Medical Justice
seeking basic rights for detainees

Healthwatch and Immigration Removal Centres

Asylum Seekers in Detention Centres

HAPIA ACTION

Healthwatch and Public Involvement Association

CONTENTS

Healthwatch and Immigration Removal Centres

Summary

People held in indefinite immigration detention in Immigration Removal Centres (IRCs) and Short-term Holding Facilities are among the most powerless and vulnerable people in our society. Many detainees have suffered torture or ill-treatment, have significant and chronic health problems, and a few may be pregnant, or have been detained for prolonged periods of time without any realistic prospect of release or removal. Some are powerless, still awaiting determination of their immigration status and may fear that if they make a complaint there will be repercussions, which will affect their immigration case.

Numerous reports from Her Majesty's Inspector of Prisons (HMIP) and others, indicate serious problems in the standards of healthcare provided. As HM Chief Inspector of Prisons, Nick Hardwick points out "…*away from public scrutiny, it is all too easy for even well intentioned staff to become accepting of standards that in any other setting would be unacceptable"*.[i]

Most IRCs are run by private companies - such as G4S and Serco. The rest are run by the National Offender Management Services (NOMS, i.e. ex-Prison service). For the IRCs run by private companies, responsibility for healthcare commissioning is being transferred to NHS England from the Home Office. When this happens Local Healthwatch (LHW) will have the same statutory rights as they have with other NHS and social care services. This provides an important opportunity to Local Healthwatch to improve life for the most vulnerable in our society and open up areas hitherto largely closed to public scrutiny.

Background

Approximately 29,000 people are detained each year under immigration powers, with about 4,000 people detained in England and Scotland at any one time, including people detained in police cells or prisons. About 25% of immigration detainees are held in prisons.

In 2012, asylum seekers accounted for nearly half of all immigration detainees (http://migrationobservatory.ox.ac.uk/briefings/immigration-detention-uk). People who may not have a right to remain in the UK and those whose cases are yet to be determined through the "fast track" process can be held until they can be removed or are released on bail or obtain the right to remain. This is administrative detention – they are detained in Immigration Removal Centres (IRCs), but are not there because they have committed any crime and have no charges pending against them. In spite of this some people are detained for months and even years.

Under Home Office rules detention should be used only in very exceptional circumstances for certain vulnerable categories of detainees - and only if the health of the detained person can be 'satisfactorily managed'. People who should not normally be detained include:

- Unaccompanied children and anyone under the age of 18
- Elderly people, especially if they need continuing care and support or if they are suffering from cognitive impairment
- Pregnant women, especially after 24 weeks of pregnancy
- Those suffering from serious medical conditions or mental illness
- Those where there is evidence that they have been tortured
- People with serious disabilities

If someone has been tortured or raped they should only be held in detention in 'very exceptional circumstances'. This is covered by Rule 35 (Detention Services Order 17/2012). However, many detainees who have been tortured remain in detention, as their evidence is not believed.

There are ten IRCs in England. They are run on behalf of the Home Office by the prison service and private contractors. These are listed below (table one).

Table 1 Immigration removal centres in the UK

Centre	Healthwatch	IRC run by	Healthcare provided by	CQC Registered Healthcare Provider on site	Transfer of healthcare commissioning to NHS England	Accommodation
Brook House RH6 0PQ	W. Sussex and Surrey	G4S	G4S*	No – in reach	September 2014	426 men
Campsfield House OX5 1RE	Oxfordshire	Mitie	The Practice	No –in reach	April 2015	216 men
Colnbrook UB7 0FX	Hillingdon	SERCO, Mitie from Sept 2014	Central and NW London NHS Trust	YES	September 2014	308 men
Dover CT17 9DR	Kent	NOMS	NOMS	YES	N/A	314 men
Dungavel ML10 6RF	Local Health Councils	GEO	Primecare	N/A	N/A	190 men
Harmondsworth UB7 0HB	Hillingdon	GEO Mitie from Sept 2014	Central and NW London NHS Trust	YES	September 2014	615 men
Haslar PO12 2AW	Portsmouth	NOMS	Central and NW London NHS Trust	Exempt	N/A	160 men
Morton Hall LN6 9PT	Lincolnshire	NOMS	G4S[1]	YES	N/A	393 men
Tinsley House RH6 0PQ	West Sussex and Surrey	G4S	G4S*	No – in reach	September 2014	116 men, 5 women and 4 families
Yarl's Wood MK41 6HL	Bedfordshire	SERCO	SERCO*	YES	September 2014	405 women and families whiteout children
The Verne – currently run as a prison	Dorset	NOMS	NOMS		N/A	600+ men shortly
Pennine House STHF	Manchester	Reliance			Sept 2014	32 men
Cedars (STHF)		G4S and Barnados	G4S*		Sept 2014	25 children/ families

[1] Already commissioned by NHSE

* Tendering process being run by NHSE Health and Justice for healthcare service provision from Sept 2014

Healthcare in IRCs

Healthcare in privately-run IRCs has, up until now, been commissioned by the Home Office from contractors, such as Mitie, SERCO and G4S, who often sub-contract healthcare to other companies.

There are serious concerns raised about the conflicts between the 'duty of care' towards detainees and the desire of the Home Office to remove people from this country. This was a key reason for the responsibility for commissioning healthcare being transferred to NHS England, which will commission healthcare services for IRCs, separately from the main Home Office contract to run detention centres.

Home Office policy is that healthcare in IRCs is NHS equivalent (Detention Services Operating Standards manual for IRCs). All IRCs have a Health Care Unit staffed by nurses providing primary care, which should be up to the standards of NHS services provided in the community, with visiting doctors doing clinic sessions. A few IRCs have inpatient beds (Harmondsworth, Colnbrook and Dover), which are used for a variety of medical conditions, including detainees on suicide watch or hunger strikers.

Reports from the HMIP, independent monitoring boards (IMBs), Medical Justice and others working with detainees often reveal serious problems with the standards of basic healthcare in IRCs.

Primary Care

There are concerns about the standards of primary care and detainees often complain of a culture of disbelief towards them by healthcare staff. Sometimes detainees are taken from their homes in raids without warning and have little chance to pack their things or collect their medication. As a result, detainees may find that when they come into detention they do not have their medicines with them or only a short supply. This may include medication for HIV and painkillers for chronic conditions.

There are also reports that IRC healthcare providers have sometimes failed to provide regular check-ups or tests, including blood tests, ECGs, x-rays, monitoring of blood pressure and insulin management. One complainant stated that out-of-date or incorrect medication, including intravenous medication, was administered.

In others, there is a failure to adhere to patients' clinical care plans, including psychiatric plans. It is often claimed that healthcare providers in the privatised IRCs use inadequate clinical information systems and so mistakes are easily made.

Diabetics, and others with chronic diseases, who are used to managing their condition in the community, find that in detention they may be required to go to the healthcare clinic to get their medication, increasing their feelings of powerlessness and ability to manage their condition effectively.

Emergency Cover

When investigating deaths in custody the Prison and Probation Ombudsman has highlighted poor emergency care in IRCs. They have concluded that the staff is often inadequately trained and equipped to deal with medical emergencies[ii]. The Ombudsman has pointed out that he is making the similar recommendations now, as those made after the first investigation into a death in custody in 2004.

Poor emergency care

Mr A died of a heart attack. He complained of chest pains and his room-mate pressed the emergency call alarm in the room. Healthcare staff attended, but thought his symptoms were heartburn and he was told the doctor would see him next day. The room-mate pressed the emergency alarm again and the detention officer found the complainant in bed and unresponsive.

In spite of first aid training, the Healthcare staff did not attempt resuscitation, nor did the next two custody officers do so on arrival in the room. Two nurses came with a resuscitation bag and oxygen cylinder and began CPR. One nurse went back to get the defibrillator but it did not have a battery and could not be used. Finally an ambulance was called, but Mr A could not be resuscitated.

The inquest concluded that neglect contributed to his death and there had been a total breakdown in his healthcare.

2011

Mental Health Services

Mental illness is the greatest health issue for detainees. The rate of mental illness is already high in those who are subject to detention, in part due to the stresses in their life up to that time.

Post Traumatic Stress Disorder (e.g. following torture), can be exacerbated by further incarceration. In many cases detention exacerbates mental illness and distress, and consequently many report significant symptoms. The indeterminate nature of immigration detention adds to the distress. This can include illness at the highest level of severity, such that transfer for compulsory treatment in a mental hospital may be regarded as appropriate.

Many people in detention suffer a crisis in their mental health, as demonstrated by the many Court cases where successful action has been taken against the Home Secretary.[iii]

Amongst detainees with significant mental illness, are those without the mental capacity to make important judgments for themselves. There is no tradition of independent advocacy for these people in detention and in any event, the lack of mental capacity is often not picked up or is ignored.

Mental Health Act visits by the CQC can take place for people whose rights are restricted under the Mental Health Act, to monitor how the Act is being used and if their rights are being infringed in any way. The CQC can visit anywhere and have private meetings with people who are detained under the Act. When requested, arrangements can also be made for the CQC to meet people who are on a Community Treatment Order.

A legal judgement in 2014 found that S had been unlawfully detained for 3 months because of his severe mental illness. The treatment and care he received was so inadequate that it amounted to significant breach of articles 3 [inhuman and degrading treatment] of the Human Rights Act.

The failure to apply and comply with the policies was described as wilful or grossly negligent. The judge found it clear that many involved with S had little understanding of mental illness or of the assessment process needed to provide adequate assessments of the nature, extent, treatment and after-care of psychotic illness and no inclination to treat S …

The judge concluded that S has only been able to bring this case, and indeed was only able to secure his release from detention, because he had the good fortune to be advised by a duty immigration solicitor who sought Medical Justice's assistance to arrange for an independent psychiatric assessment of him in Harmondsworth who then arranged that assessment and S's representation by experienced detention solicitors. ...

Cancelled Hospital Appointments

Detainees who need specialist care are taken to local NHS hospitals - this does not always happen or at least in a timely fashion. In order for a detainee to be taken to an outpatient appointment, transport needs to be arranged. Transport for hospital visits is de-prioritised in favour for other trips such as to the airport for removals. Problems with transport lead to repeated cancellations or postponement of medical appointments, including treatment for serious conditions.

Appointments can also be missed if the detainee is moved to a different IRC. Moving detainees around is common, often with no reasons being given. If the detainee is waiting for a hospital appointment and their appointment is lost, the process has to start all over again at the next IRC. The Detention Centre doctors and nurses have the power and the duty to stop a transfer, by insisting on a "medical hold" to prevent a detainee missing an appointment, but their views are often ignored.

Missed Appointments

X missed three external cardiologist appointments to investigate uncontrolled hypertension at different IRCs over a four-month period. Following a complaint, UKBA accepted that X should have been put on "medical hold" and not transferred from IRC to IRC. The detainee won compensation in a case brought for unlawful detention - partly based on X's unfitness for detention as a result of ill-health. Y had a stroke and was referred to the local hospital for rehabilitation and physiotherapy. Because of transport and escort problems, Y missed many appointments. The Head Physiotherapist made a complaint to healthcare in the IRC that the patient had to be discharged because Y's attendance was so poor that appropriate care and treatment could not be provided.

Handcuffing and Confidentiality During Clinical Consultations

When a detainee is taken for a hospital appointment, a Risk Assessment is meant to be undertaken concerning the likelihood of the detainee absconding. HMIP have recommended that detainees should not be routinely handcuffed during escorts or during hospital appointments. Restraints should be applied only if a Risk Assessment indicates a specific risk of escape or a potential threat to the safety of the public or staff.[iv]

The Home Office also has guidance on this.[v] A recent legal case found that the continuing use of handcuffs on a detainee in hospital amounted to inhumane and degrading treatment under Article 3 of the European Convention on Human Rights.[vi] The detainee was shackled for over 8 days in hospital. However, when taking detainees to hospital the IRC security staff nearly always use handcuffs, even when the detainee is clearly very ill.

British Medical Association Guidelines in these circumstances are clear that the consulting Doctor should request the removal of restraints and request guards to leave the room. The Doctors should always make this request if the method of restraint interferes with diagnosis or treatment, or if the detained person is clearly too incapacitated to threaten others or abscond.[vii] However, Doctors for some reason seem to find it difficult to challenge the guards, and be unaware that they have a duty to do so. If a Doctor fails to act appropriately in relation to the removal of restraints and ensuring privacy during consultations, this will clearly result in a breach of the patient's right to dignity, privacy and confidentiality and can have serious consequences for the patient. In one instance, a guard present during a consultation reported back – incorrectly - that the patient had TB, and this false rumour became widely circulated in the IRC.

Every doctor in the UK is bound by the following duties:

General Medical Council - Good Medical Practice (2013)[viii]
Communication, Partnership and Teamwork

- Treat patients as individuals and respect their dignity.
- Treat patients politely and considerately.
- Respect patients' right to confidentiality.
- Work in partnership with patients.
- Listen to, and respond to, their concerns and preferences.

- Give patients the information they want or need in a way they can understand.
- Respect patients' right to reach decisions with you about their treatment and care.
- Work with colleagues in the ways that best serve patients' interests.

Maintaining Trust

- Be honest and open and act with integrity.
- Never discriminate unfairly against patients.

Never abuse your patients' trust in you, or the public's trust in the profession.

Handcuffing and privacy

Her Majesty's Inspector of Prisons has reported:

'Although we found a small number of exceptions, most detainees were handcuffed on external appointments, even though they all underwent individual risk assessments. This included some detainees assessed as low risk.

A detainee who was wheelchair bound following a stroke, had recently been handcuffed on a journey to hospital, and for no obvious reason. He had been assessed as low risk. We noted other cases where use of handcuffs was grossly excessive.

In November 2012, a dying man had remained handcuffed while sedated and undergoing an angioplasty procedure in hospital. His restraints had only been removed seven hours before his death …

In another case, an 84-year-old man who was considered frail and was suffering from Dementia, died while still in handcuffs, having been kept in them for around five hours. Only after his heart had stopped and cardiopulmonary resuscitation started were the handcuffs removed.'[ix]

ASSAULTS AND RACISM

Any physical assault is a criminal offence. However, Detention Centre Officers have the power to use force where necessary and proportionate – it only becomes an assault when excessive or unnecessary force is used.

There are many reports of abuse and serious mistreatment of detained asylum seekers, by the companies hired by the Home Office to run IRCs and by their transport services, including beatings and torsions to limbs, as in the case of Jimmy Mbenga's death, where the guards face manslaughter charges.[x],[xi]

Where a detainee is harmed by use of force or alleges harm, the IRC should refer the detainee to a doctor who should photograph the injuries.[xii]

Injuries following use of force are often not examined, recorded or photographed. Nevertheless, if a detainee is injured during removal and the removal goes ahead, there is apparently no requirement for the incident to be reported.[xiii]

Numerous reports have examined allegations of racism at IRCs. In 2008, the Institute of Relations was commissioned by the Border and Immigration Agency of the Home Office, to examine a number of serious allegations and it was found that the staff training was poor; that racist abuse by staff was common, including the taunting of detainees. The Institute found that repeated patterns of alleged racist incidents, was missed by the in-house investigation process and that regular taunting of detainees by some officers went unchallenged. The report stated that: "The detainees that were interviewed all reported either personally experiencing or witnessing harassment and intimidation perpetrated by staff" and that". Banter and taunting was not seen as discriminatory behaviour or harassment, but as part of the natural relationship between a detainee and custody officer." The audit team found that the atmosphere at Colnbrook was "distressing" and "turbulent" and said many detainees who had previously been held in jails said they would prefer to be back in prison. It is difficult to measure improvement in the behaviour of staff towards detainees, but the inquest report dated 31/7/2013 by the Assistant Deputy Coroner, Karen Monaghan QC into the death of Jimmy Kelenda Mubenga said at paragraph 46 of her report:

> "It seems unlikely that endemic racism would not impact at all on service provision. It was not possible to explore at the Inquest the true extent of racist opinion or tolerance amongst DCOs or more widely. However,

there was enough evidence to cause real concern, particularly at the possibility that such racism might find reflection in race - based antipathy towards detainees and deportees and that in turn might manifest itself in inappropriate treatment of them.

One witness said that the potential impact on detainees of a racist culture is that detainees and deportees are not *"personalized."* This may, self-evidently, result in a lack of empathy and respect for their dignity and humanity potentially putting their safety at risk, especially if force is used against them. It is for that reason that the subject properly forms part of this Report.[xiv]

Difficulties in making complaints

Both HMIP and Independent Monitoring Boards have expressed concerns about the Complaints Procedures in immigration detention.

Complainants report facing disbelief from Home Office staff, contractors, and escorts. There are repeated failures to take detainee complaints seriously, to record injuries where necessary, or to reform practices where there is evidence of systemic malpractice.

Few complaints are upheld by the Home Office and many are not adequately investigated … even cases that subsequently are considered strong enough to get Legal Aid.

This engenders a sense of hopelessness amongst detainees, many of whom feel that their mistreatment and abuse is not taken seriously. Even more seriously, it allows poor practice to continue unchallenged.

When IRC healthcare complaints follow the rest of the NHS, this does not necessarily ensure that healthcare for detainees will meet the standards of other NHS patients. Detainees have no choice as to which health services can be used, and some NHS services - like the advice from a community Pharmacist - are unavailable to them.

The Care Quality Commission (CQC) has recognised that "*there is some frustration at the current system of complaints handling".*[xv]

Complaints procedures

The IMB received representations from some detainees, whose complaints had been dismissed as unsubstantiated. IMB members agreed that responses to complaints were inadequate.

Following this, all complaints received in a month were reviewed by the IMB. They identified further complaints that were not upheld, where the Board felt that the complaints were substantiated - or partially substantiated - on the basis of the evidence examined in the Investigation Report that forms part of the response letter[xvi].

DA was injured in a removal attempt, and his complaint was not upheld by the Home Office. They made this finding, in spite of evidence from one escort who described himself as experiencing "tunnel vision" during the assault, and was unable to remember what happened during the period of time in which the assault took place.

Subsequently, the case passed the merits threshold required to obtain Legal Aid. He is now represented by a solicitor and is bringing a claim against the Home Office.

Healthwatch – Public Watchdog with Statutory Powers[xvii]

Every Local Authority in England commissions an independent local Healthwatch organisation, which has statutory powers to monitor all local health and social care services. This power includes monitoring the care provided within IRCs and to people detained in IRCs, which are commissioned by - or provided by - any part of the NHS or by Local Authorities.

Local Healthwatch (LHW) also has the power to meet with people detained in IRCs to obtain their views about their experiences of care services. LHW often recruits volunteers to carry out inspections of health and social care services, and interview services users about their experience of care and treatment. No other community-based organisation has the statutory rights of entry into all premises where health and social care is being provided.

The statutory powers of Local Healthwatch include:

1. Promoting and supporting the involvement of local people in the commissioning, provision and scrutiny of local care services

2. Enabling local people to monitor for the purpose of influencing the commissioning and provision of local care services, including the standard of provision of local care services and whether, and how, local care services could and ought to be improved

3. Providing advice and information about access to local care services and about choices they can make

4. Making Healthwatch England (HWE) aware of:
   - The views of local people about their experiences of care services

   - Any reports made to commissioners and providers of services containing recommendations about local care services could, or ought to be, improved

   - LHW can also request HWE to conduct special reviews or investigations, and publish reports about particular matters of concern. In addition HWE has statutory powers enabling it to influence NHS England, the Care Quality Commission (CQC), Monitor, Local Authorities and the Secretary of State for Health - to improve the care and treatment for people using services, including those detained in IRCs.

Independent Advocacy

Every Local Authority in England provides an Independent Advocacy Service to help patients and their families who wish to make complaints against the NHS. In some cases, this service is provided by LHW, but in most cases, the service is run independently of LHW. LHW will put people in touch with the advocacy service.

Access to complaints advocacy for 'non-EU citizens' will be at the discretion of Local Authorities.[xviii] If Healthwatch England and Local Healthwatch are to promote equality amongst all services users who wish to make a formal complaint, this guidance needs reviewing.[xix]

What can local Healthwatch can do? [xx]

The detention of asylum seekers and other migrants is out of the public eye - and carried out behind high walls and barbed wire fences. There is a lack of transparency about the conditions detained people have to endure, and an absence of effective public scrutiny of the care, treatment and assessment they receive in IRCs and in the NHS - for instance, the inhuman practice of handcuffing detainees when they are receiving medical care.

Healthwatch has unique statutory rights and duties in relation to IRCs in monitoring the access, quality, provision and commissioning of health and social care.

HEALTHCARE in IRCs

Healthwatch can, in collaboration with other local organisations working in the area, monitor the healthcare provided to detainees. The first step for groups that work with people detained in IRCs, is to approach LHW for the area, and discuss whether it can collaborate to carry out the following activities: .

- Interview detainees to find out about the quality of care they receive
- Follow up reports on the local IRC from HMIP/CQC and Independent Monitoring Boards (IMB), to ensure recommendations are implemented.
- Meet with these bodies before, during and after their visits to IRCs.
- Healthwatch can join stakeholder meetings, run quarterly or bi-annually by some IRCs
- It can ensure that the local adult Safeguarding Board is aware of - and discharging its duties -in relation to the many vulnerable adults (and children) held in detention.

- Local groups may be able to join LHW and establish a Monitoring Group specifically for the purpose of monitoring a local IRC.

All of the statutory LHW statutory activities - described above - can be carried out in IRCs but negotiation with the IMBs, CQC and local health/social care commissioners will be required to ensure access to IRCs and the carrying on of LHW activities.

HOSPITAL NHS SERVICES AVAILABLE TO DETAINEES

Detainees rely on local NHS hospitals for specialist care, and Healthwatch members can work with local health service managers and commissioners to make sure that detainees receive appropriate and adequate services.

It is essential that every hospital has a Policy on Handcuffing and Privacy for Patients during consultations - and that these meet BMA guidelines and GMC duties. All medical staff is to be made aware of the Policy and their duties, and ensure that the Policy is implemented. This will need regular monitoring as Doctors change jobs regularly. All medical staff must ensure that consultations are not carried out in the presence of guards, except under very exceptional circumstances.

Healthwatch could also monitor how many hospital appointments are missed by detainees owing to the failure of the IRCs to provide transport. Hospitals should be able to access this information by co-locating 'Did Not Attend' (DNA) reports with the addresses of IRCs. The HMIP could also request this data from IRCs.

As the commissioner of IRC medical services, NHS England will be expected to monitor contract performance, and is expected to do this in collaboration with HMIP, CQC, Safeguarding Boards and IMBs. However, the performance of NHSE with respect to monitoring contracts is weak. Working with the NHSE Area Team would be a useful way forward in the longer term.

USEFUL CONTACT AND FURTHER INFORMATION

Care Quality Commission (CQC)

The CQC registers providers of health and social care services and ensures they meet the Essential Standards of Quality and Safety[xxi].

The CQC makes unannounced inspections of services at least once a year, and at other times in response to concerns. It monitors providers' performance through these inspections, in addition to data analysis and other checks. The CQC can take enforcement action, when it finds services are not meeting CQC standards. It has a duty to protect patients whose rights are restricted under the Mental Health Act, and those on community treatment orders and people detained in IRCs. Listening to service users about their experiences of care is a fundamental CQC role. http://www.cqc.org.uk

The CQC attends the inspection of all IRCs (regardless of the registration arrangements) with HMIP as part of a five-year programme that inspects all Prisons, Youth Offender Institutions and IRCs. The CQC focuses on health provision, and works jointly with the HMIP health lead.

During all visits the CQC checks what services are being provided by each of the health care providers, and whether there are any registration irregularities. It publishes an individual inspection report for each "location" or, where this does not apply, a service being provided in the establishment from another location.

CQC findings for all services are shared with HMIP, as part of the evidence gathering arrangements and HMIP include CQC reports in their published report.

HM Inspector of Prisons (HMIP)

HMIP has a statutory responsibility to inspect all IRCs and 'holding centres', and provide independent scrutiny of the treatment experienced by detainees and conditions in the IRCs. These inspection reports cover healthcare in IRCs and provide useful background information on the state of healthcare in each centre. www.justice.gov.uk

Independent Monitoring Boards (IMB)

These Boards are appointed by the Secretary of State, in accordance with the Immigration and Asylum Act 1999, to monitor the conditions and operation of IRCs.

The Board members have a statutory obligation to hear complaints from detainees and can question staff. They also have the right to monitor the way in which complaints are heard and managed in IRCs and short term holding facilities, but cannot take up individual complaints themselves.

Comments on healthcare and complaints handling are included in the Annual Reports for each IRC. www.justice.gov.uk/about/imb

Visitors Groups

Most IRCs have a local Visitor's Group who visit detainees. AVID (Association of Visitors to Immigration Detainees) works with, and through, a membership network of grassroots visitors groups. It collates evidence on the daily realities of immigration detention, and uses this to present a collective voice for change, based on 'lived' experiences. The network includes 19 Visitors Groups visiting places of detention across the UK. www.aviddetention.org.uk.

Publications

The following publications on 'health issues in detention' are available to download from www.medicaljustice.org.uk

Assault - Outsourcing Abuse
The use and misuse of state-sanctioned force during the detention and removal of asylum seekers, 2008.

Children in detention - State Sponsored Cruelty, Children in immigration detention, 2012

Complaints in Immigration Detention, 2014

HIV - Detained and Denied, The Clinical Care of Detainees living with HIV, 2011

Mental Health - Mental Health in Immigration Detention Action Group: Initial Report 2013,

Pregnancy - Expecting Change
The case for ending the detention of pregnant women, 2013

Torture survivors - The Second Torture
The immigration detention of torture survivors, 2013

Medical Justice Medical Justice is a charity that arranges for a doctor to visit detainees who are victims of torture or have serious physical or mental health conditions. It carries out research and campaigns based on casework. http://www.medicaljustice.org.uk	**HAPIA** - Healthwatch and Public Involvement Association is a charity open to organisations and individuals who want to improve the quality of health and social care services in their area, and to develop the very best NHS and local services. HAPIA's members lobby for, and promote effective public involvement to government, parliamentarians and national health and social care bodies. www.HAPIA2013.org

References

[i] National Preventative Mechanism (NPM). (2012:4) 'Monitoring places of detention, Second Annual Report of the United Kingdom's National Preventative Mechanism 2010-2011, (online). Available from: http://www.justice.gov.uk/downloads/publications/inspectorate-reports

[ii] Prison and Probation Ombudsman, Learning Lessons Bulletin, Issue 2, March 2014.

[iii] Mental Health in Immigration Detention Action Group: Initial Report 2013, www.medicaljustice.org.uk

[iv] HM Chief Inspector of Prisons, Report on an unannounced inspection of Harmondsworth Immigration Removal Centre, 5–16 August 2013.

[v] UKBA, DSO 08/2008 "Use of Handcuffs on Detainees"

[vi] *FGP v Serco Plc & Anor* [2012] EWHC 1804 (Admin) (05 July 2012)

[vii] BMA (2007) Providing Medical Care and treatment to people who are detained: Guidance from the British Medical Association.

[viii] General Medical Council. Good Medical Practice. 2013 http://www.gmc-uk.org/static/documents/content/Good_medical_practice_-_English_0414.pdf

[ix] HM Chief Inspector of Prisons, Report on an unannounced inspection of Harmondsworth Immigration Removal Centre, 5–16 August 2013.

[x] See for example Coroner's report on the death of Jimmy Mubenga: http://www.theguardian.com/uk-news/2013/jul/09/jimmy-mubenga-unlawfully-killed-inquest-jury.

[xi] Medical Justice, *'Outsourcing Abuse.* The use and misuse of state-sanctioned force during the detention and removal of asylum seekers' 2008.

[xii] UKBA, Detention Service Orders, DSO05/2012 and DSO14/2008.

[xiii] Letter to Mr R Whiteman, Chief Executive UKBA from Liberty dated 15 May 2012.

[xiv] Report by the Assistant Deputy Coroner, Karon Monaghan QC under the Coroner's Rules 1984, Rule 43. Inquest into the death of Jimmy Kelenda Mubenga. (1/8/2013). London: Ministry of Justice.

[xv] CQC (2012: 20), 'The Next Phase: Our consultation on our strategy for 2013 to 2016
http://www.cqc.org.uk/sites/default/files/media/documents/cqc_strategy_consultation_2013-2016_tagged_0.pdf

[xvi] IMB Colnbrook IRC, Annual Report 2012.

[xvii] Healthwatch England. Understanding the Legislation: An overview of the legal requirements for Local Healthwatch. August 2013.
http://www.healthwatch.co.uk/sites/default/files/20130822_a_guide_to_the_legislation_affecting_local_healthwatch_final.pdf

[xviii] Local Government Association (LGA). (2012) 'Commissioning Independent NHS Complaints Advocacy',
http://www.local.gov.uk/c/document_library/get_file?uuid=1924abde-49d9-4...

[xix] Crichton E, BMJ - Rapid Response to Pickles, H. and Hartree, N.Transferring healthcare for immigration detainees in England to the NHS: BMJ.2013;346:f1884; 31 March 2013.

[xx] Healthwatch England. Find Your Local Healthwatch
http://www.healthwatch.co.uk/find-local-healthwatch

[xxi] Care Quality Commission. Essential Standards of Quality and Safety 2011
http://www.cqc.org.uk/sites/default/files/documents/gac_-_dec_2011_update.pdf

Asylum seekers and refugees | Institute of **Race Relations**
Feb 26 **2008** ... Feb 21 **2008**.... A **race relations audit** of removal centres, commissioned by the Border and Immigration Agency.

APPENDIX ONE

Deaths in immigration detention since 2010

04/06/14	…	Bruno Dos Santos - in his 20's	…	Angolan
30/03/14	…	Christine Case - 40	…	Jamaican
26/07/13	…	Tahir Mehmood - 43	…	Pakistani
14/04/13	…	Khalid Shahzad - 52 … … (died within a few hours of his release)		Pakistani
10/02/13	…	Alois Dvorzac - 84 … … …		Canadian
30/10/12	…	Prince Kwabena Fosu - 31 … …		Ghanaian
02/08/11	…	Ianos Dragutan - 31 … … … (found hanged)		Moldovan
31/07/11	…	Brian Dalrymple - 35… … …		American
02/07/11	…	Muhammad Shukat -, 47 … …		Pakistani
12/10/10	…	Jimmy Mubenga - 46 … …		Angolan
15/04/10	…	Eliud Nguli Nyenze - 40 … …		Kenyan

APPENDIX TWO

Verdicts in the last 3 inquests – neglect / unlawful killing

Brian Dalrymple (35) – Neglect contributed to his death. An American tourist, BD's behaviour was noted to be "odd" and he was detained. He was found to be suffering from schizophrenia and severe hypertension, and was not taking his medication. Even when BD refused the hypertensive medication, which he desperately required, and exhibited increasingly bizarre behaviour, no psychiatric assessment was carried out during the six weeks he was detained. A psychiatric expert at the inquest said that the fact that no clinician had seen BD at all in the critical nine days between his return from a brief spell in hospital and the period when medication could have saved him, amounted to a "lamentable" failure. BD was put in segregation where he died.

Jimmy Mubenga (46) – Unlawful killing. During deportation, 15 witnesses heard Jimmy Mubenga say that he could not breathe and that the G4S guards were killing him, yet no-one attempted to resuscitate him, including the airline crew who were trained in CPR.

Muhammed Shukat (47) - Neglect contributed to his death. The inquest found:

> "There was a total and complete failure of care in the management of his health".

Mr Shukat's cell-mate used the emergency button in their locked cell 10 times in a frantic effort to get help for Mr Shukat, who was groaning in agony, complaining of very bad chest pains, and who was disbelieved by a guard and nurse until it was too late. He died.

APPENDIX THREE

High Court finds 'inhuman and degrading treatment' in 6 cases of mentally ill detainees

Medical Justice doctors regularly encounter detainees in detention with Post Traumatic Stress Disorder, severe depression and schizophrenia. The parliamentary Home Affairs Committee raised concerns in March 2013 about cases where inhuman and degrading treatment was identified and that they: "may not be isolated incidents but may reflect more systemic failures in relation to the treatment of mentally ill immigration detainees." The committee should explore further.

- BA - The High Court judge found "a deplorable failure" by those responsible to recognise the detainee's illness and a "callous indifference" to his plight, including forgetting to give him his medication. The Harmondsworth healthcare manager considered that the detainee could die imminently and drew up an end of life care plan, but the Home Office failed to take appropriate action.

- S (2014) - The court described the care S received as "inadequate in many varied and extensive ways" and that the failures to apply and comply with the applicable policies "as wilful or grossly negligent".

- MD - A woman with no history of mental illness had become mentally ill as the result of detention. She had a valid visa to enter the UK to join her husband who had refugee status. The judge said that detention "caused the onset of the mental disorder that was subsequently manifest."

- S (2011) - Medical reports from the hospital specifically warned that detention would cause the detainee to regress to a state that he would once again require hospital admission. Yet the Home Office detained him, stating that there was "no evidence" that he was mentally ill. He had deteriorated to the point that he lacked capacity to make decisions in his own best interests. He was presenting with psychotic symptoms and there were further serious episodes of self-harm.

- HA – HA was not given appropriate medical treatment and as a result he descended into an acute mental health crisis that left him lying on the floor

of his cell for hours on end, drinking from the toilet, avoiding other detainees and refusing food and medication for weeks at a time.