mr Dalrymple was not seen by a doctor for the next 9 days, during which time custodial staff noted his unusual behaviour over a period of weeks: they noted him being rude, aggressive and incoherent, observed him standing in the corner muttering to himself, urinating on the floor of his cell and throwing food. Still, no concerns were raised about his mental health.

On the 24th of July IRC staff reacted to his deteriorating mental health by placing him in segregation, which is known to lead to deterioration of mental health, but at no point did they explore any possible medical reasons for his deteriorating behaviour. There was no medical assessment of fitness to be segregated carried out. Such assessment are not part of the standard process in IRCs as opposed to prisons. Considering the severe medical issues and refusal to comply with treatment it is worrying that a clearly at risk individual would be segregated in this manner. During the inquest two officers

stated *"that they were not concerned about people in Harmondsworth "muttering to themselves", because a lot of people in Harmondsworth did that."* Though they accepted during questioning that this might mean that all those people were in fact exhibiting signs of mental illness.

On the 26th of July he was transferred to Rule 42 due to being racist and abusive to staff and urinating on the floor. He refuses to see the doctor during the daily visit. During the inquest these medical rounds were described as wholly inadequate and as the *'alive or dead round'* as that was all they were considered fit to assess, whether the detainee was alive or dead. Unit staff note increasingly bizarre behaviour but still no referral is made for psychiatric assessment.

On the 27th of July Mr Dalrymple is transferred to Colnbrook IRC next door. No medical records were transferred so they were unaware of ongoing medical issues but healthcare staff immediately reacted to his behaviour, referred him for a psychiatric assessment and placed him in a single cell. Unfortunately, Mr Dalrymple died, alone and isolated in a single cell, from a ruptured aorta caused by elevated blood pressure before any assessment can be carried out. During the inquest Dr Ilsley, an expert cardiologist, *"told the inquest that Brian's blood pressure had been "ridiculous" and in 30 years he had never seen one that high. It was a "medical emergency" requiring a degree of attention which was absent from the medical notes. Had Brian been treated as he should have been, (...) he would not have died. Four to five days of oral hypertensive medication – pills – would have prevented the death."*

Clearly all safeguards failed Mr Dalrymple. His bizarre behaviour, noted by border staff, should have brought into question his suitability for detention in the first place, whilst in detention healthcare staff should have picked up on his deteriorating mental health and arranged for psychiatric assessment, a Rule 35 report should have been completed to trigger a review of his detention. None of this happened. Instead, Mr Dalrymple was placed in segregation to manage his deteriorating behaviour when the facility failed to satisfactorily manage his mental health.

CASE STUDY - D

Courts find that failure of safeguards and 'premeditated' neglect of medical needs leads to exacerbation of mental suffering as mentally ill man placed in segregation

D, a severely mentally ill man diagnosed with paranoid schizophrenia, was detained at Brook House and Harmondsworth between February 2011 and April 2012. He had been detained on occasions prior to this and his mental health condition was documented in his medical records. As there were no exceptional circumstances cited he should not have been considered suitable for detention under EIG 55.10. After being released D challenged his detention as unlawful and the Court ruled his treatment between February and November 2011, when he was detained at Brook House and Harmondsworth, should be considered 'inhuman' and a breach of his rights under Article 3 of the European Convention on Human Right. The court found that the absence of

CASE STUDY - UJAY

Use of force on mentally ill detainee to remove him from healthcare to segregation despite recognised mental health issues

Ujay says he started developing mental health issues after entering detention. Prior to being detained he had never experienced hearing voices. In detention he had nightmares every night and these got worse the longer he was detained. He reported hearing voices of strangers telling him to kill himself and to cut himself. He bashed his ears to make it stop and shoved toilet paper in them to try to block out the voices.

The medical notes from detention refers to Ujay trying to hang himself and repeatedly cutting himself since being in detention. A Rule 35 report had been submitted but Home Office decided to maintain detention.

He was observed hiding under his bed and behind the door trying to get away from the voices. In the medical notes from early September he is recorded as singing and dancing around his room at night. His appearance was unkempt and he had toilet paper wrapped around his head and in his ears. He was recorded as being tearful and distracted, unpredictable and at risk of deliberate self-harm.

proper psychiatric treatment at Brook House and Harmondsworth exacerbated D's mental suffering. It was "premeditated" in the sense that those with responsibility for his well-being at the two centres persisted in a medical regime for him which involved neglect, particularly in relation to ensuring he took anti-psychotic medication and denying him access to a psychiatrist. The staff at the IRCs also resorted to the use of segregation under Rule 40 and 42, which was in effect a disciplinary sanction and unsuitable for a person with his condition, in order to manage his condition. The court also found undisputed expert evidence that D's mental state deteriorated as a direct result of his mental health needs not having been met, in particular the fact he had deteriorated to the extent that he lacked capacity to participate in his immigration case. D was released to the community on bail in April 2012 where he could access the treatment he needed.

Ujay repeatedly self-harmed and was repeatedly put on ACDT.

On 26.9.14 it was felt that he was fit to be discharged from Healthcare. It is recorded that he became upset and tearful and that he banged his head on the table and punched himself when told this.

He was then forcefully removed to segregation. Ujay said *"he was beaten by the officers. He said that he was hit on his head, arms and testicles. He said he was bleeding from his head and lip and afterwards he vomited blood (...) He said that he has had pains in his head, neck and back since being beaten and that his friends have to help him to stand up in the morning and that he is unable to stand for long. (...) He said he is scared of the officers in Harmondsworth I.R.C."*

Whether or not the use of force was excessive, he was clearly unwell prior to the inappropriate use of force which was extremely traumatising to him. Unable to manage his mental health issues he was placed in segregation for behaviour which was most likely rooted in his ongoing mental health issues.

CASE STUDY - ZACHARIAH

Conditions of detention trigger flashbacks which are managed through the use of segregation rather than release into community until mental health deteriorates

Zachariah is a survivor of the Rwanda genocide who had been receiving mental health treatment in Rwanda for 6 years before coming to the UK. His mental health would usually deteriorate around February-March and the anniversary of his family's murder. He arrived in the UK in 2009 to promote a documentary and whilst here he received news that his life would be in danger if he was to return to Rwanda. He decided to claim asylum in the UK.

In October 2010 he was detained at Brook House. Zachariah informed the detention staff that he suffered from depression. Healthcare staff noted that he suffered from PTSD, flashbacks and that he had scars on his head "from genocide attacks". Despite this, the nurse who saw him ticked NO in the box for 'Victim of Torture' and no Rule 35 report was done.

Following an aborted removal attempt Zachariah was moved to Colnbrook IRC where the doctor again noted that he suffered from PTSD, disturbed sleep, nightmares and flashbacks and completed a Rule 35 report for him. The Home Office responded that they considered continued detention appropriate as they "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 statement which was incorrect.

On the 4th of November Zachariah was taken to segregation after his roommate raised the alarm about the level of distress he was experiencing. Officer used control and restraint mechanisms to move him to segregation due to "non-compliant behaviour". In the segregation unit he "was hysterical and trying to drop himself to the floor. He was crying, gabbling and staring past all staff at possible hallucinations. When a third officer brought out the wand to search him he screamed "no machete" and tried to pull himself away. Then he seemed to re-orientate himself and looked directly at all of us. (...) After checking his medical

file, PTSD was confirmed and the incident attributed to night terror."

Zachariah was seen by a psychiatrist who noted that he "finds some of the routines in Colnbrook trigger anxieties & flashback." The monthly detention review noted his segregation but made no mention of his mental health or history of torture. He continued to suffer repeated flashbacks, severe PTSD and recurrent dissociative episodes.

On the 16th of December a removal attempt was cancelled when a letter from his MP drew attention to his ongoing mental health issues.

He was moved to Tinsley House where he continued to suffer flashbacks. He believes he is back in Rwanda, and that people are trying to kill him and chop him up with machetes. He was repeatedly placed under ACDT and segregated (on 21-22 December 2010, 23-24 December 2010, 3 January 2011, 6 January 2011, 10 January 2011) Zachariah states that "Most of the time, I was locked in a room and there were security guards watching me. On one occasion, there were two security guards in the room sitting on my bed watching me and two outside. The light was also on 24 hours a day. I was unwell but I found this invasive. I remember saying something like, "I am not a terrorist, why am I being guarded like this?"

During a removal attempt on the 7th of February 2011 Zachariah's mental health deteriorates further. He only has partial recollection of events. He states he was too ill to walk and had to be carried off plane by four guards. He was taken to Brook House where he has no recollection of attempting suicide but was told he was found on the floor on his room with a ligature around his neck. He was subsequently placed in segregation for observation where he remembers that "the light was on, the door to the room was open and there guards outside watching me." On the same day he was walked from Brook House back to Tinsley House in handcuffs. On the 26th of February 2011 a Rule 35 report was filled by a consultant psychologist stating that "detainee is not medically fit to be detained. The intensity of his Post-Traumatic Distress Disorder is amongst the

most intense and severe that I have seen over the past 16 years working with patients in the detention environment".

Zachariah's mental health condition was known from the outset and the fact that the conditions of detention triggered his PTSD was discovered very

CASE STUDY - HA

Detainees 'bizarre behaviour' goes unassessed for months as he is transferred from segregation unit to segregation unit. Detention found to be a breach of his Article 3 rights.

HA was arrested for a non-violent crime and sentenced to 14 months in prison, after completing his sentence he was held in prison under immigration powers. Already during his time in prison he began to develop psychiatric problems and was referred to the mental health team due to displaying 'odd behaviour' (this is a phrase which was to be repeated by almost every person that deals with HA during his detention for the next 15 months). HA stopped eating as he believed his food may have been poisoned and tampered with, he is observed drinking and washing from the toilet bowl, had erratic sleep patterns, refused to communicate with staff and was found lying on his bed with a cardboard cross in his mouth. The doctor felt there was an urgent need for "an urgent psych assessment and possible hospital transfer".

Instead, HA was transferred to Dungavel IRC on the 25th of September. No medical notes accompanied this move and none were obtained by the healthcare staff at the IRC so they were unaware of the previous history of mental health issues. However, HA exhibited disturbed behaviour and was still refusing to eat.

This was the beginning of a long journey of HA being passed around IRCs like a bad penny and being placed in segregation repeatedly as the staff were unable to deal with his underlying mental health problems. In the absence of satisfactory

early on. However, he was kept in detention and segregation used as a means to manage his mental health which clearly deteriorated in relation to removal attempts.

management segregation became the preferred mode of treatment, something which was later to be found to constitute 'inhuman and degrading treatment' in breach of Article 3 of the European Convention on Human Rights.

On the 7th of October he was transferred to Colnbrook IRC.

On the 9th of October he was transferred to Dover IRC where he was placed into segregation. It was noted that his behaviour was disturbed and strange and a fax was sent to the Home Office stating that HA has "serious mental health problems and needs to be transferred to a more suitable establishment"

On the 24th of October HA was transferred to Harmondsworth. On the 28th a referral for a psychiatric assessment was made. HA was placed in segregation under Rule 42.

On the 3rd of November he was again transferred back to Colnbrook IRC – still in segregation. Again, his records were not transferred with him. At Colnbrook HA was assessed by three individuals, including a Registered Mental Health Nurse but not a psychiatrist. Following an extremely brief consultation carried out through a locked cell door they assessed that he had 'nil psychotic symptoms' and did not require a mental health assessment. Instead, they attributed his behaviour to his personality. In the absence of medical records this became the standing statement of HA's mental health and it is clear from the record that subsequent treating physicians believe this to have been a psychiatric assessment.

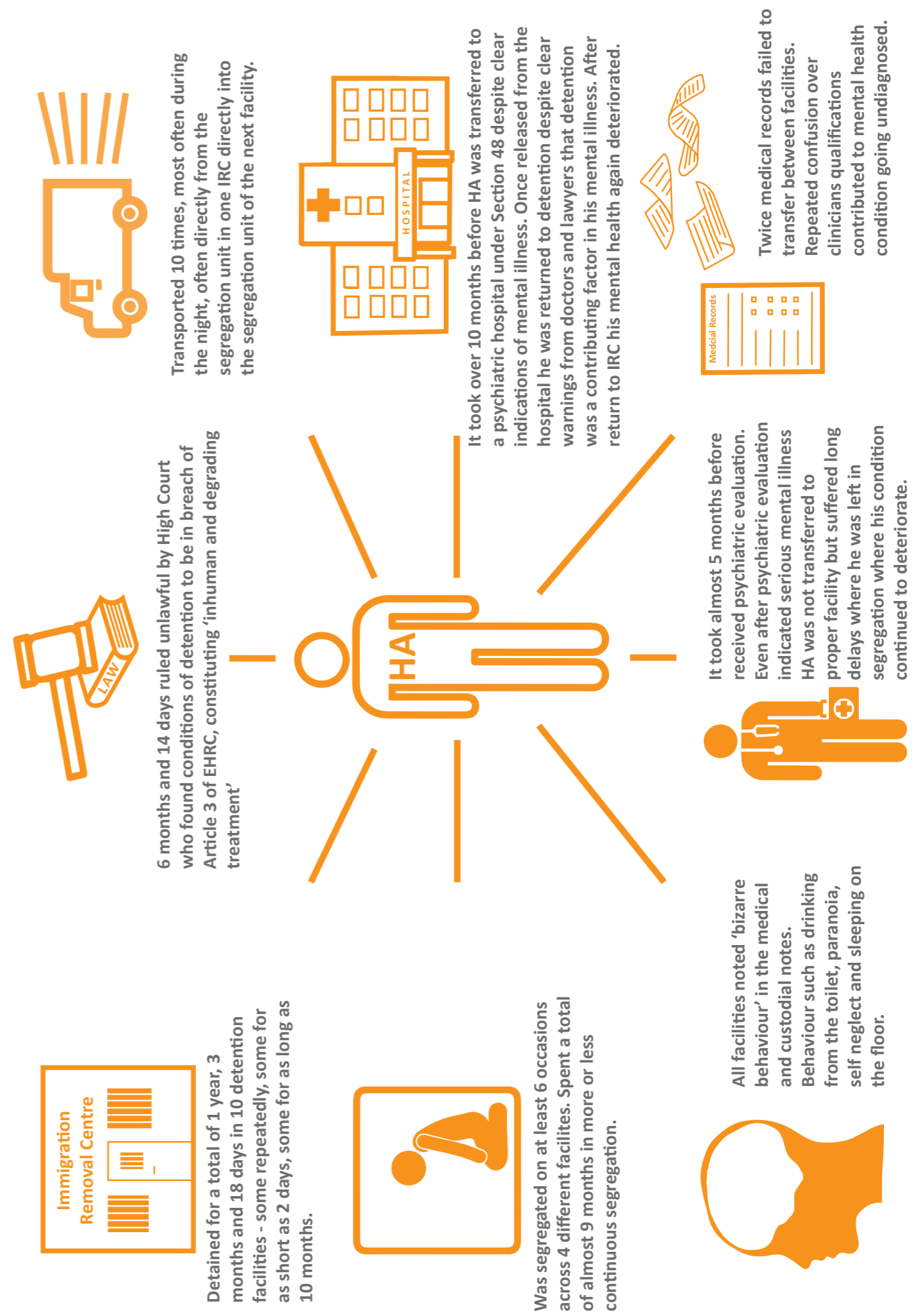
On the 9th of November HA was transferred to Brook House IRC where they noted his 'bizarre behaviour' – but seeing the notes in his medical record, and mistakenly believing they were made by a psychiatrist, repeated the conclusion that there were 'nil psychotic symptoms'. HA was placed straight into segregation because of concerns over his behaviour and interaction with others. Twice during his stay at Brook House transfer requests were sent to Harmondsworth IRC who refused to accept him. HA slept in the toilet area, refused to wash or to socialise with other detainees. He was eventually seen by a psychiatrist who was unable to carry out an assessment but who recommended transfer to psychiatric hospital. A Rule 35 report was completed stating that continued detention would be detrimental to his health but this was turned down by Home Office on the grounds that he was an absconder risk. HA refused to leave the segregation unit. A scheduled HMIP inspection of Brook House may have prompted HA's transfer a week prior to inspection.

On the 7th of March 2010 HA was moved to Harmondsworth and placed straight into the segregation unit where he would spend the next 4 months until he was transferred to a psychiatric hospital. HA still had not received a psychiatric assessment.

On the 5th of July HA was transferred to hospital where he was found to suffer from a psychotic illness which was made worse by the conditions of detention. The psychiatrists recommended that he not be transferred back to immigration detention as this would most likely lead to a deterioration of his condition.

In direct contravention of the doctors request HA was transferred back to Harmondsworth on the 5th of November 2010. Predictably his mental health rapidly deteriorated until he was released on bail on the 15th of December 2010.

Clearly HA's mental health could not be satisfactorily managed in detention. He did not receive a timely psychiatric assessment, medical records were incomplete or missing and the safeguards designed to stop the detention of those unsuited for segregation became the preferred mode of treatment, something which was later found to constitute 'inhuman and degrading treatment' in breach of Article 3 of the European Convention on Human Rights.



THE USE OF SEGREGATION TO MANAGE RISK OF SELF-HARM

Increased risk of self-harm - segregated due to risk of self-harm - removes natural protective mechanisms - deterioration in health and wellbeing - compromised ability to cope with segregation conditions

THE USE OF SEGREGATION TO MANAGE RISK OF SELF-HARM

“Detainees at risk of self-harm or suicide should not be located in the separation accommodation solely for reasons of vulnerability” (HMIP Tinsley House 2014)^[87:17]

Detention Centre Guidance stipulates that *“Where use of Rule 40 is under consideration and the detainee may be at risk of self-harm or suicide Rule 40 must only be used as a last resort and must be with the authority of the contract monitor (in contracted out centres) or the centre manager (in directly managed centres).”^[28]*

Segregation should only be used in exceptional circumstances when no other alternative is possible. As detention is optional one alternative would be to release individuals into care in the community unless there are exceptional circumstances. In prisons the PPO found that *“[s]taff appeared to complete exceptional circumstances forms as a matter of routine, rather than in truly exceptional situations”^[79:6].*

Inappropriate use for vulnerable detainees in crisis

In their inspection reports HMIP repeatedly stress that *“Separation should not be used solely to keep safe a detainee at risk of self-harm”^[136]* nor should it be used solely for reasons of vulnerability. HMIP goes on to describe the use of segregation to manage detainees at risk of suicide and self-harm as *‘poor practice’^[86:12]* and have repeatedly pointed out over the years that segregation is a totally unsuited environment for vulnerable detainees^[84, 87, 94, 109, 115, 126, 128, 161, 162]. In some institutions, such as Tinsley House, this criticism has been repeated year on year, in the HMIP inspection report in 2008, 2011, 2012 and most recently in 2014, yet segregation continues

to be used as a means of managing detainees at risk of self-harm.

Conditions not suitable

The facilities in segregation cells have been discussed in earlier chapters and there is some variety between the centres but in general segregation cells tend to be unfurnished except for a plinth bed with mattress and cell toilet. They have been described variously as *‘stark and depressing’^[86]*, *‘bleak and austere’^[87]*, *‘unfurnished’^[88]*, *‘bare, containing just a shelf table and built-in locker, with no television and no chair’^[89]*. In some centres there had been attempts to soften the décor of the segregation cells with furnishings or by painting murals on the cell wall it remains a stark and untherapeutic environment^[87, 97, 163]. Even when centres attempted to purpose build care rooms for the segregation of detainees at risk of self-harm this was not always successful. At Dover IRC *“[c]onstruction of a new cell for constant watches was under way (...) The new cell did not have a therapeutic atmosphere: the mattress was on a large plinth, the in-cell toilet had no seat and the sink had no taps. These attempts at minimising ligature points were undermined by the presence of other, obvious ligature points.”^[94:23]*

Frequency of use

Segregation is used in most IRCs across the UK to manage detainees at risk of self-harm and suicide. In some centres detainees are kept in the usual segregation cells certified under Rule 40 or Rule 42 whilst other centres have special cells equipped to facilitate constant watch in that it has either a gated cell door (e.g. The

Verne IRC) or a special door with a large Perspex panel to aid observation (e.g. Brook House IRC).

There is no central collection of data on the reasons for segregation so it is difficult to know how widespread the use of segregation to manage detainees at risk of self-harm really is though some reports state that detainees assessed as being at high risk of self-harm were routinely placed in separation^[97]. HMIP and IMB at Tinsley House reported that out of all detainees segregated in a year between 32-39% of all detainees placed under Rule 40 were placed in segregation due to risk of self-harm^[115, 164].

“Nearly half the detainees segregated in the separation cell (Room 12), during 2012 had been on ACDTs, and some had been there solely because of the risk of self-harm. Staff we spoke to considered it routine practice for anyone requiring constant watch to be segregated, and in one ACDT record such segregation was an objective in the care plan. Detainees were sometimes transferred to Brook House care suite. The use of Room 12 or transfer for detainees at risk of self-harm was inappropriate and increased the isolation of already vulnerable detainees” (HMIP Tinsley House 2012)^[128:21]

“Although managers said separation was not used for monitoring those at risk of self-harm, this was recorded as the primary reason in a number of cases. Some staff felt that separation was the most effective way of monitoring individuals at risk of self-harm, although this was likely to take them away from the active support of peers and compatriots” (HMIP Yarl’s Wood 2009)^[136:73].

Removed from support mechanisms

“Detainees were also sometimes moved to other cells in the segregation unit because of risk of self-harm. This deprived them of the social interaction that could help provide support and improve mood, simply to facilitate staff observation.” (HMIP Brook House 2011)^[126:38]

The act of removing a detainees at risk of self-harm from the general population of the centre and placing them in segregation risks removing them from the active support of their peers and compatriots just at the moment when they may require this support more than ever and placing the individual in a stark and bare environment with nothing to distract them from their own thoughts. In some centres (such as Colnbrook^[90], Dover^[94], Haslar^[95], Yarl’s Wood^[46], Brook House^[126] and Campsfield^[93]) detainees are usually not allowed to keep their mobile phones whilst locked in their cells and therefore have no means of reaching out to their wider community for support.

“Detainees assessed as being at high risk of self-harm were routinely placed in separation (...). Although managers had made efforts to fit out and furnish the safer cell and to provide activity for those held in it, which they saw as the safest option for monitoring a detainee at risk, it increased distress in many cases. The threshold for separating those at risk of self-harm appeared too low. (...) Detainees were sometimes strip searched on entry to the special accommodation unit, which was authorised by the duty manager on the basis of risk assessment. In some cases, the purpose appeared to be the removal of any item that could be used for self-harm, despite the absence of any ground for suspicion that a weapon was concealed. A strip search was likely to increase the distress of a vulnerable detainee on top of the punitive action of separating him because of the risk of self-harm” (HMIP Haslar 2009)^[97:53].

In addition, the overuse of segregation as management for self-harm or suicide prevention may lead detainees to hide their ongoing mental health issues to avoid being placed in segregation: *“A consistent problem is the overuse or misuse of suicide prevention segregation. Detainees have stated that the seemingly arbitrary use of segregation led them to hide suicidal thoughts from facility staff for fear that confiding such thoughts or seeking mental health treatment would result in segregation. One detainee stated she needed mental health medication and ‘just wanted to talk to someone about her fears’ but*

was unwilling to seek medical care for fear of being placed in segregation”^[53:7].

In the case of Zachariah described above he described the stress of being under constant watch in segregation: *“Most of the time, I was locked in a room and there were security guards watching me. On one occasion, there were two security guards in the room sitting on my bed watching me and two outside. The light was also on 24 hours a day. I was unwell but I found this invasive. I remember saying something like, ‘I am not a terrorist, why am I being guarded like this?’”*

Another detainee reported feeling suicidal after being in the block for a few hours stating *“I took my underwear and tried to strangle myself, but this did not work as there was nowhere to hang myself from. Then I started throwing water in the electricity [socket] to kill myself. Then I got moved to another cell and they disconnected the water. In this cell I found a piece of metal on the floor and began to cut myself. Six security staff tried to take it [the piece of metal] off me, but they didn’t manage as I put it in my mouth”*

Poor self-harm management in general

Self-harm is a significant problem in immigration detention^[165]. Data for self-harm in detention is fragmented and unreliable^[165] but from the available data it is clear that self-harm is an increasing problem in detention and there is reliable evidence that the rates are significantly under-reported^[166]. Self-harm and suicidal intentions are administered through Assessment, Care in Detention and Teamwork (ACDT)^[167] plans where detainees are put on constant or periodic surveillance with regular reviews. As we have seen above the use of segregation to manage those at risk of self-harm may, inappropriately, form part of this strategy in IRCs.

Self-harm monitoring documentation has been found to be of variable or poor standard^[84, 88]. ACDT is handled by custodial staff and proceedings are

rarely multidisciplinary. There is often no analysis of incidents of self-harm to inform the suicide prevention strategy^[88]. HMIP inspections have found poor identification of triggers, inadequate care maps, lack of assessment interviews as well as insufficient multidisciplinary involvement^[84, 111].

“During the inspection, a man on ACDT case management procedures was held under Rule 40 in a completely unfurnished cell. The impact of these austere conditions was only partially alleviated by the fact that cell doors remained open during the day for those on Rule 40 (...) Care plans had been introduced for vulnerable people, but actions tended to be generic and not focused on active support; for example, in one review ‘monitor behaviour’ and ‘encourage to comply with centre rules’ were the only actions identified” (HMIP Harmondsworth 2013)^[89:30]

*“During the inspection, a young man was picked up by a UKBA arrest team. On his way to the centre, he threatened self-harm and was immediately placed in the safer cell. An assessment, care in detention and teamwork (ACDT) form was opened and specified that he should be observed at least once an hour. He was subsequently locked in the safer cell, **which was not staffed. This meant that there were at least two locked doors between the detainee and a member of staff, which was potentially unsafe.**”* (HMIP Haslar 2011)^[163:14 emphasis added]

This shocking situation persisted despite the criticism from HMIP and the irrationality of placing someone vulnerable and at risk of self-harm and suicide in an unstaffed and unsupervised unit. In 2014, HMIP were again *“concerned to find that the special accommodation unit was not routinely staffed when used to hold detainees who had been separated or, more worryingly, when they were at risk of self-harm. This omission was particularly concerning as we had raised it at our last inspection.”*^[95:5]

Vicious cycle and vulnerable detainees

Segregation has a “potentially damaging effect (...) on those who may be at risk of suicide and self-harm”^[79:1] and “inherently reduces protective factors against suicide and self-harm, such as activity and interaction with others, and should only be used in exceptional circumstances for those known to be at risk of taking their own life”^[168].

Researchers have noted that self-mutilation or cutting is often “a result of sudden frustration from situational stress with no permissible physical outlet... Self-addressed aggression forms the only activity outlet”^[169:341 quoted in Shalev (2008)]. Former prisoners have testified that self-harm played another role for them when they were held in segregation – it asserted that they were still alive^[27]. Or it may be a mechanism through which a detainee can assert control over their situation in an environment designed to remove all control.

One detainee said guards threatened him in segregation “I can kill you in here. No one would know. We would call it a suicide” leaving him to fear for his life. “If you kill yourself they don’t care. If you kill yourself they don’t care” (Detainee Harmondsworth)

In addition, a 2008 study by Cohen et al found that levels of self-harm and suicide were significantly higher amongst immigration detainees than amongst the prison population in the UK^[170].

Whatever the reasons for self-harm, contemporary studies have shown that self-harm and suicides were both significantly more likely in isolation units than in the general prison population ^[171]. One study found that “[i]nmates punished by solitary confinement were approximately 6.9 times as likely to commit acts of self-harm”^[172:445]. It is difficult to obtain figures for forms of self-harm that do not result in death. Nonetheless, there is compelling anecdotal evidence that the prevalence of such

incidents in segregation and isolation units is particularly high^[27].

As one detainee phrased it: “They used [segregation] as a threat. I didn’t want to go there again so I had to do what they said. But I was boiling inside. I reacted in other ways, by self-harming” (Detainee at Yarl’s Wood).

Segregation has “been found to have potentially negative effects on individuals, particularly those who are already vulnerable or have mental health problems. A period of segregation may cause deterioration in a prisoner’s health and well-being, compromising their ability to cope with segregated conditions.”^[79:4] Thus creating a vicious cycle of vulnerability that can easily lead to fatal incidences. The Prisoner and Probation Ombudsman reports a 9 year high in suicides in segregation in prisons – 50% of which were under a self-harm care plan at the time of their death^[79].

Thus, arguably, detainees segregated due to a risk of self-harm are removed from natural protective mechanisms such as the social support of their peers. This may lead to a deterioration in the health and wellbeing which again compromises their ability to cope with segregation conditions and increases their risk of self-harm. The only way to shortcut this cycle would be to ensure that those who may be damaged by segregation are not placed in segregation in the first place. Individuals under a self-harm care plan are particularly vulnerable - so locating them in segregation units should be avoided whenever possible and should only happen when all other options have been considered and exhausted. Other detainees that are particularly vulnerable are Food and Fluid refusers who may have underlying undiagnosed mental health issues or who become vulnerable by their food refusal. Also these detainees are sometimes inappropriately segregated following a few days of hunger striking^[86].

The PPO stresses the importance of the Initial Segregation Health Screen which according to prison guidelines must be carried out within two hours of a prisoner being placed in segregation to counter any threat to a person’s wellbeing by being placed in segregation. It is important that any such screening tool takes into consideration not just the person current demeanour, as

this may mask underlying problems, but to also consider any history of self-harm, suicidal ideation, mental health issues or other factors that may make segregation particularly difficult for them. However, no such mechanisms exist in IRCs.

CASE STUDY - ISAM

Isolated and removed from social interaction against medical advice leads to acts of self-harm.

Isam is a victim of torture who should not have been detained except in exceptional circumstances according to Home Office policy.

A Rule 35 report was completed by a doctor at the IRC. However, it was only completed three weeks after Isam requested one and only after he had asked for it repeatedly. The Home Office dismissed the report and decided to maintain detention as the “doctor has only described your account”. No further clarification or evidence was requested.

Medical Justice arranged for an independent clinician to visit Isam in detention. The doctor noted that Isam claimed to have been held in ‘isolation’. However, the only reference to segregation in the medical notes is a reference to a stay in the Care and Segregation Unit (CSU).

The doctor goes on to note that “[i]t is unclear why he was segregated, especially as medical advice

had been to interact more with other detainees and to socialise (...). It is not clear how long he was held in the CSU. This setting was distressing to [Isam] who said he felt that his act of self harm was related to it, as he felt worried and anxious, and upset by having no one who could speak to him in Arabic.”(emphasis added)

On the 23.08.14 [Isam’s] ACDT was closed without any input from healthcare. The doctor notes that “it is of concern that decisions about [Isam’s] mental health should be made in this way without a formal assessment of his current state.”

Isam’s case shows the failure of the safeguards intended to protect vulnerable detainees unsuited for detention from being inappropriately detained and the failure to pick up his growing vulnerability within the IRC. Instead he ends up in the segregation unit, removed from the protective mechanisms of social interaction and peers who speak his language. Isam ascribes his self-harming to his exposure to segregation.

evidence of torture, such as an examination by the Medical Foundation”.

Abbas was taken to segregation under Rule 42 following an incident where he became frustrated after his phone disappeared during a transfer. Staff told him it was broken so they had removed it.

The Rule 42 report states that he was placed in temporary confinement “due to his aggressive behaviour towards staff and damaging the fabric of the centre”. Abbas claims that staff provoked him and were verbally and physically abusive towards him in the process of removing him to segregation. Once in segregation Abbas grew increasingly frustrated and engaged in self-harm by banging his head repeatedly on the wall until he was bleeding. Abbas claims staff were watching him for the whole time, laughing and shouting encouragements at him, asking “can I help you with that” in response to his self-harming. Was held in segregation for 5 days. Following the incident Abbas refused food for 14 days and fluids for 10 days putting his health at serious risk.

CASE STUDY - ABBAS

Removal from segregation exacerbates acts of self-harm.

After the completion of his prison sentence for a non-violent offence Abbas was detained in prison for over three months. During this time his medical records from prison note that he suffered from PTSD and depression and that he has a history of suicide attempts and self-harming (including by sewing up his mouth and refusing food and fluids). His acts of self-harm were often in response to feeling frustrated. He was then transferred to Harmondsworth IRC where he spent almost a further 3 months during which time he repeatedly self-harmed by banging his head on the wall, cutting and refusing food. He also attempted to take his own life by hanging.

Abbas is a victim of torture and should therefore not have been detained in the first place. When he was transferred to Harmondsworth the doctor complete a Rule 35 report. The Home Office decided to maintain detention based on the erroneous assessment that it did not constitute “independent

CASE STUDY - MD

Handcuffed and segregated to stop self-harming whilst mental health left to deteriorate without intervention to the point where she lost capacity to instruct solicitor. The condition of her detention was ruled to have been in breach of Article 3.

In April 2011 MD arrived at Heathrow Airport on a family reunion visa. She was joining her husband who was living in the UK as a refugee, and whom she had not seen for more than 3 years. At the airport she became confused when questioned by the Border Officers and gave contradictory answers about her age, date of birth and marriage. The judge would later describe MD as ‘an inexperienced young woman of 24 who may have had a propensity for an emotional reaction to a situation she perceived as frightening... but who was otherwise in good mental health.’ MD was transferred to Yarl’s Wood IRC where she was to remain for over 17 months.

In her initial health screening the nurse noted that MD was ‘settled mentally, no concerns’ with no intentions of self-harm. However, after 4 months in detention MD “was restrained, removed from association with other detainees and handcuffs were used to stop her harming herself. MD self-harmed on at least eleven occasions between August and November 2011 including occasions when she cut her forehead with the top of a sardine tin, when she again cut her forehead and the right side of her face this time with pieces of china, when she tried to strangle herself using a mobile telephone cable as a ligature and placed a pillow over her head, when she banged her head against the wall, when she cut her neck using pieces of china and occasions when she cut her stomach, neck and arm.”

The Judge found that “Frequently, her distress, self-harm and aggressive outbursts were responded to by removing her from association and isolating her. In my opinion, isolation is rarely an appropriate way of managing a highly distressed person, let alone someone as vulnerable, dependent and anxious as MD. Instead, someone like that is likely to get more anxious in isolation and so isolation is counter-productive. On many occasions physical force was used in response to her distress. While such a response may sometimes be effective, I would think that this frequently increased her anxiety and was

experienced as traumatic. The records indicate that physical force was used quite frequently, often by a number of male officers. I have significant doubts that this was necessary in most incidents”.

Medical Justice arranged for MD to be seen by independent doctors on 4 occasions between October 2011 and July 2012. MD was assessed as “unfit for detention because as far as can be determined she was mentally well prior to being held in detention and has become ill specifically because of being in the situation of confinement in (the detention centre).” Each of the doctors warned that her condition would likely deteriorate unless she was released from detention and, indeed, MD’s condition got progressively worse between each assessment and in the meantime the instances of self-harm and the use of segregation to manage this continued. It took over 9 months before Yarl’s Wood IRC arranged for their own psychiatric assessment and one of the independent psychiatrists warned that “[i]t is a major concern that MD has not been assessed by a psychiatrist in order to diagnose and treat her serious mental illness (...) The lack of any local psychiatric assessment and a treatment plan is extremely concerning, especially as MD is at severe risk of suicide and nothing is being done to address the underlying illness.”

The doctors’ reports were not fully addressed in the monthly reviews of MD’s detention and nor was the policy of not detaining those suffering from a serious mental illness which could not be satisfactorily managed in detention explicitly considered in those reviews. Also, at no point was a Rule 35 report submitted by healthcare.

By August 2012 MD’s condition had deteriorated to the point where she was assessed as lacking capacity under the Mental Capacity Act and an Official Solicitor was appointed to act on her behalf. The Official Solicitor lodged an application for judicial review of the decision to detain, and to continue to detain. On the 13th of September 2012 MD was released on temporary admission after some 17 months and six days in detention.

The High Court ruled that she had been detained unlawfully for almost eleven months, and that her mistreatment in detention reached the high

CASE STUDY - MD (CONT.)

threshold of inhuman and degrading treatment, breaching her rights under Article 3 of the European Convention on Human Rights.

The Judge further conclude that: the Home Office failed to demonstrate exceptional circumstances for continuing detention; the repeated use of force, restraints and separation was entirely inappropriate without the underlying mental illness being addressed; that the stress of detention was the main causative factor of MD's mental illness; the advice of examining doctors was ignored and the mental illness allowed to continue untreated leading it to deteriorate and causing serious suffering. He went on to state *"that the management and treatment of MD's psychiatric condition at Yarl's Wood was inadequate in a number of ways and not appropriate to her mental state and her severe suffering. In my view it contributed to the deterioration of her mental state in detention and the prolonging of her mental suffering.(...) "I also accept that removal from association and isolation*

and restraint in its various forms (...) was degrading because it was such as to arouse in MD feelings of fear, anguish and inferiority likely to humiliate and debase [her] in showing a serious lack of respect for her human dignity."

Clearly MD's mental illness was caused by detention. Even when her deteriorating mental health was pointed out by successive independent clinical reports this failed to activate safeguards such as EIG 55.10, be assessed in monthly detention reports nor trigger a Rule 35 (1) report. Unable to satisfactorily manage MD's mental health and associated self-harming in detention the IRC responded by placing her in segregation and handcuffing her to stop her self-harming, which contributed to her mental suffering and distress.

CASE STUDY - MRS Q

We have also chosen to include a case study provided by the IMB at Yarl's Wood:

Detained for 800 days despite deteriorating mental health. Segregated on at least 8 occasions and repeatedly placed on ACDT before eventually being released with permanent sequelae.

*"The number of long stay detainees has decreased slightly. Only 1 resident had been detained for more than 12 months and none for more than 18 months by the end of the year, however the longest stay resident during the year was released in May after just over 800 days. This detainee was a Chinese national who was detained at the Centre on 22/03/12 after serving a short prison sentence. She was released on 17/06/14. She was first placed on ACDT Constant Supervision, reserved for detainees deemed to be at risk of suicide, in May 2012. She then made several attempts at self-harm, banging her head against the wall, swallowing sachets of shaving gel, using a ligature and running into the middle of the road on a hospital visit. She complained of hearing voices and first threatened to throw herself down a stairwell in March 2013. On 24/4/14 she jumped from the first floor over the stairwell sustaining serious injuries, and was taken by emergency ambulance to Bedford Hospital. This was deemed to be an immediate attempt to end her life and following a psychiatric review and consideration of her injuries she was released into the community on Permanent Discharge. **During her period of detention this resident was removed to RFA or TC (solitary confinement) on at least eight occasions and spent at least seven periods***

on Constant Supervision and varying degrees of ACDT. 5.7.3. Although this resident refused to co-operate with any of the authorities to effect her removal, there does not seem to have been any realistic prospect of removing her to China and she was deemed fit to fly during the whole period of her deteriorating mental and physical health. After all this she was eventually permanently released into the community. We cite her case as an example of the extremely harmful effects of long term and indefinite detention.^[148:16-7 emphasis added]

In total she was detained administratively for over two year and a judge later ruled that the last year of her detention was unlawful. The Judge also ruled that the *"longer her detention went on, the more vulnerable she became. Her physical health has been significantly compromised, probably permanently. Her mental health also declined in detention"*^[173: para 2]

Clearly Mrs Q's mental health was not being satisfactorily managed in detention. The fact that she was repeatedly put on Assessment Care in Detention and Teamwork (ACDT) self-harm reduction strategy for her repeated self-harming behaviour and was placed in segregation to manage this risk would indicate that her situation was not being satisfactorily managed and that she had indeed entered a vicious cycle of deterioration. In the end, her prolonged detention and the conditions of that detention led to her becoming ever more vulnerable and, eventually, led to her health being significantly compromised in a manner that may affect her for the rest of her life.

THE INDISCRIMINATE USE OF SEGREGATION TO AID IN REMOVAL



THE USE OF SEGREGATION TO AID IN REMOVAL

“The Board has raised its concern at RFA [removal from association] being used as a prelude to removal.” (IMB Yarl’s Wood 2012) [122:14]

Detainees who are set to be removed from the country are often segregated under Rule 40 prior to removal in order to prevent disruptions to the normal running of the centre and to prevent detainees from self-harming.

“Towards the end of 2010, there have been a number of detainees who have resorted to concealing fragments of razor blades in their mouths or on rare occasions swallowing razor blades, in an attempt to frustrate removal directions. R40 is being utilized as a means of isolating such detainees and restricting their access to razor blades for periods ahead of them being notified of removal directions in order to thwart these attempts. Whilst the Board recognise the need to develop strategies to deal with detainees who are deliberately endangering their lives and those of staff involved in their removal the time frames involved are becoming a real concern. The Board recommend that senior management in Detention Services apply greater scrutiny to the use of R40/42 at CIRC and that full compliance with Detention Centre Rules is achieved.” (IMB Colnbrook 2010)[105:9]

Such segregations can only be justified on the basis of individual risk assessments and with due regard to the potential negative impact segregation can have on individuals. A time of imminent removal is already a stressful and vulnerable time for detainees who may fear for their life should they be returned to their country of origin. Removing detainees from association during this time serves to further isolate them from their support networks both inside and

outside of detention^[103]. This can serve to add to their vulnerability.

HMIP raised similar concerns about the situation at Colnbrook IRC during the unannounced 2013 inspection when they found that a number of detainees had been segregated under Rule 40 for what was described as ‘operational instructions for reason of complex removal’: *“In these ‘complex removal’ cases, we were told that detainees were considered to be attempting to thwart removal, often through self-harming behaviour. In the 12 cases we examined we were not assured that separation was justified. Individual operational plans were poor and did not address the needs of the detainee. The prescribed regime was always too austere and security measures such as strip-searching were routine and not supported by adequate assessments of current risk.*

Recommendation: 4.29 The planning and management of ‘complex removal’ cases should be based on detailed risk assessments and address individual vulnerabilities as well as risks. Draconian measures such as routine strip-searching should cease.”[90:52-3]

The limited regime in segregation units means that detainees may not be able to effectively address their resettlement needs in the event of removal^[174]. In addition, limited access to telephones, internet and fax machines may hinder detainees in mounting vital last minute legal defences to challenge their removal directions. Some IRCs even remove mobile phones when placing detainees in segregation further restricting their ability to communicate with legal representatives and family members.

At Dover IRC HMIP found that no individual risk assessments had been carried out for detainees

segregated prior to removal but that they were routinely segregated “to avoid disruption to other detainees in shared accommodation and for the convenience of staff escorting the detainees to reception overnight. Detainees held on the unit for this reason were usually moved there between 8pm and 8.30pm so they had access to the normal regime until the usual lock up time. Despite these efforts, it was not appropriate for detainees to be placed in separation when there was no justification under rule 40 to remove them from association.”^[130:36]

In the past some centres have practiced the routine segregation of detainees prior to removal as are reflected in e.g. the extremely high segregation rates at Brook House, approximately 1500 instances of Rule 40 applied per year for the first few years of operations^[86, 99]. Such routine use of segregation to manage removals cannot be seen as justified.

Brook House IRC have made changes to their processes and the IMB notes in their 2013-14 report that detainees are no longer routinely segregated under Rule 40 prior to their departure. Instead, the E Wing has been remodelled and separated in two by a dividing wall and door. So that the unit now comprises of the Care and Support Unit which houses 6 segregation cells and 12 cells on the Eden Wing which function as a ‘departure wing’^[143]. It is unclear under what regime detainees are held in the Eden Wing but if the intention of segregating detainees prior to departure remains the same, namely to avoid disruption to the removal and to the centre, then it follows that detainees on Eden Wing are subject to a restricted regime with limited access to the facilities of the rest of the centre. “Detainees were unlocked for most of the day. However, they were usually restricted to the unit and those spending longer periods on E wing for any reason were therefore subject to a disproportionately restricted regime”^[85:59] Segregation of detainees onto Eden Wing should also be subject to risk assessments to avoid the wing merely being a means to removing the label, procedures and safeguards of Rule 40 from those segregated in such a manner.

A similar blanket policy was found to be in place at Tinsley House IRC for all who had disrupted their removals and HMIP described this regime as “punitive and unnecessary”^[128:12] The IMB at Harmondsworth has raised concerns at the excessive amount of time some detainees are spending in segregation prior to their removal e.g. “Mr I, who was held at Elm for 7 days ahead of his deportation”^[96:18]

CASE STUDY - SAMUEL

Placement in segregation to aid in removal despite previous knowledge of his mental health issues and repeated suicide attempts leads to retraumatisation.

Samuel was detained in January 2014. He has a history of torture and a Rule 35 report including body map was done for him when he entered detention. He suffered from PTSD, had made repeated suicide attempts and been placed on suicide watch for two weeks. Medical records note him feeling depressed and hopeless.

On the 5th of June 2014, Medical Justice arranged for Samuel to be seen by an independent psychiatrist who concluded that he was suffering from a moderate depressive episode and attempts to remove him “will significantly increase his risk of suicide”. She went on to state that “[Samuel] remains at high risk of suicide and would be likely to pose a high risk to himself and others if his removal from the UK were attempted. From the medical information available to me, flight is contra-indicated in terms of [Samuel’s] own safety and that of others on the flight.” She commented that during a flight “there is high risk that he could become acutely distressed, could attempt to end his life or could be highly disruptive, and if so his behaviour could be very difficult to control. In that situation it is likely that he would not respond to verbal attempts to calm him and he would be likely to require physical restraint”. The doctor also raised concerns about the harmful effects of using restraints on his mental health.

Despite this, removal attempts went ahead a few days later. The independent psychiatrist recorded Samuels account of the removal attempt. Samuel “was moved into segregation in anticipation of his removal. He refused to go and was restrained. He said his elbow was injured and his head banged against the wall and is now painful. He was stripped naked and asked to bend down - he found this humiliating. The reason for this to be done may be that he disclosed he had a razor blade on him yesterday and showed this to staff. He says he is now naked in the segregation room, because he refused to wear the clothes he was given. (...) On the day of the flight, he was visited by a female representative of the Home Office. He told her that

he had been declared not fit to fly and she told him she would go to check documentation regarding this, and would subsequently return. [Samuel] says that she did not come back. Approximately 10 minutes after the Home Office representative left the room, [Samuel] said approximately 12 men with helmets and shields arrived. He had previously obtained a razor blade and at this point he began to cut his arms and abdomen in front of them. He was handcuffed and pushed to the floor and the razor blade was removed from him. He said that during this episode, a doctor and a mental health nurse were present.”

Samuel was handcuffed and taken to a van where he waited for the flight for 8 hours surrounded by six guards. He was still only wearing boxer shorts. He was given water but no food. Samuel was provided with clothing during a stopover in a European city. Upon arrival in his country of origin Samuel was denied entry clearance and returned to the UK on the same plane.

The independent psychiatrist assessed Samuel on the 17th of July and found that he was “suffering with depression which appears to have deteriorated since his attempted removal from the UK. It will not be possible for him to recover from these conditions in the setting of detention. (...) [Samuel] has been traumatised by his recent removal attempt.”

Samuel was placed in segregation to aid in his removal despite previous knowledge of his mental health issues and repeated suicide attempts. Medical Justice faxed our concerns to the IRC to raise the independent psychiatrists concerns that he was not fit to fly and that any attempt to remove him might pose a risk to his own and others safety. It argued that he was likely to react badly to removal attempts so that it would be necessary to use force. And that any use of force would be severely re-traumatising for him. Which is exactly what happened when the independent psychiatrists warning was ignored and removal attempted despite well founded concerns.

Samuel was later released from detention.

CASE STUDY - ABDUL

Placed in segregation 12 days prior to removal despite knowledge of PTSD and history of self-harm.

Abdul had a history of sexual abuse. Upon disclosing this abuse, his father got very angry as *'he lost respect in our community, he cannot take it, he thinks I am guilty.'* Abdul stated that on one occasion his father had cut his throat, by stabbing the point of a long knife into the front of his neck.

Abdul was diagnosed as having PTSD in March 2010 by an early intervention psychosis team and was put on medication.

Whilst in detention he suffered with depression, flashbacks and hallucinations. He said he would hear the voices of his father and the shop keeper who abused him, that the shopkeeper would enter his cell at night as a 'ghost' and that he would sometimes see blood pouring from the scar on his neck where his father stabbed him.

A Rule 35 report was completed but Home Office decided to maintain detention.

On the 24th of January 2012 Abdul was placed in segregation prior to being removed despite the IRCs knowledge of his PTSD and mental health issues. The Rule 40 notice states that *"[Abdul] has been placed in Room 12 on Rule 40 regime having been served his escorted Removal Directions set for 4th February 2012. He has also been placed on an ACDT Constant Watch as this was one of his trigger points. To maintain [Abdul's] safety and as he will be a high profile removal it was deemed necessary and in consultation with UKBA and Duty Director that he be transferred to Brook House in the Safer Suite. He has subsequently refused to do so and is therefore now deemed to be non-compliant, and a suitable crew will be arranged to facilitate this move. UKBA, Duty Director, IMB and Medical aware"*

Removing Abdul to segregation in Tinsley House and to the Safer Suite at Brook House 12 days prior to his removal seems excessive. In addition the notice recognises that removal or segregation are trigger points for his self-harming. Placing a vulnerable detainee known to suffer from high

levels of distress and who is at risk of self-harm and suicide in segregation for such a prolonged period seems excessive and it is difficult to understand why it would be necessary for the safety and security of the centre.

A psychiatric report from Colnbrook determines that Abdul is unfit to be detained and should be released in order to access the treatment he need in the community. A report by an independent doctor arranged by Medical Justice argues that *"While [Abdul] is in detention he requires a high degree of support and supervision to ameliorate his high level of distress and manage his risk of self-harm or suicide."*

The prospect of removal is terrifying to those who fear for their safety upon return to their country of origin. Removing detainees from association with peers during such a stressful time risks increasing the traumatic effects, especially in someone already known to be vulnerable. Placing the individual on constant watch, especially without additional support, may in fact serve to increase this distress.



SEGREGATION BY ANY OTHER NAME

"all those protocols could be considered hidden forms of segregation, the basic separation from both staff and peers" (Hayes 2004)^[175].

Segregation is not only the formal segregation of detainees under Rule 40 and Rule 42 of the detention centre rules – nor is it always a form of solitary confinement. There exist a number of grey areas across the detention estate where detainees are segregated for a variety of reasons. The regimes that govern the use of these facilities are varied. In some, detainees can associate with each other but not with detainees outside of this regime. In others detainees can access facilities like library, dining hall or outside exercise, but usually not alongside other detainees not on this same limited regime. So, though they are not in solitary confinement they are effectively segregated from other detainees. These regimes are sometimes referred to as Care and Support Units, Induction Units, Assessment and Integration Units or they may be part of in-patient healthcare facilities at IRCs.

de facto segregation – unrecorded and unmonitored

This is not to suggest that all uses of such segregation is inappropriate. Some IRCs state that these facilities are needed to house detainees that feel vulnerable or would be at risk in the general detention population. In some cases these facilities are used to isolate detainees with infectious illnesses or to provide calm for detainee with mental health issues who find the stress and noise of the general detention wards too much to cope with.

However, for many detainees the journey between enhanced support facilities, healthcare,

segregation, and possibly back to enhanced support units often appear to be part of the same regime. Many are vulnerable, struggling with mental illness or florid psychosis – the distinctions between one regime and the other is not always immediately apparent and one regime blends into another.

For example, at Brook House IRC E wing, Care and Support Suite and Segregation Unit are next door to one another. Detainee may be shunted back and forth from one to the other depending on their changing circumstances. They may have access to association with other detainees in the same unit but not freedom to associate with whom one wants or to move freely around the centre. A vulnerable detainee may be placed in the Care and Support Unit in a room very similar to those used for segregation under Rule 40 but with access to TV and furniture. Following an incident the detainee may be placed under Rule 42 and subsequently be moved to a featureless and furniture-less room next door. Once the detainee has calmed down they may be moved to back to the Care and Support Unit. Often the whole process is under constant observation from officers as the detainee may have been placed on ACDT. The distinctions between the different regimes are often not clear to detainees.

The main concern with de facto segregation is that detainee subject to these regimes are not subject to the paperwork and safeguards that go along with segregation under Rule 40 and Rule 42 – with requirements for daily checks and behavioural observations as well as justifications for continued segregation. Overstretched guards wary of more paperwork may view this as a compromise solution – but in fact it risks leaving vulnerable detainees without the scrutiny and safeguards asserted by the Detention Centre

Rules. For instance, any segregation needs to be authorised by the contract manager or centre manager and any stay in the excess of 24 hours needs to be authorised by the Secretary of State. However, facilities that may constitute de facto segregation that are not covered by the detention centre rules and the limited safeguards provided by this framework. The removal of individuals out of the general wards removes these individuals from the oversight of other detainees and may limit their visibility and access to organisations that could provide support. It also removes individuals from the active support of their peers and compatriots. Though they are often free to associate with other detainees held in these facilities there is a potential for confounding negative influence of several vulnerable and sometimes unstable detainees held together. Such facilities often lack proper guidelines for use or proper governance structures.

The facilities are most commonly found in the larger centres dealing with larger populations – there is also a tendency to transfer more complex and vulnerable cases to these facilities indicating that these facilities may be dealing with a larger number of complex detainees with support needs and possible mental illnesses. However, the need for such facilities would indicate that these individual’s conditions cannot be satisfactorily managed within the detention setting. These facilities often have misleading names such as the Care and Support Unit when in reality their main utility is to contain risk rather than to provide care or support. Rather than expanding reliance on such facilities what is needed is a proper review of the detainees suitability for detention and whether they can truly access the care and treatment equivalent to that which is available in the community.

De facto segregation could render the detention unlawful and subject to legal challenges. As those held in de facto segregation are not subject to the same paperwork and authorisation procedures as those held under Rule 40/42 could render it less evident in the absence of a thorough paper trail.

Many of these facilities appear modelled on

prison facilities such as the Vulnerable Prisoner Unit or the Care and Separation Unit – though these may be appropriate in a prison setting where the prisoner must remain under law to complete their sentence – the transfer of such facilities to an Immigration Removal Setting raises questions about the suitability of detainees for continued detention.

Examples of de facto segregation

The Rose Unit at Colnbrook IRC

Prior to 2011 Colnbrook IRC had a Vulnerable Persons Unit (established 2008) with the intention of offering more extensive support for detainees who struggle with the custodial environment^[105]. The Unit was located on the 1st floor adjacent to Healthcare. The operation of the unit was frequently criticised by HMIP who, both in 2008 and 2010, recommended that the unit be shut down as it was not fit for purpose^[91, 92]. HMIP pointed out that the unit offered little privacy, was cramped, claustrophobic and constituted an oppressive and degrading environment. Detainees had limited access to centre activities and were dependent on availability of guards to escort them. Two detainees lived in single rooms with cameras so they could be continuously observed by staff whilst the remaining 6 shared a large bedroom. There was not sufficient space to house 8 people in the unit. There was little natural light and it constituted “an inappropriate environment in which to hold people.”^[92]

“The centre had appropriately sought to provide better care for vulnerable detainees, but the vulnerable persons unit that had been created to this end was an oppressive and degrading environment (...)There was no policy setting out the unit’s role and function, no assessment process, a lack of referral criteria and no gate-keeping mechanisms. There was no evidence of multidisciplinary care planning necessary to care for vulnerable detainees held there or elsewhere

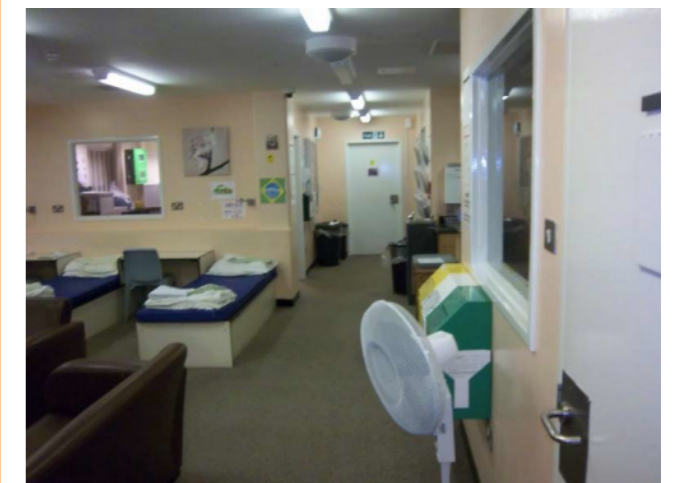
in the centre (...) the general instructions set out a requirement that detainees needed to be assessed against set criteria for entry to the vulnerable persons unit, but there were no such criteria and no assessment procedure. The list of examples of vulnerability included ‘lack of social skills, lack of personal hygiene, personal protection issues related to other detainees and wheelchairbound or other disabilities such as blindness or partial sight/deafness’. The layout of the unit was particularly unsuitable for detainees in the last category” (HMIP Colnbrook 2008)^[91].

During 2011, the unit was re-purposed for the use of female detainees. It was named the Rose Unit and housed up to 8 women^[176]. The Unit had dedicated shower and toilet facilities, access to the internet, TV and laundry facilities. The women held in the unit were free to associate with each other but did not have access to the wider facilities in the IRC^[177]. Again, the Unit was criticised by HMIP for being cramped, poorly ventilated, detainees having poor access to legal surgeries, and almost no access to the welfare services available in the main centre. The women did not have easy access to outdoor exercise which they took in a bleak exercise yard, this was also their only opportunity to smoke. *“The centre had no systematic arrangements for monitoring the participation of this group or for assuring or improving the quality of its provision.”^[90]*

In 2013, a newly refurbished unit, the Sahara Unit, was established for female detainees following frequent criticism of the conditions in the Rose Unit. At the same time the lack of facilities for physically disabled detainees became an issue and the Rose Unit seems to have been re-purposed as a facility for those with physical and mental health issues despite the toilet and washing facilities not being adequately adapted for this use^[178]. This would appear to have returned the Rose Unit to its previous guise as the much criticised Vulnerable Person Unit.

There has not been a HMIP inspection since the re-purposing of the Rose Unit. We remain concerned about the regime in place at the Rose Unit where detainees appear to be kept in segregation from other detainees in the main

centre and, if the centre conditions remain the same, without proper access to the facilities and welfare services of the rest of the centre. We are unaware of specific guidelines in place to regulate the use of this facility.



Rose Unit (HMIP 2013)

The Assessment and Integration Unit at Colnbrook IRC

The secure unit has twelve single rooms and there are a further four single rooms on the 2nd floor which have evolved into an Assessment & Integration Unit (AIU), which houses vulnerable detainees who are being assessed before integration into the IRC^[177]. The AIU is described in a fatal incident report by the Prison and Probation Ombudsman as such *“The AIU is a small residential unit containing four single bedrooms with a living room style area. AIU is intended to be a supportive environment in which residents that have difficulty in coping with detention can be supported and cared for, and be given the assistance needed to integrate into a residential unit. Typically, residents on the AIU are those who experience a significant feeling of being unsafe or do not have the coping or social skills required to stay safe in normal residential units.”^[179]*

However, it is not clear what the purpose and criteria for use for the AIU are. HMIP pointed out that the unit had been used to support

some vulnerable detainees though it had primarily been used for other purposes. HMIP recommended that the purpose of the unit be clarified. The proximity of the secure unit and the AIU means that it may be difficult for detainees to distinguish between the two. Originally AIU started out as being another 4 cells used for Rule 40 segregation but has evolved into the much wider purpose AIU. Though for detainees bouncing between segregation and AIU and back the distinction may be lost. Also, those held in AIU are segregated from the rest of the detainees in the centre. Though they can associate with each other, if the other cells are occupied, this does not afford the same peer and compatriot support as the general centre. In addition, those held in the AIU do not have access to the same activities and support as the general regime in the centre.

In 2008 the HMIP inspection report referred to the unit as the last night unit and said *“the unit appeared to be used for detainees considered likely to resist removal or to self-harm. There was no evidence that detainees moved onto this unit were subjected to a care plan and there was no detailed log of the use of the unit.”*^[91:59]

In 2010 the HMIP report again referred to the unit as used for detainees likely to resist removal or at risk in some other way. The report goes on to describe it as *“a bleak unit, comprising four rooms, formerly part of the separation accommodation and unchanged since that time. The rooms contained no furniture beyond a mattress on a tiled concrete plinth, and a concrete toilet without a seat. (...) This accommodation was not suitable for those preparing for departure, especially for those at risk of self-harm.”*^[92:77] It is not clear whether the unit has been significantly upgraded since that time which raises questions about how appropriate it is to house vulnerable detainees there.

The Bunting Unit at Yarl’s Wood IRC

According to the HMIP inspection in 2013 the

separation unit in Bunting Unit is no longer used for segregation^[111]. However, as recently as 2011 the *“Bunting unit care suite was used to separate individuals or families from the main population when there was evidence of a risk of non-compliance with removal; the level of supervision, support and oversight of such detainees was appropriately the same as for Kingfisher unit, with care plans in each case. Those in the care suite were able to attend some activities, accompanied by a member of staff, and a member of staff was with them at all times.”*^[98] This kind of usage does not comply with the detention centre rules and authorisation procedures were not always followed.

The use of the Bunting Unit was recorded in the monthly security reports as ‘Bunting RFA’ but was not governed by Rule 40. Detainees were segregated for up to 48 hours, *“renewable on the authority of a UKBA senior manager. This did not appear to be under any detention centre rule. The forms specified initial authorisation by a UKBA senior manager, but this was sometimes completed by a SERCO senior manager. If there was an assessed risk of resistance, single women were sometimes located in the Bunting care suite for a few hours before removal. This amounted to separation. They could in this case have access to activities, but only when other detainees were not in the relevant place”*^[136].

“An unofficial, but among staff widely acknowledged, policy existed whereby single women detainees on Dove and Avocet units could be returned to Bunting main unit following disruptive behaviour on their main units. Theoretically, this move was for reinduction purposes, although no records were kept. This practice had not been evaluated and there was no evidence that detainees had actually been through the induction process again. Some occasions when women were ordered off their main unit ended up in a use of force incident following a refusal. Not all senior managers were aware of this practice, which had the potential to be misused as an unofficial punishment without the paperwork safeguards that existed for Kingfisher [segregation unit]” (HMIP Yarl’s Wood 2008)^[100].

The Eden Wing and the Care and Support Unit at Brook House IRC

“Of significant concern was the excessive and often illegitimate use of the separation unit. The use of Detention Centre Rule 15 – an administrative measure to certify all accommodation – as a catch-all to authorise and justify the separation of many detainees was unacceptable, not least because the normal safeguards afforded by the proper use of Rules 40 and 42 were not in place” (HMIP Brook House 2011)^[126:5].

At Brook House there was, for a period of time, a parallel system of segregation where detainees would be segregated under Rule 15 of the Detention Centre Rules. As described above, this is a rule which governs the general condition of all accommodation and does not pertain to segregation. Segregation under this rule was used to segregate a large number of detainees, usually before removal. Detainees held under Rule 15 were not subject to the same safeguards as under Rule 40 and 42. The segregation of those held under Rule 15 was not authorised by a senior manager, nor were segregation in excess of 24 hours authorised by a UKBA manager. Reasons for separation were given to those held under Rule 40 or 42 but not for those segregated under Rule 15. In addition there was no analysis of segregation under key categories such as ethnicity, nationality or age of those segregated under Rule 15. In other words, the use of Rule 15 as a justification for segregation created a parallel system which, from the perspective of detainees, was for all intents and purposes identical to the regime under Rule 40. However, the system was not monitored or authorised along the same guidelines. Thus creating a parallel system which had all the restrictions of Rule 40 without any of the associated safeguards, oversight or paperwork of Rule 40. Rule 15 constituted a system of illegitimate segregation^[126] since *“[s]eparation justified by rule 15 was not subject to the governance required for legitimate separation. (...) under ‘rule 15’ (...) detainees could have a TV and their mobile phone, and smoking requisites in their cells. These privileges*

were normally not available to rule 40 detainees – during the inspection they were taken away from a detainee because his status had changed to rule 40, even though there were no risks involved.”^[126:63]

The use of Rule 15 as a segregation scheme has now ceased at Brook House and is no longer used as a justification for segregating detainees in E Wing or the Care and Custody Suite. However, concerns still remain over the use of E Wing as a pre-departure wing and for the segregation of ill and vulnerable detainees.

Tinsley House IRC

The above examples refer to structured regimes and specific units being used as de facto segregation. However, there are also sporadic references to de facto segregation at other IRCs such as at Tinsley House where the HMIP found that *“[s]eparate observation rooms were sometimes used informally to separate detainees, such as those at risk of self-harm, but there was no log to show such use or its reasons.”*^[88:11] and that some detainees were illegitimately separated under rule 15: *“Staff also separated detainees under rule 15 of the Detention Centre Rules, which applies to the certification of rooms for various purposes, rather than the authorisation of separation. This rule was not subject to the governance required by legitimate separation and use of it for this purpose was at best illegitimate and at worst unlawful.”*^[128:25]

CONCLUSION

RECOMMENDATIONS

Medical Justice believes that the conditions of detention, including segregation, are so detrimental to the health and wellbeing of those detained that the only way to remedy this situation is to close IRCs.

In light of the well documented negative health effects of segregation on detainees, the use of segregation in immigration detention is disproportionately retributory for a low risk population detained for administrative purposes. The over-reliance on and misuse of segregation in immigration detention reflects the abdication of the state and its private contractors of their moral and legal obligation to treat those in their custody humanely.^[180] Medical Justice believes that segregation is inappropriate in immigration detention and that the Detention Centre Rules should be changed to reflect this fact.

Thinking outside of ‘the box’

There is lingering belief within the secure settings that segregation is essential to the operation of detention and that without recourse to segregation there would be no way to ensure the security and safety of the facility. However, it is notable that some prisons, both open and closed, do not have segregation units and report that this has contributed to the positive atmosphere of the prison^[7]. IRC populations are not held as part of any criminal sentence and are thus lower risk than prisons population so there

does not seem to be a reasonable argument why this population needs to be subject to segregation when prisons such as HMP North Sea Camp (open), HMP Spring Hill (Cat D), HMP Blantyre House (Cat C/D), HMP Send (closed), HMP Asham Grange (open), and HMP Hatfield (Cat D) manage without segregating prisoners. Thus, it is clearly possible to operate a secure setting without resorting to this most draconian of measure.

What is needed is an end to the use of segregation in IRCs. A step towards achieving this is to create a culture shift within the system. A move towards a greater emphasis on release of those unsuited for detention. And a move away from a culture of disbelief in which detainees are dehumanised by custodial staff, as was seen in the recent Channel 4 undercover footage at Yarl’s Wood where detainees were referred to as ‘animals’ and as ‘bitches’, to one where detainees are seen and treated as human beings.

For this we need more transparency and public scrutiny. In Kafka’s famous story *The Penal Colony* the inhuman and cruel treatment of prisoners continued until an external person, the traveller, brought the scrutiny and judgement of the wider community into the insulated prison setting. “Kafka vividly portrays how, even with the best of intentions, the mental and physical well-being of inmates will be jeopardized when total control is given to people who run the prisons with no independent oversight.”^[181] The traveller

offered a damning judgement, ‘*I do not support this procedure*’, and thereby enabled a shift in culture inside the organisation and a move away from cruel punishments. With this report Medical Justice hopes to open up the misuse of segregation in immigration detention to public scrutiny and offer a damning judgement of our own – we do not support the use of segregation in immigration detention.

Remedial Actions

In recognition that it may take some time before we see the end of segregation in IRCs we believe that it is essential that the use of segregation in the meantime be limited and governed by strict guidelines that prohibit prolonged segregation, the use of segregation as punishment, segregation of the mentally ill or those at risk of self-harm. Medical Justice calls for the publication of strict guidelines governing the use of segregation, for improved safeguards to ensure vulnerable detainees are not inappropriately detained, mandatory health screening prior to segregation and stringent independent monitoring of the use of segregation. In line with Home Office policy, segregation must therefore be used in extreme moderation and only in exceptional circumstances when all other options have been exhausted.

In the absence on a ban on the use of segregation there are several remedial actions which should be taken in order to bring current practice in line with the Detention Centre Rules and international standards.

Home Office:

Immigration detention is optional and, according to Home Office policy, should be a solution of last resort only for those who cannot appropriately be monitored in the community. In addition, EIG 55.10 sets out the limitations on vulnerable individuals who are not suitable for detention except in exceptional circumstances; amongst these are individuals with mental health issues

that cannot be satisfactorily managed in detention. Clearly, having to resort to segregation indicates the condition is not being satisfactorily managed.

- **Identification of vulnerable detainees:**
Procedures for identifying vulnerable individuals who are not suitable for detention need to be strengthened so that vulnerable individuals are not inappropriately detained.
- **Improved safeguards:**
Safeguards need to be strengthened to ensure that anyone who becomes vulnerable whilst in detention is identified and alternatives to detention found to avoid further harm being caused.
- **Training:**
All staff need to be trained in signs of trauma and torture as well as mental health awareness training to ensure that signs of mental health issues are not inappropriately treated as behavioural issues. Special training needs to be provided to those working in segregation unit.
- **Punishment:**
The use of segregation as a form of punishment must cease
- **Oversight and review:**
The Home Office must allow independent organisation to visit detainees in segregation. The Home Office must track the use of segregation from the moment of placement in solitary to release; these comprehensive statistics must be made public on a regular basis and should be regularly reviewed by an independent auditor.

Governance:

Proper governance of the use of segregation is vital to ensuring that misuse does not occur within immigration detention. Clear guidelines must apply to all IRCs in order to be able to ensure that the regime is the same across all

centres. These guidelines must be published and centralised data on the use of segregation and the attributes of those segregated must be published or made publically available to ensure proper monitoring, oversight and comparability.

- *De Facto segregation:*

All segregation must be processed under Rule 40 and 42 of the Detention Centre Rules with appropriate guidance and safeguards that accompany this. All forms of de facto segregation, where detainees are segregated without the benefit of these safeguards, whatever the reason given or name applied, must be explicitly forbidden.

- *Self-harm:*

Segregation under Rule 40 and Rule 42 should not be used for the management of vulnerable detainees in crisis or to manage self-harm or suicidal behaviour.

- *Regime:*

All facilities used for segregation under Rule 40 and Rule 42 must comply with Rule 15 and be appropriately furnished and suitable for the use. All IRCs should follow the same guidelines on regime whilst under Rule 40 and 42. The regime should be the least restrictive and provide as much stimulation as possible. Social interaction should be maximised, be this through education opportunities or meaningful social contact with other detainees either in the unit or in other settings. Detainees should be allowed mobile phones whilst in segregation to ensure contact with their wider support network and legal representatives. Visits must be allowed and unrestricted. All detainees should have access to up-to-date legal texts and other materials required to gather evidence for their case or to plan for their return to their country of origin, this should be both through library facilities and the internet, on an equal footing with other detainees.

- *Last resort:*

Policies and practices must be developed to ensure that challenging behaviour is not met

by the use of segregation, the use of force and other disciplinary measures but, rather, is dealt with in the least restrictive and most therapeutic way possible. Segregation should only be used in exceptional circumstances, as a last resort when all other options have been exhausted and for the shortest time possible. The exceptional circumstances as well as efforts to find alternatives must be thoroughly recorded in each case.

- *Guidance:*

Home Office must develop and publish binding guidance on the utilisation of Rule 40 and 42, the daily regime of those held in segregation and the reporting of segregation to apply to all immigration detention facilities. This information should be comparable and centrally collated and published by the Home Office on quarterly basis to ensure oversight and transparency around the use of segregation in IRCs. Specific rules must be published for Short Term holding Facilities.

- *Health Screening:*

The Home Office should implement HM Inspector of Prisons' recommendation^[86, 99] that an initial health screening should be carried out before segregation and at regular review intervals during segregation. This is in addition to daily visits. All medical interactions must be thoroughly recorded and added to medical notes of detainee.

- *Mental Health:*

Solitary confinement should never be used as a means of managing detainees with mental health issues. Training must be rolled out to better enable staff to recognise behaviour that is rooted in mental health issues and ensuring that the detainee gets help or is released to a setting where they can access the help they need rather than placed in segregation.

- *Prohibition of prolonged segregation:*

Home Office should introduce policy to prohibit the use of segregation of vulnerable individuals and the prolonged segregation of any one (prolonged segregation being

defined as more than 15 days (as set out by the UN Special Rapporteur on Torture), absent a clear and exceptional threat to safety and security, in recognition that health issues may become irreversible after this point. The maximum length of segregation must be communicated to detainees at the beginning of their period of segregation as the uncertainty of indefinite segregation compounds the negative impact of the isolation.

- *Authorisation of segregation:*

All authorisation for segregation of detainees under Rule 40 or 42 must be authorised by a senior manager and all segregation for more than 24 hours must be provided by an external representative of the Secretary of State.

- *Review and appeal:*

Multi-disciplinary reviews of segregation similar to arrangements in the prison context. Following *Bourgass v SSJ* the Home Office must implement policy which allows detainees held in segregation access to the reasons for their segregation in a language they understand as well as access to a neutral and independent adjudication process and financially aided legal counsel to challenge their segregation in a timely manner.

REFERENCES

1. UN, *Interim report of the Special Rapporteur of the Human Rights Council on torture and other cruel, inhuman or degrading treatment or punishment. Torture and other cruel, inhuman or degrading treatment or punishment - Note by the Secretary-General. United Nations General Assembly 5 August 2011, A/66/268*, <http://solitaryconfinement.org/uploads/SpecRapTortureAug2011.pdf>. 2011.
2. I Urbina and C Rentz, *Immigrants Held in Solitary Cells, Often for Weeks*. March 23 2013. http://www.nytimes.com/2013/03/24/us/immigrants-held-in-solitary-cells-often-for-weeks.html?_r=0, in *The New York Times*. 2013.
3. Amnesty, 'If someone is suffering, does he have to be kept in an isolation cell? Isolation in Detention Summary'. *Joint Report by Amnesty, Dokters van de Wereld and LOS Foundation*. https://mdmeuroblog.files.wordpress.com/2015/05/summary_report_isolation_2015_eng.pdf. 2015.
4. UN, *United Nations Standard Minimum Rules for the Treatment of Prisoners (the Mandela Rules)*. E/CN.15/2015/L.6/Rev.1. <http://www.penalreform.org/wp-content/uploads/2015/05/MANDELA-RULES.pdf>. 2015.
5. IMB, *Annual Report Harmondsworth Immigration Removal Centre, "Monitoring fairness and respect for people in custody"*, March 2013, *Independent Monitoring Board*. <http://www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2012/harmondsworth-2012.pdf>. 2012.
6. *Khordorkovskiy v Russia (2014) 59 EHRR 7*, <http://hudoc.echr.coe.int/eng?i=001-122697>. 2014.
7. F Crook, *STATEMENT OF FRANCES RACHEL CROOK in the case of Bourgass V SSI*. 2011.
8. HO, *Detention Centre Rules*. <http://www.legislation.gov.uk/uksi/2001/238/made>. 2001.
9. HMIP, *HM Chief Inspector of Prisons for England and Wales Annual Report 2012–13*. <http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2012-13.pdf>. 2013.
10. HO, *Home Office Enforcement Instructions and Guidance. Version 10 (June 2014 update)*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/307995/Chapter55.pdf. 2014.
11. HO. *Home Office Immigration Statistics*. <https://www.gov.uk/government/collections/immigration-statistics-quarterly-release>. Available from: <https://www.gov.uk/government/collections/immigration-statistics-quarterly-release> (Accessed 11/07/2014).
12. APPG, *The Report of the Inquiry into the Use of Immigration Detention in the United Kingdom. A Joint Inquiry by the All Party Parliamentary Group on Refugees & the All Party Parliamentary Group on Migration*. <https://detentioninquiry.files.wordpress.com/2015/03/immigration-detention-inquiry-report.pdf>. 2015.
13. De Beaumont G. and De Toqueville A., *On the Penitentiary System in the United States and Its Application in France with Appendix on Penal Colonies, and also, Statistical Notes*. 1833, Philadelphia: Carey, Lea & Blanchard.
14. M Foucault, *Dicipline and Punish. The Birth of the Prison*. 1995 [1977], New York: Vintage Books - a division of Random House Inc. .
15. S McConville, *A History of English Prison Administration*. 1981, London: Routledge and Kegan.
16. S Grassian and N Friedman, *Effect of Sensory Deprivation in Psychiatric Seclusion and Solitary Confinement*. *International Journal of Law & Psychiatry*, 1986. 8: p. 49-65.
17. P Scharff-Smith, *A Religious Technology of the Self: Rationality and religion in the rise of the modern penitentiary*. *Punishment and Society*, 2004. 6(2): p. 195-220.
18. C Dickens, "Philadelphia, and its Solitary Prison", in *American Notes*. 1842.
19. P Scharff Smith, *Solitary confinement: History, practice, and human rights standards*. <http://www.jstor.org/stable/10.1086/500626>. *Prison Service Journal*, 2009. 181: p. 3-11.
20. P Scharff Smith, *The Effects of Solitary Confinement on Prison Inmates: A Brief History and Review of the Literature*. <http://www.jstor.org/stable/10.1086/500626>. *Crime and Justice*, 2006. 34(1): p. 441-528.
21. NHRI, *Thematic report: Use of solitary confinement in prison. Norwegian law and practice in a human rights perspective*. *Norwegian Human Rights Institute, Norwegian Centre for Human Rights. Univeristy of Oslo*. http://solitaryconfinement.org/uploads/NHRI_Norway_Thematic_report_on_solitary_confinement.pdf. 2012.
22. J Pizarro and VMK Stenius, *SUPERMAX PRISONS: THEIR RISE, CURRENT PRACTICES, AND EFFECT ON INMATES*. <http://www.supermaxed.com/NewSupermaxMaterials/Supermax-Rise-Errect..pdf>. *The Prison Journal*, 2004. 84(2): p. 248-264.
23. H Klykken A, *Prison studies of solitary confinement: A bibliography of research on psychological effects of social isolation, pre-trial isolation and supermax conditions*. *University of Tromso*. http://solitaryconfinement.org/uploads/BibliographyResearchPrisonStudiesByAre_Haram_Klykken.pdf. 2012.
24. Watch Solitary. *Obama, in Criminal Justice Speech, Denounces the "Overuse of Solitary Confinement" in U.S. Prisons*. *Solitary Watch, Jean Casella and Garrett Zehr, July 14th 2015*. <http://solitarywatch.com/2015/07/14/obama-in-criminal-justice-speech-denounces-the-overuse-of-solitary-confinement-in-u-s-prisons/>. 2015.
25. AP, *Justice Kennedy Provides Hope to Solitary Confinement Foes*. By THE ASSOCIATED PRESS. AUG. 11, 2015. <http://www.nytimes.com/aponline/2015/08/11/us/politics/ap-us-supreme-court-solitary-confinement.html>, in *The New York Times*. 2015.
26. I Lovett, *California Agrees to Overhaul Use of Solitary Confinement*. By IAN LOVETT. SEPT. 1, 2015. http://www.nytimes.com/2015/09/02/us/solitary-confinement-california-prisons.html?partner=rss&emc=rss&_r=0, in *The New York Times*. 2015.
27. S Shalev, *A Sourcebook on Solitary Confinement*. London: Mannheim Centre for Criminology, London School of Economics. Available online at: www.solitaryconfinement.org/sourcebook. 2008.
28. HO, *Detention Services Operating Standards Manual for Immigration Service Removal Centres*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257352/operatingstandards_manual.pdf. 2002.
29. MJ, *The Second Torture: The immigration detention of torture survivors*. *Medical Justice*. <http://www.medicaljustice.org.uk/images/stories/reports/2ndtfull.pdf>. 2012.
30. I Sinnerbrink, et al., *Compounding of premigration trauma and postmigration stress in asylum seekers* *J Psych*, 1997. 131: p. 463-70.
31. M Porter and N Haslam, *Predisplacement and postdisplacement factors associated with mental health of refugees and internally displaced persons. A meta-analysis*. *JAMA*, 2005. 294(602-12).
32. K Robjant, R Hassan, and C Katona, *Mental health implications of detaining asylum seekers: systematic review*. *Br J Psychiatry*, 2009. 194(4): p. 306-12.
33. MJ, *Outsourcing Abuse - The use and misues of state-sanctioned force during the detention and removal of asylum seekers*, *Medical Justice*. 2008.
34. MJ, "Briefing for the Home Office on Food and Fluid Refusers" 14th November 2013, *Medical Justice*, <http://www.medicaljustice.org.uk/images/stories/reports/FoodFluidRefusalBriefing.pdf>. 2013.
35. MJ, "Detained & Denied: The clinical care of immigration detainees living with HIV", *Medical Justice*, <http://www.medicaljustice.org.uk/images/stories/reports/d%26d.pdf>. 2011.
36. S, R (on the application of) v *The Secretary of State for the Home Department [2011] EWHC 2120 (Admin) (05 August 2011)*. <http://www.bailii.org/ew/cases/EWHC/Admin/2011/2120.html>. 2011.
37. BA, R (on the application of) 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>. 2011.
38. HA (Nigeria), R (on the application of) v *Secretary of State for the Home Department (Rev 1) [2012] EWHC 979 (Admin) (17 April 2012)*. <http://www.bailii.org/ew/cases/EWHC/Admin/2012/979.html>. 2012.
39. D, R (on the application of) v *Secretary of State for the Home Department [2012] EWHC 2501 (Admin) (20 August 2012)*. <http://www.bailii.org/ew/cases/EWHC/Admin/2012/2501.html>. 2012.
40. MD, R (On the Application Of) v *Secretary of State for the Home Department [2014] EWHC 2249 (Admin) (08 July 2014)*. <http://www.bailii.org/ew/cases/EWHC/Admin/2014/2249.html>. 2014.
41. PPO, *Investigation into the death of a man at Colnbrook Immigration Removal Centre in July 2011. Report by the Prisons and Probation Ombudsman for England and Wales*. <http://www.ppo.gov.uk/wp-content/uploads/2014/11/G088-11-Death-of-a-male-detainee-Colnbrook-31-07-2011-Nat-31-40.pdf>. 2012.

42. PPO, *Investigation into the circumstances surrounding the death of a man at Colnbrook Immigration Removal Centre in July 2011*. Prison and Probations Ombudsman. http://www.ppo.gov.uk/wp-content/ReddotImportContent/Colnbrook_-_2_July_2011_-_Death_of_a_male_detainee.pdf#view=FitH. 2012.
43. MJ, *Expecting Change: the case for ending the immigration detention of pregnant women*. Medical Justice. <http://www.medicaljustice.org.uk/images/stories/reports/expectingchange.pdf>. 2013.
44. HMIP, *Report on an announced inspection of Harmondsworth Immigration Removal Centre 11–15 January 2010*, http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/harmondsworth/Harmondsworth_2010_rps.pdf. 2010.
45. HMIP, *Inquiry into the quality of healthcare at Yarl's Wood Immigration Removal Centre (20-24 February 2006) by HM Chief Inspector of Prisons*. http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood/yarls_wood_inquiry_final-rps.pdf. 2006.
46. HMIP, *Report on an unannounced inspection of Yarl's Wood Immigration Removal Centre (13 April – 1 May 2015)*. <http://www.justiceinspectorates.gov.uk/hmipris/wp-content/uploads/sites/4/2015/08/Yarls-Wood-web-20151.pdf>. 2015.
47. S Grassian, *Psychopathological Effects of Solitary Confinement*. American Journal of Psychiatry. 140(11): p. 1450-1454.
48. C Haney, *'Infamous Punishment': The Psychological Consequences of Isolation*. National Prison Project Journal, 1993. Spring: p. 3-7.
49. C Haney, *Mental Health Issues in Long-Term Solitary and 'Supermax' Confinement*. Crime & Delinquency, 2003. 49(1): p. 124-156.
50. NIJC and PHP, *Invisible in Isolation. The use of segregation and solitary confinement in Immigration Detention*. National Immigratn Jusitce Centre & Physicians for Human Rights. https://s3.amazonaws.com/PHR_Reports/Invisible-in-Isolation-Sep2012-detention.pdf. 2012.
51. H Toch, *Mosaic of Despair: Human Breakdown in Prison*. 1992, Washington DC: American Psychological Association.
52. IHRP, *"We Have No Rights" Arbitrary imprisonment and cruel treatment of migrants with mental health issues in Canada*. University of Toronto, Faculty of Law, International Human Rights Programme. http://ihrp.law.utoronto.ca/utfl_file/count/PUBLICATIONS/IHRP%20We%20Have%20No%20Rights%20Report%20web%20170615.pdf. 2015.
53. ACLU, *Conditions of confinement in immigration detention facilities*. American Civil Liberties Union. https://www.aclu.org/sites/default/files/field_document/unsr_briefing_materials.pdf. 2007.
54. CAP, *Dignity Denied. LGBT Immigrants in U.S. Immigration Detention*. Centre for American Progress. By Sharita Gruberg. <https://www.americanprogress.org/wp-content/uploads/2013/11/ImmigrationEnforcement.pdf>. 2013.
55. ACLUA, *In their own words. Enduring abuse in Arizona immigration detention centres*. American Civil Liberties Union of Arizona. <http://www.acluaz.org/sites/default/files/documents/detention%20report%202011.pdf>. 2011.
56. C Rentz, *Mendez says solitary 'can be cruel'*. Sunday March 24th, 2013. <http://investigativereportingworkshop.org/investigations/the-hole/story/mendez-says-solitary-can-be-cruel/>, in *The Hole*. 2013.
57. ACLU, *Warehoused and Forgotten. Immigrants trapped in our shadow private prison system*. June 2014. American Liberties Union. https://www.aclu.org/sites/default/files/field_document/060614-aclu-car-reportonline.pdf. 2014.
58. DNO, *Immigration Detention: penal regime or step towards deportation? About inspecting human rights in immigration detention*. De Nationale Ombudsman Netherlands. 7 August 2012. 2012.
59. UN, *The Universal Declaration of Human Rights*. <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>. 1948.
60. UN, *Geneva Convention Relative to the Treatment of Prisoners of War*, Aug. 12 1949, http://www.loc.gov/rr/frd/Military_Law/pdf/GC_1949-III.pdf. 1949.
61. UN, *International Covenant on Civil and Political Rights*. Adopted and opened for signature, ratification and accession by General Assembly resolution 2200A (XXI) of 16 December 1966 entry into force 23 March 1976, in accordance with Article 49. <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>. 1966.
62. UN, *General Assembly. A/RES/43/173, 76th plenary meeting, 9 December 1988, 43/173. Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*. <http://www.un.org/documents/ga/res/43/a43r173.htm>. 1988.
63. UN, *Human Rights Committee, General Comment 21, Article 10 (Forty-fourth session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 33 (1994)*. <https://www1.umn.edu/humanrts/gencomm/hrcom21.htm>. 1992.
64. UN, *Standard Minimum Rules for the Treatment of Prisoners*. Adopted by the First United Nations Congress on the Prevention of Crime and the Treatment of Offenders, held at Geneva in 1955, and approved by the Economic and Social Council by its resolutions 663 C (XXIV) of 31 July 1957 and 2076 (LXII) of 13 May 1977. <http://www.ohchr.org/Documents/ProfessionalInterest/treatmentprisoners.pdf>. 1955.
65. A Manduric, *UN's "Mandela Rules" to Set New International Standards for Treatment of Prisoners, Including Limits on Solitary Confinement*. July 17, 2015 by Aylin Manduric, in *Solitary Watch*. 2015.
66. UN, *A/RES/45/111. UN General Assembly, 68th plenary meeting, 14 December 1990. 45/111. Basic Principles for the Treatment of Prisoners*. 1990.
67. D Abels, *Chapter 2. The Protection of Detained Persons under International Law*, in *Prisoners of the International Community. The Legal Position of Persons Detained at International Criminal Tribunals*. , A. D, Editor. 2012, Springer.
68. UNCAT, *UN Committee Against Torture (CAT), Report of the UN Committee against Torture : . 10/09/97, 10 September 1997, Supplement No. 44 (A/52/44), available at: http://www.refworld.org/docid/453776a62.html [accessed 4 September 2015]*. 1997.
69. CoE, *European Prison Rules. COUNCIL OF EUROPE, COMMITTEE OF MINISTERS. Recommendation Rec(2006)2 of the Committee of Ministers to member states on the European Prison Rules. (Adopted by the Committee of Ministers on 11 January 2006 at the 952nd meeting of the Ministers' Deputies)*. <https://wcd.coe.int/ViewDoc.jsp?id=955747>. 2006.
70. CoE, *European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT). CPT Standards. CPT/Inf/E (2002) 1 - Rev. 2011. Council of Europe*. www.cpt.coe.int/en/documents/eng-standards.doc. 2011.
71. Statement Istanbul, *The Istanbul statement on the use and effects of solitary confinement. Adopted on 9. December 2007 at the International Psychological Trauma Symposium, Istanbul*. http://solitaryconfinement.org/uploads/Istanbul_expert_statement_on_sc.pdf. 2009.
72. UN, *Human Rights Committee, General Comment 20, Article 7 (Forty-fourth session, 1992), Compilation of General Comments and General Recommendations Adopted by Human Rights Treaty Bodies, U.N. Doc. HRI/GEN/1/Rev.1 at 30 (1994)*. <https://www1.umn.edu/humanrts/gencomm/hrcom20.htm>. 1992.
73. UN, *UN General Assembly. Sixty third session. A/63/150. Item 67 (a) of the provisional agenda: Promotion and protection of human rights: implementation of human rights instruments: Torture and other cruel, inhuman or degrading treatment or punishment. Note by the Secretary-General*. www.un.org/disabilities/images/A.63.175.doc. 2008.
74. HO, *Detention Centre Rules Guidance - Home Office*. 2002.
75. HMIP, *Expectations. Immigration Detention Expectations: Criteria for assessing the conditions for and treatment of immigration detainees; HM Inspectorate of Prisons*, <http://www.justice.gov.uk/downloads/about/hmipris/immigration-expectations.pdf>. 2012.
76. MoJ, *Prison Service Order 1700. Segregation*. <https://www.justice.gov.uk/downloads/offenders/psipso/psopso-1700.zip>.
77. *KEENAN v. THE UNITED KINGDOM, 27229/95*. <http://hudoc.echr.coe.int/eng/?i=001-59365>. 2001.
78. *R (on the application of Bourgass and another) v SSJ [2015] UKSC 54 On appeal from [2012] EWCA Civ 376*. <https://www.supremecourt.uk/cases/docs/uksc-2013-0230-judgment.pdf>.
79. PPO, *Learning Lessons Bulletin - Fatal incident Investigation Issue 8 - Segregation. Prison and Probation Ombudsman for England and Wales*. 2015.
80. al Shames A et, *Solitary Confinement: Common Misconceptions and Emerging Safe Alternatives*. New York, NY: Vera Institute of Justice, 2015. http://www.vera.org/sites/default/files/resources/downloads/solitary-confinement-misconceptions-safe-alternatives-report_1.pdf 2015.
81. IMB, *DOVER IMMIGRATION REMOVAL CENTRE. ANNUAL REPORT 2010*. <http://www.imb.org.uk/wp-content/uploads/2015/01/dover-2010.pdf> 2010.
82. IMB, *Dover Immigration Removal Centre. Annual Report 2011*. <http://www.imb.org.uk/wp-content/uploads/2015/01/dover-2011.pdf>. 2011.
83. BlackLetterPress, *Inquest into US citizen's death in immigration custody finds neglect*. <http://www.blackletterpr.co.uk/news/inquest-dalrymple-death-immigration-custody-finds-neglect/>. 2014.
84. HMIP, *Report on an unannounced inspection of The Verne Immigration Removal Centre (2 – 13 March 2015)*. <http://www.justiceinspectorates.gov.uk/hmipris/wp-content/uploads/sites/4/2015/08/The-Verne-web-2015.pdf>. 2015.

85. HMIP, *Unannounced full follow-up inspection of Brook House Immigration Removal Centre (28 May – 7 June 2013)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/brook-house-2013.pdf>. 2013.
86. HMIP, *Report on an unannounced full follow-up inspection of Brook House Immigration Removal Centre 12 – 23 September 2011 by HM Chief Inspector of Prisons*. http://www.gdwg.org.uk/media/news_2012feb-HMIP-report-IRC-Brook-House.pdf. 2011.
87. HMIP, *Report on an unannounced inspection of Tinsley House Immigration Removal Centre (1 – 12 December 2014)*. <http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/05/Tinsley-House-web-2014.pdf>. 2014.
88. HMIP, *Unannounced short follow-up inspection of Tinsley House Immigration Removal Centre (13-15 July 2009)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Tinsley_House_2009_rps.pdf. 2008.
89. HMIP, *Report on an unannounced inspection of Harmondsworth Immigration Removal Centre, 5–16 August 2013*, <http://www.migrantsrights.org.uk/files/news/14.01.16-HMIP-Harmondsworth-IRC-5-16-August-2013.pdf>. 2013.
90. HMIP, “*Report on an unannounced inspection of Colnbrook Immigration Removal Centre*” 28 January – 8 February 2013. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/conbrook/colnbrook-irc-2013.pdf>. 2013.
91. HMIP, *Full announced inspection of Colnbrook Immigration Removal Centre and short-term holding facility (17-21 November 2008)*. <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/05/Colnbrook-2008.pdf>. 2008.
92. HMIP, *Unannounced full follow-up inspection of Colnbrook Immigration Removal Centre and short-term holding facility (16-27 August 2010)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Colnbrook_2010_rps.pdf. 2010.
93. HMIP, *Report on an unannounced inspection of Campsfield House Immigration Removal Centre (11 – 21 August 2014)*. <http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2015/02/Campsfield-House-web-2014.pdf>. 2014.
94. HMIP, *Unannounced inspection of Dover Immigration Removal Centre (3 –14 March 2014)*. <http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/07/Dover-2014-Web.pdf>. 2014.
95. HMIP, *Unannounced inspection of Haslar Immigration Removal Centre (10-11 and 17-21 February 2014)*. <http://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/07/Haslar-2014-Web.pdf>. 2014.
96. IMB, *Independent Monitoring Board Harmondsworth Immigration Removal Centre. Annual Report 2014*. <http://www.imb.org.uk/wp-content/uploads/2015/04/Harmondsworth-IMB-Annual-Report-2014.pdf>. 2014.
97. HMIP, *Announced inspection of Haslar Immigration Removal Centre (20-24 April 2009)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Haslar_2009_rps.pdf. 2009.
98. HMIP, *Announced inspection of Yarls Wood Immigration Removal Centre (4 – 8 July 2011)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/yarls-wood-2011.pdf>. 2011.
99. HMIP, *Full announced inspection of Brook House Immigration Removal Centre (15-19 March 2010)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Brook_House_2010_rps_.pdf. 2010.
100. HMIP, *Announced inspection of Yarls Wood Immigration Removal Centre (4-8 February 2008)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/yarls_wood_2008-rps.pdf. 2008.
101. HMIP, *Unannounced full follow-up inspection of Harmondsworth Immigration Removal Centre (14-18 January 2008)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/harmondsworth_2008-rps.pdf. 2008.
102. IMB, *Harmondsworth IMB Annual Report for 2012*. <http://www.imb.org.uk/wp-content/uploads/2015/01/harmondsworth-2012.pdf>. 2012.
103. IMB, *Annual Report. Independent Monitoring Board. Yarls Wood Immigration Removal Centre 2010*. 2010.
104. IMB, *Independent Monitoring Board Harmondsworth Immigration Removal Centre. Annual Report 2011*. <http://www.imb.org.uk/wp-content/uploads/2015/01/harmondsworth-2011.pdf>. 2011.
105. IMB, *Independent Monitoring Board. COLNBROOK IMMIGRATION REMOVAL CENTRE. Annual Report 2010*. http://imb.wpengine.com/wp-content/uploads/2015/01/Colnbrook_IRC_2010_FV.pdf. 2010.
106. IMB, *Annual Report 2014. Yarls Wood Independent Monitoring Board (IMB)*. <http://www.imb.org.uk/wp-content/uploads/2015/06/Yarls-Wood-IRC-2014.pdf>. 2015.
107. IMB, *Annual Report. Independent Monitoring Board. Yarls Wood Immigration Removal Centre 2011*. 2011.
108. DHS, *Management of Mental Health Cases in Immigration Detention. Department of Homeland Security. Office of Inspector General. OIG-11-62*. 2011.
109. HMIP, *Full announced inspection of Tinsley House Immigration Removal Centre (10-14 March 2008)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/tinsley-house-irc-2008-rps.pdf>. 2009.
110. HMIP, *Unannounced short follow-up inspection of Campsfield House Immigration Removal Centre (16 – 18 May 2011)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/campsfield-house-irc-2011.pdf>. 2011.
111. HMIP, *Report on an unannounced inspection of Yarls Wood Immigration Removal Centre by HM Chief Inspector of Prisons, (17–28 June 2013 & 30 Sept – 1 Oct 2013)*, <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/yarls-wood/Yarls-Wood-2013.pdf>. 2013.
112. HMIP, *Announced inspection of Dungavel House Immigration Removal Centre (21 – 25 June 2010)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Dungavel_House_2010_rps.pdf. 2010.
113. HMIP, *Report on an announced inspection of Morton Hall Immigration Removal Centre, 5–16 August 2013*, <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/morton-hall-2013.pdf>. 2013.
114. HMIP, *Announced inspection of Campsfield House Immigration Removal Centre (5-9 October 2009)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Campsfield_House_2009_rps.pdf. 2009.
115. HMIP, *Announced inspection of Tinsley House Immigration Removal Centre (7-11 February 2011)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/tinsley-house-report2011.pdf>. 2011.
116. HMIP, *Announced inspection of Cedars Pre-Departure Accommodation (30 April – 25 May 2012)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/cedars-2012.pdf>. 2012.
117. HMIP, *Unannounced full follow-up inspection of Campsfield House Immigration Removal Centre (12-16 May 2008)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/campsfieldhouse_2008-rps.pdf. 2008.
118. F Webber, *REVEALING THE IMPACT OF IMMIGRATION DETENTION*. December 21, 2012. *Two recent reports add fuel to growing demands to rethink indefinite immigration detention*. <http://www.irr.org.uk/news/revealing-the-impact-of-immigration-detention/>, in *Institute of Race Relations*. 2012.
119. HMIP, *HM Chief Inspector of Prisons for England and Wales Annual Report 2011–12*, <https://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hm-inspectorate-prisons-annual-report-2011-12.pdf>. 2012.
120. HMIP, *HM Chief Inspector of Prisons for England and Wales Annual Report 2010–11*, <http://www.justice.gov.uk/downloads/publications/corporate-reports/hmi-prisons/hmip-annual-report-2010-11.pdf>. 2011.
121. IMB, *Annual Report of the Independent Monitoring Board for Brook House Immigration Removal Centre . 1 April 2009 to 31 March 2010*. http://www.imb.org.uk/wp-content/uploads/2015/01/Brook_House_IRC_2009-2010.pdf. 2009.
122. IMB, *Annual Report. Independent Monitoring Board. Yarls Wood Immigration Removal Centre 2012*. 2012.
123. MIND, *Mental health crisis care: physical restraint in crisis. A report on physical restraint in hospital settings in England*. June 2013. http://www.mind.org.uk/media/197120/physical_restraint_final_web_version.pdf. 2013.
124. K King, B Steiner, and S Richer Breach, *Violence in the Supermax: A Self-Fulfilling Prophecy*. <http://www.wjthomasniu.org/class/Temp/violsupermax11.pdf>. The Prison Journal, 2008. 88(1): p. 144-168.
125. HMIP, *An announced inspection of Harmondsworth Immigration Removal Centre (17-21 July 2006)*. <https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/harmondsworth-immigration-removal-centre/#.VfW5WBFViko>. 2006.

126. HMIP, *Unannounced full follow-up inspection of Brook House Immigration Removal Centre (12-23 September 2011)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/brook-house-2011.pdf>. 2011.
127. HMIP, *Full announced inspection of Dover Immigration Removal Centre (24-28 May 2010)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/dover.pdf>. 2010.
128. HMIP, *Announced full follow-up inspection of Tinsley House Immigration Removal Centre (8-11 October 2012)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/tinsley-house-2012.pdf>. 2012.
129. HMIP, *Unannounced inspection of Cedars pre-departure accomodation and overseas family escort (6 – 27 January 2014)*. <https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/05/2014-Cedars-final-report-Web.pdf>. 2014.
130. HMIP, *Unannounced short follow-up inspection of Dover Immigration Removal Centre (19-21 January 2009)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/dover_2009-rps.pdf. 2009.
131. IMB, *Independent Monitoring Board Campsfield House. Annyal Report 2009-2010*. <http://imb.wpengine.com/wp-content/uploads/2015/01/campsfield-house-2013.pdf>. 2010.
132. IMB, *Independent Monitoring Board. Brook House Immigration Removal Centre. Annual Report 2011-12*. <http://imb.wpengine.com/wp-content/uploads/2015/01/brook-house-irc-2011-12.pdf>. 2012.
133. HMIP, *HM Chief Inspector of Prisons for England and Wales. Annual Report 2008–09*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/247923/0323.pdf. 2009.
134. MJ, *RULE 35 SAFEGUARD IN DETENTION*. Written evidence submitted by Medical Justice to the APPG on Immigration Detention. <http://www.medicaljustice.org.uk/images/stories/texts/Medical%20Justice%20APPG%20submission%20-%20Rule%2035%20-%20Submitted.pdf>. 2014.
135. HMIP, *Unannounced full follow-up inspection of Colnbrook Immigration Removal Centre (18-22 June 2007)*. https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2014/05/2007-Colnbrook_IRC.pdf. 2007.
136. HMIP, *Unannounced full follow-up inspection of Yarl's Wood Immigration Removal Centre (9-13 November 2009)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Yarls_Wood_2009_rps.pdf. 2009.
137. C Nye, *What goes on inside Yarl's Wood? 28 August 2015 BBC report*. <http://www.bbc.co.uk/programmes/p030yich>. 2015.
138. Voices Detained, *Instead of helping us they locked us up. Detained Voices. Stories from inside UK immigration detention. March 30th, 2015*. <https://detainedvoices.wordpress.com/2015/03/30/instead-of-helping-us-they-locked-us-up/>. 2015.
139. Remain Right to, *"WE WANT FREEDOM": the women of Yarl's Wood demand to be heard, July 20th, 2015*. <http://www.righttoremain.org.uk/blog/we-want-freedom-emergency-action-needed/>. 2015.
140. MHIDWG, *Mental Health in Immigration Detention Working Group. Initial Report*. <http://medicaljustice.org.uk/images/stories/reports/MHIDAGreportR.pdf>. 2013.
141. *Detention Action v Secretary of State for the Home Department, [2014] EWHC 2245 (Admin), United Kingdom: High Court (England and Wales), 9 July 2014, available at: http://www.refworld.org/docid/53bd255a4.html [accessed 13 August 2014]*. 2014.
142. MJ, *MENTAL HEALTH IN DETENTION*. Written evidence submitted by Medical Justice to the APPG on Immigration Detention, <http://www.medicaljustice.org.uk/images/stories/texts/Medical%20Justice%20APPG%20submission%20-%20Mental%20Health%20-%20Submitted.pdf>. 2014.
143. IMB, *Annual Report of the Independent Monitoring Board for Brook House Immigration Removal Centre . 1 April 2012 to 31 March 2013*. <http://www.imb.org.uk/wp-content/uploads/2015/01/brook-house-2012-13.pdf>. 2013.
144. IMB, *Independent Monitoring Board. Harmondsworth Immigration Removal Centre. Annual Report 2013*. <http://www.imb.org.uk/wp-content/uploads/2015/01/harmondsworth-2013.pdf>. 2013.
145. RCPsych, *The Royal College of Psychiatrists "Position Statement on detention of people with mental disorders in Immigration Removal Centres"*, <http://www.rcpsych.ac.uk/pdf/Satisfactory%20Treatment%20in%20Detention%20document%20March%202014%20edit.pdf>. 2013.
146. DoH, *Mental Health Act 1983: Code of Practice. Department of Health. Revised 2015*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/435512/MHA_Code_of_Practice.PDF. 1998.
147. IMB, *2009 Annual Report of the Independent Monitoring Board for Harmondsworth Immigration Removal Centre*. <http://www.medicaljustice.org.uk/images/stories/reports/imbharmondsworth2009.pdf>. 2009.
148. IMB, *Yarl's Wood Independent Monitoring Board (IMB). Annual Report 2014*. <http://www.imb.org.uk/wp-content/uploads/2015/06/Yarls-Wood-IRC-2014.pdf>. 2014.
149. H Venters, et al., *Into the Abyss: Mortality and Morbidity Among Detained Immigrants*. *Human Rights Quarterly*, 2009. 31(2): p. 474-495.
150. M Griffiths, *Living with Uncertainty: Indefinite Immigration Detention*. *Journal of Legal Anthropology*, 2013. 1(3): p. 263-286.
151. IMB, *Independent Monitoring Board. Harmondsworth Immigration Removal Centre. Annual Report 2010*. <http://www.imb.org.uk/wp-content/uploads/2015/01/harmondsworth-2010.pdf>. 2010.
152. HMIP, *"Report on an unannounced full follow-up inspection of Harmondsworth Immigration Removal Centre"*, November 2011. <http://www.justice.gov.uk/downloads/publications/inspectorate-reports/hmipris/immigration-removal-centre-inspections/harmondsworth/harmondsworth-2011.pdf>. 2011.
153. IMB, *Independent Monitoring Board. The Verne Immigration Removal Centre. Annual Report covering period 28 March 2014 to 31 March 2015*. <http://www.imb.org.uk/wp-content/uploads/2015/09/The-Verne-2014-15.pdf>. 2015.
154. MJ, *Biased and Unjust : The Immigration Detention Complaints Process*. *Medical Justice*. <http://www.medicaljustice.org.uk/images/stories/reports/BiasedUnjustComplaintsProcess.pdf>. 2014.
155. HO, *Detention Service Order 17/2012 - Application of Detention Centre Rule 35*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/300366/17.2012_v2.0_-_Application_of_Detention_Centre_Rule_35_ext.pdf. 2012.
156. H Pickles, *Fitness to detain in those held under immigration Powers in the UK and rule 35(1)*. <http://www.crimeandjustice.org.uk/sites/crimeandjustice.org.uk/files/PSJ%202020%20July%202015.pdf>. *Prison Service Journal*, 2015. 220: p. 43-48.
157. HO, *Home Office. Detention Centre Rule 35 Audit. 4th of February 2011*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257174/det-centre-rule-35-audit.pdf. 2011.
158. M Sestfot D, et al., *Impact of solitary confinement on hospitalisation among Danish prisoners in custody*. *International Journal of Law and Psychiatry*, 1998. 21(1): p. 99-108.
159. BID, *Access to legal advice in IRCs. Written evidence submitted by Bail for Immigration Detainees to the APPG on Immigration Detention*. 2014.
160. H Miller and G Young, *Prison segregation: administrative detention remedy of mental health problem? Criminal Behaviour and Mental Health*, Vol. 7:85-94 *Criminal Behaviour and Mental Health*, 1997. 7(85-94).
161. HMIP, *Unannounced full follow-up inspection of Colnbrook Immigration Removal Centre and short-term holding facility (16-27 August 2010)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/Colnbrook_2010_rps.pdf.
162. HMIP, *Unannounced short follow-up inspection of Dungavel Immigration Removal Centre (30 September – 2 October 2008)*. http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/dungavel_2008-rps.pdf. 2008.
163. HMIP, *Unannounced short follow-up inspection of Haslar Immigration Removal Centre (31 May – 3 June 2011)*. <http://www.justiceinspectorates.gov.uk/prisons/wp-content/uploads/sites/4/2014/03/haslar-2011.pdf>. 2011.
164. IMB, *Tinsley House Immigration Removal Centre. Independent Monitoring Board. 2011 Annual Report*. <http://www.imb.org.uk/wp-content/uploads/2015/01/tinsley-house-irc-2011.pdf>. 2011.
165. J Cohen, *Safe in our hands?: a study of suicide and self-harm in asylum seekers*. *J Forensic Leg Med*, 2008. 15(4): p. 235-44.
166. M Bosworth and B Kellezi, *Quality of Life in Detention: Results from MQLD Questionnaire Data Collected in IRC Yarl's Wood, IRC Tinsley House, and IRC Brook House, August 2010 - June 2011*. *Centre for Criminology, University of Oxford*, <http://bordercriminologies.law.ox.ac.uk/wp-content/uploads/2013/09/finalmqld.pdf>. 2012.
167. HO, *DETENTION SERVICES ORDER 6/2008. Assessment Care in Detention and Teamwork*. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/257720/assessment-care-in-detention.pdf. 2008.

168. N Morris, *Surge in number of prisoners killing themselves in solitary confinement revealed by report*. Tuesday, 9 June 2015, in *The Independent*. 2015.
169. D Scott G and P Gendreau, *Psychiatric Implications of Sensory Deprivation in a Maximum Security Prison*. Canadian Psychiatric Association Journal, 1969. 14(1): p. 337-341.
170. J Cohen, 'Safe in Our Hands: a study of suicide and self-harm in asylum seekers in the UK'. *Journal of Forensic and Legal Medicine*, 2008. 15: p. 235-244.
171. C Haney and M Lynch, *New York University Review of Law and Social Change. Regulating Prisons of the Future: Psychological Analysis of Supermax and Solitary Confinement*. New York University Review of Law & Social Change, 1997. XXIII(4): p. 477-570.
172. F Kaba, et al., *Solitary Confinement and Risk of Self-Harm Among Jail Inmates*. *American Journal of Public Health*, 2014. 104(3): p. 442-447.
173. *Xue v Secretary of State for the Home Department [2015] EWHC 825 (Admin) (31 March 2015)*, <http://www.bailii.org/ew/cases/EWHC/Admin/2015/825.html> 2015.
174. IMB, *Annual Report of the Independent Monitoring Board for Brook House Immigration Removal Centre. 1 April 2009 to 31 March 2010*. http://www.imb.org.uk/wp-content/uploads/2015/01/Brook_House_IRC_2009-2010.pdf. 2010.
175. M Hayes L, *Juvenile Suicide in Confinement: A National Survey*. *National Centre on Institutions and Alternatives*. 2004.

176. IMB, *ANNUAL REPORT 2011. Independent Monitoring Board. COLNBROOK IMMIGRATION REMOVAL CENTRE*. <http://www.imb.org.uk/wp-content/uploads/2015/01/colnbrook-2011.pdf>. 2011.
177. IMB, *ANNUAL REPORT 2012. Independent Monitoring Board COLNBROOK IMMIGRATION REMOVAL CENTRE*. <http://www.imb.org.uk/wp-content/uploads/2015/01/colnbrook-irc-2012.pdf>. 2012.
178. IMB, *Annual Report. Colnbrook Immigration Removal Centre. Independent Monitoring Board*. <http://www.justice.gov.uk/downloads/publications/corporate-reports/imb/annual-reports-2013/colnbrook-2013.pdf>. 2013.
179. PPO, *Investigation into the circumstances surrounding the death of a man at Colnbrook Immigration Removal Centre in July 2011*. http://www.ppo.gov.uk/wp-content/ReddotImportContent/Colnbrook_-_2_July_2011_-_Death_of_a_male_detainee.pdf. 2011.
180. PHR, *Buried Alive: Solitary Confinement in the US Detention System. Physicians for Human Rights*. https://s3.amazonaws.com/PHR_Reports/Solitary-Confinement-April-2013-full.pdf. 2013.
181. M Mushlin, "I Am Opposed to This Procedure": *How Kafka's In the Penal Colony Illuminates the Current Debate About Solitary Confinement and Oversight of American Prisons*. <http://digitalcommons.pace.edu/cgi/viewcontent.cgi?article=1987&context=lawfaculty>. Oregon Law Review, 2015. 93(3): p. 571-630.

APPENDIX 1

Detention Services Operating Standards manual for Immigration Service Removal Centres

REMOVAL FROM ASSOCIATION

Standard

The use of removal from association must achieve the correct balance between the need to maintain safety and security and the need to show due regard for the dignity of the individual. Procedures must comply with the requirement of Rule 40.

Minimum Auditable Requirements

1. The Centre must ensure that no room is used for removal from association unless the Immigration Service has certified in writing that:
 - its size, lighting, heating, ventilation and fittings are adequate for the maintenance of health;
 - it allows a detainee to contact an officer at any time.
2. Where use of Rule 40 is under consideration and the detainee may be at risk of self-harm or suicide Rule 40 must only be used as a last resort and must be with the authority of the contract monitor (in contracted out centres) or the centre manager (in directly managed centres).
3. Use of Rule 40 may be with the agreement or at the request of the detainee where he/she feels vulnerable for any reason.
4. Where a detainee has been removed from association the Centre must ensure that he/she receives visits (those who are required to visit and frequency of visits are referred to in Rule 40 (9)), for the purposes of reviewing whether removal from association remains necessary. Association with others who are subject to Rule 40, and a staged return (but not as part of an

Incentives Scheme), must also be considered.

5. The Centre must maintain records of all cases where Rule 40 is applied and thereafter all subsequent reviews and actions in each particular case.
6. The Centre must ensure that a representative of the Independent Monitoring Board is advised in accordance with Rule 62 (1) (a) and keep a record to this effect.

TEMPORARY CONFINEMENT

Standard

Temporary confinement of refractory or violent detainees must achieve the correct balance between the requirement to maintain order and discipline whilst having due regard for the individual and in particular the need to prevent self-harm.

Minimum Auditable Requirements

1. The Centre must comply with the terms of Rule 42 of the Detention Centre Rules 2001.
2. Where the Centre has a discrete unit the staff employed there must be selected on the basis of their competency for such a role.
3. The Centre must ensure that no room is used for temporary confinement unless the Immigration Service has certified in writing that:
 - its size, lighting, heating, ventilation and fittings are adequate for the maintenance of health;
 - it allows the detainee to communicate with an officer at any time.
4. The Centre must ensure that details of all cases where Rule 42 is used are recorded and thereafter record all actions relating to visits to detainees, when the detainee was removed from the accommodation and any other relevant information.
5. The Centre must have a published routine for temporary confinement which is made known

to detainees and observed by staff and which takes account of security and control requirements and the statutory entitlements and needs of detainees.

Detention Services Order 2/2002. Guidance on the Detention Centre Rules 2001

“Rule 40: Removal from association

78. Any decision to remove a detainee from associating with other detainees (or to temporary confinement) is not one which should be taken lightly and must be taken on the basis that it appears necessary in the interests of security or safety that the detainee should not associate with other detainees, either generally or for specific purposes. Removal should be proportionate in the circumstances. For example, it may be possible for the detainee to associate with others who are subject to Rule 40. A staged return to association with others may be desirable although this must not be as part of an earned privileges scheme.

79. The decision may be with the agreement of the detainee where he feels vulnerable for any reason. Rule 40 accommodation may exceptionally be used for detainees at risk of self-harm if that would facilitate supervision by staff. It is important that where a decision to remove a detainee from association has been taken that that decision should be reviewed at regular intervals. An important part in this process will involve visits to the detainee since this will assist in judging the temperament or demeanour of the person concerned and as such will inform whether continued removal from association is necessary. Details concerning those who must visit detainees on rule 40 is provided in paragraph 83 below.

80. It is essential that details of a detainee’s removal from association are recorded on form **RCF 1** and that all entries are recorded as soon as possible after any particular action has been taken.

81. Where it is decided that a detainee’s behaviour is such as to require removal from association the centre manager (in the case of contracted-out centres) must seek authority to do so from the contract monitor or, failing that, from another local representative of the contract monitor. In the case of directly managed centres such decisions rest with the removal centre manager. The detainee must only

be removed to a room designated and certified (under Rule 15) for this purpose.

82. However, if it is an emergency and the circumstances are such that it is impractical to seek such authority the centre manager (in the case of contracted-out centres) can take the decision, but must inform the contract monitor or other local representative of the contract monitor that he has done so as soon as possible thereafter so that removal can then be properly authorised.

Duration of removal

83. The contract monitor (in a contracted-out centre) or other local representative of the contract monitor at executive officer or immigration officer level or above can authorise removal from association for periods of 24 hours and beyond as can the removal centre manager in a directly managed centre. The reason for the decision must be recorded as soon as possible following removal and the detainee given written reasons for the decision within two hours of their being removed.

84. Removal can be authorised for periods up to 14 days but should be for the shortest time possible and may be subject to review by the contract monitor (in a contracted-out centre) or the removal centre manager (in a directly managed centre). It is therefore very important to record details on form **RCF 1** of the time at which removal from association began and ended if we are to be in a position to show that periods of detention were lawful.

85. The Rules do not oblige the contract monitor (in a contracted-out centre) or the removal centre manager (in a directly managed centre) to provide a written translation of the reasons for removal from association. But it would make sense to try and ensure that the detainee understands why the measure has been taken.

Visits to the detainee

86. A member of the visiting committee, the medical practitioner and the manager of religious affairs must be notified immediately about a detainee’s removal from association. The Rule also requires the centre manager (in both contracted-out or directly managed centres), the medical practitioner and an officer of the Secretary of State (in the case of a contracted out centre this should be the contract monitor) to visit anyone removed from association at least once every day. A member of the visiting committee must visit the detainee within 24 hours of him being removed under Rule 40 (Rule 62 (1) and (2) refers) and thereafter as and when they

make their routine visits to the centre. Provision for the recording of information relating to visits is contained in form **RCF 1**. These visits are an absolute requirement if the wellbeing of a detainee is to be properly safeguarded and an assessment as to whether the original reasons for removing the detainee still apply.

Review

87. If the centre manager is of the opinion that the detainee’s behaviour is such as to suggest that the detainee can safely return to normal association he can authorise this and record details of the action taken. Similarly, if the medical advice is that the detainee should be returned to normal association this advice must be acted upon. The medical officer must record on form **RCF1** the reason for recommending this action. The centre manager should advise the visiting committee and other relevant parties so that they are aware that no further visits are necessary under the requirements of Rule 40.” Page 25-28

Rule 42: Temporary confinement

91. Information relating to a detainees move to temporary confinement must be recorded on form **RCF 3**. Only that accommodation which has been designated and certified (under Rule 15) can be used for the purposes of holding a detainee in temporary confinement.

Duration of time spent in temporary confinement

92. Temporary confinement may be authorised for periods up to three (3) days. If the detainee’s behaviour ceases to give rise for concern a decision must be taken to cease the period of temporary confinement. The reason for this must be recorded on form **RCF 3**.

93. No person should be kept in temporary confinement for any longer than necessary nor should the period go beyond 24 hours without a direction by

the head of the detention operations or Immigration Service senior on-call officer (in the case of contracted-out centres) or from the Prison Service area manager (in the case of a directly managed centre). Where such a direction is sought the grounds for keeping the detainee in temporary confinement must be notified to the head of operations or the senior on-call officer (in the case of contracted-out centres) or the Prison Service area manager (in the case of directly managed centres) whose task it will be to determine whether this should be authorised. This can be done over the phone or by e-mail, but must be supported by a fax attaching form **RCF 3** recording the original reasons for bringing into force Rule 42 and why a further period is considered necessary. The detainee must be given written notice of the direction placing him in temporary confinement no later than 27 hours following the commencement of the confinement.

94. The visiting committee, the medical practitioner and the manager for religious affairs must be notified immediately following the detainee’s confinement. This is to ensure that they are in a position to put in place arrangements for visiting the detainee. A member of the visiting committee must visit the detainee within 24 hours of his being placed in temporary confinement (Rule 62 (1) and (2) refers). The centre manager, the medical practitioner and the contract monitor (in the case of contracted out centres) must visit detainees held in temporary confinement at least once a day. Further visits by visiting committee members would take place as and when they make their routine visits to the centre. Details of all such visits must be recorded in form **RCF 3** together with any other relevant information. Again it is vital that start and end times are recorded so that it can be demonstrated that the periods in temporary confinement were lawful.”

APPENDIX 2

FOI response 34859- Segregation under rule 40 & 42 of the Detention Centre Rules

“Could you please provide me with the following information under the Freedom of Information Act: The number of individuals held under Rule 40 and Rule 42 of the Detention Centre

Rules 2001, and the total number of days the individuals were collectively held for, for each Immigration Removal Centre (IRC) from 2010-2014 or as long as these records are available. If this exceeds the cost expectation of a FOIA request please prioritise the years 2012-2014.”

Home Office replied that:
“Data prior to 2014 is not held centrally so we are unable to provide this.”

Rule 40		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Brook House	Days	9	77	53.5	58.75	73.25	13.5	12.75	21	25.5	43.75	10.5	15.5	414
	Individuals	7	27	23	35	42	19	11	15	11	31	11	10	242
Colnbrook	Days	48	56	38	69	42	47	60	55	24	55	24	79	597
	Individuals	17	24	21	34	19	17	29	24	14	24	11	39	273
Campsfield	Days	1	1	0	2	0	0	3	2	0	0	0	12.5	21.5
	Individuals	1	1	0	2	0	0	2	1	0	0	0	9	16
Dungavel	Days	5	2	7	19	4	4	13	5	14	13	12	8	106
	Individuals	3	2	7	12	3	4	10	5	7	7	7	8	75
Dover	Days	0	0	0	0	0	0	0	0	0	0	4	25.25	29.25
	Individuals	0	0	0	0	0	0	0	0	0	0	3	22	25
Harmondsworth	Days	19	13	17	34	24	35	85	62	27	71	30	12	429
	Individuals	12	20	12	33	25	29	25	33	14	27	15	12	257
Haslar	Days	0	0	0	0	0	0	0	0	0	0	4	3	7
	Individuals	0	0	0	0	0	0	0	0	0	0	4	3	7
Morton Hall	Days	4	4	0	0	0	0	0	0	0	0	0	0	8
	Individuals	4	4	0	0	0	0	0	0	0	0	0	0	8
Tinsley House	Days	0	1.02	2.25	1.5	0.75	1	0.75	0.25	1	3.4	2.25	5.5	19.67
	Individuals	0	1	3	4	3	4	2	1	1	4	3	3	29
The Verne	Days	0	0	0	0	0	0	0	0	0	92	40	86	218
	Individuals	0	0	0	0	0	0	0	0	0	25	15	35	75
Yarl's Wood	Days	13.5	44	25.2	4.5	7.75	4.5	10.5	5	20.5	38	5	4	182.45
	Individuals	4	4	7	1	4	7	2	1	2	12	8	10	62
Total Days		99.5	198.02	142.95	188.75	151.75	105	185	150.25	112	316.15	131.75	250.75	2031.87
Total Individuals		48	83	73	121	96	80	81	80	49	130	77	151	1069

Rule 42		Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	Jul-14	Aug-14	Sep-14	Oct-14	Nov-14	Dec-14	Total
Brook House	Days	0.5	1.25	0.5	3.6	3	0.5	0	0.5	0.25	1.5	0.75	0	12.35
	Individuals	1	4	2	3	1	2	0	2	1	3	2	0	21
Colnbrook	Days	3	13	7	10	8	13	10	11	1	0	0	0	76
	Individuals	2	6	5	3	5	7	5	5	1	0	0	0	39
Campsfield	Days	0	1	0	1	0	2	0	0	2	16	6	2	30
	Individuals	0	1	0	1	0	2	0	0	3	6	8	2	23
Dungavel	Days	0	0	1	2	0	0	0	0	0	0	0	0	3
	Individuals	0	0	1	2	0	0	0	0	0	0	0	0	3
Dover	Days	0	0	0	0	0	0	0	0	1	0	0	0	1
	Individuals	0	0	0	0	0	0	0	0	1	0	0	0	1
Harmondsworth	Days	0	1	2	1	2	4	7	9	0	3	0	0	29
	Individuals	0	1	1	1	1	2	6	9	0	3	0	0	24
Haslar	Days	0	0	0	0	0	0	0	0	0	0	0	0	0
	Individuals	0	0	0	0	0	0	0	0	0	0	0	0	0
Morton Hall	Days	1	0	0	0	0	0	0	0	0	0	0	0	1
	Individuals	1	0	0	0	0	0	0	0	0	0	0	0	1
Tinsley House	Days	0	0	0	0	0	0	0	0	0	0	0.25	0	0.25
	Individuals	0	0	0	0	0	0	0	0	0	0	1	0	1
The Verne	Days	0	0	0	0	0	0	0	0	0	0	0	0	0
	Individuals	0	0	0	0	0	0	0	0	0	0	0	0	0
Yarl's Wood	Days	6.5	0	22.25	0	0	0.25	0	0	1.75	2	1	1	34.75
	Individuals	1	0	3	0	0	1	0	0	2	1	1	5	14
Total Days		11	16.25	32.75	17.6	13	19.75	17	20.5	6	22.5	8	3	187.35
Total Individuals		5	12	12	10	7	14	11	16	8	13	12	7	127

“They used [segregation] as a threat. I didn’t want to go back there so I had to do what they said. But I was boiling inside. I reacted in other ways, by self-harming” (detainee Yarl’s Wood)