



'First do no harm'

Clinical roles in preventing and reducing damage to vulnerable immigration detainees

Medact submission to the review by Mr Steven Shaw

December 2017

Summary

The available evidence shows that the objectives of significantly reducing the number of vulnerable individuals detained and the duration of their detention have not been achieved by the changes to policy and practice introduced since the “Review into the Welfare in Detention of Vulnerable Persons (A report to the Home Office by Stephen Shaw)” January 2016 (hereinafter ‘the first Shaw report’). In some respects these changes have actively impeded progress.

A major factor in this failure (to date) is the lack of quality improvement processes based on competent audit and feedback to the key actors - UK Visas and Immigration (UKVI) decision makers and Immigration Removal Centre (IRC) healthcare staff.

Key Recommendations

We recommend the introduction and publication of cyclical audits, overseen by HM Inspector of Prisons (HMIP), the Care Quality Commission (CQC) and HM Chief Inspector of Borders and Immigration (HMCIBI) and carried out (at least initially) by independent clinicians with the requisite expertise reporting to them. These audits should seek to identify cases of vulnerability and harm, to understand the mechanisms through which they have occurred, and lead to practical and demonstrably effective means of harm reduction.

We consider that the Rule 35 process, as currently operated, is unfit for purpose. It cannot compensate for frequent mistaken decisions to maintain detention, particularly under circumstances where the duration of detention is indefinite.

We agree with the first Shaw report’s recommendation, that Rule 35 should be redrafted rather than done away with. This will require an amendment to Statutory Instrument 2001 No. 238 The Detention Centre Rules 2001. Any such amendment should be preceded and directed by transparent consultation with all relevant stakeholders.

Acknowledgements

Medact is grateful for the advice of doctors who are members and associates of Forrest Medico-Legal Services (www.forrestmls.org) and who have extensive experience of examining detainees (and in consideration of their IRC medical notes) during or after immigration detention. If time allows, some of these colleagues will be submitting brief anonymised case studies illustrating the issues discussed below. This submission was drafted by Dr Frank Arnold for Medact. He accepts sole responsibility for any errors.

This submission is intended to be read in conjunction with that presented by Medact to the first Shaw review.

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I. Chronology

Audit of Rule 35 process conducted by UKVI	01/01-30/03/2014
First Shaw review commissioned, announced on	09/02/2105
First Shaw review reports	14/01/2016
Government statement accepts some Shaw report recommendations	14/01/2016
Section 59 of Immigration Act 2016 enacted (requires issuance of guidance on identification and release of vulnerable persons)	12/07/2016
Adults at Risk policy introduced	??/08/2016
Second Shaw review announced by Immigration Minister	05/09/2016
UNCAT definition of torture introduced	12/09/2016
DSO 9/2016 published	06/12/2016
“UNCAT definition of torture” suspended	07/12/2016
Commons briefing paper on Immigration Detention	13/06/2017
Home Office “Asylum Claims in Detention” published	18/09/2017
UNCAT definition overturned by High Court	10/10/2017
Home Office Enforcement (EIG) chapter 55.10 withdrawn	25/10/2017
HMIP report on Yarl’s Wood published	15/11/2017
Audit of Rule 35 process published (after FOI request made in 2015)	15/11/2017

II. Background

1. In response to growing concerns about the welfare of vulnerable persons in administrative immigration detention, the Government commissioned ‘the first Shaw report’ to which Medact contributed evidence (appendix 1).
2. On 14 January 2016 Mr James Brokenshire (then Minister for Immigration) responded to the Shaw report, undertaking that
3. “The Government expects these reforms, and broader changes in legislation, policy and operational approaches, to lead to a reduction in the number of those detained, and the duration of detention before removal, in turn improving the welfare of those detained.”
4. Mr Shaw has now been asked to review progress in implementation of his original recommendations and has kindly invited submissions.

III. Statistical data – numbers and duration of detentions

5. The Home Office has published data for the period between January 2016 and the latest available published data (table 1a). This showed that In Q4 2015 there were 8,612 episodes of detention. In Q1 2017 this had fallen by about 17% to 7,173. The quarterly numbers have fluctuated since.

Quarter	Number detained
2015 Q4	8,612
2016 Q1	6,937
2016 Q2	7,607
2016 Q3	7,039
2016 Q4	7,078
2017 Q1	7,173

Table 1b: Numbers detained quarterly

6. The **duration** of detention has changed even less, except for those held for the longest periods (table 1b). During 2015, 48% of detainees were held for more than one month. In the year ending June 2017 this figure was 45%. The most recent centre-specific data, from HMIP inspections of Yarl's Wood (2017), Colnbrook (2016) and Brook House (2016), were 50% and 57% and 48% respectively.

<https://www.justiceinspectorates.gov.uk/hmiprisons/inspections/?s&prison-inspection-type=immigration-removal-centre-inspections>

	2015	To year end June 2017
Total:	33,189	27862
Left IRC after	<i>percent</i>	
<29/7:	62%	64%
1-2mo:	18%	17%
2-4mo:	12%	11%
>4mo:	8%	7%
Left IRC after	<i>absolute numbers (percentage change)</i>	
1-2Y:	255	172 (-33%)
>2Y:	41	28 (-32%)

Table 1b: Duration of detention, annual

[Data for detention of more than one year are cited as absolute numbers, because the numbers are small by comparison, though not necessarily in importance. (Data from Home Office Transparency Statistics - <https://www.gov.uk/government/collections/migration-transparency-data>). There is a small amount of double-counting as a few people have been detained two or more times.]

7. This does not tell us how many *vulnerable* individuals have been detained or for how long or the severity of the consequences. We accept that excellent descriptions of vulnerability have been produced, particularly as discussed in the first Shaw report; however we consider that these do not lend themselves to categoric or quantitative measurement.
8. That said unless there have been substantive improvements in identifying such people and preventing their detention or expediting their release, there is no reason to believe that there has been any significant achievement of the primary objectives set out by the government, i.e. *a reduction in the number of vulnerable persons detained and the duration of detention before removal, in turn improving the welfare of those detained.*
9. We are not aware of any evidence that changes in policy and practice introduced since the first Shaw report have had those intended effects. Indeed, there is hard evidence from numerous case examples and some quantitative data which indicate that various aspects of the Adults at Risk (AAR) and other recent innovations have had the effect of actively impeding these objectives. These changes may also have exacerbated existing difficulties for the provision of adequate healthcare in IRCs.

IV. Clinical Context

10. Certain fundamental medical principles and facts have been learned (too often the hard way) by clinical professions:

- 1) **Prevention is better than cure.** The most effective way to minimise harm to individuals identified as potentially vulnerable to the experiences of detention is not to detain them in the first place.
- 2) Where prevention fails, safeguarding mechanisms are required to achieve harm reduction in this case, through identification and timely release of vulnerable detainees.
- 3) **Avoidable medical harm can be caused by individual error, but is much more commonly the result of system flaws.** This is illustrated graphically by the Swiss cheese model, in which multiple systemic safeguards are or become misaligned in such a way as to fail in their aims of protection and so increase the probability of harm to the point of certainty.

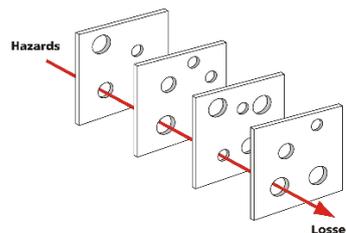


Figure 1 Swiss cheese model of systems failure.

(https://en.wikipedia.org/wiki/Swiss_cheese_model)

- 4) There is hard evidence from numerous examples and some quantitative data which show that various aspects of the Adults at Risk (AAR) policy create system flaws which have the effect of actively impeding harm reduction by increasing the porosity of, or removing, significant safeguards intended to prevent the detention of vulnerable individuals. For example:
 - A) The safeguards previously operative through concessions regarding release on the basis of prima facie evidence submitted by “the Foundations” have been withdrawn. We understand that those organisations (Freedom from Torture and the Helen Bamber Foundation) will be submitting their own evidence to this point.
 - B) As the number of Rule 35 reports has increased there appears also to have been an increase in use by Home Office caseworkers of the option of outweighing medical opinions expressed in a Rule 35 or IS91RA (part C) report, on the basis of “immigration factors.”
 - C) More generally, a fairly complex series of sequential steps must be taken by nurses, doctors, and caseworkers in timely fashion in order that the (secondary)

safeguarding process referred to as “Rule 35” operates effectively as intended so as to result in the termination of harmful detention of vulnerable individuals. The way in which these do and do not work is discussed further below.

11. As the HMIP report on Yarl’s Wood (report of an unannounced inspection in June 2017) points out: “The effectiveness of the adults at risk policy, which is intended to reduce the detention of vulnerable people, was questionable given that almost a fifth of those in detention were assessed by the Home Office to be at the higher levels of risk.

(<https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2017/11/Yarls-Wood-Web-2017.pdf>)

12. **Quality improvement** should be based on good evidence obtained and used through **audit cycles** (figure 2). These allow practitioners to identify and overcome impediments to better practice. However, audits must be conducted by measurements according to defined standards and consider **outcomes**, as well as inputs and processes to produce information of value.

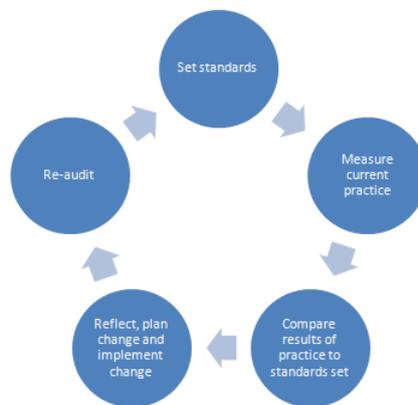


Figure 2: The Audit Cycle, a model

13. This has not been the case in our limited experience of audits conducted in IRCs, including:

- a) “Rule 35, detention centre rules: quality analysis report” based on an audit undertaken in 2014 and released on 15 November 2017 under a Freedom of Information request. (<https://www.gov.uk/government/publications/rule-35-detention-centre-rules-quality-analysis-report>)

- b) self-audits of numerous IRCs by their managing companies (<https://iasservices.org.uk/The-ICO-Orders-the-Release-of-Reports-Into-Immigration-Detention-Centres>, available from <https://corporatetwatch.org/contact>)

V. Clinicians' individual professional responsibilities

14. **Doctors** (including those working in IRCs) **have duties** as defined by the General Medical Council as set out in Good Medical Practice to:

Protect vulnerable individuals: "Whether or not you have vulnerable adults or children and young people as patients, you should consider their needs and welfare and offer them help if you think their rights have been abused or denied."

(https://www.gmc-uk.org/guidance/good_medical_practice.asp - paragraph 27)

Audit outcomes of their work: "You must take part in systems of quality assurance and quality improvement to promote patient safety. This includes:

- a. taking part in regular reviews and audits of your own work and that of your team, responding constructively to the outcomes, taking steps to address any problems and carrying out further training where necessary
- b. regularly reflecting on your standards of practice and the care you provide
- c. reviewing patient feedback where it is available. (paragraph 14)

Raise concerns: "If patients are at risk because of inadequate premises, equipment or other resources, policies or systems, you should put the matter right if that is possible. You must raise your concern in line with our guidance and your workplace policy. You should also make a record of the steps you have taken."

(https://www.gmc-uk.org/guidance/ethical_guidance/raising_concerns.asp)

Communicate honestly, all crucial medical information about patients which would otherwise be confidential: "You must be honest and trustworthy when writing reports, and when completing or signing forms, reports and other documents. You must make sure that any documents you write or sign are not false or misleading.

- a. You must take reasonable steps to check the information is correct.
- b. You must not deliberately leave out relevant information.

(https://www.gmc-uk.org/guidance/good_medical_practice.asp - paragraph 72)

15. **Medical managers** have additional duties on doctors acting as to investigate and act on concerns and complaints brought to them, according to the GMCs requirements.

(https://www.gmc-uk.org/guidance/ethical_guidance/11871.asp)

16. Other health professionals, particularly nurses, have comparable regulators and duties, which warrant examination.

VI. Structure, Governance and Responsibilities within IDC healthcare

17. **Healthcare commissioners**, e.g. NHS England and its dependent parts (except for Dungavel, where healthcare is still directly commissioned by the Home Office) have statutory and contractual responsibilities. In particular they are responsible for governance. They must make a **needs assessment** (for the patient population concerned) and translate this into specification for services and invite tenders, negotiate contracts, then manage the performance of the providers chosen.



Figure 3: NHS Commissioning cycle

18. **Healthcare providers** also have statutory and contractual responsibilities and are required to undergo inspection by the Care Quality Commission. However, in the case of IRCs, there is a Memorandum of Understanding between the CQC and HMIP. The Prisons Inspectorate are the lead body in the detention estate and publish the resulting reports, with brief addenda from the CQC. (There appears to be some confusion on this point as between the CQC and providers in that the CQC website says they have not yet inspected Colnbrook IRC, as does a summary from CNWL, although the HMIP report makes mention of their joint inspection in 2017 - <https://www.cqc.org.uk/location/RV3KJ/contact>). Some providers are NHS bodies, others private; the same is true for the overall management of immigration removal centres (table 3).
19. There are strong reasons to believe that this fragmentation impedes good medical practice in IRCs. Although the current structure of the NHS lies outside the remit of the present review, it is the context in which recommendations must be considered.

IRC	Centre management	Healthcare
Harmondsworth	Mitie	CNWL
Colnbrook	Mitie	CNWL
Yarl's Wood	Serco	G4S medical
Brook House	G4S	G4S medical
Tinsley House	G4S	G4S medical
The Verne	HMPS	NHS (Dorset)
Morton Hall	HMPS	NHS Notts
Campsfield	Mitie	Care UK
Dungavel	GEO	NHS Lanark

Table 3: contracting and subcontracting. In centres where NHS bodies are providers, the actual provision of onsite doctors is largely via further subcontracting to local general practices.

VII. Changes to UKVI policies and practices after the first Shaw report

A. The UNCAT definition of torture:

20. According to UNCAT definition torture is only inflicted “by or at the instigation of or with the consent or acquiescence of a public official or other person acting in an official capacity. It does not include pain or suffering arising only from, inherent in, or incidental to, lawful sanctions.” Its application to decisions about administrative detention by the Home Office implied that gross abuses - torture or cruel, inhuman, or degrading treatment or punishment (CIDT) - by non-state actors does not create inherent vulnerability to the experiences of detention among survivors. This contention was rejected by the High Court as lacking a “rational or evidence base” a view which was upheld by the Court of Appeal in 2017. Application of the DSO was suspended by the High Court on 7 December 2016. However, during the period of its application, it required doctors (in effect) to identify the perpetrators of torture or CIDT, before submitting a Rule 35(3) report.
21. The identification of perpetrators is a legal not a medical matter. However, attempts to obey this edict led IRC doctors to decline to produce Rule 35(3) reports on individuals who did not or who they considered did not fit the UNCAT definition. This policy is likely to have caused confusion and consternation among many other IRC doctors. It was condemned by the Royal College of Psychiatrists as without foundation in, and contrary to, observable medical fact. (http://www.rcpsych.ac.uk/pdf/PS07_2016.pdf).

B. Adults at Risk:

22. The AAR policy was published in August 2017.

(https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/547519/Adults_at_Risk_August_2016.pdf)

It introduced three new policies:

- 1) A definition of three levels of “evidence” of vulnerability. This treats self-report as level 1, a Rule 35(3) report as level 2, and a formal medico-legal report compliant with the Istanbul Protocol as level 3. It has had the effect of confusing the time, expertise, and resources available to a doctor providing medical evidence, with the strength of the actual medical evidence of past harm itself (such as scarring, psychological trauma, FGM, rape, etc). Only a Rule 35(1) report that a detained person’s “health is likely to be injuriously affected by continued detention or any conditions of detention” appears to equate to level 3 evidence, while a Rule 35(2) report that a detained person was “suspected by the doctor of having suicidal intentions” ... “will not always necessitate a review of the appropriateness of detention...”. Similarly, although the courts have accepted that a competent Rule 35(3) report can constitute corroborative evidence of a history of torture in asylum claims, such evidence is routinely judged not to be strong enough to warrant release from discretionary administrative detention. This appears to invert logic.
- 2) A second alteration was the requirement for **both** medical evidence supporting a history of gross abuse **and** medical evidence of harm resulting from detention being necessary to release a detainee; neither alone was then held to be sufficient. This change in practice meant that doctors would be required to specify in separate Rule 35(1) reports that their patient’s physical or mental health was being or was likely to be harmed by the experience of continued detention, in addition to producing a Rule 35(3) report that their patient may have been a victim of torture, in order for consideration of release to occur. This conflates Rules 35(1) and 35(3). Whether or how information about this new supposed requirement actually reached the IRC doctors is unclear. However, under these new practices, even medical prognostication of the likely consequences of continued detention in cases is not enough:

“Caseworkers should note that evidence that immigration detention for an unidentified period would cause harm does not demonstrate that immigration detention for a very short period will cause harm.” This pseudo-clinical assertion in the policy is not supported by any medical evidence.

- 3) In similar vein the policy continues that:

“It will be a rare case where detention for a very short period will cause serious harm to an individual ...” Again, no medical evidence is provided for this assertion which ignores the potential risk of re-traumatisation and the long-term harm which can flow therefrom.

The policy continues that:

“... medico-legal evidence specifying that detention, even for a short period, will cause serious harm will generally be required before a risk of such harm is accepted.”

23. This sharply moves the policy from a clinical perception of risk by the doctor's identification that the patient may have been a victim of torture to a requirement that actual and immediate harm be demonstrated by the doctor irrespective of any pre-existing potential for vulnerability.

“...where such allegations (of torture) are supported by independent evidence such as medical records or a Rule 35 report indicating that detention **for the period identified as necessary** would be likely to cause harm...” (emphasis added)

24. It is not clear who was doing the 'identification' of a period of detention 'as necessary', or whether and how this determination is communicated to and acted upon by IRC doctors nor what criteria those doctors should apply to measure risk against time

25. This policy was (as far as we can establish) first published in the guidance document Asylum Claims in Detention (V4) on 18/09/2017.

(<https://www.gov.uk/government/publications/asylum-claims-in-detention>)

However, it has appeared in evidence we have seen, in letters maintaining detention for some time before that date, where lack of medical prognostication in Rule 35(3) reports was being cited by caseworkers as grounds for maintaining detention thereby.

26. It should be noted that some time after the first Shaw report, the proformas for Rule 35 reports were revised to create separate forms for each of three categories, so that to raise concerns that a detainee “*may have been a victim of torture*” the doctor must use Rule 35(3) forms and to specify that the person’s “*health is likely to be injuriously affected by continued detention or any condition of detention*” the doctor would also need to fill out a separate Rule 35(1) form. Whilst the mere ticking of a box to indicate whether Rule 35(1), (2) or (3) has been fulfilled may warrant expansion to include a brief narrative, the time costs of extra form filling for a doctor who is already otherwise pressed for time, are obvious.

27. We are unable to provide absolute numbers of cases where a Rule 35(3) absent a Rule 35(1) report was held not to justify release, e.g. where what the doctor did NOT say about harm likely to result from continued detention has been used by UKVI as evidence that detention may be maintained. However, this is common in our experience and appears to coincide with a reduction in the proportion of Rule 35(1) reports being submitted.

28. The most obvious consequence of the AAR policy was to dilute the safeguards embodied in EIG chapter 55 (until its withdrawal on 25 October 2017) that victims of torture are one of several categories of persons who “*are normally considered suitable for detention in only very exceptional circumstances.*”

C. Gatekeeping and Safeguarding teams:

29. We understand that the approval of the **Gatekeeping** team is required before a person can be detained, and presume that they operate to some criteria, but as far as we are aware these criteria are unpublished. It is also unclear whether – when a detained person is released because of their vulnerability or detention is maintained despite it - the Gatekeepers are notified. If such feedback is not provided it is difficult to see how improvement in the quality of the Gatekeepers' decision making can be achieved.

30. The role of the **Safeguarding** team is even more obscure. According to a UKVI document (available on request from Medact) discussed at a stakeholder meeting (dated

11/10/2017) they are mandated to provide “...*high quality advice and for operational business in respect of vulnerable caseload.*” It is unclear how often, indeed whether, they are consulted by caseworkers in receipt of information about vulnerability or actual harm in the form of Rule 35, IS91 RA (part C) or Medico-Legal reports.

D. IS91RA part C:

31. We are aware that IS91RA part C reports are occasionally completed by doctors or other clinicians. An anonymised example (which was incompletely filled in by a doctor) is shown as case N. Such documents are rarely present in the medical notes and are only very occasionally produced following a subject access request for the complete UKVI file by a detainee’s legal representative. We therefore have no information about the frequency with which IS91RA part C forms are generated by IRC clinicians or of their consequences. However, they are not likely to have a major effect in reducing harm.

VIII. Production and outcome of Rule 35 reports since the first Shaw report

32. The number of detainees receiving Rule 35 reports and the numbers and frequency with which these resulted in release over time is set out in figures 4 and 5. (The number of actual reports is slightly greater because a few detainees received more than one report.) The approximate dates of the first Shaw report, the period of implementation of the new (UNCAT) definition of torture, are also indicated.

IX. Effects on clinical practice

33. In Medact’s previous submission to the first Shaw review, we cited a consensus statement agreed between doctors who are employed in IRCs and doctors who visit IRCs as independent forensic experts following a conference which took place in May 2015.
34. The agreed and published conclusions about the medical safeguard against detention of vulnerable people were that:

“Many (IRC) doctors were clear that they don't have the training and all doctors were clear that there is insufficient time to adequately assess evidence of torture or medical harms consequent upon detention. The task is made more difficult because of inadequate definition of the purposes and requirements of rule 35 and/or IS91 RA part C. There was agreement that the demand for rule 35 or part C work cannot be met within existing resources of medical time. Nor have the Home Office clarified what they require in order that they can comply with their duties to exercise “anxious scrutiny” of such reports. This means that much, if not most, of the doctors’ work in this area is wasted effort.”

<https://www.medact.org/wp-content/uploads/2015/06/RSM-Medact-IRC-Consensus-Statement.pdf>

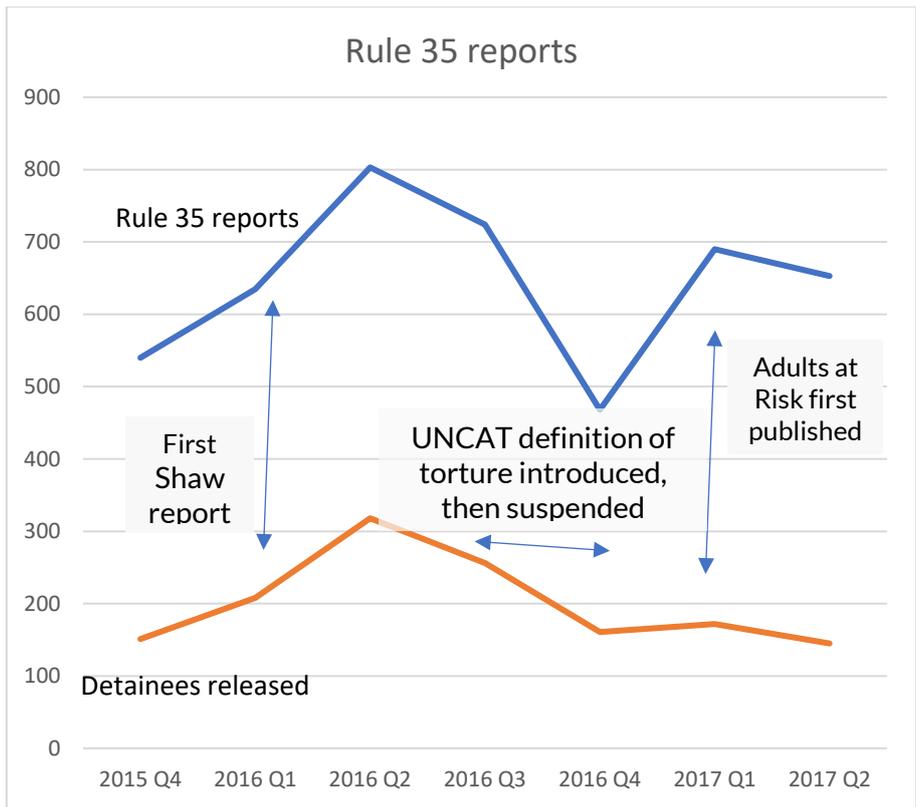


Figure 4: Rule 35 reports and numbers released as a result

[Arrows indicate dates of events]

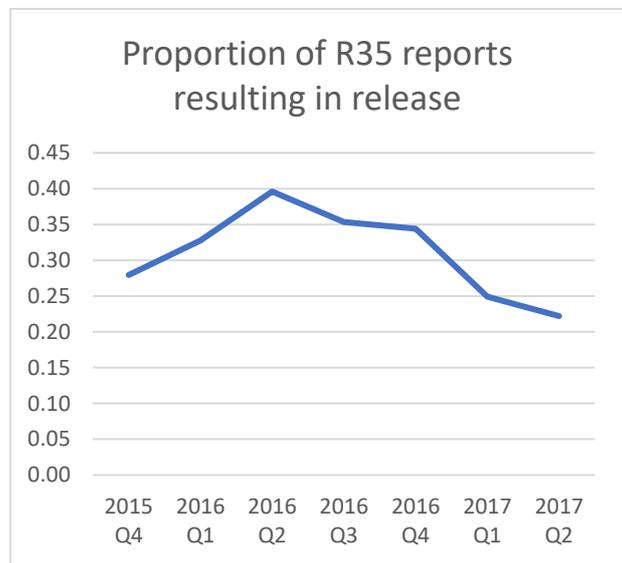


Figure 5: Detainees released as a result of Rule 35 reports

(Data from: <https://www.gov.uk/government/collections/migration-transparency-data>)

35. We are not aware of any evidence that these problems have been successfully addressed by changes in policies, practice, training or resources introduced since that time. Indeed, recent changes have tended to impede the overarching aim of reducing the frequency and extent of harm to detainees.

X. Rule 35 in Theory

36. In seeking to understand how the rule 35 process works and fails we identified the series of steps which are required for it to function as intended. Responsibilities for these steps are set out in Detention Service Order 09/2016, V4.

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/574966/dso-09-2016-detention-centre-rule-35_v4_0.pdf

37. The steps are numbered in sequence and are characterised as Medical, indicated in the box below as M, and Casework denoted in italics, C.

Box 1

M1	patient reveals history of torture or other vulnerability during nurse admission clerking, and
M2	this is recorded and the patient is referred for Rule 34 and Rule 35 examinations
M3	both of which are carried out expeditiously and adequately
M4	during either examination the patient may have painfully to revisit severely traumatic experiences
M5	examination(s) result in a vulnerability and harm (Rule 35) report of adequate quality (however defined with, for example, findings re torture and PTSD documented)
M6	which is sent to UKVI in timely fashion and following which
C1	<i>receives a timely response from UKVI</i>
M7	meanwhile, if since detention, the patient has been suffering harm this IS treated(to whatever extent is actually possible in a potentially retraumatising environment) and documented in the medical notes (for example panic attacks and flashbacks)
C2 a)	<i>IF medical evidence in the form of a Rule 35 report is accepted as mandating release, then:</i>
M8	IRC healthcare ensures that the detainee is fit to travel, has possession of necessary medication and medical notes, and (ideally) assistance in registering with a GP near their intended address.
C2 b)	<i>IF medical evidence in the form of a Rule 35 report is held not to mandate release, then:</i>
M9	responsible IRC doctor (eg the author of the Rule 35 report or some other designated doctor) reads the Home Office letter and signs to show that they have done so, considers whether the initial report has been criticised and on what grounds, responds to UKVI correcting any clinical errors of fact or understanding embodied in the decision to maintain detention.
M10	IF the patient approaches healthcare on receipt of the refusal letter, do they see a doctor?

Is that doctor aware of the situation, and able to deal with any distress or mistrust

M11 IF the patient is examined by an independent doctor at their own request, or on instructions by a solicitor, the detention centre rules require that this be “in consultation with the (IRC) doctor” and that the visitor be afforded “reasonable facilities for examining him in connection with the proceedings”.

XI. Rule 35 in Practice

38. Good medical practice requires the doctor to recognise, diagnose, investigate, treat and advise their patients about their maladies. This is often difficult even when communications are in a common language and based on shared assumptions about the nature of illness and therapy. It is more difficult to elicit essential information when these conditions do not obtain. It is also more time consuming to work via an interpreter (whose abilities may or may not be up to the task) and to have to struggle to establish common ground as to the nature of the presenting problem(s).
39. When these impediments are compounded by trauma and distrust on the part of a vulnerable and/or damaged patient, the job of the health care professional (nurse, doctor, psychological therapist, administrator etc) is even harder.
40. To this, in the case of the Rule 35 process, must be added systemic and cultural barriers to good practice in IRC healthcare. These impediments operate in a context of the frequently changing, unclear and confusing requirements of the Adults at Risk and related policies.
41. It is not surprising that many rule 35 reports are flawed and that many of which should have been done were not done. Rather, it is surprising that – despite all the factors mitigating against good practice - some of the Rule 35 reports we have seen are of high quality (medically and psychologically accurate). Many independent doctors seeing detainees and ex-detainees and their IRC medical notes have been able to confirm and amplify the findings documented in such R35 reports during our more leisurely and better resourced examinations for formal Medico-Legal Reports.
42. Equally, on examining the person and the medical notes it is often possible to determine why a Rule 35 report was never done, done only after excessive delay, and/or the reasons why it was rejected as grounds for release.
43. Several conclusions emerge from this kind of analysis. Although we cannot give hard numbers as to the absolute frequency of our findings, at least N independent doctors confirm their general nature.
44. The numbered paragraphs in Box 2 show the steps where problems have been seen, and offer a rough estimate of their frequency.

Box 2

M1 & 2 IRC medical notes for nurse admission clerkings more often than not often fail to record whether the detainee was asked about vulnerability (e.g. “the torture question”) and any answer given, or whether they were referred for a Rule 35 examination. Nor do they often record the offer of a Rule 34 examination by a doctor within 24 hours.

In some cases, where the answer to the “torture question” is recorded inaccurately as “NO” as evidenced by a subsequent Rule 35 report, MLR, or court decision. In others positive response has been followed.

These outcomes are inconsistent and not compliant with published Home Office expectations for healthcare in IRCs. Several explanations can be advanced for these errors:

It is probable that System 1, the electronic patient record system imported from the prison service, treats entries as optional, not mandatory fields, and do not prompt the relevant questions and actions by the nurse.

It is possible that nurses who fail to act or document their actions are unaware of or ignore these requirements. Lack of time, non-use of interpreters when needed, middle-of-the night clerkings, inattention, or ignorance of procedure are likely to be contributory factors.

We consider that the relative contributions of these structural and cultural factors warrants investigation.

M3 Where the nurse admission clerking has failed to identify a detainee as vulnerable, the Rule 34 examination (M3) could potentially correct the error. We have seen very few cases (if any) where that examination – when it has occurred - has revealed relevant evidence and led to a Rule 35 (or IS91 RA part C) report.

We have seen numerous cases in which detainees who have not been picked up by either LAC or R34 (when the latter is actually conducted) do eventually receive Rule 35 reports. The means by which a report is initiated in such cases is usually by a request from the detainee, who is informed of the existence and significance of the process by either another detainee or their legal advisor. The interval between detention and these reports can be long and harmful.

M4 & 5 The time budgeted or actually available for a rule 35 examination is unknown. It has been suggested to us by an experienced IRC doctor that the minimum required for an adequate examination and write-up is at least 30 minutes. Detainees report to us that the time allocated was insufficient and often as little as 5-10 minutes.

The availability, use and/or adequacy of interpreting is sometimes problematic, as reported by detainees. This statement is supported by discrepancies between less adequate Rule 35 reports and subsequent MLRs or court findings.

The adequacy of Rule 35 reports is likely to be impaired by a “culture of disbelief” - as noted in Shaw 1 - among IRC clinicians in some cases. Where this is disbelief is operative, it is likely to impair the detainee’s ability to reveal painfully traumatic events.

Further, as noted by IRC and independent doctors in the consensus statement of 2015, there is a lack of consistent standards about the required content of an adequate report. We are not aware of any evidence that the situation has improved since that time.

M6 In addition to delays occasioned by failure of the NAC and R34 examination to trigger a Rule 35 report, there are sometimes significant delays in submission to or acknowledgement by UKVI.

M7 IRC medical notes quite frequently contain clues about vulnerability and harm, which are not recognised or appreciated in subsequent clinical encounters. For example, detainees are frequently recorded as complaining of frequent nightmares, or suffer features of panic attacks, which may be indicators or previous abuse. It is not clear that these are often followed up, although 20% of Yarl's Wood detainees were on a register of vulnerability during the 2017 HMIP inspection.

UKVI 1 We have seen numerous cases where the response of UKVI (whether granting or refusing release) is delayed long after the three working day time limit set by Home Office policy.

M8 **UKVI 2a** We have also seen cases where detainees' release is so rushed as to prevent safe discharge. In at least one historic case this has contributed to death. We are not aware that the risk of recurrence has been addressed.

M9 It is very unusual for any response from UKVI to a Rule 35 report which refuses release to be present in IRC medical notes (which we have seen) as a copy signed by any doctor. This is not in accord with Good Medical Practice. It also makes audit and follow-up difficult if not impossible.

For the same reason in the 78% of cases (on most recent figures) where a rule 35 report is rejected as mandating release, it is unclear from the medical notes whether

a) Any doctor has read the refusal letter, and if so whether this was the actual author of the rule 35 report.

b) Whether that doctor responded to the author of the refusal letter to correct misunderstandings of medical fact (This potentially valuable explicit safeguard was previously required in Guidance on Rule 35 but appears to have been omitted from DSO9/2016)

M10 And what - if any - steps the doctor has taken to discuss the situation with their patient.

It is pertinent to consider the fact that the detainee will also have received the refusal letter. The examination may well have had led to high hopes of release, which have now been dashed. The detainee may or may not understand why the evidence has been rejected. They may well blame the doctor as responsible (wholly or in part) for their continued distressing detention, whether this is a reasonable belief or not. This is not likely to improve doctor patient relations.

It may also be pertinent to consider the effect on the IRC doctors of rejection of their medical evidence (and sometimes competence) by clinically unformed lay decision

makers. This is not likely to be empowering or to raise enthusiasm for efforts to improve practice even among the most conscientious of them.

It is therefore unsurprising if (as suggested by their trade union, the BMA) these doctors have previously argued (to Shaw 1) that responsibility for documentation of vulnerability should be transferred to “forensic medical examiners”. Whether desirable or otherwise, this is not feasible. Where would the trained personnel to carry out the equivalent of 2500 Rule 35 reports come from? They do not currently exist:

The current national capacity for expert reporting consists of doctors working through NGOs (FFT, HBF, MJ, Forrest MLS etc.) produces fewer (probably many fewer) than 800 MLRs per annum. And of these, fewer than 200 are probably done by visits to IRCs. It should also be recalled that MLRs can take a total of 12-20 hours or more of medical time, and may run 12- 50 pages.

M11 The requirements set out in Detention Centre Rule 33 should grant a visiting doctor contemporaneous access to the medical notes and - where a previously unrecognised health problem has been identified during the visit - that there be consultation between the IRC doctor and the independent doctor. (These provisions are almost invariably obstructed; this would be considered a violation of Good Medical Practice in most other contexts.)

This accords with the view that the culture of IRC healthcare is harmed by isolation from the mainstream of the NHS, that some practices of IRC healthcare are antithetical to Good Medical Practice and give the appearance of extreme, inappropriate and potentially dangerous defensiveness.

XII. Further Considerations

45. It should not be forgotten that a high proportion of clinical contacts between detainees and IRC healthcare are with nurses, and that nurses act as gatekeepers of access to doctors. The culture of IRC nurses and their understanding of their duties of safeguarding warrant investigation and audit.
46. There were high hopes that the transfer of the commissioning of healthcare in IRCs to the NHS would result in rapid and significant improvements in its practice. These remain largely unrealised as yet. We suggest that when the transfer occurred, NHS bodies were unaware of the extent of the task they were taking on and unprepared for complex practical and ethical issues (including dual loyalties) which are unusual in every day NHS practice.
47. And it is not clear that the responsible entities (NHS England and its local bodies, but also the CQC, GMC and NMC) have yet taken the necessary steps to identify (through conducting or mandating audit) and to direct (by contractual or other means) effective action to reduce risk and harm to vulnerable detainees.

XIII. Conclusions

48. We recommend that the performance and outcomes of the Rule 35/Adults at Risk undergo effective cyclical audit with feedback and publication of the results, to enable quality improvement. Our tentative suggestions as to how medical aspects of audits could be achieved are set out in the Appendices. We consider it will be essential to rewrite Rule 35 to better reflect its purposes, but consider this is beyond the scope of our present submission, as it will presumably require revision to the Detention Centre Rules.

XIV. Recommendations about Audit

49. As a preliminary, representative individual clinicians, particularly nurses with responsibility for admission clerking and medical managers, and those responsible for purchase and provision of IRC healthcare could and should be **interviewed** by the Shaw team about their understanding of their unusual safeguarding roles and responsibilities.
50. To facilitate quality improvement, independent clinicians with the relevant expertise should be appointed by and accountable to the regulatory bodies (HMIP, CQC, perhaps also HMIBI) with a mandate to carry out informative **audits** of clinical staffing levels in IRC healthcare, training and conduct of safeguarding processes and outcomes. The results of these initial audits should be communicated to the responsible bodies (healthcare commissioners and providers) the regulators and published by them. Subsequently audits should be carried out using templates developed by and for the regulators on a six monthly or annual basis, with increasing responsibility falling on IRC clinicians for their conduct. Rough schemata for these audits are below. They probably can and should be improved by input from IRC and independent clinicians.

51. Audit 1 - Clinical resources and demand in IRCs:

- 1) What are the intended and actual staffing levels in the centre being audited?
- 2) How many of these nursing and medical posts have been:
 - a) filled by permanent staff,
 - b) filled by agency staff
 - c) not filled in the past three months

Note: we understand that some purchasers and/or providers have consciously decided not to audit staffing levels on the grounds that they are interested in “outcomes not process.” It should not be either/or – both are important.

- 3) In what proportion of clinical encounters are interpreters used?
 - a) on what basis and how often does a clinician decide that an interpreter is needed,
 - b) how often is an adequate needed interpreter unavailable, and why?

- 4) How much time is allocated to a rule 35 examination and write up? How much medical time is spent on this work per month
- 5) What training have IRC doctors had in identifying vulnerability, evidence of torture, traumatising, trafficking, FGM etc?

52. Audit 2 - Rule 35 and IS 91 RA processes:

- 1) The initial and subsequent audits should examine:
 - a) How much time is devoted per case to Rule 35 examinations and investigations
 - b) Whether appropriate interpreters are used when needed
 - c) The views of IRC doctors on their training for and experience of the Rule 35 process.
 - d) The views of detainees of their experience of Rule 35 examinations.
 - e) The effects of doctor-patient relationships of negative decisions communicated to detainees and their doctors.
- 2) This audit (A2a) be conducted by doctors and nurses independent of the detention estate, under appointment and direction by HMIP.
- 3) The audit be conducted using a template of specific questions capable of categorical answers (plus space for free text). It could be based on the paragraphs above about **Rule 35 in theory**.
- 4) The results of this first audit be communicated to the responsible doctors and healthcare managers within NHS England and service providers, and that methods and significant findings are published as a special thematic report by the Inspectorate.
- 5) Improvements, as indicated by A2a, are designed (with the participation of independent and IRC clinicians) and implemented by IRC healthcare providers. It is essential that the modified procedures can be carried out within resources of time and skills available, and that where necessary these are enhanced.
- 6) A second audit (A2b) is conducted jointly at an agreed time (perhaps six months thereafter) by independent and IRC clinicians to identify areas where there has been or still needs to be improvement.
- 7) Further audits (A2c-n) are conducted by IRC clinicians using an agreed template (with such assistance as they may request) at appropriate intervals. The involvement of these clinicians will involve significant costs in time, which would have to be contractually recognised, remunerated and protected. However, if only because of the costs of compensation for wrongful detention for this is an investment which would save money if properly instituted.
- 8) In parallel, HMIP instruct suitable auditors (perhaps UNRA QIP) to analyse the reasons given by UKVI for non-release of adults who have been or should have been recognised as vulnerable on the basis of a Rule 35 report which was or should have been written. In particular those audits should include standards that:

- a) lay people should not make clinical judgements substituting their lack of medical qualifications for evidence supplied by a doctor.
- b) the confusion between vulnerability and evidence be removed from Home Office policy, such that properly written up Rule 35 reports are accorded a proper status as evidence of risk, and that information missing from such reports is sought when needed,
- c) decisions should not rest on what the doctor “did not say”. It should not be a requirement that the doctor state (on separate forms) **both** that the person is being or is likely to be harmed by detention **and** that the rapporteur expresses medical concerns that the person may be a victim of torture per the definition in EO.

XV. Authorship and competing interests

It is standard policy in medical publications for authors to declare their competing interests so that readers can assess the extent to which the views expressed may be influenced by dual or multiple loyalties. As lead author, Frank Arnold does so below.

The many doctors and others who contributed to the present submission also work with other charities (Helen Bamber Foundation, Freedom from Torture, detention visitors’ groups) which are presenting their own views on the administrative detention of vulnerable people. As individuals these consultants are not identified as “authors” here for a simple reason. There are no major differences between the experiences of those other charities with whom these consultants also work and those of Medact, other than perhaps of emphasis. (Medact is more “medical”, as opposed to “social” or “legal” in our approach, as befits our remit.)

But these other charities will be producing statements of their own. In the time available it is impossible to cross-check the multiple documents the review will be considering from each of them. Their members are therefore unable to speak simultaneously for the several organisations to which they owe a duty of consistency.

Author’s Competing Interests

Dr. Frank Arnold is a trustee of Medact, and a director of Forrest Medico-Legal Services (www.forrestmls.org), a not for profit community interest company. He has examined many hundreds of detainees and ex-detainees, and – when this is available – is paid under Legal Aid for some of his work. His short curriculum vitae, as appended to every medico-legal report he produces for the courts, is available on request, via arnold_frank@hotmail.com

About Medact

Medact is an organisation of doctors, nurses and other clinical professionals. Our expertise lies in investigating and analysing evidence of the social and environmental factors which adversely affect health. We provided a statement to your earlier enquiry. In the attached submission we have taken an explicitly clinical approach to the detention of vulnerable individuals.