The BMA is a voluntary professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK and supporting them to deliver the highest standards of patient care.

We have worked for many years to promote fundamental human rights in the context of healthcare. This has included advocating for individuals and populations experiencing infringements of their health-related rights, both in the UK and internationally. It was in this context that we published Locked up, locked out, a report on the health and human rights of those detained in immigration removal centres (IRCs) in December 2017.

We welcome this timely inquiry by the Home Affairs Select Committee into immigration detention. This submission outlines our concerns and recommendations in relation to health and wellbeing in immigration detention, highlighting the experiences and views of doctors working in IRCs.

Executive Summary

- The BMA believes that detention should be reserved for individuals who pose a threat to public order or safety. Ultimately, we believe that the use of detention should be phased out and replaced with alternate more humane means of monitoring individuals facing removal from the UK.
- As long as the practice continues, there should be a clear limit on the length of time that people can be held in detention, with a presumption that they are held for the shortest possible time.
- The Home Office should explore how it can streamline and improve its existing pre-screening process to better identify those with vulnerabilities before they are detained.
- We recommend that the Home Office issues specific guidelines which prevent the movement of detainees between IRCs between the hours of 9pm and 7am, other than in exceptional circumstances.
- We believe the Home Office should review its systems for raising concerns about detained individuals, including the current Rule 35 process, to ensure they are robust enough to identify and safeguard vulnerable individuals.
- Training in completing Rule 35 reports should be provided to all IRC GPs, supported by training in interpreting and assessing Rule 35 reports to all relevant Home Office staff.
- In order to improve healthcare provision in IRCs, steps must be taken to address problems with the available tools for identifying health needs; the availability of and access to services; and staffing levels.
- Respect for patients’ rights to privacy, confidentiality, respect and dignity is paramount and must be protected and promoted.

1. The initial process of detention, including the decision to detain and screening for vulnerability

1.1. The Home Office is responsible for making the decision to detain an individual and to document any reasons why detention would not be suitable. Currently there is
limited screening in place to detect vulnerability before a decision is made to detain and there is no standard approach or specific pre-screening assessment to inform this decision-making. This is further complicated by individuals entering detention through a range of routes, all of which are managed separately.\(^1\) We believe that it would be beneficial for the Home Office to consider how it can streamline and improve the pre-screening process to better identify those with vulnerabilities before a decision is made to detain.

1.2. Once in detention, we believe that the reception process could be a crucial time to identify the presence of vulnerabilities at the same time as assessing health needs of each individual. However, various elements of the assessment and screening process make this difficult, including a lack of standardised assessment tools; a reliance on self-reporting from detainees; and a fraught or anxious reception process. The existing screening process is not facilitated through a standardised screening assessment tool, resulting in variation in the information which is collected between different centres. The result of this is that detainees will have to go through a new assessment process each time they move between IRCs.

1.3. There is also a reliance on self-reporting, which means asking individuals to divulge sensitive and intimate details about their health and wellbeing to a relative stranger.\(^2\) This can be especially difficult for individuals who have experienced trauma or violence, or who are culturally inhibited from sharing sensitive information with others.\(^3\)

1.4. There are reports that these initial assessments are taking place in the middle of the night, depending on the arrival time of the detainee.\(^4\) Individuals may be exhausted or disorientated after a long journey or scared and anxious about the prospect of being detained, thus inhibiting their ability or willingness to share detailed information. The Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) recommends that every effort should be made to avoid detainees travelling between the hours of 11pm and 7am.\(^5\) We agree and recommend that the Home Office issues specific guidelines which prevent the movement of detainees between IRCs between the hours of 11pm and 7am, other than in exceptional circumstances.

2. The treatment of vulnerable persons subject to immigration detention, particularly the effectiveness of the Rule 35 process and the Adults at Risk policy

Vulnerability in immigration detention

2.1. Evidence on the welfare of vulnerable persons in detention has been clearly articulated elsewhere.\(^6\) For the purposes of our submission, we wish to draw the committee’s attention to the difficulties facing doctors in identifying and raising concerns about vulnerable individuals.

---


\(^2\) ibid

\(^3\) ibid


\(^5\) European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (2017) Report to the Government of the United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 30 March to 12 April 2016.

2.2. As noted in the section above, we believe that better systems and processes should be developed for identifying vulnerability before a decision to detain is made. We also believe there is more work to be done on processes within detention designed to identify vulnerable individuals and make arrangements for their care, particularly the Rule 35 process.

2.3. We would also note that IRCs hold individuals from all different settings, including a significant proportion who have come from prison. There is a perception that some detainees bring with them a prison “mentality” or “culture” which can be threatening and intimidating.\(^7\) Anecdotal evidence suggests that the experience of being detained alongside those who have spent time in prisons can be deeply distressing for individuals who have been detained from the community.

**Identifying vulnerable individuals**

2.4. The Rule 35 process is an important mechanism in identifying vulnerable individuals in detention and bringing them to the attention of those responsible for authorising and reviewing detention. Our concerns about the current process are in relation to the variability of Rule 35 reports between IRCs; the lack of training and support for IRC GPs in completing Rule 35 reports; and the interpretation of reports and responses by Home Office caseworkers, all of which ultimately raise a concern about whether the process adequately protects vulnerable detainees.

2.5. We note the recommendation made by Stephen Shaw, who recommended that the Home Office consider an alternative mechanism, and the concerns raised by HM Chief Inspector of Prisons, Peter Clarke in his report on Harmondsworth IRC which noted in nearly all of a sample of cases, the Home Office accepted evidence that detainees had been the victims of torture, but maintained detention regardless’.\(^8\)\(^9\) We believe the Home Office should review its systems for raising concerns about detained individuals, including the current Rule 35 process.

2.6. We believe that to address our concerns training in the Rule 35 process and in identifying and documenting concerns should continue to be provided to all doctors working in IRCs, supported by training for Home Office caseworkers in interpreting and assessing Rule 35 reports. It is crucial that where a doctor has expressed a clinical opinion, this is considered seriously and compelling reasons must be provided to justify continued detention.

2.7. The adults at risk policy is another key document in identifying vulnerability and ensuring that vulnerable individuals are not detained, and do not remain in detention. We understand that the Home Office is currently working to revise this policy and guidance to doctors and we will continue to engage with them to develop this.


\(^8\) Heathrow Report on an unannounced inspection of Heathrow Immigration Removal Centre Harmondsworth site (2-20 October 2017)

3. The management of Immigration Removal Centres, including provision of health services

3.1. We believe that the state must meet its obligations to those it detains in IRCs, particularly in terms of ensuring that they do not experience infringements of their health-related rights and are able to access high-quality healthcare, equivalent to that in the community. There are many elements of detention policy and practice which can prevent this from being achieved.

3.2. We are keen to see a role for clinical leadership and advice within the Home Office and believe it would be beneficial to have a clinically qualified individual to advise on the development of health policy in relation to IRCs. We are also keen to see a clinically qualified point of contact within the Home Office for healthcare staff working in IRCs to seek advice from, particularly in relation to concerns they may have over rule 35 reports.

Identification of health needs

3.3. A crucial part of meeting the health needs of detained individuals is ensuring that they are first identified. Doctors report that individuals frequently arrive in detention with no accompanying medical histories, either because they do not exist, or because, where information-sharing is poor, existing health records cannot be obtained promptly and efficiently. We are particularly concerned by this as it can impact on how quickly vulnerable individuals can be identified. We are aware that steps are being taken to move to an electronic health information system which will allow IRCs to access existing patient records and hope that, if implemented correctly, this will aid doctors in obtaining a full picture of an individual’s health.

Availability of and access to services

3.4. We welcomed the transfer of commissioning responsibility from what was then the UK Border Agency (now UK Visas and Immigration) to NHS England, but acknowledge that problems remain. There remains wide variation in the availability of healthcare services between IRCs. Where individuals require access to specialist services in the community, access to those services can be further restricted due to the associated costs of providing transport and escorts for individuals.

3.5. As long as the practice of detention continues, we would like to see continued investment in healthcare. If it becomes clear that the health needs of individuals cannot be appropriately met in a detention setting, this should warrant serious consideration of whether that person should be detained at all.

Staffing

3.6. Various reviews of immigration detention have been critical of staffing levels in IRCs. This includes both healthcare staff (where problems recruiting permanent

---

staff in some centres has led to an overreliance on agency workers) and security staff more generally.

3.7. These staffing shortages not only impact on the availability of health services and continuity of care, but also lead to tensions between healthcare staff and security staff if there is no capacity for a staff member to escort an individual to an external hospital appointment, or to monitor or supervise a detainee at risk.

3.8. Problems with recruitment and retention across the whole IRC workforce (including healthcare) must be urgently addressed to prevent staff shortages negatively affecting the health and wellbeing of detained individuals.

**Mental health care**

3.9. Variation in the availability of mental health services is particularly acute, which is of concern given the evidence of the high rates of mental health problems amongst detainees, and evidence of the negative impact detention itself has on health.\(^{13}\) It is clear that greater investment in ensuring consistency of mental health services and support is needed. More fundamentally, it highlights the importance of a robust process for identifying and removing vulnerable individuals suffering with serious mental health problems.

3.10. We have particular concerns about the routine use of segregation or separation units to manage detained individuals experiencing a mental health crisis. The conditions in such units can exacerbate mental health problems and lead to a further deterioration in health.\(^{14}\) Detainees at risk of suicide or self-harm should not be held in segregation units other than in exceptional circumstances, where there is no other way of managing that risk. This again highlights the importance of a robust process for identifying and removing individuals who are so seriously unwell that they should not be in detention.

**Protecting the health-related rights of detained individuals**

3.11. Detained individuals do not lose their ordinary rights to confidentiality and privacy, but these rights can be challenging to guarantee in the detention environment. The use of interpreters, third-party interest in medical information, and issues relating to resources and the physical environment of the IRC can all affect this.

3.12. Particular concerns have been raised about the confidentiality of health records in IRCs with detainees being asked to consent to their medical records being shared with the Home Office.\(^{15}\) The Shaw review into vulnerability in immigration detention also noted the concerns of some stakeholders that healthcare information provided for one purpose is then shared too widely within the IRC and Home Office.\(^{16}\) Various individuals and groups have noted open reception areas, where initial assessment, appointment booking, and collection of prescriptions are carried out in full sight and

---


\(^{14}\) BMA report ‘Locked up, locked out: health and human rights in immigration detention’


earshot of other individuals; and a lack of private rooms for consultation and therapy to take place.

3.13. We were shocked and deeply concerned by recent footage from the BBC’s Panorama programme appearing to show assault and abuse of detained individuals at Brook House IRC. Above all, therefore, it is vital that detained individuals are treated with dignity, respect and compassion. A key issue for the Committee will be to consider how such principles can be embedded in the culture of IRCs and the behaviour of staff.

4. Whether detention should be time-limited and how such a process might be applied in practice

4.1. The UK is one of only a handful of countries in Europe not to impose a maximum time-limit on detention. The indefinite or indeterminate nature of detention is the focal point of much of the criticism levelled at immigration detention, with various senior bodies and officials raising concerns about the continued use of indefinite detention, including Her Majesty’s Chief Inspector of Prisons. We believe that as long as the practice of holding people in detention continues, there should be a clear limit on the length of time that people can be held in detention, with a presumption that they are held for the shortest possible time.

4.2. We would draw the attention of the Committee, to concerns about the implementation of time-limited detention from our members who have experience working in overseas jurisdictions. Some evidence suggests that where a time-limit is in existence, detainees are released upon the expiry of that time-limit, but are neither removed from the country, nor do they depart; and nor does their immigration status change. They can then be re-apprehended and placed in detention again with the time-limit resetting itself. In this way, the immigration detention system risks becoming a ‘revolving door’.

4.3. Our members also report situations where detainees who have been receiving care and treatment in detention are released and subsequently struggle to continue to access care in the community. Perversely, many doctors working in IRCs report situations where they feel a detainee with a long-term condition may receive better care in detention than in the community. This is not an argument for prolonged continued detention, but for ensuring that any discussion about time-limits includes consideration of how to ensure access to and continuity of healthcare and other support services in the community.

---

19 BBC Panorama, Undercover: Britain’s Immigration Secrets http://www.bbc.co.uk/programmes/b094mhsn
22 BMA Report, Locked up, locked out: health and human rights in immigration detention, 2017
April 2018

For further information, please contact:
Gemma Hopkins, Senior Public Affairs Officer
T: 0207 383 6287| E ghopkins@bma.org.uk