BMA House
Tavistock Square
London WC1H 9JP

E ethics@bma.org.uk

Alison Samedi
Head, Compliance and Enforcement Policy Unit
Home Office
2 Marsham Street
2nd Floor, Peel
London
SW1P 4DF

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Dear Ms Samedi

Thank you for the opportunity to respond to the Home Office's targeted consultation on the draft Removal Centre Rules 2019.

The British Medical Association (BMA) is the voice of doctors and medical students in the UK. We are an apolitical professional association and independent trade union, representing doctors and medical students from all branches of medicine across the UK – including those working in immigration removal centres (IRCs) – and helping them deliver the highest standards of patient care.

We have a longstanding interest in health-related human rights and have worked for many years to promote fundamental human rights in the context of healthcare. This includes reducing health inequalities, ensuring access to healthcare for all, and standing up for vulnerable groups. It was in this context that we published our report on the health-related human rights of those in immigration detention, *Locked up, locked out* in 2017.

For the avoidance of doubt, our position on immigration detention remains the same, which is that detention should ultimately be phased out and replaced with alternate more humane means of monitoring individuals facing removal from the UK. As long as the practice continues, we believe there should be a clear time-limit on the length of time that people can be held in detention, with a presumption that it is for the shortest possible time.

Our response focuses on the parts of the draft Rules which relate to healthcare provision, and those which affect the health and wellbeing of those detained. This includes our views on:

- the proposed reconstitution of healthcare teams within IRCs;
- the definition of "medical practitioner" for the purposes of the Rules;
- amendments to the provisions governing screening and access to healthcare;
- the effectiveness of the Rule 35 process, and our suggested amendments to improve the process; and
- the use of force on, and temporary confinement of, those detained.

Our response has been informed by discussions with colleagues at the Royal College of Psychiatrists and the Royal College of Midwives. Whilst it should not be assumed that they endorse all of what is said in this submission, I hope it indicates the consensus on many of these issues across the medical and health professions.

I hope this information is helpful to you. If you require any further information or clarification of our comments, please do not hesitate to contact us.

Yours sincerely

Stella Dunn
Head of Professionalism and Guidance

Consultation on the draft Removal Centre Rules 2019

Rule 4: Information to detained persons

We are supportive of the provisions in **Rule 4**, which outline the obligations on IRCs to make certain information available to detainees upon admission. We know that many of those entering detention will have had little or no contact with UK health services, and it is crucial that they are made aware of their rights to, and the practicalities of accessing, healthcare services. With that in mind, we would encourage you to add a similar obligation on centres to provide detained individuals with information about the provision of healthcare in the IRC – including information on what is available; how services can be accessed; and on the role and independence of the doctor in relation to the wider detention system (crucial in establishing trust in the doctor-patient relationship).

We also recommend that **Rule 4(1)(f**) is amended so that it reads "information in this paragraph that must be available in a language and format which the detained person understands", rather than "which is available". We believe this would strengthen the obligation on the Home Office and service providers to take active steps to source and provide information in a range of languages, rather than relying on what might already exist.

Later in our submission we discuss the importance of the screening process in identifying whether a person lacks capacity, and our call for the practice of "night moves" into and between IRCs to end. Both of these issues will affect the ability of a person to take in and understand the information being provided to them at reception. We stress the importance of making sure information is presented appropriately, and in such a way that detained individuals understand their rights.

We would also like to take this opportunity to restate our concerns about the current shortcomings of interpretation services in IRCs. We note that the Detention Services Orders state that professional interpretation services must be used whenever language barriers are identified, but we are aware that this is not always achieved. Feedback from our members who work as GPs in IRCs report that it can at times be difficult to obtain the services of an interpreter, even though there are contracts in place for telephone interpreting. Even where contact is made, the quality of the interpretation provided is highly variable. The review of the Removal Centre Rules presents an opportunity to address these problems by elevating the provision of interpretation services from guidance to a statutory instrument.

Rule 16: Hygiene

We welcome the new requirement for sanitary products to be provided to all female detainees. Reliable access to sanitary products is essential for the health, wellbeing, and dignity of all women.

We are concerned, however, by the addition of a new power to withhold toiletries, bath, shower or shaving facilities in the interests of security or safety. We are hard pressed to envisage a situation where such an entitlement would present a security or safety threat that would justify a blanket policy which removes these rights from detained persons. Even where a person is deemed at risk of suicide or self-harm, there are other steps (for example, supervision) which would be a more proportionate response to the identified risk. It may be helpful to look to how similar risks are managed in secure mental health settings.

We re-emphasise that the provision of basic hygiene facilities is essential for health, wellbeing, and dignity of all persons and ask that this power is removed from the Rules unless there is compelling evidence which supports its implementation.

Rule 33: Medical practitioner and healthcare team

Constitution of the healthcare team

Rule 33(1) widens the constitution of the healthcare team in IRCs to include a nursing team as well as a practitioner. We are on the whole supportive of such an approach – it more accurately reflects a multi-disciplinary team (MDT) approach to healthcare and more closely aligns with how healthcare is provided to the wider population in the community. We suggest the changes below to further improve this provision.

First, we ask for a clearer definition of what constitutes "a nursing team" for the purposes of **Rule 33(1).** In the community, healthcare teams involve a range of nursing professionals, such as registered general nurses (RGN); mental health nurses (RMNs); and advanced nurse practitioners. It seems desirable to have a range of different backgrounds and specialties within the nursing team in IRCs, but we are concerned that unless this is specified, there will be knowledge and skills gaps in particular teams.

Secondly, the Home Office may wish to consider other components of a "healthcare team" that should be made available in IRCs – for example, specifying roles for psychologists or counsellors (of particular importance to address the current shortfall of psychological services in the immigration detention estate), occupational therapists or dentists. Discussion with colleagues at the Royal College of Midwives also highlighted the importance of a midwife, or a practitioner with a specialism in women's health, being available for pregnant women.

Although we welcome the change in constitution of the healthcare team, we do believe that there are some tasks which can only be appropriately carried out by a medical practitioner – for example, the provision of initial healthcare appointments for potentially vulnerable adults after initial screening, and the completion of a Rule 35 report. We explore these concerns in more detail below.

Definition of "medical practitioner"

The new definition of medical practitioner under **Rule 33(2**) should be reconsidered. We strongly believe that the healthcare team within IRCs must include a medical practitioner who is on the GP register. GPs are the first point of call for most health concerns in the community and are most appropriately placed to address the wide range of health concerns with which detained persons will present. This requirement for the primary medical practitioner to be a GP would not preclude other doctors (for example, a psychiatrist or another appropriately qualified specialist) being part of the healthcare team.

"Choice" of healthcare practitioner

Rule 33(8) creates a new entitlement for detainees to consult a member of the healthcare team of the same sex. Although we are supportive of the rights of patients to see a healthcare practitioner of the same sex – thinking, in particular of the importance of this to detainees who might be the victims of sexual or gender-based violence – we urge caution about the practicalities of implementing such rights. Simply put, there is not the mix of male and female staff in each IRC to be able to meet this need; particularly problematic is the lack of male nurses working in IRCs, which have a predominantly male population.

Patients in detention settings are therefore not free to choose who they see in the same way that they would be in the community, and this section must acknowledge that. We ask for this section to be amended to acknowledge the reality of clinical practice in the immigration detention setting, and to be clear that the right to consult a member of the healthcare team of the same sex can only be accommodated "so far as is reasonably practicable", or to the extent that it does not impact on the timeliness or quality of patient care. This is particularly important in relation to individuals who are identified as being vulnerable, where timely identification and assessment is crucial.

The current **Rule 33(11)** refers to the rights of detainees to have access to a medical practitioner other than the centre doctor, so long as the manager "is satisfied that there are reasonable grounds for the request". The new draft rule widens this out so that the manager and the Secretary of State are satisfied that there are reasonable grounds for the request. We are not clear of the reasons behind this amendment but are concerned that it – particularly the requirement for Secretary of State approval – creates unnecessary barriers to detained individuals seeking additional medical advice.

Continuity and equivalence of care

We have previously expressed concerns about individuals arriving in detention with no accompanying medical records – acknowledging that sometimes this is because they simply do not exist – but at other times because existing health records cannot be obtained due to poor information-sharing. This can have a considerable impact on the timeliness and appropriateness of a patient's care, which is particularly problematic when a person may only be detained for a short period of time.

We are therefore pleased to see the new addition to **Rule 33(13)** which creates a new obligation to obtain a detained person's existing health information from previous healthcare providers in the UK. Rather than placing this obligation on individual members of the healthcare team – as currently worded – we feel the responsibility should be placed on the healthcare manager, and supported by investment in IT infrastructure to allow information sharing.

We are also pleased to see a similar obligation on the healthcare team in **Rule 33(14)** to forward medical records as appropriate when a detained person is transferred to hospital or another IRC or released to the community – an essential part of ensuring continuity of care. We feel this could be strengthened by adding wording to the effect that anyone being released to the community should also be provided with their own copy of their summary care record. This would help overcome some of the difficulties associated in ensuring continuity of care where individuals are released to a different area, or without already being registered with a GP.

Finally, we have frequently raised concerns about the difficulties associated with ensuring access to specialist services. While some IRCs have healthcare bed facilities, and are able to commission specialist clinics on an occasional basis, others will be dependent on those services in the community or in local NHS hospitals or facilities. Access to those services can be further restricted on the basis of resources – for example, the staffing and costs associated with providing transport and escorts for individuals. We would welcome an additional clause at the end of Rule 33 which makes explicit that detained individuals are entitled to the same range and quality of services as the general public receives from the NHS, and which outlines the obligations on the Home Office, the NHS, and individual centres to meet this.

Rule 34: Medical screening

The initial screening process is fundamental to gathering key health information and identifying vulnerability. We have previously raised concerns about some of the problems with this process, including its reliance on self-reporting from detained individuals; individuals' ability or willingness to divulge sensitive information being inhibited by tiredness, stress or anxiety (later in our response we recommend that night-time moves to and between IRCs should cease for this reason); and the variable availability of interpretation services to facilitate screening.

We welcome the acknowledgement that the initial health screening process under **Rule 34** can be carried out by any member of the healthcare team. This reflects what currently happens in practice during the reception process in IRCs and also aligns with medical services provided in the wider community.

We would, however, like to see greater clarity on what "screening" involves and how it will operate. What is being identified through such screening? Is it intended to assess health concerns or conditions, or also to assess vulnerability for the purposes of the Adults at Risk Policy or Rule 35? If it is the latter, and concerns about vulnerability are raised, we believe the rule must be more prescriptive about the follow

up healthcare appointment: such individuals must be referred to an appointment with a medical practitioner, specifically, rather than any member of the healthcare team. This is important given the critical role of the initial screening and follow-up appointment in identifying vulnerability (see our comments on Rule 35, below).

The specific needs of perinatal women in relation to screening were raised in our discussion with the Royal College of Midwives. Here the need for prompt and timely screening and identification of vulnerability is particularly important, as the clock starts on their maximum detention time window of 72 hours. Additionally, the involvement of a local midwifery team or member of the healthcare team with a specialism in women's health should be considered.

This section would also benefit from being clearer on the general obligations of healthcare professionals carrying out the initial screening. For example, if it is a registered mental health nurse who carries out the initial screening, we would like to see a clear statement that the patient should be offered an opportunity to see a general nurse for any other health issues. In addition to there being an "offer" of an appointment with the medical practitioner, we would also like there to be a firmer obligation on the staff carrying out the initial screening to refer to the medical practitioner any patient whom they feel is in need of more urgent medical attention.

As noted in our comments on Rule 4, relating to the provision of information during the reception process, the screening process is a crucial point in time at which to identify any person who lacks decision-making capacity. If someone is found to lack capacity, this should immediately raise concerns about vulnerability and trigger safeguarding processes with a view to that person being released from detention. The Royal College of Psychiatrists' submission explores this issue in more detail.

We would also reiterate our points expressed above concerning access to interpretation services, as these apply similarly to the screening process and follow-up healthcare appointments.

Finally, our concerns to **Rule 33(8)** apply similarly here: although we support the rights of patients to see a member of the healthcare team of the same sex, we are concerned about the practical reality of healthcare provision in IRCs and how it might impact on this laudable aim. Again, we emphasise the importance of reducing delays in the identification and assessment of vulnerability.

Rule 35: Special illnesses and conditions

Rule 35 provides a critical safeguard for vulnerable individuals once in detention. In practice, however, we believe that the tightly controlled categories of Rule 35 mean that vulnerable adults who do not meet the criteria for 35(1), (2) or (3) fall through the cracks.

We support a move towards a much more simplified approach which focuses on the adverse effects on health and future harm in detention, regardless of underlying pathology, reason or cause. We ask that Rule 35 is redrafted to create an obligation on medical practitioners to report to the centre manager the case of any detained person whose health is likely to be adversely affected by continued detention or any conditions of detention – regardless of what the underlying cause for that is.

The focus of Rule 35 must be on creating a safeguarding mechanism which prevents harm, or further harm, to the individual, and promotes health and wellbeing, rather than on fitting detained individuals into defined and somewhat arbitrary categories. The reasons underlying vulnerability are complex and multi-faceted, and affect individuals in different ways. It is not an issue that can be reduced to distinct categories: someone who has experienced torture a number of years ago, for example, may be more resilient and less vulnerable than an individual who was the victim of domestic violence – a category not currently covered by Rule 35.

Adjusting Rule 35 in this way would mean that the role of the doctor is appropriately focused on the identification and assessment of vulnerability, rather than – as the current Rule 35 asks – making a

determination of whether a detainee's claim meets the definition of torture, or commenting on the veracity of a detainee's claim.

We believe very strongly that an assessment of whether someone's health will be adversely affected by continued detention is a clinical issue, and can only be appropriately assessed and reported by a medical practitioner. This would not preclude any other member of the healthcare team or wider IRC staff raising concerns about a person's vulnerability and the adverse impact of detention to a medical practitioner.

We have been made aware that in some IRCs, there are waiting lists for Rule 35 assessments, meaning that reports raising concerns are inappropriately delayed. It is of fundamental importance that assessments and reports are completed promptly, as soon as vulnerability has been identified. We propose that a section requiring Rule 35 reports to be completed within 72 hours of concerns being raised should be added to the Rules.

We have raised concerns in the past about Rule 35 forms being rejected by Home Office caseworkers. Where there is a medical opinion that health will be adversely affected by continued detention, we believe there must be compelling reasons for a caseworker to override that opinion and effect a person's continued detention.

We would be happy to provide some more detailed comments or to engage in further discussions with you on this point as you progress with your redrafting.

Rule 40: Removal from association

Rule 40(9) states that the healthcare team must be notified when any person has been removed from association. We believe that healthcare practitioners must also raise concerns about any individual for whom they feel removal from association will have an adverse effect on health and wellbeing. We are pleased that **Rule 40(12)** is clear that the manager must make arrangements for any detained person to resume association with other detained persons if the healthcare team advises so on medical grounds; we would like to see a similar provision in the rules governing the use of force and temporary confinement (see below).

Rule 40(10) goes on to say that for the period of removal, a member of the healthcare team must make daily visits to the person removed. We believe this provision should also outline what constitutes a "daily visit". We currently have concerns that this sometimes consists of nothing more than a cursory glance or simply "checking in" with the security staff on duty. It must be emphasised that the daily visit must involve meaningful engagement. We ask that it is further amended to emphasise the rights of persons removed from association to request medical attention and to receive clinically appropriate care.

Rule 41: Use of force

We believe that all persons who have experienced the use of force should be offered immediate review by a member of the healthcare team, and would like to see an additional clause to this effect included here. This is important not just so they can provide care and attention for any injuries sustained, but to provide an assessment of mental health and wellbeing – the use of force on vulnerable individuals can be particularly damaging.

Rule 42: Temporary confinement

Our concerns regarding removal from association under Rule 40 apply similarly to the provisions of Rule 42 on temporary confinement. We believe that healthcare practitioners must raise concerns about any individual for whom they feel temporary confinement will have an adverse effect on health and wellbeing, and that centre managers must act on any recommendation from a healthcare professional that someone should not be held in temporary confinement. Wording similar to that of **Rule 40(12)** should be included here.

Additionally, and as above, we would like clear direction on what a member of the healthcare team must do in conducting a daily visit to someone in confinement. We would be concerned by any suggestion that a healthcare practitioner simply has to confirm they had "seen" the individual and believe that the emphasis must be on meaningful engagement.

Rule 44: General duty of officers

We note, with interest, the duty on officers to inform the manager and Secretary of State of any abuse or impropriety that comes to their attention. Although this is implicit in the professional duties of doctors and other healthcare professionals, we believe that a duty to report on the IRC healthcare team should also be set out in the Rules.

The Rules should also require all centres to have a clear raising concerns process in place, and that members of staff must not be victimised for raising concerns. This will help to create a culture in which staff – both officers and healthcare teams – feel able to speak out or raise concerns.

The nature of working in an IRC setting, the traumatic nature of many detained persons' histories, and the stresses of providing appropriate care can take its toll, and health and morale can suffer. We therefore request that the Rules make clear that centres must provide access to appropriate occupational health and support (including psychological support) for staff.

Other comments

We have raised various concerns about the movement of detained individuals into or between IRCs, late at night. The tiredness, anxiety and stress caused by night moves can seriously inhibit the initial screening and induction process, making them far less effective. We would like to see an outright ban in the Rules on movements at night-time, specifically a clause which would prohibit detained individuals from arriving at any IRC after 10pm or leaving an IRC before 7am.

Finally, we would like to emphasise that the Rules cannot be viewed in isolation of continued investment in healthcare in detention settings and support and training for healthcare practitioners and Home Office caseworkers. We believe that there is much more to be done to assist and benefit implementation of the Rules, and we, alongside our colleagues in some of the other Royal Colleges, would like to offer a commitment to work with you to achieve this.