All-Party Parliamentary Group on Immigration Detention
Meeting on 'Adults at Risk in Immigration Detention' policy

Wednesday 24 June 2020, 10.00 - 11.30
Online using Zoom platform

Minutes

Parliamentarians:	Alison Thewliss MP (SNP) - Chair Baroness Bennett of Manor Castle (Green Party) Baroness Hamwee (Liberal Democrat) Christine Jardine MP (Liberal Democrat) Baroness Lister of Burtersett (Labour) Anne McLaughlin MP (SNP) Hywel Williams MP (Plaid Cymru)
Secretariat:	Emma Ginn (Medical Justice) Kris Harris (Medical Justice) Elspeth Macdonald (Medical Justice)
Speakers:	David Bolt (Independent Chief Inspector of Borders and Immigration) Michael Darko (Freed Voices) Dr Mary Kamara (Medical Justice)
Others participants:	Over 40 experts by experience and representatives from relevant external organisations

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1. Welcome

1.1 The chair welcomed the speakers and attendees to the meeting of the APPG on Immigration Detention.

2. Presentation 1: David Bolt (DB), Independent Chief Inspector of Borders and Immigration (ICIBI)

2.1 DB thanked the group for inviting him to speak. He welcomed the interest from parliamentarians in the report, as it increased the level of accountability around implementation of the report's recommendations.

2.2 Stephen Shaw's second Review of the Welfare in Detention of Vulnerable Persons (2018) had recommended that there be an annual inspection of the Adults at Risk in Immigration Detention (AAR) policy. The government had accepted this recommendation and commissioned the ICIBI to conduct the first such inspection.

2.3 The time period for the inspection was April 2018 to May 2019. As it was the first inspection, it had been wide-ranging and looked at the AAR process end-to-end. The next inspection was likely to focus on particular aspects of the policy. He welcomed input as to which specific aspect to focus on.

2.4 The report was completed and sent to the Home Secretary on 29 July 2019. There was a convention by which reports should be published by the government, with their response, within eight weeks of submission. On this occasion however the Home Secretary had taken nine months to publish the report. This delay had meant that certain recommended deadlines in the report were missed, and impacted on the timetable for the next inspection.

2.5 The Home Office had told the ICIBI that the AAR policy was a 'work in progress'. The ICIBI had approached the inspection in that spirit. It had been difficult to understand, however, what the Home Office's final goals on the AAR policy were, and therefore to assess how far it had come.

2.6 The report was detailed and comprehensive, but there were three key areas to highlight:

Alternatives to detention

a) Previous ICIBI inspections had looked at the reporting process (whereby individuals liable to detention were managed in the community). The inspections had highlighted various problems with the process.
b) The Home Office was currently running an alternative to detention pilot, with women who would otherwise have been detained at Yarl's Wood IRC. So far, however, only around 10 women had been involved in the pilot.

Problems at key stages of the detention ' journey'

a) Decision to detain aka Detention Gatekeeper stage - this stage was not working. The Detention Gatekeeper official did not interact with the person who was being proposed for detention as it was a paper-based process only. Neither did they receive any professional medical advice on the case. This meant the official was unable to make a proper judgement on the person's level of vulnerability.

b) Admission into detention - there was not enough coordination between various officials/teams who saw the person at this point.
c) Review process once in detention - the Case Progression Panels in particular were not working effectively.

Foreign national offenders (FNOs)

a) In particular there were significant disparities in the way that FNOs held in prison after completion of their sentences were treated, compared to people held in IRCs.

2.7 Of the eight recommendations in the report, the Home Secretary had accepted two, partially accepted five, and rejected one. Interestingly the recommendation rejected in full had arguably been the most simple - improving Home Office data around Adults at Risk.

2.8 The ICIBI was starting the second annual inspection. Given the delay in publishing the first report, the second inspection would not just be a retrospective on 2019-20. It would also need to take account of what had happened as a result of Covid-19.

3. Presentation 2: Michael Darko (MD), Member, Freed Voices

3.1 Freed Voices (FV) welcomed the ICIBI report, but were not surprised by its findings. They had campaigned on immigration issues for six years, and many reports had been issued in that time. There was no mechanism in place, however, to ensure accountability and that changes were implemented. Such a mechanism needed to be introduced.

3.2 There were at least five current members of FV who had been assessed at Level 2 under the AAR policy. They had been detained for periods of between two and 14 months. Two members affected by the AAR policy had found reading the report very traumatic.

3.3 Home Office identification of vulnerable individuals did not work. The department avoided accountability, including in FV's view intentionally avoiding collecting data. FV would like to see the ICIBI's recommendation on improved data collection to be implemented. Without good data, you could issue as many reports as you liked, but people would still die.

3.4 A key issue was that healthcare staff within IRCs often assumed detainees were lying. This made it very difficult for detainees to approach healthcare. Healthcare staff within IRCs were not impartial, but toeing the line of the Home Office.

3.5 The ICIBI report had made many important observations and recommendations. It was crucial to have these written down. Without things being written in black and white, it was just hearsay. However, much more was going on in detention beyond what was in the report.

3.6 FV members felt that detainees were treated worse than animals. One example was of a police officer who had locked a dog in a car and it had died. He was suspended and forced to issue a public apology. How many apologies had there been from the Home Office or IRC providers when time after time people had died in detention?

3.7 The ICIBI report created a path for other organisations to follow. But without any meaningful accountability mechanism in place, the report could be ignored. FV welcomed the report, but saw it only as a beginning. Unfortunately it was not clear what came next.

3.8 One FV member had realised, after a Subject Access Request, that he had been deemed unsuitable for detention at the point of detention. Yet he was detained for 14 months. He came out of detention with serious mental health issues. He was not an asylum seeker, and was struggling with access to mental health services.

3.9 Rule 35 reports should act as a red flag in detention. However the Home Office could turn a blind eye to them, because no-one challenged this behaviour. They were free to keep ignoring Rule 35 reports.

3.10 There had been more than 35 deaths in detention since the first detention centre opened. An FV member had pointed out that even a vet surgery, if it had had as many deaths as this, would be closed down.

4. Presentation 3: Dr Mary Kamara (MK), Clinical Advisor, Medical Justice

4.1 Medical Justice (MJ) had a large team of experienced clinicians with a broad range of expertise. Clinicians visited people during their time in detention. They would make a clinical assessment of both the person's physical and psychological health, and write a medico-legal report which provided medical evidence for their ongoing immigration case. During this process clinicians had to consider, describe, and predict the harm caused by detention itself.

4.2 From a clinical and academic perspective, there was no doubt that IRCs were inherently harmful to health. Research across different settings consistently demonstrated that detention both caused new health problems, and exacerbated existing ones. Logistical and practical reasons played a part - when the Home Office detained someone suddenly, they would often not have their healthcare records or medication with them, and / or they might have upcoming medical appointments that were missed. But there was also an inherent psychological harm done to a person during the process of being detained and then staying in a detention centre.

4.3 MJ's experience showed that the vulnerability screening and safeguarding procedures in the detention system were not working. MJ found people with medical histories that made it very clear they would be at risk of harm in detention. This included incidents such as previous

admissions to psychiatric units, a longstanding history of requiring antidepressant medication, and multiple previous suicide attempts. Yet this information was apparently missed by the screening and safeguarding processes and the person was still detained.

4.4 Detention screening and safeguarding processes required a very sophisticated ability to advocate for oneself. This was something that people with mental health problems could find very difficult to do - detainees that MJ met were invariably in a broken state, unable to function. There were also practical difficulties of language barriers and long waiting times for medical appointments. This all meant that vulnerable people might not be noticed at all, and/or that their distress might be mislabelled as aggression.

4.5 Medico-legal reports were written in formal medical language. This could mask the suffering being described. For example, doctors might use a clinical description such as “low mood”. This would not usually be in relation to somebody who was merely ‘a bit blue’, but rather someone who had completely lost the ability even to imagine the possibility of a future for themselves. The fear and anxiety experienced in detention led to poor sleep, lack of appetite, and an inability to concentrate. Eventually people began to become isolated, and preoccupied with thoughts of harming themselves or ending their life, and with finding inventive ways to do so. How could someone in this state be expected to advocate effectively for themselves? Yet this was exactly the state that a safeguarding system should detect.

4.6 Michael had mentioned lack of trust in IRC healthcare professionals. A useful example of why this trust could not be built was the use of restraints (e.g handcuffs, waist restraint belts, leg restraints or mobile chairs). Many Medical Justice clients had experienced or witnessed use of restraints either in the day-to-day running of the IRC, or as part of a removal attempt. Frequently a doctor or nurse had to be present when a restraint was used. It was easy to appreciate that for detainees, there was no difference between the guard, the officer, and the doctor or nurse. It was simply not realistic to then expect a detainee to disclose sensitive information about their medical histories to those same doctors and nurses. It was also clear that in this environment a subjective sense of safety, and therefore psychological recovery, was impossible to achieve.

4.7 Most unforgivable in all of this was that many of the people MJ saw had wholly treatable conditions. Many had functioned well in the community. Removing them suddenly from family, support networks and treatment plans was a perfect recipe for deterioration or a clinical relapse, which was exactly what MJ doctors observed.

4.8 It was plain that screening tools and safeguarding measures were failing to prevent the detention of vulnerable individuals. The resulting damage could be lifelong. Medical Justice agreed with the conclusion of the BMA 2017 report, “Locked up, Locked out”, that ultimately the use of immigration detention needed to end.

5. Q & A

5.1 The ICIBI report had identified problems with the reporting process. Could it be made to work? It currently had no purpose beyond compliance.

DB - Capacity and volume were issues here. One key change would be to not require people to report simply for compliance, thereby reducing the number of reporting events. When the ICIBI conducted its inspection of the reporting process in 2017, approximating 80,000 reporting events occurred each year. This volume meant limited time for each event, rendering them fairly meaningless. Reporting should be reserved for cases where there was a realistic prospect of moving the case to some kind of resolution. When it considers whether or not to release someone from detention, the Home Office had concerns around absconding. If no means of reconnecting when someone absconds, this raised concerns about public protection and other risks.

5.2 Only two recommendations had been fully accepted by the government. Of the recommendations that had not been accepted, which were the ones which were most crucial for improving the treatment of adults at risk?

DB - A key finding in the report was that the further a person goes into the detention system, the more difficult it becomes to extricate them from it. As such the Detention Gatekeeper function was key and preventing vulnerable people from being detained in the first place. It had therefore been disappointing that the Home Office had rejected, for example, the report's recommendation to have medical professional input into the Detention Gatekeeper team. With lower numbers of people held in detention due to Covid-19, there was an opportunity for a 'reset' on detention. Lower numbers meant improvements and better scrutiny at the Detention Gatekeeper stage were easier to implement. Whether or not medical professionals would be willing to be involved in that process was another question.

MK - It would undoubtedly put medical professionals in a difficult position. The GPs working inside IRCs were already asked at various points to comment on whether a person was fit to be detained or fit to fly. The BMA report mentioned earlier highlighted that this put doctors at odds with the stated aim of their professional work. When doctors did raise concerns, e.g. through Rule 35 reports, Part Cs or other mechanisms, this often had very few results. This could be quite disheartening and give doctors less confidence in the system.

5.3 How far had current and former detainees' views been taken into account in making recommendations?

DB - The ICIBI had visited five IRCs and four prisons to gather evidence, including group meetings with detainees and prisoners to hear their stories and perspectives. It had also received evidence

from people with prior experience of detention. It was a good point though, and the ICIBI would welcome hearing the views from more people who had been detained. It was important to have the voice of people who had been directly affected by these policies running through the reports.

5.4 Regarding absconding, it was important to appreciate that the Home Office's approach, including its culture of disbelief, often caused people to abscond.

DB - People had anxieties and concerns about being detained and removed whilst reporting, and it was clear this would affect their willingness to comply with reporting conditions. The point in the report was about what happened when someone did abscond. The Home Office had no real means of re-connecting with such persons.

MD - It was an important point. If funding improvements to the Detention Gatekeeper team was difficult, the Home Office should consider different approaches. This could include input from those who volunteered with people who were liable for detention. The Home Office was addicted to enforcement. People, including parents, could be detained, released, then re-detained multiple times. Reporting was a traumatic experience - people went knowing they might be detained or re-detained. They had to take a bag containing essentials with them each time, in case it happened. The rate of absconding on probation from prison was around 9.8%. The rate of absconding amongst those liable to removal was much lower. Did the risk of absconding mean that prisoners should not be released on probation? The Home Office could not hide behind such excuses.

5.5 Covid-19 had put much greater attention on the Department of Health's public health responsibilities. Had the report gained much traction at the Department and were there greater opportunities for engagement with them, compared to the Home Office?

DB - The ICIBI had looked at Home Office's interactions and collaborations with other departments on various occasions. It was not very effective in this area and tended to resist recommendations for improvement. This situation would likely affect the degree to which other departments, such as Health and Social Care, could influence the Home Office.

5.6 Was the APPG aware that the Home Office was considering very serious changes and tightening of the rules about which types of medical evidence they would accept in asylum claims? This risked a lot of good quality, bona fide evidence being rejected, and also the health concerns that it documented being ignored.

DB - The ICIBI was not aware of the specific changes mentioned. A lot of the language from the Home Office in recent months had been stressing 'abuse of the system'. The concern around abuse was valid, but there did not seem to be any available metrics for it. There was a risk it could be overstated and allowed to play a much greater part in decision-making than it should.

5.7 Regarding the problem of lack of impartiality of healthcare in detention, could any changes be made to strengthen the arm of NHS staff to fulfil their medical responsibilities? Were there institutional structures that could be introduced to support staff in this? How could the initial medical assessment be conducted in order to recognise that the person is an adult at risk?

MK - both questions were about how medical staff could be supported to focus on their clinical work and not play a dual role. There were various things that made it difficult for people to disclose vulnerabilities during the initial medical assessment upon arrival in detention. This included factors such as the assessment taking place in the middle of the night, when people might be very frightened and tired, and not having access to adequate language interpretation for example. While a lot of healthcare services within IRCs were commissioned by the NHS, most detention centres used private companies to run those services. The sense of connection to the NHS might be less than people would imagine. There were also serious problems in terms of quality and continuity of care.

MD - People could find it very difficult to advocate or stand up for themselves in detention. There should be a system in place whereby detainees could access an external advocate to advocate on their behalf during, for example, medical assessments.

5.9 How could the Detention Gatekeeper function be improved to ensure that vulnerable people were not detained, particularly in light of the ICIBI's previous finding that the Home Office fundamentally did not understand vulnerability? Ongoing structural failures of the safeguards in detention, as well as the harmful nature of detention, made it increasingly difficult for people to evidence their vulnerability and deterioration the longer they were detained. The current AAR policy required such evidence to be balanced against so-called 'immigration factors', yet these were quite amorphous and hard to understand.

DB - All three points came back to the willingness of the Home Office to accept other judgements than its own, and in particular those who were in fact better placed to make those judgements. The ICIBI report on vulnerability found that the Home Office was never likely to become sufficiently expert in vulnerability that it could rely entirely on its own judgements. It ought to be reaching out to others with greater expertise and trusting their judgements.

There was a real question about who had authority to make decisions in the detention process. Even when a Case Progression Panel had come to the view that someone should be released, the panel did not have authority to instruct that the release went ahead. It could be overruled by a Home Office caseworker. Changes were needed in this area if progress was to be made.

5.10 How long did Medical Justice's volunteer doctors spend with detainees during an assessment, and were they able to return and see the detainee again? Was it difficult to fully assess someone in just one session, not least from the perspective of building trust?

MK - Building trust quickly with clients was critical. MJ doctors had the advantage of having been able to access a client's medical records and documents in advance, with their consent. Clients would also have had considerable contact with MJ's casework team, who would have explained that the organisation was completely independent of the Home Office and detention centre. This point was crucial in terms of trust. Appointments were usually three to six hours. This could be followed up by telephone as well. Occasionally doctors would visit clients a second time, and/or see them after leaving detention. If clients needed ongoing support after leaving detention, Medical Justice would signpost them to organisations that provided this.

5.11 The Home Secretary had accepted all the recommendations of the Windrush Lessons Learned Review. The review had identified a 'culture of disbelief' as a key problem at the Home Office. Might linking to this be a useful way to raise some of the issues discussed?

DB - The Home Office was genuinely looking at ways of doing things differently, pressed into this by the Windrush scandal and review. There were a lot of opportunities for the Home Office to reset and rethink. However, the rhetoric around foriegn national offenders appeared to be going in the other direction. The review did offer an opportunity to raise some of the issues discussed. The lower numbers of detainees because of Covid-19 also presented an opportunity to make changes, and not simply return to the status quo ante.

5.12 How were people with addiction issues managed in the detention estate? The approach at Dungavel IRC for example seemed more harsh than in the community, in terms of reducing a person's methadone prescription.

MK - Medical Justice saw people with histories of drugs and alcohol use. Often they had been receiving help with those problems in the community. Unfortunately they had also often faced a lack of sympathy. A key concern was always what happened once they were released from detention. This of course should not be used as a reason to maintain their detention. Instead, they should receive support in the community upon release.

MD - Many people had their medication removed from them upon arrival in detention. Allowing a person to keep their medication would be an admission by the Home Office and detention centre that that person had health issues. It could take a long time, even months, before the individual received the medications again, particularly if they could not advocate effectively for themselves. The impact of this was very serious. He had witnessed many people put into the isolation block because their mental health had deteriorated without medication, for example.

5.13 FNOs were often the group that received the least amount of sympathy in the media and from government ministers. What could be done to improve understanding of the situation faced by them?

MD - It was important to engage with the topic. MPs often might not want to, because the people involved had criminal records. However, it was important to understand that many FNOs had these records as a result of the harsh treatment they had received from the state. For example, the fees to regularise one's status were very high and people were often forced into the crime of working illegally in order to pay them.

FNOs could be held in prison or at an IRC for a long time after their custodial sentence had finished. UK nationals, who might have committed far worse crimes, were released back to the community. The same should apply to FNOs. Immigration was a civil matter, not a criminal matter. It was not right that people were locked up over a civil matter.

DB - There was little public sympathy towards FNOs and the topic was not seen as a 'vote winner'. There was an issue of basic fairness, however. Where people were detained in prison on immigration powers, they should at least have the same access to services as people detained in IRCS. This was not the case. It was something that could and should be fixed by the Home Office. There was a genuine concern about putting 'dangerous' FNOs into IRCs. However this meant that many remained in prison, and were denied the opportunity to be in a less restricted regime despite having completed their custodial sentences.

Another issue was that of people who had come to the UK as children and had subsequently been convicted of a crime and imprisoned. They were then subject to deportation, despite having spent most of their lives in the UK. This was an issue raised by Stephen Shaw in his 2016 and 2018 reviews. The government had been resistant to any change around this, but it was something that was worth continuing to argue.

6. Agreed follow up actions

6.1 The APPG would write to the Home Office to raise various concerns discussed in the meeting. Home Office oral questions would also take place on 13th July. The secretariat would liase with Members interested in submitting questions for this.

6.2 The group would be interested in further information around the Home Office's proposed changes on medical evidence, including data on the true scale of the issue. Members would table written questions to try and get a better understanding of the evidence base.

6.3 The Chair was keen to table a debate in Parliament to discuss detention-related issues, including those discussed today. It was difficult at the moment given parliamentary working arrangements, but would be looked at again once opportunities became available.

7. AOB

7.1 The APPG had received a response from Chris Philp MP, Immigration Minister to their joint letter sent on 15 May 2020. The response was disappointing but not unexpected. It was important for the group to continue to hold the government to account on its response to Covid-19, which had been inadequate. This would be done in various ways, including through the ongoing tabling of questions and future correspondence where useful.

8. Meeting closed