INTRODUCTION TO IMMIGRATION DETENTION IN THE UK

BRIEFING 3: WHAT HARM IS CAUSED BY IMMIGRATION DETENTION?

Home Office safeguards in detention are dysfunctional and fail to identify and protect vulnerable individuals. This contributes to shocking levels of health deterioration, self-harm, suicidality and inhuman and degrading treatment in the immigration detention system. Since 2000, there have been more than 50 deaths in detention, 30 of which were self-inflicted.[1]

WHY ARE PEOPLE IN DETENTION AT RISK?

There is a high prevalence of mental health conditions amongst detained people,[2] along with histories of torture, trafficking and other trauma.[3] Mental health conditions include depression, anxiety and post-traumatic stress disorder. These have been found to be around twice as prevalent among detained refugees and migrants, as compared with the same groups when not detained.[4]

Immigration detention compounds these vulnerabilities. People in detention have described a range of contributing factors, including fear for their safety, the prison-like environment in Immigration Removal Centres (IRCs), feelings of criminalisation, and experiences of physical and verbal abuse. All of these contribute to experiences of loss of agency, entrapment and feelings of hopelessness.[5] In addition, the indefinite nature of detention and detained individuals' uncertain legal status exacerbate this harm (see Briefing 2 in this series). Unmet medical needs, language barriers and isolation can all add to, and further complicate, deteriorating health.

The Royal College of Psychiatrists' 2021 position statement on the detention of people with mental disorders concludes that being detained in an IRC is likely to cause a significant deterioration of mental health in most cases.[6] Detention can also act as a causal factor in the onset of new mental health problems in people who were previously well,[7] and it has been found that the "only efficient way to improve… detainees' mental health is to release them from detention".[8]

WHAT SAFEGUARDS EXIST IN DETENTION?

Certain statutory safeguards are intended to identify people particularly vulnerable to harm in detention:

Rule 34 of the Detention Centre Rules 2001: Detained people must be given a physical and mental examination by a medical practitioner within 24 hours of admission to an IRC, provided they consent.[9]

Rule 35 of the Detention Centre Rules 2001: Medical practitioners in IRCs have a legal duty to report safeguarding concerns about people who: 1) are likely to be harmed by detention; (2) who are suspected of having suicidal intentions; (3) who may have been a victim of torture. These reports should trigger the Home Office to urgently review a person's detention, which may or may not lead to release.[10]

Adults at Risk in Immigration Detention Statutory Guidance (AAR SG): The Home Office's detention review decision is taken in accordance with the AAR SG. This provides that vulnerable adults at particular risk of harm in detention should not normally be detained and can only be detained when "immigration factors" outweighs the presumption to release.[11] [12] [13]

Other relevant processes include: the Detention Gatekeeper (a Home Office team that reviews the suitability of individuals for detention prior to them being detained);[14] Case Progression Panels (which review a person's detention every 3 months, and evaluates the progression of their case);[15] and Assessment Care in Detention and Teamwork (ACDT) (a process to manage detained individuals at risk of self-harm or suicide).[16]

This is the third of five briefings introducing the law, policy and practice of immigration detention in the United Kingdom. The briefings have been produced by Detention Action, Bail for Immigration Detainees and Medical Justice, with assistance from the Immigration Law Practitioners' Association. The briefings are current as of 15 October 2024. Please share and adapt these briefings as you see fit. Any queries or feedback may be directed to: admin@detentionaction.org.uk, enquiries@biduk.org or info@medicaljustice.org.uk.

HOW ARE SAFEGUARDS FAILING?

In reality, the statutory safeguards and mechanisms listed above have serious, long-standing flaws, are poorly operated, and often fail to identify a detained person's vulnerability or lead to their release. The problems are so serious that the recent Brook House Inquiry[17] "found the entire [detention] safeguarding system in a number of areas to be dysfunctional."[18]

As an example, medical examinations under Rule 34 are often inadequate, delayed or too short for sufficient investigation of mental and physical conditions, missing key opportunities to identify people at risk.[19] The Home Office does not include Rule 34 data in its official statistics. However, in research conducted by Medical Justice more than 45% of the cases analysed did not see a GP within 24 hours of arrival at an IRC as required by law.[20]

Case Study 1: Medical Justice client Edward is a torture and trafficking survivor. He suffers from suspected complex PTSD. When he entered detention, Edward had a history of self-harm and suicide attempts, including in prison. However, his healthcare screening recorded "no history of deliberate self-harm in a secure estate". Edward saw the IRC GP for his Rule 34 appointment, who noted "no mental health issues identified" in the medical records. One week after he was detained, Edward took an overdose of medication with the intention to take his own life.[21]

There are also serious problems with the Rule 35 process. Virtually no Rule 35 reports identifying concerns about suicidal intention are completed, despite Home Office data showing significant numbers of people in detention at risk of suicide and self-harm.[22] Research has also shown that reports are rarely issued for those likely to be harmed by detention.[23] Even when issued, the quality of Rule 35 reports is often poor, including failures to investigate and document relevant symptoms properly or even at all.[24] The Home Office often misses the required deadline for responding to a report, in some cases by weeks or more.

Case Study 2: Medical Justice client 'Aaron' is a trafficking and torture survivor with significant trauma-related symptoms and depression. He was detained and saw an IRC doctor, who prescribed him medication and referred him to the mental health team for an urgent assessment as he was "expressing suicidal thoughts".

However, the doctor failed to complete a Rule 35 (2) report for Aaron. As a result, the Home Office was not made aware of his suicide risk in detention and did not consider Aaron's vulnerability or consider his release under the Adults at Risk Policy. After Medical Justice's clinician assessed Aaron in detention, they came to the conclusion that detention had already caused Aaron significant harm.[25]

Recent revisions to the AAR policy have reduced the already inadequate protections for vulnerable people.[26] The changes include removing a statutory commitment to reducing the number of vulnerable people in detention. The Home Office decision is often to maintain a person's detention, despite evidence of their vulnerability,[27] meaning they are left to languish in detention, suffering further deterioration and harm as a result. Detained people who, through mental ill-health or impairment, lack mental capacity to make certain decisions are at particular risk of suffering serious harm. Important safeguards that exist elsewhere for such people, such as independent mental capacity advocates, are not provided in detention.[28]

WHAT HARM IS CAUSED BY FAILING SAFEGUARDS?

As result of failing safeguards, people in detention are at risk of deterioration in their health, including high levels of self-harm and suicidality. Recently, independent inspectors at Harmondsworth IRC reported that 48% of people they surveyed at the IRC said they had felt suicidal during their detention, with numerous serious suicide attempts taking place including during the inspection visit itself, poor self-harm prevention work, and a known ligature point left in place despite being used in three previous suicide attempts.[29]

The inspectors described conditions at the centre as "the worst" they had ever documented in detention. Last year, detention centre staff documented an "attempted mass suicide" after a man died at Colnbrook IRC, reportedly by suicide, while another man died following a suicide attempt at Brook House IRC.[30]

Failures in the statutory safeguards also contribute to mistreatment and risk of human rights violations in detention. Article 3 of the European Convention on Human Rights prohibits torture and inhuman and degrading treatment. The 2023 report of the Brook House Inquiry found evidence of 19 credible breaches of Article 3 at Brook House IRC within a 5-month period in 2017. The Inquiry found extremely serious failings across all areas of its investigation, including in the safeguarding of vulnerable people, healthcare, segregation, and the use of force, and identified a "toxic culture" amongst staff. The Inquiry also raised concerns about the government's repeated failure to learn lessons on detention, describing it as a "dark thread" running throughout the Inquiry's final report. Crucially, it also exposed how many of the practices which led to those abuses still continue today across the detention system.[31]

The consequences of these failures can be extremely serious. Inquests have found that neglect has contributed to deaths in detention. In one instance, a man died after six days in detention, held in a segregation cell, naked and emaciated, having suffered psychosis, dehydration, malnourishment and hypothermia. He had received no medical treatment whatsoever.[32]

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1. 'Deaths of immigration detainees', INQUEST (2 January 2024)
2. Verhülsdonk, I., Shahab, M., & Molendijk, M. (2021) "Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-analysis", BJPsych Open, 7(6)
3. Medical Justice, 'If he dies, he dies': What has changed since the Brook House Inquiry? (2023); Helen Bamber Foundation et al, Abuse by the system: survivors of trafficking in immigration detention (2022)
4. Verhülsdonk, I., Shahab, M., & Molendijk, M. (2021) "Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-analysis", BJPsych Open, 7(6)
5. Medical Justice, 'If he dies, he dies': What has changed since the Brook House Inquiry? (2023)
6. Royal College of Psychiatrists, Position Statement: Detention of people with mental disorders in immigration removal centres (IRCs) PS02/21,3.
7. Medical Justice, 'If he dies, he dies': What has changed since the Brook House Inquiry? (2023)
8. Verhülsdonk, I., Shahab, M., & Molendijk, M. (2021) "Prevalence of Psychiatric Disorders Among Refugees and Migrants in Immigration Detention: Systematic Review with Meta-analysis", BJPsych Open, 7(6)
9. Rule 34 of the Detention Centre Rules 2001
10. Rule 35 of the Detention Centre Rules 2001
11. Home Office (2024) Adults at risk in immigration detention: Statutory Guidance, updated 21 (May 2024)
12. Per the AAR SG, this includes: people with mental health difficulties and physical disabilities; victims of torture and trafficking; victims of gender-based violence; transgender and intersex people, pregnant women; and those over the age of 70 years old. Home Office (2024) Adults at risk in immigration detention: Statutory Guidance, updated 21 May 2024, para 13
13. 'Immigration control factors' is defined widely and can include compliance issues such as having failed to agree to voluntary return, or previous failure to comply with immigration bail conditions, restrictions on release from detention and conditions of temporary admission.
14. Home Office (2022) Guidance: Management of adults at risk in immigration, updated 13 December 2022, para 26
15. Home Office (2023) Guidance: Detention Case Progression Panels version 8.0
16. Home Office (2022) Assessment care in detention and teamwork (ACDT): detention services order 01/2022.
17. The Brook House Inquiry was a statutory inquiry established to investigate the mistreatment of individuals detained at Brook House Immigration Removal Centre (IRC) in 2017, as revealed by undercover BBC reporting. Its report was published in September 2023.
18. Brook House Inquiry (2023) Report of the Brook House Inquiry Volume 1, 9
19. Medical Justice (2023) 'If he dies, he dies': What has changed since the Brook House Inquiry?, 29-31
20. Medical Justice (2023) 'If he dies, he dies': What has changed since the Brook House Inquiry?. The report analysed aggregate data from 66 detained people who had a medico-legal assessment by a Medical Justice clinician between 1 June 2022 and 27 March 2023 in an IRC.
21. Medical Justice (2023) 'If he dies, he dies': What has changed since the Brook House Inquiry?, 33
22. For example, Home Office statistics show that just three such reports were issued by GPs at Brook House IRC, throughout the whole of 2023. See Immigration Enforcement data: Q1 2024, Table DT_03. By comparison, Home Office data obtained by Medical Justice via Freedom of Information (FOI) requests reveals that during the same 12-month period, 121 self-harm incidents were recorded at the centre, and 240 new Assessment Care in Detention and Teamwork (ACDT) processes (used to manage people in detention who have been identified by Home Office / IRC staff as at risk of suicide or self-harm) were opened. FOI request and responses available from Medical Justice upon request.
23. Medical Justice (2023) 'If he dies, he dies': What has changed since the Brook House Inquiry?, 33
24. Medical Justice (2022) Harmed Not Heard, 34.
25. Medical Justice (2023) 'If he dies, he dies': What has changed since the Brook House Inquiry
26. See Medical Justice et al (2024) Briefing on the revised Adults at Risk in Immigration Detention Statutory Guidance
27. Medical Justice (2023) 'If he dies, he dies': What has changed since the Brook House Inquiry?, 33-42
28. Brook House Inquiry (2023) Report of the Brook House Inquiry Volume 2, 207
29. "Harmondsworth Immigration Removal Centre: drugs, despair and decrepit conditions", HM Inspectorate of Prisons (9 July 2024); HMIP (2024)
30. Report on an unannounced inspection of Harmondsworth Immigration Removal Centre, 5, 11, 18
31. Brook House Inquiry (2023) Report of the Brook House Inquiry Volume 2, 12, 257-261
32. 'Jury concludes neglect and gross failures contributed to the death of Prince Fosu in immigration detention' INQUEST (2 March 2020)