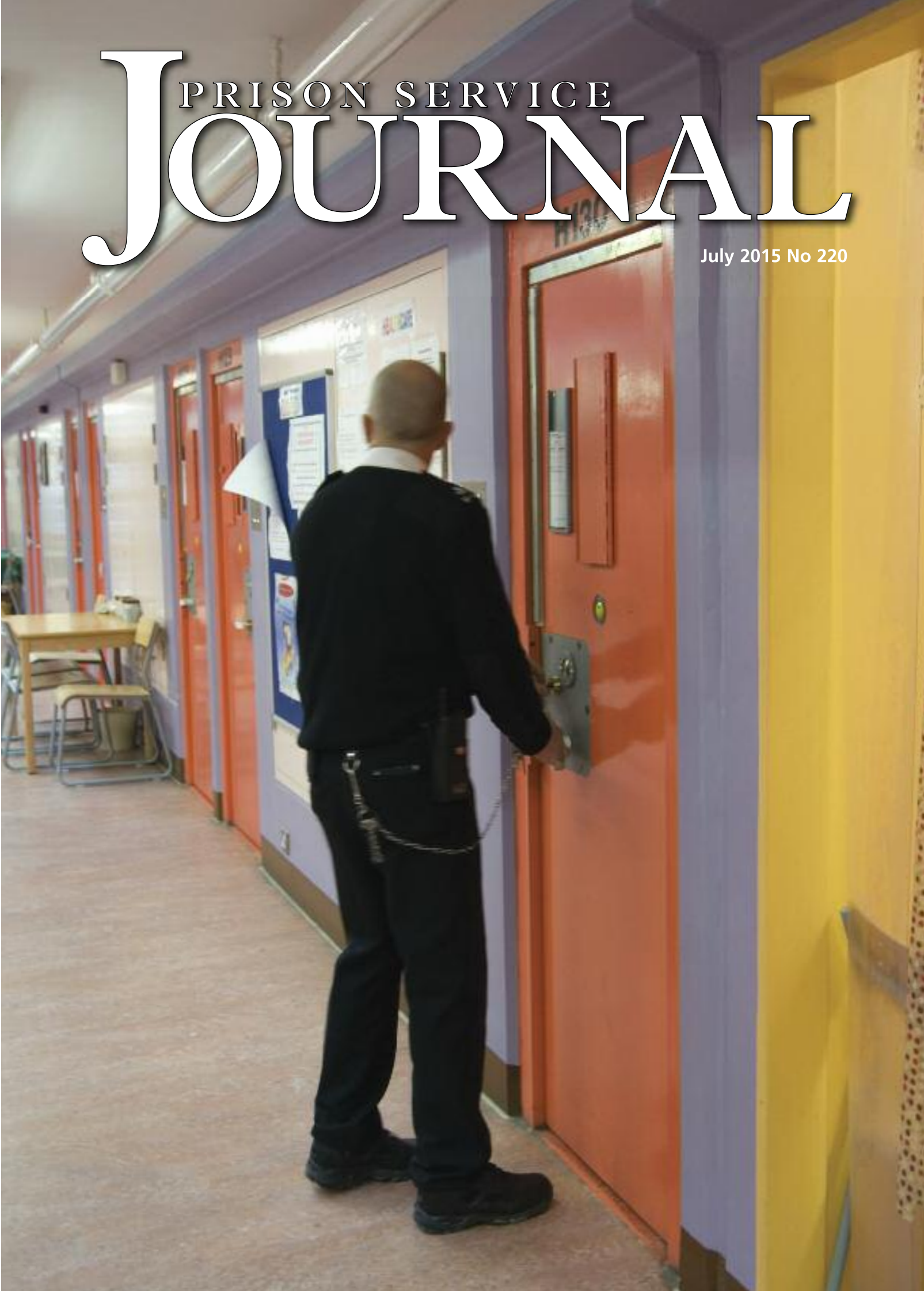

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Fitness to detain in those held under immigration Powers in the UK and rule 35(1)

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Those detained under immigration powers in the UK are held in administrative detention, not within the criminal justice system. The expected safeguards against inappropriate use of administrative powers include the presumption against detention for those whose mental or physical well-being is likely to be adversely affected by detention. Judgements about the fitness to detain are expected to be made by their GPs for those within immigration removal centres but the system for reporting and acting on such concerns appears largely ineffective. A new approach is needed.

There are currently around 4000 immigration detainees held in immigration removal centres (IRCs), short term holding facilities (STHFs) and for some who have completed criminal sentences, also in prisons. They are held without time limit under executive powers administered by officials from Home Office Immigration Enforcement. The detention under immigration powers is expected to be used sparingly and only when it can be justified, with national policy being a presumption of liberty with detention as a measure of last resort. The position is thus different from that of convicted prisoners or those suspected of serious crime and held on remand. Assessments on fitness to detain in immigration detainees need to recognise that detention itself is optional in all but exceptional circumstances.

Who should not be detained

Whether in IRCs or in prisons, there are some groups of people considered suitable for detention in only very exceptional circumstances.[1] These include:

- The elderly, especially where significant or constant supervision is required which cannot be satisfactorily managed within detention
- Pregnant women, unless there is the clear prospect of early removal and medical advice suggests no question of confinement prior to this
- Those suffering from serious medical conditions which cannot be satisfactorily managed within detention
- Those suffering from serious mental illness which cannot be satisfactorily managed within detention.[2] In exceptional cases detention at a removal centre may be necessary while individuals are waiting to be assessed, or are waiting transfer under the Mental Health Act
- People with serious disabilities which cannot be satisfactorily managed within detention

[also others such as the under 18s, those where there has been independent evidence of torture, and victims of trafficking].

Identification and reporting of those who are unfit to be detained

This paper considers those serious medical or mental conditions which cannot be satisfactorily managed within detention, and the elderly and disabled. Those held in IRCs (but not those in prisons or STHFs) are covered by rule 35 which says: 'R 35 The medical practitioner shall report to the manager on the case of any detained person

1. whose health is likely to be injuriously affected by continued detention or conditions of detention.....'[3]

The purpose of Rule 35 is 'to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. The information contained in the report needs to be considered in deciding whether continued detention is appropriate in each case'. In particular, the requirement

1. Home Office Immigration Enforcement Enforcement Instructions and Guidance. 55.10 Persons considered unsuitable for detention (rule 35) on https://www.gov.uk/government/uploads/system/uploads/attachment_data/file400022/chapter55_external_v
2. Changed in August 2010 from 'the mentally ill', which has been challenged, and made subject to a consultation in Jan-Mar 2014 under the Equality Act.
3. Home Office DSO/17/12 Application of detention centre rule 35 on https://www.gov.uk/government/publications/application-of-detention-centre-rule-35

to make reports under Rule 35 provides a mechanism by which IRC doctors can alert Home Office caseworkers to concerns about a detainee's health (35(1)), suicide risk (35(2)) or torture history (35(3)). This paper concerns rule 35(1), ie that is general fitness to detain. The specific issues with pregnant detainees have been covered elsewhere.[4]

The regulations require every immigration detainee to have a physical and mental assessment by a doctor within 24 hours of admission to an IRC. This requirement is normally met by a health professional carrying out such an assessment within 2 hours of arrival in detention, with an appointment with a GP available within 24 hours. As well as the assessment at induction, it is expected that the GP prepares and submits a report under Rule 35(1) if at any time it is concluded that a person's health is likely to be injuriously affected by continued detention.

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The health of those in immigration detention

Those entering immigration detention are mostly male, often young and vulnerable, with the sorts of clinical conditions that might be expected for their ethnicity and life history to date. Some have been years in the UK, like many of the over-stayers or those detained after serving a criminal sentence. Compared to prisoners, there is a much lower rate of alcoholism or drug misuse. Mental ill health, AIDS, and TB are all found more commonly than in those of similar age settled in the community. Very many of the female detainees, perhaps the majority, will have experienced rape or sexual abuse. Even though under rule 35(3) those who have been subject to torture should not be being detained, in practice many detainees report such experiences.[5]

Mental health is often poor on entry to detention, and unlike with prisoners, all the evidence suggests that mental health deteriorates whilst in immigration detention, not helped by the indefinite nature of detention.[6] Expert advice is that certain conditions cannot be satisfactorily managed in detention and patients with conditions such as post traumatic stress disorder (PTSD) should not be being detained.[7] Nevertheless, this is still happens commonly.

Factors to be considered in satisfactory management in detention

There is no explicit clinical guidance to help IRC doctors. There is an official position on those who should not be being detained (eg those whose serious mental or physical condition cannot be satisfactorily managed within detention) and another on the reporting by GPs about health being injuriously affected by continued detention. But there is no definition of how poor attempted management has to be to fail to be satisfactory. Health may deteriorate and be adversely affected by detention in spite of excellent attempts at managing it. Whilst this may become apparent to experienced medical staff who witness such deterioration in patients with whom they are familiar, detainees may be moved around the detention estate every few weeks and there is considerable churn among medical staff in IRCs anyway, many of whom are currently locums.

The situation is likely to be dynamic, so there would also need to be clinical judgement about the prognosis, bearing in mind the discretionary nature of immigration detention. In general, IRC healthcare staff are expected to consider the range of healthcare needs that should be provided according to 'NHS equivalence' and the ability to provide them in the detention setting, including access to external healthcare services. There may be shortfalls in clinical expertise or in equipment, such as disability equipment. With some conditions such as advanced cancer both the disease and the likely prognosis mean that it can be difficult for the patient to be satisfactorily managed within detention, as well as pointless for detention to continue.

The most problematic area has proven to be mental illness, which unfortunately is so very common in detention. Some aspects were resolved in the test case of 'Das' at the Court of Appeal where general points included: the threshold for the policy to apply (ie for detention to be inappropriate) is that the mental illness must be serious enough to mean it cannot be satisfactorily managed in detention. In assessing this, matters such as the medication the person is taking,

4. Expecting change: the case for ending the detention of pregnant women Medical Justice 2013 on www.medicaljustice.org.uk
5. Tsangarides N The second torture: the Immigration detention of torture survivors 2012 www.medicaljustice.org.uk
6. Mental Health in Immigration Detention Action Group interim report Dec 2013 on www.medicaljustice.org.uk
7. Royal College of Psychiatrists (2013) Position statement on detention of people with mental disorders in Immigration Removal Centres www.rcpsych.ac.uk/policyandparliamentary/projects/live/asylumseekers.aspx

whether or not their demonstrated needs at the time are such that they cannot be provided in detention, and the expected period of detention...should be taken into account.[8]

Decisions on continued detention

Decisions whether to continue detention are made by an immigration case worker from the paperwork and they will not themselves have interviewed or seen the detainee.[9] Whilst release from detention might be expected for those where the removal process is not progressing as initially expected, any decision on release has to be made at a more senior level. For some types of detainee, like fluid and food refusers, that decision may need to be made at strategic director level. The net effect of this is that, although detention is expected to be used as a last resort, once in detention the path of least resistance for immigration case workers is to continue that detention until the immigration aspects are resolved. Any release on medical grounds requires a detailed justification to be provided by them up the line. This generates more work and, where there has been a report under rule 35, the detail may not seem sufficient, yet going back to the GP for more information may not be productive either.

Currently around 50 per cent of detainees go from detention to the community, rather than being removed or deported.

In any event whatever the clinical advice, detention can be continued in spite of clinical deterioration if the circumstances are very exceptional. In theory, everyone held in detention should be exceptional in some way, though this is hardly the case in practice and especially not for those who enter the fast-track with little prior vetting. Currently around 50 per cent of detainees go from detention to the community, rather than being removed or deported.

The usual grounds that have been articulated for exceptionality in those cases made public are the risk to the public and the risk of absconding. Not all of these detainees have a history of absconding or any forensic history. Many of those that do have a criminal history may have this only for the possession of false documents, not for violence which is what the public might interpret as presenting a potential risk for them. Evidence suggests that risk assessments made by the immigration service are more harsh than those made by others such as NOMS.[10] It seems even the most determined efforts by the IRC GP may sometimes fail to get the release of an unfit detainee.[11]

Getting it wrong: what might be the consequences?

Continued detention can be a difficult call, so it will not always be right. There are no audit data to help determine how well the whole process operates at present.

If an unfit person remains detained, the consequences for their health could be unfortunate, with suboptimal clinical outcomes right up to long-term disability or avoidable death. The actions and inactions of health professionals and others can be examined at Inquests and at other public Court proceedings, such as claims for unlawful detention, and they may be called to give evidence. However, the eventual health outcome is not known for most of those considered to be 'unfit to be detained' but continue in detention: they end up being removed or released.

Health professionals are not part of the machinery of immigration enforcement, but provide advice in good faith to those with such responsibility. If a person is released on bail because their GP considered them unfit to detain, they might abscond and so the determination of immigration status could get further delayed. In extreme circumstances they might act out that 'risk to the public'. Or they may report as expected and get their immigration claim determined in the same way that applies to the very many thousands of others without current lawful right to remain.

How it has been working in practice

Until very recently, commissioning responsibility for healthcare in IRCs has rested with the Home Office,

8. Regina on the application of Pratima Das and Secretary of State for the Home Department and (1) Mind and (2) Medical Justice (Interveners) [2014] EWCA Civ 45 28 Jan 2014 case summary on www.iclr.co.uk
9. Home Office. Detention Rule 35 process. Updated 07/08/13 www.gov.uk/government/publication/detention-rule-35-process; and Home Office DSO/17/12 Application of detention centre rule 35 on https://www.gov.uk/government/publications/application-of-detention-centre-rule-35
10. Bail for Immigration Detainees 2012 The Liberty deficit: long-term detention & bail decision-making on www.biduk.org
11. Alois Dvorzac, an 84 year old Canadian with dementia, died while still in handcuffs on the 10 Feb 2013 in spite of the many efforts of his IRC GP to get him out of detention http://www.channel4.com/news/left-to-die-in-british-detention-who-was-alois-dvorzac

though has now transferred to the NHS. The Home Office is not known for its openness, so much is deduced indirectly. Insight into assessments on fitness to detain is provided through reports made under rule 35 (1). Only GPs employed by IRCs are permitted to make these reports and they have been doing so rarely, and for only 1 in 2 in every 1000 of those newly detained. The majority of longer term detainees are expected to have mental illness.[12] Many detainees where it has subsequently been demonstrated that health deteriorated severely in detention, including where this went as far as inhuman and degrading treatment, did not have reports made on their behalf by their IRC GPs. (see table below)

Reasons for low numbers of rule 35 reports, in spite of the widespread deterioration of health seen in longer-term detention, could include:

- ❒ The GP is ignorant of the system, maybe because a temporary locum
- ❒ There is confusion about existence and use of rule 35(1) since all the recent guidance appears to cover only rule 35 (3), ie that is torture
- ❒ The inappropriate use of other forms for reporting health concerns, eg for example IS91R Part C
- ❒ The preparation of a rule 35 report may take longer than the usual time available for a GP consultation
- ❒ difficulties about obtaining the patient's consent, especially for the more detailed justification required if the report is initially 'rejected'
- ❒ the exceptional barrier that is said to be overcome to gain release, especially for some groups like food and fluid refusers
- ❒ The very poor return rate for the effort, so this may not be seen as a good use of precious medical time[18]
- ❒ concern that in spite of severe disease, treatment might not be accessed were the detainee released to the community[19].

As well as rule 35 reports not being provided when perhaps they should be, there are often criticisms about the quality of those reports that are written.

Even when reports have been made under rule 35(1), they appear rarely to change the decision to continue detention. This 'failure' of the rule 35 process has been a concern for some time, with criticism from many parties including parliamentarians.[20,21] It should be noted that rule 35

Some prominent cases of unfitness to detain without rule 35(1) reports			
S	Ghanaian with severe mental illness	Adverse comment from judge on failure to produce rule 35(1) report	[13]
BA	Nigerian, ex foreign national prisoner, psychotic and food refusing, deteriorating in detention	Recognised as unfit for detention, but the only rule 35(1) report was very late	[14]
MD	Guinean woman who developed mental illness during 17 months detention	No rule 35(1) report done	[15]
S	Indian, psychotic with mental health deteriorating in detention	Found unfit for detention by IRC GP and psychiatrist, but no rule 35(1) reports done	[16]
D	Paranoid schizophrenic from Congo-Brazzavile	No rule 35(1) report.... 'mental state was not capable of being satisfactorily managed' at (either Colnbrook or Harmondsworth IRC).	[17]

12. Four -fifths of the respondents were classified as having depression M Bosworth & B Kellezi (2013) Developing a Measure of the Quality of Life in Detention *PSJ* 205 10-15.
13. R (S) v SSHD (2014) EWHC 50 case CO/2809/2012 28th Jan 2014.
14. R (BA) & SSHD [2011] EWHC 2748 (Admin) on www.bailii.org/ew/cases/EWHC/Admin/2011/2748.html
15. R(MD) v SSHD [2014] EWHC 2249 (Admin) case CO/8155/2012.
16. R (S) & SSHD [2011] EWHC 2120 (Admin) on www.bailii.org/ew/cases/EWHC/Admin/2011/2120.html;
17. R (D) v SSHD [2012] EWHC 2501 (Admin)on www.bailii.org/ew/cases/EWHC/Admin/2012/2501.rtf
18. Only one in 6 rule 35(1) reports were associated with release of the detainee Jan 2012 to September 2014, ie 13 released from 81 reports in 78 detainees.
19. Prisons and Probation Ombudsman Aug 2013 Investigation into the circumstances surrounding the death of a man in December 2011 at hospital while in the custody of Harmondsworth Immigration Removal Centre.
20. Home Affairs Committee 2013 'The Agency cannot plausibly claim to take Rule 35 reports very seriously when its Chief Executive does not understand his own guidance....The Agency must tell Parliament the reasons for which its caseworkers overrule the advice of medical practitioners...Further intransigence will continue to pose a risk to individuals, as mental health issues may not be properly identified' on www.publications.parliament.uk/pa/cm201223/cmselect/cmhaff/792/792.pdf
21. Medical Justice 2014 Rule 35 Safeguard in Detention. Submission to APPG on immigration detention on www.medicaljustice.org.uk

only applies within IRCs, and for the increasing number held under immigration powers in prisons there is no information at all on delivery of the expectations in EIG 55.10 on those whose medical state leads to them being or becoming unsuitable for detention. The lack of interest and priority given to rule 35 reports is exemplified by them not being specified initially in the detailed service specifications for healthcare services operated by those IRC healthcare providers newly commissioned by the NHS.

Dilemmas with rule 35(1)

Some of the practical problems include:

- Expectations from immigration case workers about clinical details to be provided by the IRC GPs, and the difficulty or unwillingness to provide that information, and the lack of reciprocal sharing of intelligence about exceptional reasons for continued detention
- Clinical information being shared with those outside the health family: consent being given on the basis this would help the patient/detainee, even though this happens very infrequently as reflected by the very rare subsequent releases from detention
- Mixed messages about whether there should be a clear clinical recommendation on fitness to detain, which GPs feel may go beyond their expected expertise as non-specialists, especially when this could be challenged in Court
- Those whose health is adversely affected are expected to be identified and reported to detention decision-makers, and yet deterioration in health is pretty universal with time
- The lack of a system for rule 35(1) reports to prevent those whose health deteriorated until needing section under the Mental Health Act from, once improved, then being returned to the setting that led to that deterioration
- For clinicians involved in IRC healthcare, expectations on them in continuing to participate in a system that leads to their professional advice on damage being done to their patients to be so frequently disregarded[22]
- Poor overall decision-making about fitness to detain, with mismatch between the stated official position and the practice, hence an inbuilt potential for blame-transference if/when things go wrong

The human rights aspects

'Freedom from executive detention is arguably the most fundamental and probably the oldest, the most hard won and the most universally recognised human right'.[23] The right to be free from arbitrary detention is covered by article 5 of the Human Rights Act. There are rules and regulations which enable administrative detention to still be lawful. Those include the stipulations in EIG 55.10 about detention not being suitable in those with significant mental or physical illness. The very exceptional circumstances which might be allowed to countermand these expectations are expected to be indeed very exceptional, recently outlined as a high risk of murdering someone or being due for removal in a very short time.[24] Current practice falls far short of these expectations, raising questions about the lawfulness of detention as it is currently practised in the many detainees who have physical and particularly mental health conditions which cannot and are not being satisfactorily managed in detention.

'Freedom from executive detention is arguably the most fundamental and probably the oldest, the most hard won and the most universally recognised human right'

In extreme circumstances, this can lead to breaches of article 3, with inhuman and degrading treatment. There are now 6 reported cases where the Home Secretary has been found wanting in relation to article 3 in mentally ill detainees, and there are yet further cases which have been settled.

The way forward?

The current system does not work. Suggestions for improving the rule 35(1) process include:

- guidelines with greater clarity over expectations, perhaps with an amended rule 35 report template,

22. Physicians for Human Rights. Dual Loyalties: The Challenge of Providing Professional Health Care to Immigration Detainees. 2011 on www.physiciansforhumanrights.org
23. Bingham (2003) 52 ICLQ 841.
24. Regina on the application of Pratima Das and Secretary of State for the Home Department and (1) Mind and (2) Medical Justice (Interveners) [2014] EWCA Civ 45 28 Jan 2014 case summary on www.iclr.co.uk

with worked up examples of common clinical issues

- ❒ development of a structured decision-making tool to make clinical decision-making more reproducible as well as consistent with official guidelines
- ❒ training of healthcare staff on how best to assess and report on concerns about continued detention, and of immigration case owners how to respond better to these reports
- ❒ audit of clinical practice with feedback to clinicians, to supplement the current but limited audit of aspects of administrative practice
- ❒ similar standards/rules for immigration detainees in all settings (ie also for those held under immigration powers in prisons or in STHFs)

However, tinkering with minor improvements to delivery of the rule 35 policy might do little to affect the fundamentals, if the responses from immigration case workers remain basically the same. The expectation of 'hostile environments' appears to have led to a policy shift which undervalues clinical opinion and the human rights of those immigration detainees who are the most vulnerable because of illness. There are worrying parallels from overseas.[25] There has been an increase in the use of immigration detention, even though its cost effectiveness as a means of accelerating removals is very much in doubt.

Unless there is a willingness to see major changes, there will continue to be injustices for those who are detained. If indeed the intention is to identify and not detain those whose health is adversely affected by detention, then the period of permitted detention should be restricted, since lengthy and indeterminate detention are especially damaging to mental health. Were the expert advice from the Royal College of Psychiatrists followed, those with severe mental illness would not be detained, as indeed was the expectation when the rules were first drawn up. The circumstances for over-ruling clinical concerns should be indeed very exceptional, and subject to more public scrutiny. The use of detention as a whole could be restricted, limited say to those ex-foreign national prisoners convicted of violent and equally serious crimes and those with removal directions, thereby making great savings for the public purse.

Those more familiar with the criminal justice system need to remind themselves of the important differences between prisoners and immigration detainees.[26] There is no suggestion that IRC doctors are somehow less competent than their prison colleagues in managing their patients, nor any attempt to downplay the very severe health problems found within prison settings. The facts are that immigration detention is expected to be optional, creates damaging ill-health which is avoidable and the expected safeguards to protect the most vulnerable detainees who are not fit to detain are not working.[27]

Post-script
Fitness to detain in other circumstances and settings

This note has focussed on healthcare concerns to be considered in relation to the detention of immigration detainees. This has important differences from the fitness to detain for criminal suspects to be interviewed in police cells, for which there is guidance from the BMA and APCO. It is different yet again from assessments relating to the compassionate release of convicted prisoners, for which the threshold will be higher. It is also different from assessments on the fitness to fly, where the standard guidelines from IATA and CAA need to be considered alongside the special issues that arise from an unwilling passenger in a forced removal. The fitness to be interviewed for immigration detainees is different yet again: this requires the ability to retain and digest information which may determine their life chances, potentially without the benefit of a friend or legal advice and maybe in a foreign language too. For this, mental capacity will be highly relevant.

25. Australia's detention regime sets out to make asylum seekers suffer, says chief immigration psychiatrist on http://www.theguardian.com/world/2014/aug/05/-sp-australias-detention-regime-sets-out-to-make-asylum-seekers-suffer-says-chief-immigration-psychiatrist
26. Paper on this topic on www.medicaljustice.org.uk
27. Cutler S (2005) Fit to be detained? Challenging the detention of asylum seekers and migrants with health needs. Bail for Immigration Detainees on www.biduk.org