APPG on Immigration Detention

Meeting on the detention of people for removal under the UK-France Treaty

Wednesday 5 November 2025

Presentation: Dr Rachel Bingham – Clinical Advisor, Medical Justice

Dr Bingham explained that she was a Clinical Advisor at Medical Justice and an NHS GP in London. At Medical Justice she had been visiting people in IRCs to do health and mental health assessments for about 15 years and her current role involved providing supervision and support to Medical Justice's network of clinicians doing the same.

Medical Justice's clients

So far, Medical Justice had assisted 33 clients who had been detained under the UK–France agreement.

Of these people, Medical Justice clinicians had conducted medical assessments of 28 individuals for medico-legal reports. These assessments were extensive — involving face-to-face physical and mental health examinations lasting several hours, along with review of medical and background records.

Medical Justice had so far audited the first 20 reports.

The people in that group came from Eritrea, Afghanistan, Syria, Ethiopia, Iran, Palestine, Somalia, and Yemen. Most were young men. Three were women. Five were under 20 years old — and two of these were age-disputed minors.

Among asylum seekers from these countries, there was a well-documented high prevalence of torture, trafficking, and other severe abuses.

Many of the people Medical Justice clinicians had assessed remained in detention on the day of the meeting; others had been released, or had been returned to France. Those who were released were detained between 1 and 3 months.

These were individuals who were already high risk for being harmed by detention through having had no opportunity to recover from past trauma, before being forced into another destabilising experience.

Experiences in France

Medical Justice clinicians also explored people's accounts of what they had faced in France.

Many described experiences of severe violence, intimidation, and death threats, from people smugglers, border forces, police, and organised gangs. Two had witnessed the violent death of another person.

Many spoke of having been hungry, cold, destitute, and frightened.

Two young people had witnessed another person die by suicide during their journey.

Understandably, the fear of being sent back to those conditions had a profoundly destabilising impact on mental health. Several individuals described suicidal thoughts directly related to the threat of return to France.

For people already struggling with symptoms of post-traumatic stress or depression, fear of removal severely impeded their recovery. It eroded their trust in authorities and made engagement with healthcare and support services much harder.

Medical Justice clinicians were clear that, if returned to France and/or onward in Europe, many of these individuals would be too unwell or too distrustful to access the help they might need to avoid further exploitation or destitution and were therefore highly vulnerable.

Safeguards and healthcare in detention

Dr Bingham explained there was no appropriate medical screening before people were detained. Those arriving by small boat also rarely had medical records or adequate healthcare access from their journey.

The initial asylum screening interviews that Medical Justice reviewed showed that the interviews often took place the same night or early the next morning after arrival in the UK. This was not a setting in which meaningful disclosures of trauma should be expected.

Many of the group had post-traumatic stress disorder (PTSD). Dr Bingham explained that avoidance of discussing past experiences was a central symptom of PTSD; however it could sometimes be misinterpreted as a lack of truthfulness or cooperation. Identifying individuals with PTSD required processes that were proactive, sensitive, and consistent. Those safeguards were not in place.

Once in detention, safeguarding relied on a reporting process that had been repeatedly described as unsafe.

Within the first 24 hours of arriving at the IRC, there should be an initial medical assessment — known as a Rule 34 assessment. Of 16 people for whom Medical Justice had medical records from this initial point, only two had had a Rule 34 assessment.

Medical Justice's previous research suggested that some people may have declined this because they did not understand what was being offered — which was another indication of poor communication and lack of trauma-informed practice, often compounded by lack of appropriate interpreting.

Later, a GP could complete a Rule 35(3) report. The purpose of such reports was to ensure that survivors of torture were brought to the attention of the Home Office, as they were particularly vulnerable to suffering harm in detention. The Home Office must then consider whether to release them. Fourteen of Medical Justice's cohort had such reports completed — but waiting times for completion of the report were up to two months.

Of the 11 Home Office responses to the Rule 35(3) reports that Medical Justice obtained, every single one maintained detention - nobody was released as a result.

These were not new failures. Medical Justice had repeatedly raised concerns that detention safeguards were unsafe. Medical Justice' recent experiences and research indicated that these remained as dysfunctional and dangerous now as they were before the attempted removals to Rwanda in 2022 — and as they were during the period examined by the Brook House Inquiry in 2017.

Re-traumatisation in detention

One of Medical Justice's greatest concerns was the re-traumatisation of people who had already survived torture or modern slavery.

Re-traumatisation occurred when someone was exposed to new experiences of powerlessness or threat that echoed their original trauma, provoking and exacerbating psychological symptoms.

Detention was intrinsically stressful. It could recall memories of captivity and abuse. People described intrusive memories, poor sleep, high anxiety, difficulty trusting others, and a constant sense that something terrible was about to happen. These symptoms were exhausting.

Clinical guidance was unequivocal: detention was not an appropriate setting for recovery from trauma. Survivors required stability, safety, and trust to recover — these conditions were not compatible with immigration detention.

In the community, with consistent and trauma-informed care, most people with post-traumatic stress disorder could recover well. The Code of Conduct for Trauma-Informed Care described the need for a calm, consistent, and welcoming environment where trust can be rebuilt.

By contrast, detention was unpredictable, isolating, and often perceived as punitive. It directly undermined rehabilitation.

As one of Medical Justice's clinicians had observed, "*detention risks converting what might otherwise be transient trauma responses into chronic psychiatric conditions*."

Among the 20 cases that Medical Justice audited, every individual deteriorated in their mental state while in detention. Sixteen experienced additional harms such as impeded recovery and lack of appropriate healthcare.

Diagnoses in the cohort included 15 people with PTSD, 8 with depression, and others with acute stress or anxiety disorders.

Suicidality

Suicidality was alarmingly common. Twelve of the 20 people in Medical Justice's cohort had had suicidal thoughts while in detention.

Six had said they would take their own life if removed to France.

Two people self-harmed.

One person attempted suicide.

For many, detention in the UK — not their past trauma — was described as the moment when they lost hope. From a clinical perspective, this was very dangerous.

Dr Bingham then shared, with the affected person's permission, the case study and testimony of a Medical Justice client who had been subjected to the use of force during an attempt to remove him to France.

Case study and testimony of Medical Justice client

The client was detained under the UK-France Treaty on arrival. A torture survivor, his medical records noted that in detention he was stressed and distressed, with symptoms of post-traumatic stress disorder. No Rule 35 safeguarding report to raise concerns that he might be a victim of torture was completed while he was detained.

The morning of the client's attempted removal, he was confused and unsure what was happening. He asked to talk to his lawyer with an interpreter but he could not get through as it was before 9am.

The client told Medical Justice that:

“*Then they started to open their bags and take out four different belts and they started to forcefully use them and tie me. They banged my head against the wall several times while I was screaming in pain, but they were not kind to me.*”

The client was tied very tightly.

He continued: “*One of the women there was trying to pull my hair to make me feel pain, and one of them was bending my fingers backwards to make me feel pain. I was in a very serious situation. The belt that was tied around my shoulders got stuck in my throat. I started screaming and saying I want to die, untie the belt from my neck, but they thought I just wanted to be let go. After a few minutes, I became dizzy, and my voice became weak and my strength was limited to just tears. They saw me struggling for air and honestly, my eyes were turning white and my breathing was difficult. I said in a low voice, I can't breathe, and I thought to myself, "Oh, my God.*”

On return to the detention centre, the medical records confirm that, in the presence of a medical escort, handcuffs, pain compliance techniques, restraint belts and leg restraints had been applied.

Dr Bingham concluded by explaining that it was very difficult as a doctor to keep observing and recording these types of harms. She was therefore very grateful to all those attending the APPG meeting for giving the issue their attention.