

Adults at Risk: the ongoing struggle for vulnerable adults in detention

An evaluation of the 'Adults at Risk' policy in practice

Evidence from BID's casework

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Jeremiah

Whilst we were in the process of finalising this report, we were informed that a former client, Jeremiah*, had been re-detained in an IRC by the Home Office in order to attend an interview. Jeremiah was first detained under immigration powers in September 2016, at the same time the Adults at Risk policy was first introduced. He is a highly vulnerable torture survivor. Jeremiah's health deteriorated in detention to such a degree that he tried to commit suicide on a number of occasions. Following his third attempt, he was placed under 24-hour suicide watch for three months. Jeremiah was confined to a room by himself, with an officer constantly watching him. He only left his room a handful of times over three months. The Home Office made an assessment under the Adults at Risk policy, and decided to maintain Jeremiah's detention. In the written Adults at Risk response, the Home Office stated: "you are the origin of this decline and... the increased isolation that you feel is an unintended consequence of your current behaviour". This traumatising period of detention only came to an end when Jeremiah was released on bail by the High Court, after nearly a year in detention.

As we write, Jeremiah is locked up once more, the Adults at Risk policy having failed him again.

*name changed

Executive Summary

The Adults at Risk (“AAR”) policy was introduced by the Home Office in September 2016 to address the many failings identified by Stephen Shaw’s review of the welfare of vulnerable people in detention. The government’s AAR policy response aimed to “lead to a reduction in the number of vulnerable people detained and a reduction in the duration of detention before removal.”¹ This research examined the operation of the new AAR policy and found that the policy fails to achieve its stated aims. The number of vulnerable people detained remains unacceptably high and Home Office decision makers are routinely failing to identify and respond to worrying cases of vulnerability. BID considers that there are serious problems with both the design and the implementation of the AAR policy. We outline a number of problems relating to the structure of the AAR policy in part 1 of the report, which sets out how the new AAR policy works. The structural problems identified are expanded upon in our findings, along with concerns about its implementation. Part 1 of the report also frames the scope of the research and the methods chosen.

The study consisted of an analysis of 30 of BID’s detained casework files (our methodology is set out in part 2). All the cases examined involved an indicator of vulnerability that should have triggered the application of the AAR policy. There were two separate sample groups - an IRC sample and a prison sample - to highlight the differences in the application of the AAR policy in prisons and in IRCs.

Key Findings

Vulnerable adults are being detained inappropriately for long periods of time in both IRCs and prisons, both before and after assessments take place under the AAR policy (sections 3.2, 3.3, 3.4 and 4.2). The key findings in relation to the IRC sample (detailed in Part 3, Findings A) were:

- The gatekeeper process is failing to identify vulnerabilities prior to detention (section 3.1).
- Initial medical assessments in IRCs under Detention Centre Rule 34 are not leading to assessments under the AAR policy even where indicators of vulnerability are identified (section 3.3.1). The ongoing assessment process is also failing to trigger AAR assessments (section 3.3.2).
- Medical practitioners as well as Home Office decision makers are failing to consider certain indicators of vulnerability under the AAR policy, particularly those that do not fit within the definition of torture (section 3.3.3).
- Level 3 risk is rarely designated even in the case of the most vulnerable of clients. This can be attributed to policy design as considered in Part 1.3 and 1.4, but also

¹ James Brokenshire, Minister of State for Immigration, HC Deb 14 January 2016 HCWS470
<<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-01-14/HCWS470>>

implementation through inadequate completion of rule 35 reports; the structure of the rule 35(3) template and Home Office responses to rule 35 reports (section 3.4.1, 3.4.2 and 3.4.3).

- The quality of evidence available of risk is conflated with actual risk by Home Office decision makers (sections 1.3 and 3.4.4).
- The balancing of well-being against immigration control factors is a superficial exercise (section 3.4.5). In this regard we found that:
 - Home Office decision-makers consistently provided inaccurate removal predictions to justify maintaining detention; and
 - Home Office decision-makers relied upon public protection concerns without meaningfully considering the particular facts at hand. Previous offending tended to automatically outweigh any well-being concerns, regardless of the seriousness of the offending or the risk to the detainee's health if detention was maintained.
- Contrary to Shaw's recommendation, vulnerability was treated as fixed rather than dynamic. Once Home Office decision-makers had decided to maintain a detainee's detention following an AAR assessment, the issue was not meaningfully revisited, even where there was a change in the client's health. This was also so for the immigration control factors which had been used to justify detention. When immigration control factors changed (such as where new barriers to removal emerged) this did not trigger another AAR assessment (section 3.4.6).

The key findings in relation to the prison sample (detailed in Part 4, Findings B) were:

- The detainees held in prisons were some of the most vulnerable in the study and suffered from a number of different and complex conditions.
- There was no equivalent rule 35 mechanism which was capable of triggering an AAR assessment.
- Even where there was independent evidence of an indicator of risk and evidence that detention was having an injurious impact on the detainee's health, Home Office decision-makers generally failed to apply the AAR policy (6 of the 7 cases). Furthermore, in the one case within the sample where the detainee was categorised as level 2 risk under the AAR policy, the AAR was only applied partially. The appropriateness of their continued detention was not considered.

Recommendations

While detention continues to be used for immigration purposes, BID makes the following recommendations (in Part 5):

1. The categorisation of vulnerability based on evidence levels should cease. There should be a very low threshold required to demonstrate that an individual exhibits an indicator of vulnerability.
2. Once an indicator of vulnerability has been identified, the Home Office should not detain the individual or should release the individual from detention if they are

already detained. It is unacceptable that release should be predicated on whether or not the individual is likely to suffer future harm in detention.

3. Individuals' wellbeing should take primacy over immigration enforcement or control interests of the Home Office.
4. The current indicators of vulnerability - "torture" and "victims of sexual or gender-based violence" - should be replaced with a more inclusive category based on the UNHCR detention guidelines, namely "victims of torture or other serious, physical, psychological, sexual or gender-based violence or ill-treatment".
5. The detention gatekeeper should be required to make reasonable investigations prior to detention to confirm that an individual does not exhibit an indicator of vulnerability.
6. There should be judicial oversight of all decisions to detain with vulnerability central to an assessment of the overall necessity of detention.
7. Home Office decision-makers should undertake regular, meaningful reviews of decisions to detain, which take into account vulnerability and its dynamic nature. Reviews should occur regularly through monthly progress reviews, but also whenever circumstances change. Home Office internal monthly reviews and Gatekeeper reviews of suitability or maintenance of detention should always be disclosed to detainees and their representatives.
8. Medical practitioners and Home Office staff should receive comprehensive training regarding the identification of indicators of vulnerability (including staff and practitioners who operate within prisons).
9. While prisons continue to be used for immigration detention, there should be equivalent regimes applied in prisons to those held there under immigration powers as apply to those in IRCs.

Preface

About BID

BID is an independent national charity established in 1999 to challenge immigration detention and to increase access to justice for immigration detainees facing deportation. We believe that asylum seekers and migrants in the UK have a right to liberty and access to justice and should not be subjected to immigration detention. We assist those held under immigration powers in removal centres and prisons to secure their release from detention through the provision of free legal advice, information and representation. Alongside our legal casework, we engage in research, policy advocacy and strategic litigation to secure change in detention policy and practice. Since 2014 we have also provided legal advice, information and representation to time-served foreign national prisoners, many with British partners and children who are facing deportation despite long-term residence in the UK, and for whom there is no legal aid. In the last 12 months, BID provided support to 5,840 people.

BID regularly assists detainees who come under the ambit of the Home Office's AAR policy, in particular victims of torture, modern slavery victims and/or human trafficking, as well as those who suffer from serious mental and physical health conditions. It should be noted that while this report will discuss health conditions, BID is a legal charity rather than a specialist healthcare organisation. The report will therefore focus on Home Office decision-making and the application of policy in relation to vulnerable detainees.

Immigration detention in the UK

Any individual subject to immigration control can be detained. Nevertheless, according to Home Office policy, there exists a presumption in favour of liberty and, wherever possible, alternatives to detention should be used.² Despite this presumption, BID's experience is that detention is used as a first rather than a last resort. Decisions to detain are taken by an immigration officer and there is no judicial oversight of such decisions.

Although there is no time limit on immigration detention, it can only be lawfully used for the purpose of effecting individuals' removal from the UK or to establish an individual's right to be in the UK. The 1983 case of *Hardial Singh* set out basic limits on the power to detain, which can be summarised as follows and are known as the "Hardial Singh principles"³:

1. The SSHD must intend to remove the individual and can only detain an individual for the purpose of removal;

² Chapter 55, *Enforcement Instructions and Guidance* which forms part of the *Offender Management Guidance* (published 27 April 2016)

³ *R (Hardial Singh) v Governor of Durham Prison* [1983] EWHC 1 (QB)

2. Individuals may only be detained for a period that is reasonable, based on all the circumstances;
3. If it becomes apparent that the SSHD will not be able to effect removal before a reasonable period ends, the SSHD should release the individual; and
4. The SSHD should act with reasonable diligence and expedition in order to effect removal.⁴

The Home Office's AAR policy is designed to provide additional protections for vulnerable individuals over and above the Hardial Singh principles, in order to reduce the number of vulnerable people in detention. It is therefore important to bear in mind these overarching principles which apply to all immigration detainees when considering the approach taken to vulnerable adults subject to immigration control.

According to the AAR policy, "vulnerable" individuals are defined as those who exhibit one of the following risk indicators: mental health condition or impairment; post-traumatic stress disorder (PTSD); pregnancy, serious physical disability or other serious physical health condition or illness; old age (70 years +); transsexual or intersex; or victim of torture, sexual or gender-based violence, female genital mutilation (FGM); human trafficking or modern slavery⁵ (see section 1.3 below).

While this report focuses on the detention of these vulnerable individuals and the quality of Home Office decision-making in these cases, it is our position that no individual should be held in immigration detention. The detention process itself renders every individual vulnerable to harm; as Shaw notes, "vulnerability is intrinsic to the very fact of detention"⁶. Studies have consistently demonstrated the negative impact of immigration detention on the mental health of detainees.⁷ Detainees experience loss of liberty, social isolation, uncertainty about their future, lack of agency and poor healthcare. There is no denying that the characteristics of immigration detention can work to re-traumatise those who have suffered from trauma in their past. Such damage is well- documented and informs the AAR policy. However, the environment of immigration detention can also lead to mental illness

⁴ R (Hardial Singh) v Governor of Durham Prison [1983] EWHC 1 (QB)

⁵ This list is not exhaustive. The guidance allows case workers to consider other conditions which may render an individual particularly vulnerable under the Adults at Risk policy.

⁶ Stephen Shaw, Report to the Home Office, "Review into the welfare in detention of vulnerable persons" (January, 2016), p.8.

⁷ See: Mary Bosworth, "Appendix 5: the Mental Health Literature Survey Sub-Review" in Stephen Shaw, Report to the Home Office, "Review into the welfare in detention of vulnerable persons" (January, 2016); Guy Coffey, Ida Kaplan, Robyn Sampson, Maria Montagna, "The meaning and mental health consequences of long-term immigration detention for people seeking asylum," *Social Science & Medicine* 70 (2010) 2070-2079; Pauline McLoughlin, Megan Warin, "Corrosive places, inhuman spaces: Mental health in Australian immigration detention," *Health & Place* 14 (2008) 254-264; Katy Robjant, Rita Hassan; Cornelius Katona, "Mental health implications of detaining asylum seekers: systematic review, *The British Journal of Psychiatry*" (2009)194, 306-312; Medical Justice, "Mental Health in Immigration Detention Action Group: Initial Report 2013" (2013).

in previously healthy people. The negative effects of immigration detention on detainees and their families endure long after a person is released from confinement. Furthermore, while longer periods of detention do increase the risk of harm, research has demonstrated that short periods in detention can also have an adverse impact on individuals' mental health.⁸ Even the instance of immigration arrest before detention can cause harm.

1. The Adults at Risk policy

1.1 Policy prior to 2016

Prior to the new AAR policy, vulnerable adults were covered by policy set out in Section 55.10 of the Home Office's Enforcement Instructions and Guidance ("EIG"). According to this policy, anyone suffering from serious mental health conditions that could not be "satisfactorily managed" within detention should only be detained in "very exceptional circumstances". The onus was on the Home Office to demonstrate that there were very exceptional circumstances which justified detention and the courts had held there was a very high threshold for proving very exceptional circumstances.

Stephen Shaw's independent review into the welfare of vulnerable persons in detention, published in January 2016, highlighted serious failings in the implementation of this policy. The review found that many vulnerable detainees were being detained for long periods of time at significant cost to their wellbeing.⁹ The report recommended that pregnant women be excluded from detention as well as a presumption against the detention of victims of rape, other sexual or gender-based violence and female genital mutilation, transgender people, those suffering from post-traumatic stress disorder, and people with learning difficulties. Shaw also emphasised that the dynamic nature of vulnerability should be recognised by Home Office policy and recommended that the Home Office consider strengthening legal safeguards in order to address excessive lengths of detention.¹⁰

1.2 The Adults at Risk policy framework

The Government implemented the current AAR policy in response to Shaw's report (a flowchart of the legal framework can be found at Appendix 1). The AAR Statutory Guidance ("AARSG") was introduced by negative resolution pursuant to section 59 of the Immigration

⁸ For instance, Cleveland and Rousseau (2013) compared the mental health of 122 detained asylum seekers with 66 non-detained asylum seekers. A greater proportion of those in detention scored above the clinical cutoff for PTSD, depression and anxiety than those in the community. The median time respondents had been in detention when they answered the questionnaire was 18 days, with 94 percent of the sample held for less than 2 months. The study indicated that even a brief period of detention adversely affected mental health outcomes ("Psychiatric symptoms associated with brief detention of adult asylum seekers in Canada," The Canadian Journal of Psychiatry. 58(7): 409-416).

⁹ Stephen Shaw, Report to the Home Office, "Review into the welfare in detention of vulnerable persons" (January, 2016)

¹⁰ Ibid.

Act 2016.¹¹ In addition to the AARSG, the Home Office published guidance for its caseworkers, entitled “Adults at risk in immigration detention” guidance (“**AAR caseworker guidance**”).¹² The AAR caseworker guidance forms part of the broader Offender Management Guidance “for officers dealing with enforcement immigration matters within the UK” (“**Offender Management Guidance**”).¹³ The Offender Management Guidance also contains chapter 55 of the EIG which refers to the AAR policy throughout.¹⁴

It is important to note that the AARSG, the AAR caseworker guidance and the EIG apply to *all* immigration detainees held in both prisons and IRCs.¹⁵ There are, however, various AAR policies and procedures that apply only in IRCs. Home Office staff and IRC staff must follow various procedures set out in Detention Services Orders (“**DSOs**”) which engage the AAR policy, such as: DSO 08/2016 Management of Adults at Risk in Immigration Detention February 2017¹⁶; DSO 09/2016 Detention centre rule 35¹⁷; and DSO 05/2016 Care and Management of Pregnant Women in Detention¹⁸. Like the Detention Centre Rules, DSOs do not apply in prisons.

1.3 Policy design: how the AAR policy works

The AARSG was developed in direct response to Shaw’s report. The AARSG states that it:

“aims to introduce a more holistic approach to the consideration of individual circumstances, ensuring that genuine cases of vulnerability are consistently identified, in order to ensure that vulnerable people are not detained inappropriately. The guidance aims to strike the right balance between protecting the vulnerable and ensuring the maintenance of legitimate immigration control”

According to the policy, an individual will be regarded as an adult at risk if: (a) they declare that they are suffering from one of the indicators of risk; or (b) if those considering or reviewing detention are aware of medical or other professional evidence, or observational evidence of an indicator of risk.¹⁹ (A summary of the policy is at Appendix 1.) The indicators of risk are set out in the AARSG, as those who:-

¹¹ *Adults at Risk Statutory Guidance August 2016 (SI 18081601 08/16)*

¹² *Adults at risk in immigration detention guidance* (v.2, 6 December 2016) which forms part of the *Offender Management Guidance* (published 27 April 2016)

¹³ *Offender Management Guidance* (published 27 April 2016)

¹⁴ Chapter 55, *Enforcement Instructions and Guidance* which forms part of the *Offender Management Guidance* (published 27 April 2016)

¹⁵ NB. The AAR caseworker guidance includes a section on the rule 35 process which only applies in IRCs.

¹⁶ *DSO 08/2016 Management of Adults at Risk in Immigration Detention* (v.1, 27 February 2017)

¹⁷ *DSO 09/2016 Detention centre rule 35* (v.4, 6 December 2016)

¹⁸ *DSO 05/2016 Care and Management of Pregnant Women in Detention* (v. 2, November 2016)

¹⁹ *Adults at Risk Statutory Guidance August 2016 (SI 18081601 08/16)*

- are suffering from a mental health condition or impairment (this may include more serious learning difficulties, psychiatric illness or clinical depression, depending on the nature and seriousness of the condition);
- have been victims of torture;²⁰
- have been a victim of sexual or gender-based violence, including female genital mutilation
- have been a victim of human trafficking or modern slavery;
- are suffering from post-traumatic stress disorder (which may or may not be related to one of the above experiences);
- are pregnant (pregnant women will automatically be regarded as meeting level 3 evidence);
- are suffering from a serious physical disability;
- are suffering from other serious physical health conditions or illnesses;
- are aged 70 or over; and
- are transsexual or intersex.

The guidance also allows caseworkers to consider other unforeseen conditions which may render an individual particularly vulnerable under the Adults at Risk policy.²¹

The new AAR policy introduced a risk level system based on the amount of independent evidence available to demonstrate the risk. Under this system, once an individual has been identified as exhibiting an indicator of risk, the decision maker must make a consideration of the level of evidence of the risk that is available, and make an assessment of the likely risk of harm to the individual if detention is maintained for the period for which it is necessary to effect their removal. The three levels of evidence, as set out in the policy, are:

1. Level 1: “a self-declaration of being an adult at risk - should be afforded limited weight, even if the issues raised cannot be readily confirmed.”²²
2. Level 2: “professional evidence (e.g. from a social worker, medical practitioner or NGO), or official documentary evidence, which indicates that the individual is an adult at risk - should be afforded greater weight.”²³
3. Level 3: “professional evidence (e.g. from a social worker, medical practitioner or NGO) stating that the individual is at risk and that a period of detention would be likely to cause harm – for example, increase the severity of the symptoms or

²⁰ The definition of torture has been the subject of legal challenge and has changed during the course of the AAR policy. Please refer to appendix 3 for a discussion of these challenges and changes.

²¹ Paragraph 12 Adults at Risk Statutory Guidance August 2016 (SI 18081601 08/16)

Note that the wording of paragraph has been slightly amended in the revised Adults at Risk Statutory Guidance published 2 July 2018.

²² Adults at Risk Statutory Guidance August 2016 (SI 18081601 08/16)

²³ Ibid.

condition that have led to the individual being regarded as an adult at risk – should be afforded significant weight.”²⁴

From the outset, BID made clear its objections to this approach. The categorisation of risk in this way inappropriately focuses on the quality of evidence available of risk rather than the actual risk to the person. This is so even though many types of vulnerability are not readily verifiable with evidence; the AARSG states that level 1 should be afforded limited weight, *even if* the issues raised cannot be readily confirmed.²⁵

Disappointingly, the new AAR procedure was compromised further by the introduction of the immigration control factors exercise. After a decision maker is satisfied of the level of risk, instead of proving that there are “very exceptional circumstances” which nevertheless justify detention, the new AAR policy requires the decision maker to balance the risk factors against what are termed “**immigration control factors**”. This involves a highly problematic exercise of weighing the level of risk to the detainee’s well-being against an increased number of immigration control priorities, such as:

- **Length of detention/ imminence of removal.** (“the higher the level of risk to the individual ..., the shorter the length of detention that should be maintained.... In each case the length of likely detention will be a key factor in determining whether an individual should be detained.”²⁶)
- The individual’s **compliance history** (this includes consideration of: having failed to comply with attempts to effect voluntary return; having made a protection or human rights claim only after having been served with a negative immigration decision unless there is good reason for them to have delayed the claim; having previously absconded; having failed to comply with re-documentation processes.²⁷)
- any **public protection concerns** (this includes consideration of: criminal history; seriousness of offence/s; risk of harm to the public.²⁸)

The weight that decision makers should give to the immigration control factors varies depending on the level of risk assigned to the person. The immigration control factors should only outweigh level 3 evidence of risk where removal has been set for an immediate date and there are no barriers to removal, *or* where the individual represents a significant public protection concern.²⁹ This can be contrasted with level 2 evidence of risk, which can be outweighed by the individual’s immigration compliance history factors alone. The Immigration Law Practitioners Association (ILPA) has rightly pointed out that the protection provided under the AAR policy to those designated Level 1 or Level 2 amounts to much the

²⁴Ibid.

²⁵Ibid.

²⁶*Adults at risk in immigration detention guidance* (v.2, 6 December 2016)

²⁷Ibid.

²⁸Ibid.

²⁹Ibid.

same protection as that afforded by the Hardial Singh principles which apply to *all* immigration detainees.³⁰ There is already a presumption against detention for *all* immigration detainees, and a consideration of the likelihood of removal, compliance issues and public protection issues are considerations for all decisions to detain. On paper, the additional categorisation as level 2 at risk provides no clear additional protection, despite the existence of independent evidence of vulnerability.

Even less protection is provided to those who are deemed level 1 evidence of risk, as this acts at best as a flag of vulnerability within detention only. Level 3 evidence of risk is therefore the only designation that is capable of providing protection. The lack of protection afforded to individuals who are deemed level 1 and level 2 are fundamental flaws in the AAR policy design.

BID objected to the introduction of the new immigration control factors' balancing exercise from the outset. In a joint letter to the Guardian published 11 September 2016 with nine other NGOs, BID maintained that the new AAR policy "increases the burden of evidence on vulnerable people and balances vulnerability against a wider range of other factors. We fear this will lead to more vulnerable people being detained for longer."³¹ Unfortunately NGOs' misgivings proved well founded as vulnerable detainees remain in detention and detainees are on average being detained for longer than they were when the Shaw report was released.³²

1.4 The operation of the AAR policy in IRCs: evidence of risk

The framework for the management of individuals detained in IRCs is contained in the Detention Centre Rules which are implemented through DSOs. Though the rules pre-date the AAR policy, rule 34 and 35 of the Detention Centre Rules 2001 are particularly important for the operation of the policy in IRCs. Rule 34 states that "every detained person shall be given a physical and mental examination by the medical practitioner... within 24 hours of his admission to the detention centre", provided they consent. Rule 35 states medical practitioners shall prepare a report which is sent to the manager of the IRC and the SSHD "without delay" regarding any detained person:

³⁰ Submission of the Immigration Law Practitioners' Association (ILPA) to Stephen Shaw's Further Review into Immigration Detention (November 2017)

³¹ Schleicher, T., et al. (11 September 2016) "New immigration detention policy for 'adults at risk' needs urgent review", The Guardian, <<https://www.theguardian.com/society/2016/sep/11/new-immigration-detention-policy-for-adults-at-risk-needs-urgent-review>>

³² Home Office "Immigration Statistics, Detention tables Q1 2018", <<https://www.gov.uk/government/statistics/immigration-statistics-year-ending-march-2018-data-tables>> (24 May 2018); "Home Office Immigration Statistics, Immigration Enforcement Transparency Data Q1 2018", <<https://www.gov.uk/government/publications/immigration-enforcement-data-may-2018>> (24 May 2018).

- (1) whose **health is likely to be injuriously affected** by continued detention or any conditions of detention (**rule 35(1) report**);
- (2) who is suspected of having **suicidal intentions** (**rule 35(2) report**);
- (3) who may have been the **victim of torture** (**rule 35(3) report**).

A rule 35(1), (2) or (3) report constitutes independent evidence for the purposes of the assessment of the level of risk under the AAR policy (as is any medical report prepared by a medical practitioner). Though the rule 35 process predated the Shaw review, it was hoped that the new AAR policy would address issues that were identified by Shaw with the implementation of the rule 35 mechanism.

Disappointingly, since the implementation of the new AAR policy, there has not been an increase in the release of vulnerable detainees from detention following submission of rule 35 reports to the Home Office. Home Office official statistics show that rule 35 reports leading to the release of detainees peaked around the release of Shaw and have steadily declined since. In Q3 2016 prior to the introduction of the policy, 39% of those with a Rule 35 report were released.³³ Home Office statistics for Q1 2018 show that this has fallen to 12.5%.³⁴

This research sought to explore why this is so by closely examining rule 35 reports to consider how medical practitioners are communicating vulnerability to the Home Office, as well as analysing how the Home Office applies the AAR policy with such evidence at hand.

1.5 The operation of the AAR policy in prisons: evidence of risk

The AAR policy applies to all immigration detainees, whether they are held in IRCs or prisons.³⁵ Home Office figures show that as at 31 March 2018, there were 358 detainees held in the prison estate in England and Wales solely under immigration powers.³⁶ These detainees are often held in prisons for administrative convenience. Where a detainee is housed is a matter of discretion for the Home Office, and in BID's experience it appears to be largely a matter of chance. Notwithstanding this, those held in prisons are not protected by rule 34 or rule 35 processes, nor any other equivalent mechanisms which might identify and evidence their vulnerability and trigger an assessment under the AAR policy.

³³ Home Office "Immigration Statistics, Immigration Enforcement Transparency Data Q1 2018", <<https://www.gov.uk/government/publications/immigration-enforcement-data-may-2018>> (24 May 2018).

³⁴ Home Office "Immigration Statistics, Immigration Enforcement Transparency Data Q1 2018", <<https://www.gov.uk/government/publications/immigration-enforcement-data-may-2018>> (24 May 2018).

³⁵ Immigration Act 2016; Adults at Risk Statutory Guidance August 2016 (SI 18081601 08/16); Offender Management Guidance (published 27 April 2016).

³⁶ Home Office, "National Statistics: Summary of latest statistics", <<https://www.gov.uk/government/publications/immigration-statistics-year-ending-march-2018/summary-of-latest-statistics>> (24 May 2018).

Rule 21 of the Prison Rules provides that a prison governor report to the Secretary of State for Justice on any, “prisoner whose health is likely to be injuriously affected by continued imprisonment or any conditions of imprisonment”. Furthermore, as the HMIP has pointed out, there is no obligation for the governor to report to the Immigration Enforcement in the Home Office.³⁷ In addition rule 21 does not apply to those with suicidal ideation or those who have been victims of torture. Rule 21 is therefore not equivalent to rule 35. BID also questions whether detainees held under immigration powers are indeed prisoners for the purpose of the prison rules. Individuals held under immigration powers in prisons are not serving prisoners and they should not be treated as such.

Shaw’s review found the lack of safeguards for detainees held in prisons “unacceptable”, and recommended in his 2016 report “that rule 35 (or its replacement) should apply to those detainees held in prisons as well as those in IRCs”³⁸. This recommendation was not heeded by the Home Office and there remains no reporting mechanism for adults at risk in prison.

BID maintains that prisons should not be used for the purpose of immigration detention, but while this continues, an equivalent regime should operate in both IRCs and prisons in order to protect vulnerable detainees.

There is also no access to free legal advice surgeries in prisons, unlike in IRCs, and thus the detention of vulnerable people that runs contrary to the AAR policy is less likely to be reviewed by a lawyer and drawn to the attention of the Home Office or a court. In addition, detainees in prisons are also less likely to be able to find a legal aid lawyer to help them apply for bail. Automatic bail provisions do not apply to former offenders, and so their detention will not be subject to any judicial consideration unless a bail application or judicial review application is made.

In this study we looked at vulnerable individuals held in prisons separately from those held in IRCs to consider if and how detainees held in prisons are considered under the AAR policy.

1.6 New detention gatekeeper process

In response to Shaw’s 2016 report, a new “detention gatekeeper” system was also introduced as part of the new approach to adults at risk. The then Minister of State for

³⁷ Colin Carroll (HMIP inspector), HMIP, “A findings paper by the HMIP, People in prison: Immigration detainees” <<https://www.justiceinspectorates.gov.uk/hmiprison/wp-content/uploads/sites/4/2015/11/HMIP-Immigration-detainees-findings-paper-web-2015-1.pdf>> (November 2015).

³⁸ Stephen Shaw, Report to the Home Office, “Review into the welfare in detention of vulnerable persons” (January, 2016).

Immigration, Robert Goodwill MP advised that the “gatekeeper” was designed to “ensure that there is no evidence of vulnerability which would be exacerbated by detention, that return will occur within a reasonable timeframe and check that any proposed detention is lawful.”³⁹ According to James Brokenshire, this “rigorous” gatekeeper procedure would “ensure that the minimum possible time is spent in detention”⁴⁰.

The gatekeeper team considers proposed detention independently of the arresting team. Individuals can only enter immigration detention with the authority of the gatekeeper.

When the Home Office plans to detain an individual, the gatekeeper receives a referral from a Home Office arresting officer or staff member who seeks to detain the individual. The referral provides an opportunity to flag areas of concern about the detainee’s suitability for detention. The gatekeeper is also given access to the detainee’s online file, if one exists. The gatekeeper process is therefore internal within the Home Office. There is no investigative duty upon the gatekeeper to make reasonable inquiries prior to making a decision to detain. Decisions to detain are therefore often made on the basis of insufficient or incomplete information.⁴¹ Regrettably, there is also no opportunity for legal representatives *or indeed detainees themselves* to provide the gatekeeper with evidence of vulnerability, and the rule 34/rule 35 assessment processes can only occur once the individual has been detained.

What is more, often information that *is* on the Home Office file is not taken into account. Recent research conducted by Amnesty International UK found that more than half of the cases studied (16 of 28) involved decisions to detain without consideration of important information that was on the Home Office file, such as the individual’s travel documentation, or information concerning their family, health or history.⁴²

It should be noted we were unable to conduct an in-depth examination of gatekeeper decision-making in this study, as (unlike other Home Office decisions made under the AAR policy) in BID’s casework we do not come across evidence of the gatekeeper’s decisions on detainee’s bail files. BID considers that it would be reasonable and fair for such information, like all internal reviews of detention, to be readily disclosed to detainees and their representatives to allow for meaningful representations to be made and considered by the Home Office.

1.7 Ongoing assessment of risk in detention

³⁹ HC Deb 26 April 2017 71612 <<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-04-21/71612/>>

⁴⁰ HC Deb 14 January 2016 HCWS470 <<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-01-14/HCWS470>>

⁴¹ Amnesty International United Kingdom, “A matter of routine: the use of immigration detention in the UK” (December 2017)

⁴² Ibid.

The ongoing assessment of vulnerability is vital. Stephen Shaw's 2016 review argued that vulnerability should be understood as dynamic concept: "vulnerability is intrinsic to the very fact of detention, and an individual's degree of vulnerability is not constant but changes as circumstances change"⁴³. In recognition of this, the Home Office AAR caseworker guidance states:

"there should be an ongoing assessment of risk made by the case owner throughout the period of detention which will facilitate the identification of any emerging risk, or changes to known risk factors. Should any new risk factors emerge, or any existing risk factors change, there should be a formal review of the case, with a fresh consideration of the balance of risk factors against the immigration factors."⁴⁴

There are also case progression panels which are "peer-led" panels which review all immigration detention cases. According to Robert Goodwill MP, "[t]hese panels focus on ensuring that there is progression toward return for all individuals detained, and that detention remains lawful."⁴⁵

All immigration detainees (in both prisons and IRCs), must be provided with monthly progress reports which usually provide details of the detainee's immigration history, the progress of their immigration case, and also an up-to-date review of why detention is still deemed necessary. Monthly progress reports should provide a good opportunity to review Home Office ongoing decision-making and the reasons which are used to justify the maintenance of detention before and after vulnerability has been identified. Our study therefore analysed monthly progress reports to consider Home Office decision makers' ongoing assessments of risk.

⁴³ Stephen Shaw, Report to the Home Office, "Review into the welfare in detention of vulnerable persons" (January, 2016) p.8.

⁴⁴ *Adults at risk in immigration detention guidance* (v.2, 6 December 2016)

⁴⁵ HC Deb 26 April 2017 71612 <<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-04-21/71612/>>

2. Methodology

2.1 Sampling

This study involved 30 cases in total. Within this, there were two separate sample groups:

- The **IRC sample** consisted of 23 cases of BID clients detained under immigration powers in IRCs. Individuals in the sample were detained at the following IRCs: Brook House (n= 4); Campsfield (n= 1); Colnbrook (n= 4); Harmondsworth (n= 6); Morton Hall (n= 1); the Verne (n=1); Yarl's Wood (n= 6).*
- The **prison sample** consisted of seven cases of BID clients detained under immigration powers in prisons. Individuals in the sample were detained in the following prisons: HMP Birmingham (n=1), HMP Bronzefield (n=1); HMP Hewell Redditch (n=1); HMP Pentonville (n=3); HMP Wandsworth (n= 1).*

* These are the places of detention recorded on the BID file at the time of the study. Some detainees were detained at many different detention centres or prisons under immigration powers.

The individuals in both samples had been represented by BID for bail. Cases were chosen which involved an indicator of vulnerability, and sampling was therefore purposive rather than random. The individuals in the sample were in detention when the new AAR policy was in operation. Several cases were still open when we began our analysis in mid-2017; however, by the time the study was complete in spring 2018 all the files were closed.

Consent to participate in research

Every detainee whose file was reviewed had signed a letter of authority authorising the use of their data for research. All names have been anonymised.

2.2 Method

The study involved a document analysis of detainees' BID bail files for both the prison sample and the IRC sample. We sought to assess how the AAR policy has been applied to our vulnerable clients in detention. In order to consider this, our analysis focussed on the following thematic areas:

- (a) Time spent in detention: length of detention (including cumulative periods of detention); length of detention before identification of risk under the AAR policy; length of detention after identification of risk under the AAR policy; timeframe in which Home Office maintained that removal could be enforced compared with detention length.

- (b) Vulnerability: types of vulnerability/indicators of risk; evidence/ risk levels under the AAR policy.
- (c) Identification of risk: mechanisms for identification of vulnerability/ risk (e.g. medical practitioner's completion of rule 35 reports, or in prison, measures taken by medical practitioners instead of r35 reports if any).
- (d) Home Office decision-makers' application of the AAR policy: evidence of safeguarding processes; Home Office decision makers' responses to rule 35 reports/ evidence of risk; Home Office decision makers' reviews of decisions to detain in light of vulnerability.

Documents reviewed

The documents reviewed in the document analysis varied between samples, due to the differences in the application of the AAR policy in prisons and IRCs. For case reviews of the IRC sample, we reviewed: rule 35 reports; Home Office responses to rule 35 reports; medico-legal reports or other expert reports; monthly progress reports; bail application bundles and bail summaries; and medical records where these documents existed on the detainee's bail file.

As detainees held in prisons do not have access to the rule 35 process, for our prison sample we instead reviewed: monthly progress reports; bail application bundles and bail summaries; medico-legal reports or other expert reports; medical practitioners' identification of risk; Home Office responses to identification of risk; and medical records where such documents existed on the detainee's bail file.

2.3 Limitations of the research

Both the IRC sample and the prison sample consist of vulnerable detainees who find themselves in detention. The sample does not consist of a random selection of individuals who are liable to detention. The individuals in the sample became represented clients of BID from within detention in order to make applications for their release as this is the nature of BID's casework. BID is therefore unlikely to have clients for whom the AAR policy results in quick release. Similarly, the sample will not contain individuals for whom the gatekeeper process has successfully prevented detention.

3. Findings A: IRC sample

3.1 The gatekeeper process is failing

Although our study was not designed to analyse the decision-making or stages of the gatekeeper process it must be noted that the gatekeeper failed to identify the vulnerable adults in our sample in order to prevent their detention. The gatekeeper process failed to identify risk factors that were raised days, weeks or months later in detention. Many indicators of risk could have been identified with minimal investigation by the gatekeeper. For others, there was already evidence of the detainee's vulnerability on the Home Office file prior to detention. In at least four of the 23 cases, the gatekeeper should have been aware that there were vulnerability considerations based on the evidence available to them when the individual was detained.

According to a recent Freedom of Information response from the Home Office received by BID, just 141 people were prevented from entering detention by the gatekeeper in 2017 because they were found to be vulnerable (0.5% of detainees entering the detention estate).

3.2 Length of time vulnerable adults spend in IRCs

The detainees in our IRC sample were detained for very long periods of time. The average length of detention was 286 days for the IRC sample (table 1).⁴⁶ None of the detainees in our IRC sample were released as a result of a rule 35 report and subsequent assessment under the AAR policy. If we treat the detainee that spent 936 days in detention as an outlier, the average length of detention was still 256 days (table 1).

Tab. 1. Length of detention			
Detainee	total length of detention ⁴⁷ (days)	length of detention before r35 (days)	length of detention after r35 (days)
WA	186	158	28
VB	173	7	166
UC	291	52	239
TD	305	194	111
SE	936	936	0*
RF	380	165	215

⁴⁶ This figure is conservative. We referred two cases to solicitors before they were out of detention and we therefore do not know how long they spent in detention after the solicitors took their files. For these clients, we assumed the end of detention was the date of our referral.

⁴⁷ This does not include other periods of detention.

QG	379	101	278
PH	125	49	76
OI	146	27	119
NJ	138	138	0*
MK	292	82	210
LL	228	56	172
KA	260	68	192
JB	612	108	504
IC	413	70	343
HD	367	367	0*
GE	259	259	0*
FG	159	40	119
EH	277	226	51
DI	195	71	124
CJ	101	41	60
BK	78	32	46
AL	275	220	55

* A rule 35 report was never prepared in these cases.

3.3 Length of time spent in IRC detention prior to identification of vulnerability

Vulnerable adults often spend a long time in detention before their vulnerability is identified and they are assessed under the AAR policy. Although rule 35 reports are merely a form of evidence that can be provided to the Home Office to trigger an AAR assessment, they provide the key mechanism for facilitating information-sharing between the Home Office and the contractors who manage and provide healthcare in IRCs regarding detainees' vulnerability and suitability for detention.

Detainees in the IRC sample spent an average of 158 days in detention before a rule 35 report was prepared (if one was prepared at all). In all the cases in the sample, there was evidence of vulnerability long before vulnerability was identified by the Home Office for the purpose of the AAR policy (if it was identified at all). This is illustrated in cases studies EH, NJ and SE below.

As a consequence, detainees' mental health often deteriorates before their vulnerability has been assessed and reported to the Home Office. These concerning results can be attributed to various failures in the operation of the AAR policy relating to:

- the rule 34 process;
- the ongoing assessment process; and
- the propensity for certain indicators of vulnerability to be disregarded.

3.3.1 Rule 34 medical assessments are not leading to identification of vulnerability

Under rule 34 of the Detention Centre Rules 2001, medical assessments should take place within the first 24 hours of entering detention.⁴⁸ The assessments should provide an opportunity for medical practitioners to identify indicators of risk that have yet to be identified, and trigger an assessment under the AAR policy where appropriate. Medical examinations should work alongside the rule 35 processes so that vulnerabilities can be flagged to the Home Office.⁴⁹ Detainees should be referred for a rule 35 report following a medical examination when they enter detention if:

- there are indications that the detainee's health may be injuriously affected by detention; or
- there are concerns regarding suicidal ideation; or
- there are concerns that the detainee may have been tortured.

In none of the cases in the IRC sample did an initial medical examination trigger a rule 35 report and an assessment under the AAR policy. Rule 34 ought to be a valuable screening tool for identifying health needs and vulnerabilities in the first 24 hours of detention where the gatekeeper has failed to identify indicators of risk, and especially so given the gatekeeper does not make investigations. The evidence in our findings is that vulnerability is generally considered under the AAR policy long after detention has begun, despite serious concerns being evident from the outset.

The failure to refer individuals for rule 35 reports may relate to a misconception on the part of medical practitioners that rule 35 concerns torture victims only (discussed in section 3.3.2 below). In addition, initial assessments have been criticised for an over-reliance on self-reporting, as individuals are required to divulge often sensitive and intimate details about their health and wellbeing to a stranger. This might be difficult for individuals who have experienced trauma or violence, or those who feel culturally inhibited from sharing such information.⁵⁰ This is supported by our findings where details of past traumatic events such as torture are less likely to be disclosed immediately on entering detention, whereas health conditions were more likely to be reported in the initial assessment. Further, initial medical assessments sometimes take place in the middle of the night,⁵¹ and as the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment (CPT) has found, this may result in an ineffective induction process because individuals are tired and disoriented. Another concern about initial screening, highlighted by the British Medical

⁴⁸ Provided that the detainee consents to such (Detention Centre Rules 2001)

⁴⁹ It should be remembered that a rule 35 report is not necessary for an assessment under the AAR policy; however, the submission of such is the only reliable means of triggering an AAR assessment.

⁵⁰ Stephen Shaw, Report to the Home Office, "Review into the welfare in detention of vulnerable persons" (January, 2016)

⁵¹ Lawlor D, Sher M, Stateva M. (2015) Review of Mental Health Issues in Immigration Removal Centres: A report prepared for the Home Office. The Tavistock Institute: London. Para. 4.5) Cited in BMA report "Locked up, Locked out – health and human rights in immigration detention".

Association (BMA) is that the initial health questionnaire elicits closed ‘yes/no’ answers instead of creating space for detainees to broach vulnerabilities in an open-ended manner.⁵²

3.3.2 Failure of the ongoing assessment process prior to the identification of vulnerability

If the ongoing assessment process and case progression panels are working effectively, risk factors not identified by the gatekeeper or rule 34 assessments ought to be identified soon after. The policy guidance states: “An individual will be regarded as being an adult at risk if [there is] professional evidence, or observational evidence, which indicates that an individual is suffering from a condition... that would be likely to render them particularly vulnerable to harm if they are placed in detention or remain in detention – *whether or not the individual has highlighted this themselves*” (emphasis added).⁵³ It is therefore not the sole responsibility of the detainee to make their vulnerability known to the Home Office where there is evidence that they are suffering from a condition. Moreover we believe it should be the Home Office’s responsibility to actively identify vulnerability, given that it is the detaining authority.

In our sample, only one detainee had been assessed as an adult at risk within a month of being detained. If the gatekeeper process, the initial examination process or the ongoing assessment process were operating effectively, we would expect that vulnerable adults would be identified and assessed under the policy far earlier. The case studies presented below illustrate the inadequacies of these processes:

Case study: EH

EH was detained in December 2016. His IRC medical records show numerous issues that unquestionably fall under the list of ‘indicators of risk’ in the policy guidance. For example:

- 5 days after date of detention: “history of deliberate self-harm” and “history of food refusal”.
- 1 month after date of detention: “physical health assessment- not been able to sleep for 6-7 days. Mental health problems. Bipolar and depression”
- 2.5 months after date of detention: “He uses drug to cope with mental health concerns- hears voices, not sleeping, feeling low, angry, unhappy”.
- 7.5 months after date of detention: rule 35(3) submitted.

The gatekeeper process and ongoing assessment process did not identify this individual as an adult at risk in the 226 days before the AAR policy was applied. As a result, a highly vulnerable detainee with serious mental health problems (including a diagnosis of bipolar and depression) spent seven and a half months in detention before the Home Office accepted he was an adult at risk, and assessed whether he was suitable for detention in the light of this. (Continued on following page)

⁵² All Party Parliamentary Group (APPG) on Refugees, All Party Parliamentary Group (APPG) on Migration (2015) “The Report of the Inquiry into the Use of Immigration Detention in the UK” The Stationery Office: London. 53.

⁵³ *Adults at Risk Statutory Guidance August 2016 (SI 18081601 08/16)*

Case study continued: EH

This detainee's mental health issues were documented in his IRC medical records and this should have prompted a medical practitioner to prepare a rule 35 report. Indeed, five days after he entered detention, it was clear that there was evidence of risk. The rule 35 report that was eventually submitted detailed his experience of torture. Although the Home Office decided to maintain his detention in the rule 35 response, he was released on tribunal bail a month and a half later.

Case study: SE

SE suffered from severe mental ill-health, including paranoid schizophrenia, PTSD and depression. He has a history of suicide attempts, including one attempt in immigration detention. He had also jumped from a height which left him with a shattered knee which required surgery. Immediately after a 35 day criminal sentence, he was kept in immigration detention for 2 and a half years, until he was eventually released on bail by the Tribunal. In spite of the length of his detention and the severity of his mental ill-health, he was never identified as a vulnerable adult, and his suitability for detention was never considered. There was extensive medical evidence of his condition, including an independent psychiatric report prepared shortly after he was detained, which was provided to the Home Office. The report confirmed the diagnosis of paranoid schizophrenia, depression and PTSD. It stated: "the applicant is vulnerable to experiencing an acute relapse of his illness", and that if detained, he would be "potentially significantly vulnerable". This report should constitute level 3; however, it did not trigger a consideration under the AAR policy.

Case study: NJ

Having been released after a 7 month period of detention in April 2016, NJ was re-detained in July 2017. She is one of the two clients in our IRC sample who were never assessed as an adult at risk. Her IRC medical records document numerous indicators of risk, such as:

- During her initial rule 34 assessment, the nurse recorded that she was suffering from drug withdrawal, had previously been admitted to a psychiatric ward, and that she had self-harmed.
- She was diagnosed with paranoid schizophrenia and has had numerous admissions to hospital. She "has been known to the psychiatric services since 1999" and had previously attempted suicide during psychotic episodes.
- She "has also had experiences with sexual exploitation in relation to drug use".

However, a rule 35 report was never submitted, and an assessment under the AAR policy was never made. Her monthly progress reports do not make any reference to her vulnerability in detention. In this second period of detention, she was detained for 138 days. An effective gatekeeper or ongoing assessment process should have flagged up an individual with a diagnosis of paranoid schizophrenia and a history of suicide attempts.

3.3.3 Failure of certain indicators of vulnerability to trigger an AAR assessment

Our IRC sample included detainees who exhibited various indicators of risk. The detainees often presented with a range of complex and interrelated vulnerabilities which should have given cause for concern. A summary of the vulnerabilities present in both samples can be found in Appendix 2.

It tended to be when the detainee disclosed that they had been tortured that the rule 35 process was triggered and an AAR assessment made, despite the fact that various indicators of risk were often evident much earlier. Rule 35(3) reports are the most common type of rule 35 reports submitted to the Home Office. In evidence given to the Home Affairs Select Committee in May 2018, Inspection Team Leader at HM Inspectorate of Prisons (HMIP) Hindpal Singh Bhui reported that:

“Torture is only one reason why a rule 35 could be considered, but almost all the rule 35 reports we see are about torture... [W]e were in a detention centre recently where there were 60 people who had been considered to be at risk of self-harm over the previous six months and half of them were considered to be at such a high level of risk that they were under constant supervision by the staff, yet there were no rule 35s at all on suicidal ideation, which is another reason why you could have a report put in.”

Indeed, the only type of rule 35 reports we viewed in the cases reviewed were rule 35(3) reports, despite medical practitioners confirming in many instances that detainees were suffering from other health conditions which might be exacerbated by detention (such as schizophrenia, PTSD, anxiety, depression and bipolar) as well as suicidal ideation. The two detainees who had paranoid schizophrenia in our sample did not have rule 35 reports prepared and were never assessed under the AAR policy. For these conditions, rule 35(2) or rule 35(1) reports could have been submitted when such conditions came to light (which was often at the outset of detention), either alongside a rule 35(3) report where there were concerns that the detainee may have also been tortured, or alone if not. This did not happen. In 17 of the 23 IRC sample the individuals were experiencing suicidal ideation or a health condition that might well have been exacerbated by detention. Of the 19 cases for which a rule 35(3) torture report was prepared, 14 were also suffering from other health conditions and/ or suicidal ideation. In none of these cases were rule 35(1) or rule 35(2) reports submitted.

Case study: IC

IC was suffering from serious brain trauma caused by a car crash. An IRC medical practitioner was concerned about the impact of detention on the detainee and submitted a rule 35(3) torture report (instead of rule 35(1) reports or rule 35(2) reports). As the car crash did not meet the definition of torture, the Home Office dismissed the rule 35 report and the detainee remained in detention for another year.

Case study: HD

HD spent a year in detention before being removed. A rule 35 report was never produced. He had depression and was suicidal, including several suicide attempts within detention. Towards the end of his detention, he was on hourly watch by IRC staff due to self-harm concerns. The Home Office recognised that he was a vulnerable adult. His Home Office bail summary stated: “he was placed on observation by healthcare within the IRC, as he had made threats to staff that he will kill himself, due to the issues surrounding his section 4 accommodation request, and the length of time it can take to secure a travel document. I had noted him as an adult at risk level 1”. Later monthly progress reports noted “you have been assessed as meeting level 2 of the adults at risk policy on the basis of evidence provided by the IRC, that you have threatened to self-harm, should you remain in detention”. A rule 35(2) report should have been submitted to the Home Office which considered the impact that detention was having. However, no rule 35 report was produced. The assignment of risk level 2 by the Home Office did not constitute a proper review of his suitability for detention; it was merely an identification of risk.

Case study: RF

RF was detained in July 2017. He is blind, suffers from depression, and has a history of suicidal behaviour. His medical records document his mental health problems, his suicidal history; and the fact that he is blind. Despite the existence of clear and serious indicators of risk upon entry into detention, a rule 35 report was not submitted until 165 days later when it came to light that he was also a victim of torture.

3.4 Length of detention after identification of vulnerability

As discussed in part 1 of the report, rule 35 reports rarely trigger an adults at risk assessment that results in release. This was confirmed by our findings. Not one detainee in our sample was released as a result of the submission of rule 35 report and subsequent AAR assessment. Furthermore, even when the Home Office was provided with evidence of a detainee’s vulnerability, this did not prevent them from continuing to detain that person for excessive periods. Detainees in our sample spent an average of 164 days in detention after having submitted a rule 35 report. This figure would be higher if 14 individuals had not made successful bail applications to the tribunal (which the Home Office opposed in all cases) (table 2 below). Of the 23 detainees in the IRC sample, only four were removed at the end of their period of detention, and the Home Office released only three on temporary admission (now ‘Home Office bail’).

Tab. 2. Case outcomes for IRC sample	
Case Outcome	Number of detainees
Removed	4
Released on Tribunal Bail	14
Released on Temporary Admission	3
Unknown (cases passed to a solicitor)	2

These figures show the failure of the AAR process to lead to the release of vulnerable adults once an individual comes under the policy. As discussed in the following sections, our findings indicate that such failings relate to the following:

- The difficulty of meeting evidence level 3 in a rule 35 report;
- Evidence of risk being conflated with the actual risk;
- Variable quality of medical practitioners' rule 35 reports;
- Inadequate Home Office responses to rule 35 reports and consequent AAR assessments;
- Flaws in the 'immigration control factors' balancing exercise; and
- The failure of the ongoing assessment process following an AAR assessment.

3.4.1 The difficulty of meeting evidence level 3 in a rule 35 report

The study found that it is difficult for detainees to demonstrate that they should be categorised as level 3 adult at risk, the only category seeming to provide any sort of protection from detention. Among our sample of 20 detainees who were considered under the AAR policy, only one was assessed as meeting the requirements for level 3 evidence. The difficulty in meeting level 3 explains in part why so few detainees are released under the AAR policy. It would appear that the reasons for this relate to both policy design, discussed above, and its implementation by medical practitioners and Home Office caseworkers. In order to be assessed as a level 3 Adult at Risk, there must be professional evidence "stating that the individual *is* at risk *and* that a period of detention *would be likely* to cause harm". This is a higher threshold than level 2 evidence which requires "professional evidence that the individual is (*or may be*) an adult at risk" (emphasis added). Level 3 evidence therefore requires a degree of certainty on the part of medical practitioners (or other professionals) that is not necessary for level 2. Our study demonstrated that medical practitioners are unlikely to designate an individual level 3 as it requires making definitive statements about the likelihood of future harm. As a result individuals are designated level 2, which offers very little protection. Home Office decision makers rely on the fact that level 2 evidence does not contain definitive statements about future harm to dismiss evidence of risk.

Case study: KA

KA was a victim of trafficking and experienced multiple traumas. As a consequence KA suffers from depression and PTSD. His IRC medical records state that he was being treated for PTSD, and also that he has long term problems with rectal bleeding. A rule 35(3) (torture) report was prepared. The assessment section of his rule 35(3) report stated:

“this gentleman’s account is plausible. His wound on his left buttock, which is his only scar, appears to have been deliberately inflicted, and consistent with incision injury from a knife... In detention, he also reports feeling stressed, and has flashbacks, with nightmares and poor sleep. He reports episodes of urinary incontinence also.”

Although the doctor has not made an explicit statement that detention is having an injurious impact on the KA’s health, they have provided evidence which indicates that might be the case. The Home Office response to the rule 35 report does not consider the evidence in the rule 35 report regarding the impact of detention:

“no issues in regard to your physical or mental health, whilst in detention, were indicated. In addition the doctor has not indicated in the R35 report that continued detention will have a negative impact on your health... it is acknowledged that you are an AAR however, it is concluded that your removal can be enforced within a reasonable timescale.”

The evidence of flashbacks was treated as self-declaration. This case illustrates the high threshold applied by the Home Office for evidence of level 3 risk. Unless the medical practitioner is definitive in their description of the condition and their assessment of the impact of detention, the decision-maker tended to dismiss evidence of harm.

In most cases in the IRC sample the rule 35 report failed entirely to consider the impact of detention, discussed in the next section.

3.4.2 Problems with medical practitioners’ rule 35 reports

When announcing the AAR policy, James Brokenshire stated that it would include “bespoke training to GPs on reporting concerns about the welfare of individuals in detention and how to identify potential victims of torture”⁵⁴. The rule 35 reports we viewed in the study were often lacking in detail and formulaic. In most instances the rule 35 reports were silent regarding the impact that detention was having. As noted above, the rule 35 reports we viewed were concerned with torture, under rule 35(3) (despite several cases of suicidal ideation and health conditions which were exacerbated by detention, discussed in section 3.3.3).

⁵⁴ HC Deb 14 January 2016 HCWS470 <<https://www.parliament.uk/business/publications/written-questions-answers-statements/written-statement/Commons/2016-01-14/HCWS470>>

Often inadequacies in the rule 35 reports produced by medical practitioners were a significant reason why individuals failed to meet the level 3 threshold. In the DSO 09/2016 “Detention centre rule 35” rule 35(3) forms (“**DSO 09/2016 35(3) report form**”) includes an “assessment” section which states the following:

“Please set out your reasoned assessment of why, on the basis of the detainee’s account together with your own examination and clinical findings, you are concerned that the detainee may have been a victim of torture. This should include your assessment of:

- the consistency of any physical (eg scars) and/or psychological findings with the detainee’s allegations, including any evidence to the contrary
- whether there might be other plausible causes for the findings
- the impact detention is having on the detainee and why, including the likely impact of ongoing detention”⁵⁵.

Given that the main purpose of a rule 35 report is to help the Home Office assess whether detention is having a detrimental impact on the detainee’s health, the impact consideration in the assessment section is of critical importance. However, we found that it was often not completed fully as many medical practitioners do not make assertions about the impact of detention. Below are several representative examples of the “assessment” section of the rule 35 form that has been insufficiently completed:

- VB: “the patients account and clinical findings correlate. His scars are consistent with his account”.
- MK: “On examination he has scars on his head which may be due to the history given’
- FG: “history of torture consistent with claimed injuries”.
- RF: “he suffers with back pain since the attacks. He suffers with flashbacks and nightmares. He does not have any visible scars to see”

In all of these cases, the Home Office decision-maker relied upon the fact that the medical practitioner had not explicitly stated that detention was having a negative impact on the detainee to maintain detention.

As well as the recurrent failure to record the impact of detention, we also found cases where the medical practitioners were unable to carry out a full assessment, and advised the Home Office that a particular matter should be looked into further. For example:

- LL: “He has scars on his left leg and abdomen as well as his face which may be consistent with his account as described in the previous section. As a result we would advise that this is looked into further as he may be a victim of torture”

⁵⁵ DSO 09/2016 Detention centre rule 35 (v.4, 6 December 2016)

- TD: “It is difficult to comment on the state of mental health on-going though he currently has been referred to mental health and there are no acute concern”
- IC: “Her personality change and memory issues can also be due to significant head injury, but a specialist neurology opinion would be needed to assess this”... “I have referred her to a specialist regarding her head injury”

In respect of the first example (LL), no further enquiries were made and the Home Office did not provide the detainee with a risk level. The Home Office decision-maker provided a response to the rule 35 report which simply stated that that they had decided to maintain his detention because his removal was imminent without making an assessment of the vulnerability. In respect of the second and third examples (TD and IC), a referral did occur. However, problematically, the decision to maintain detention was made prior to these referrals taking place and no further AAR assessment was made when the additional information was received. A reassessment based on the further referral information would likely have led to a categorisation of level 3 but, as discussed in section 3.4.6 below, once an AAR decision had been made, case workers did not revisit such risk considerations.

The consistent failure of medical practitioners to make an assessment of the impact of detention may be related to medical practitioners’ aversion to making definitive statements; however, it may also be attributed in part to the structure of the template in which medical practitioners are required to submit the rule 35(3) report. The DSO 09/2016 rule 35(3) report form assessment section (section 6) extracted above contains distinct questions under one heading. These forms replaced the DSO 17/2012 rule 35 forms, which contained a number of distinct questions, including an answer box for each question that the doctor was required to answer. The outdated rule 35(3) report form was therefore designed so that the question of consistency or ‘authenticity’ was separated from the question of the impact of detention. In contrast, on the DSO 09/2016 35(3) report form it is possible for medical practitioners to provide an answer to every section while failing to consider the impact detention is having on the detainee’s health.

Furthermore, unlike the DSO 17/2012 rule 35 report forms, the DSO 09/2016 rule 35(3) report form does not include a section on the expected impact of *release*. This would provide an opportunity for the medical practitioner to consider the impact of detention on health, relative to the possibly beneficial effect that release would have. There is case law which sets out the importance of considering the impact of detention relative to the impact of release. In 2016 the courts found that a condition may not be satisfactorily managed if there was treatment available in the community that was not available in detention that may lead to improvement.⁵⁶

⁵⁶ *R (O) v SSHD* [2016] UKSC 19

3.4.3 Inadequate Home Office responses to rule 35 reports and consequent AAR assessments

Although it is the responsibility of medical practitioners to complete the rule 35 reports with rigour and detail, the guidance states that in cases where rule 35 reports are lacking, the Home Office should seek further information:

“On receipt of a rule 35 report, the decision-maker should review the report to ensure that it meets the required standards and, if the report does not meet the required standard it should be returned to the medical practitioner with a request for the necessary information”.⁵⁷

In practice, responses do not follow this guidance. The cases in the IRC sample demonstrated that when rule 35 reports are vague or silent about the impact of detention on a detainee’s health, the Home Office did not ask for further information but instead took note of this to infer that detention wasn’t likely to be injurious to a detainee’s health. As discussed, this occurred both in the examples provided above where the rule 35 report was silent on the impact of detention, but also in the cases where the doctor implied (with varying degrees of certainty) that detention is having some harmful impact, such as in the following case studies.

In some cases, the Home Office identified the risk but did not conduct an actual assessment of the appropriateness of detention under the AAR risk policy. Applied in this way, the AAR policy works merely to flag vulnerable individuals, rather than working to ensure that fewer vulnerable individuals are detained.

Case study: WA

WA’s rule 35 report documents his traumatic experience of torture, and the fact that he has suffered anxiety, insomnia, low mood and fear since the event. His rule 35(3) report stated:

“the scars appear consistent with his account of torture. He reports to feel unsafe in detention and is exacerbating his mental health symptoms”

This should alert the Home Office that detention is potentially injurious to the detainee’s health, and that the detainee might therefore be a level 3 adult at risk. If the Home Office caseworker considered that more information was required, they could have followed the policy guidance and sought this from the medical practitioner. Instead, the response assesses him as a level 2 adult at risk and states: “although it is accepted that you are an adult at risk, the doctor has not indicated that a period of detention is likely to cause you harm”.

This is a standard response that was reproduced across many rule 35 responses in circumstances where medical practitioners have failed to provide a definitive opinion on the future harm in detention, despite confirming the detainee’s vulnerability. (Continued on following page)

⁵⁷ *Adults at risk in immigration detention guidance* (v.2, 6 December 2016)

(WA case study continued)

In addition, this response was careless in a way that was typical across the Home Office decision-making examined across the study. The Home Office response claims that “information within the report has been considered carefully”; however, sections of the report have been lifted verbatim and do not make sense (for example: “you stated you feel unsafe in detention and this is exacerbating his mental health symptoms”).

3.4.4 Evidence of risk and actual risk

The risk levels correlate with the availability and quality of independent evidence rather than risk; however, the AAR framework tends to lead decision-makers to conflate evidence levels with actual risk. An emphasis on the evidence of risk can lead vulnerability to be dismissed, despite the risk being significant.

This appeared to be of particular consequence for individuals in the IRC sample when they failed to meet the evidence threshold for the definition of torture. The evidence of torture varied; some detainees had scarring, where others did not show physical signs. Other detainees’ reports will have been inappropriately submitted as torture victims when they should have been considered in rule 35(1) or rule 35(2) assessments. And yet once a torture claim is dismissed, evidence of other risk factors, such as PTSD or depression, tends to be completely disregarded.

Furthermore, those who have experienced types of ill-treatment which fall outside the definition of torture provided in the AAR policy are often disregarded despite being extremely vulnerable. Significant traumas, such as rape, are often by their nature difficult to evidence, and particularly so from within detention. And yet the associated vulnerability remains significant and is often overlooked. This was evident in Home Office decision making in many instances in the sample group, but is best illustrated by the case of QG below.

Case study: QG

QG is a victim of rape and FGM and has been diagnosed with depression, PTSD and borderline personality disorder. A medical practitioner completed a very detailed rule 35(3) which recorded her history of trauma including rape (considered by the doctor to constitute torture) and that detention was causing her to experience sleep walking, bed-wetting and flashbacks. The rule 35(3) report stated that if released the detainee could expect improved sleep and mood and a reduction in flashbacks and sleep disturbance. The medical practitioner also noted that her release would enable her to access specialist community organisations for PTSD and for victims of sexual violence and LGBT discrimination. (Continued on following page)

(QG case study continued)

The rule 35(3) report response from the Home Office decision-maker ignored the evidence that detention was having a negative impact on the detainee's health and categorised the detainee level 1 at risk. The Home Office decision maker stated that the medical practitioner had confused rape with torture, and dismissed the torture claim. The response further stated: "That is not to diminish your claim to have been raped, although it is noted that no medical evidence was submitted with the rule 35 report to corroborate your claim". It was acknowledged that rape is an indicator of risk and thus the detainee was assessed as level 1 under the AAR policy.

Case study: GE

GE was never identified as an adult at risk and spent a total of 259 days in detention before being granted bail. He is a victim of torture, who was suffering from depression, insomnia and stomach problems. He was refused a rule 35 by a medical practitioner on the basis that he did not have "any large scars".

3.4.5 The 'immigration control factors' balancing exercise***Inaccurate removal predictions***

A recurrent theme in the cases examined was the tendency of decision-makers to provide inaccurate removal predictions in order to outweigh level 2 risk. Home Office decision makers are required to balance the risk to a detainee's well-being against the imminence of the detainee's removal (along with the other immigration control factors). The AAR caseworker policy guidance stipulates that there should be a "highly case specific consideration", and that:

"In each case, there must primarily be a careful assessment of the likely length of detention necessary and this should be considered against the likely impact on the health of the individual if detained for the period identified given the evidence available of the risk to the individual."⁵⁸

We found that when decision-makers make an AAR assessment which involves weighing the imminence of removal against risk of harm to the detainee's well-being, ongoing detention was often justified by the claim that removal could be effected within a short period of time. However, there was not one case in the IRC sample where the Home Office's predicted timeframe for removal proved accurate. Detainees tend to remain in detention much longer

⁵⁸ *Adults at risk in immigration detention guidance* (v.2, 6 December 2016)

than the projected removal date, and subsequent monthly progress reports postpone removal to another “imminent” date that is further postponed.

Case study: MK

The Home Office recognised MK as an adult at risk level 2 as he was or was likely to have been a victim of torture. The Home Office specified that “once (his) asylum claim has concluded” his removal was “likely to take place within 6 weeks”. It should also be noted that this client had no criminal background and so the imminence of his removal is of particular importance for balancing the immigration factors against his level 2 risk.

Contrary to the predicted removal, the client was in detention for a further 7 months. Indeed he was only released when BID applied for bail on his behalf (with the bail application opposed by the Home Office). There was no review of detention in the light of his vulnerability in subsequent monthly progress reports. His monthly progress reports simply refer to the date on which a rule 35 report was received, and the date on which the Home Office decision-maker responded and the decision taken to maintain detention. It is of great concern that there seems to have been no ongoing review of whether detention remained appropriate, even though the decision to maintain his detention following the AAR assessment was made in part on the basis of that he would only be detained for a further 6 weeks.

Case study: BK

BK was the only detainee in our sample who was assessed as a level 3 adult at risk. He had been a victim of torture, as well as having symptoms of depression, thoughts of self-harm, flashbacks and nightmares. His rule 35 report recorded these conditions and stressed the fact that his symptoms had worsened in detention “due to provoking factors e.g. hearing keys, sounds of doors, transport in a van”. The Home Office response to the rule 35 report assessed him as level 3. However, the Home Office chose to maintain his detention on the basis that his removal was immediate:

“there are currently no barriers to your removal and your directions for removal have been requested... in conclusion, it is acknowledged that you are an AAR but it is considered that your removal can be enforced within 2-3 weeks”

(Continued on following page)

(BK case study continued)

He was not removed within 2-3 weeks. He was released 6 weeks after the rule 35 report when he was granted bail by the Tribunal. The Home Office again opposed the client's bail application. It is not possible to know how long the Home Office would have detained this client had BID not made a bail application. A monthly progress report prepared one month after the rule 35 response records the fact that a rule 35 report was considered, but does not reassess whether detention remained appropriate one month later. This is unacceptable in a case of such high risk of harm to the detainee and where the decision to continue detention was made predominantly on the grounds that his removal could be effected within a very short time frame. The monthly progress report was written after the estimated time frame had elapsed, but this was not acknowledged.

Public protection

Many individuals in the IRC sample had completed criminal sentences in the past (16 of the 23), with such crimes ranging in seriousness. Our research demonstrated that regardless of how serious the crime was or the level of risk of reoffending, Home Office decision-makers relied upon any past offence to justify maintaining detention on public protection grounds. Similarly, when undertaking the balancing exercise, criminality was framed as outweighing *all* vulnerability concerns, no matter how significant such vulnerability concerns were. According to the AAR policy guidance documents, the balancing exercise of immigration control factors against the promotion of well-being should be conducted on a case by case basis, based on the particular facts at hand; a "holistic approach to the consideration of individual circumstances"⁵⁹. However, we observed the same standard formulation of words reproduced by decision-makers, no matter what the offence or the vulnerability. In the case studies below even the same grammatical mistakes are reproduced, confirming a copy-paste approach.

Case study: OI

OI arrived in the UK aged 8 and was taken into foster care aged 10 after being severely abused and neglected by his father. He suffered from multiple conditions including bipolar disorder, depression, PTSD and type-2 diabetes. The Home Office accepted the medical practitioner's evidence that the detainee's scars were consistent with the client's version of events and that the OI was an adult at risk. Balanced against his wellbeing was his conviction of burglary and affray, along with the purported imminence of his removal (which also proved completely inaccurate). (Continued on following page)

⁵⁹ *Adults at Risk Statutory Guidance August 2016* (SI 18081601 08/16)

(OI case study continued)

The decision maker stated in the rule 35 response:

“Your criminal history has been noted and account has been made of the severity of your offending behaviour in view of which it is considered that would [sic] pose a risk of re-offending and harm to the public if you are released.”

“Careful consideration has been given to balancing the need to promote your well-being against the risks to the public and the imminence of your removal. Your detention is considered proportionate to your circumstances, particularly taking into account your poor Immigration history and serious criminal history.”

Case study: DI

DI was a victim of severe abuse as child which constituted torture in his country of origin. DI had burn marks on his legs and lacerations on his feet and back that were found by the medical practitioner to be consistent with his account in a rule 35(3) report. The Home Office decision-maker found that his account of ill treatment met the definition of torture and weighed his well-being against public protection concerns. He had been arrested on two occasions whilst in the UK for attempting to fraudulently remain in the country. The first for possessing “false/improperly obtained/ another’s identity document” and on the second occasion for entering an “arrangement to facilitate acquisition retention use or control of criminal property” as well as for possessing “identity documents with intent”. Almost entirely the same words were produced as the previous case study (OI), including the same grammatical error, notwithstanding the very different circumstances. The rule 35 response stated:

“Your criminal history has been noted and account has been made of the severity of your offending behaviour in view of which it is considered that would [sic] pose a risk of re-offending and harm to the public if you are released”.

“Careful consideration has been given to balancing the need to promote your well-being against the risks to the public and the imminence of your removal. Your detention is considered proportionate to your circumstances, particularly taking into account your poor Immigration history and serious criminal history.”

3.4.6 Failure of the ongoing assessment process after an assessment under AAR policy

Although Home Office AAR case worker guidance states that “there should be an ongoing assessment of risk made by the case owner throughout the period of detention which will facilitate the identification of any emerging risk, or changes to known risk factors”⁶⁰, this did not happen for individuals in our study. Once a Home Office decision-maker had decided to maintain a detainee’s detention following an AAR assessment, the issue was never revisited. This was so even where the immigration control factors that were used to justify detention changed, such as where new barriers to removal emerged.

Similarly vulnerability and risk levels were not re-considered. Our research found that the Home Office in practice treats vulnerability as though it is static, rather than dynamic. This contradicts the general principles set out in the AAR case worker guidance:

“The nature and severity of a condition, as well as the available evidence of a condition or traumatic event, can change over time. Therefore decision makers should use the most up-to-date information each time a decision is made about continuing detention.”

Monthly reviews should provide an opportunity for decision makers to assess whether a vulnerable adult, who has been identified as an adult at risk, continues to be suitable for detention. Where the Home Office has new information, a new assessment under the AAR policy should take place. However, instead of making a fresh review, AAR decisions were simply repeated every month. This suggests that once a detainee has been assigned a level of risk and detention maintained under the AAR policy, this becomes immutable.

Out of the 20 detainees in our IRC sample who were identified as AAR under the policy, there were no monthly progress reports which we examined that provided a meaningful review of the detainee’s vulnerability and whether detention remained suitable. For some of these detainees, the fact that they are an Adult at Risk is not even mentioned on their monthly progress reports. Others record the date on which a rule 35 report was submitted, followed by the date that the response was written, the level of risk which was assigned, and the fact that detention was maintained. This content is then reproduced verbatim in the next monthly progress report.

⁶⁰ *Adults at risk in immigration detention guidance* (v.2, 6 December 2016)

Case study: JB

JB suffers from PTSD as a result of his service in the British army. He was in immigration detention for 612 days. His health steadily deteriorated whilst in detention and medical practitioners who treated him became increasingly concerned. Two rule 35 reports and three expert/ medico legal reports were submitted to the Home Office throughout the period of his detention. The Home Office received the evidence and decided to maintain detention on each occasion (despite risk assessments finding he was of low risk of re-offending). The reports detailed the negative impact that detention was having on the detainee's mental health; for example, one report stated: "Unfortunately he is currently held in detention which is aggravating his mental health difficulties as it puts him back into the traumatic situation.... It is likely that he will continue to deteriorate mentally".

The monthly progress reports we examined simply record the receipt of medical evidence and the decision to maintain detention. The decision-maker does not register any consideration made of the detainee's current vulnerability nor do they revisit the AAR policy assessment, but instead repeat the phrase: "consideration has been given to all relevant factors in favour of release but in the light of the above, it is considered that detention for the purposes of deportation is reasonable. Your detention will continue to be reviewed on a regular basis and any significant material changes to your case will be considered against this decision."

These circumstances were typical in the sample and illustrate the fixed and artificial approach to vulnerability taken in the monthly review process contrary to Shaw's recommendations and the AAR case worker guidance.

Monthly progress reports should provide an opportunity for Home Office decision-makers to assess prospects of removal and whether the detention of those considered at risk remains reasonable, whilst bearing in mind that the risk of harm increases over time. Indeed the AAR case worker guidance states that "there must in each case be a careful assessment of the likely length of detention necessary, and this should be considered against the likely impact on the health of the individual". As discussed above in section 3.4.5, we found that monthly progress reports failed to take note of whether predictions for removal had been accurate and to update decisions made under the AAR policy accordingly.

4. Findings B: prison sample

4.1 Vulnerability

The detainees held in prisons were some of the most vulnerable in the study. A summary of the vulnerabilities present can be found in Appendix 2. All seven cases from the prison sample faced complex challenges from being detained in prison. All had independent evidence of risk and harm in detention, which would be capable of satisfying the criteria for level 3 evidence of risk. Only one member of the sample was recognised as an adult at risk; however, there is no evidence that this detainee's detention was reviewed in the light of that fact, it was simply used as a flag. There was no assessment of their well-being balanced against the immigration control factors in order to assess whether detention continued to be appropriate.

4.2 Length of detention in prisons

Highly vulnerable detainees are often detained in prison under immigration powers following their sentence, for unreasonable periods of time (Table 3). All but one of the cases spent over six months detained under immigration powers in prison, and the average was 442 days.⁶¹ The lack of an equivalent rule 35 mechanism for identifying and reviewing vulnerability meant their vulnerabilities were often completely ignored, in which time detention caused significant harm.

Tab. 3. Length of detention and application of the AAR policy in Prison Sample		
Detainee	Days in detention	Application of AAR policy whilst detained in prison
XA	175	no
YB	237	no
ZC	870	no
AD	438	no
BE	214	level 2
CF	255	no
DG	903	no

4.3 Failure to apply the AAR policy

Where the failures of the AAR policy in IRCs can be broken down into specific issues regarding its structure and application, the problem in prisons is much simpler: there is no

⁶¹ This figure is an underestimate, as we are not sure of when or if one detainee left detention, and so we have used the final date on which we spoke with him inside detention instead.

mechanism through which it can be applied and as a result it generally isn't. There is no equivalent rule 35 process (flawed as it is) which will trigger an AAR assessment in IRCs.

The below case studies demonstrate how difficult it is for vulnerable detainees held in prisons to access protection from the harm of detention.

Case study: ZC

ZC was detained under immigration powers on his release date in early 2015, and remained in detention for almost two and half years such that he was detained long after the new AAR policy was introduced. He was transferred twice: first to another prison in August 2016 and then to an IRC in April 2017, before securing release on bail in June 2017. He was diagnosed with depression with psychotic features, instability in mood, and ongoing symptoms of PTSD, and suffered from these conditions for the duration of his immigration detention. He is also a victim of torture. There is no evidence that the Home Office ever applied the AAR policy.

Following an unsuccessful bail application in April 2015, a clinical psychologist wrote a letter concerned about the lack of acknowledgement given to the severity of ZC's mental health condition in the Tribunal's decision to refuse bail. The judgment had inaccurately stated that "his mental health is being well treated at HMP [X] and the Applicant is taking the antipsychotics prescribed to him". The psychologist argued that this ignored two previous reports detailing the negative impact of detention on his mental health. Her letter details his diagnoses and clearly indicates the harmful impact of being detained in prison:

"Mr [ZC's] mental health remains unstable and his continued detention in prison is certainly a detrimental factor to stability of his mood. [ZC] reports on-going auditory hallucinations in the form of hearing his past abusers' voices, on-going hyper-vigilance, periods of chronic low mood and de-motivation. There is (sic) also times when Mr [ZC] presents with suicidal ideation.

"The prison environment is reported by [ZC] to be challenging because it maintains his feelings of hyper-vigilance and unease. It is difficult for Mr [ZC] to ever complete any extensive work on his past traumas as he constantly maintains he feels unsafe in a prison environment. This is compounded by his previous experience of being assaulted in another prison."

A report written by the Mental Health Nurse in November 2016 confirms the contents of the medical practitioner's letter: "On a day to day basis, Mr [ZC] reports on-going derogatory and persecutory auditory hallucinations at night that cause him great distress". These two letters are clearly sufficient to meet the criteria for level 3 evidence and ought to have engaged the AAR policy when it was implemented (and chapter 55.10 of the EIG before that). For detainees held in prisons, the level of care they receive is a lottery. The quality of ZC's treatment declined quickly once he was transferred from one prison to another in August 2016. His weekly appointments with a psychologist and CMHT stopped and he only saw a member of the mental health care team twice in his first three months; he did not receive any anti-depressants or anti-psychotics for a period of almost two months. (Continued on following page)

(ZC case study continued)

ZC had to lodge eight formal healthcare complaints relating to the level of care he received whilst detained; two complaint letters were written to the head of healthcare on his behalf by the Community Care Caseworker at Prisoners' Advice Service. He writes of the distress this caused him in one complaint: "The constant denial of key services as pathways to recovery is causing me undue levels of anxiety and thoughts of suicide as a direct result of the lack of attention to my specific case". These added to the growing body of evidence of the harm that detention was causing.

None of ZC's monthly progress reports contained any reference to the AAR policy after it came into force, or to any aspect of his vulnerability to harm in detention. Along with the body of independent evidence of his vulnerability, ZC was eloquent and proactive in defending his rights and holding healthcare to account; and yet this did not lead to the Home Office applying the AAR policy.

Once transferred to an IRC in April 2017, he began the process of obtaining a rule 35 report, and this was almost complete by the time he was granted bail in June 2017. It is likely that the ensuing review of ZC's detention would have been a flawed process, but still preferable to the two and a half years he was detained in prison under immigration powers without having his vulnerability recognised or his conditions adequately treated.

Case Study: AD

AD was detained in prison under immigration powers in December 2015, for 1 year and 2 months and was thus detained for five months following the implementation of the new AAR policy. He suffers from severe depression, repeated psychotic episodes, paranoid personality disorder, and HIV for which he had been prescribed various medications.

While he was detained in prison, his son passed away five days after his birth, and both his mother and his mother in law also died. Detention profoundly affected his mental health and interfered with the bereavement process. His diagnoses and various prescriptions predate his period of immigration detention. Six months after his detention began in a psychiatric report stated the following:

"Personality disorder pervades 'all major aspects of his life, affecting his functioning level to a large extent. This personality makeup appears to have developed in his case due to his childhood adverse experiences and abuse that he suffered... He has suffered repeated psychotic episodes. His mental health condition appears to have deteriorated due to various deaths that have occurred. He appears not to have grieved appropriately"

"In a community setting should he be provided with effective mental health support and appropriate accommodation he is likely to make a recovery much quicker, i.e. come to terms with the death of his child and also re-establish himself within a community setting." (Continued on following page)

(AD case study continued)

Although this report was prepared just prior to implementation of the new AAR policy, the information remained on the file and should have triggered an AAR assessment when the policy was implemented, as it constitutes level 3 evidence of risk. His medical assessments also detail sexual trauma suffered in prison, and a document from CMHT which confirms that he would be offered care from a mental health foundation trust if released.

However, the only recognition of such vulnerability by the Home Office is a monthly progress report in January 2017 (over a year after detention began and months after the implementation of new AAR policy), which states:

“on [X]/04/16, we requested your mental health and physical health report from HMP [X] healthcare team. On [X]/05/16 we received your mental health and medical report, and this has been passed to return logistics team to consider”

This note implies that the Home Office was considering the mental health and medical report seven months after receipt of the evidence. These statements do not constitute an application of the AAR policy, although they do indicate that the Home Office was apprised of independent evidence of AD’s vulnerability. AD’s case typifies the treatment that immigration detainees in prisons receive from the Home Office; their cases are forgotten for long periods of time, and it appears that Home Office decision-makers are not concerned to apply the AAR policy even where they have acknowledged indicators of vulnerability.

Case Study: BE

BE was detained in a prison under immigration powers for seven months. He was diagnosed with psychotic disorder and was under heavy medication for the duration of his detention in prison. His medical records also record various suicide attempts, both in the UK and back in Iraq. BE was the only person in the prison sample whose vulnerability was recognised under the AAR policy. A monthly progress report classifies the client as a level 2 adult at risk. However, the policy was not fully applied as the client’s vulnerability was not balanced against the immigration control factors in order to assess whether his detention continued to be appropriate. And yet for vulnerable immigration detainees held in prisons, recognition of their vulnerability is the most protection they can hope for.

5. Recommendations

BID maintains that the only way to stop vulnerable individuals from being detained is to end immigration detention. The use of immigration detention for administrative convenience is shown to lead to the improper and injudicious use of detention, which causes great harm to individuals. While detention remains, BID makes the following recommendations:

1. The categorisation of vulnerability based on evidence levels should cease. There should be a very low threshold required to demonstrate that an individual exhibits an indicator of vulnerability.
2. Once an indicator of vulnerability has been identified, the Home Office should not detain the individual or should release the individual from detention if they are already detained. It is unacceptable that release should be predicated on whether or not the individual is likely to suffer future harm in detention.
3. Individuals' wellbeing should take primacy over immigration enforcement or control interests of the Home Office.
4. The current indicators of vulnerability - "torture" and "victims of sexual or gender-based violence" - should be replaced with a more inclusive category based on the UNHCR detention guidelines, namely "victims of torture or other serious, physical, psychological, sexual or gender-based violence or ill-treatment".
5. The detention gatekeeper should be required to make reasonable investigations prior to detention to confirm that an individual does not exhibit an indicator of vulnerability.
6. There should be judicial oversight of all decisions to detain with vulnerability central to an assessment of the overall necessity of detention.
7. Home Office decision-makers should undertake regular, meaningful reviews of decisions to detain, which take into account vulnerability and its dynamic nature. Reviews should occur regularly through monthly progress reviews, but also whenever circumstances change. Home Office internal monthly reviews and Gatekeeper reviews of suitability or maintenance of detention should always be disclosed to detainees and their representatives.
8. Medical practitioners and Home Office staff should receive comprehensive training regarding the identification of indicators of vulnerability (including staff and practitioners who operate within prisons).
9. While prisons continue to be used for immigration detention, there should be equivalent regimes applied in prisons to those held there under immigration powers as apply to those in IRCs.

Appendix 1: AAR policy legal framework and assessment summary

Legal framework

Applies to
immigration
detainees held
in prisons and
IRCs

Legislation

Immigration Act 2016

Section 59 Guidance on detention of vulnerable persons

Provides that the SSHD must issue guidance setting out what needs to be taken into account in determining “(a) whether a person (“P”) would be particularly vulnerable to harm if P were to be detained or to remain in detention, and (b) if P is identified as being particularly vulnerable to harm in those circumstances, whether P should be detained or remain in detention”.



Statutory Guidance

“Immigration Act 2016: Guidance on adults at risk in immigration detention” published August 2016, implemented September 2016 (“AARSG”)

Sets out the general Adults at Risk policy principles and processes as required under s59



Home Office Guidance

Guidance on Immigration Offender Management for Officers dealing with Immigration Enforcement matters in the UK (“Offender Management”) which is comprised of policy guidance documents for Home Office staff that set out processes which Home Office staff must apply in relation to vulnerable adults and detention, most importantly:

- **“Adults at Risk in Immigration Detention”** Version 2.0 published on 6 December 2018 “This guidance tells you what to do to assess if a person, who is being considered for immigration detention, is an ‘adult at risk’ in the terms of this policy.”
- **Chapter 55 Enforcement Immigration Guidelines:** sets out generally how the power to detain may be exercised.

Rules

Detention Centre Rules 2001

- **Rule 34**

All detained people shall be given a physical and mental examination by the medical practitioner within 24 hours of their admission to the IRC.

- **Rule 35**

Staff in detention must send a report to the SSHD notifying them of any detainee (1) whose health will likely be injuriously affected by detention (2) for whom there are concerns of suicidal ideation; (3) who may have been a victim of torture.

Detention Services Orders

Further guidance for Home Office Immigration Enforcement, staff responsible for authorising, managing and reviewing detention, as well as IRC supplier and healthcare provider staff working in IRCs.

Eg: DSO 08/2016 Management of Adults at Risk in Immigration Detention February 2017; DSO 09/2016 Detention centre rule 35; and Detention Services Order 05/2016 Care and Management of Pregnant Women in Detention

Applies to
immigration
detainees in
IRCs **only**

Adults at Risk Assessments Summary

A. Indicators of risk

- ⇒ Torture victim;*
 - ⇒ SGBV victim, (including FGM);
 - ⇒ Victim of human trafficking or modern slavery;
 - ⇒ PTSD;
 - ⇒ Pregnancy;
 - ⇒ Suffering from a serious physical disability;
 - ⇒ Suffering from serious physical health conditions or illnesses;
 - ⇒ aged 70 or over;
 - ⇒ transsexual or intersex;
- And other conditions which may render an individual particularly vulnerable.

B. Evidence levels

Evidence Level 1

The individual has made a “self-declaration” that he/ she is at risk .

Evidence Level 2

There is “professional evidence” or “official documentary evidence” stating that the individual is at risk.

Evidence Level 3

There is “professional evidence” stating that the individual is at risk;

AND

That a period of detention would be likely to cause harm.

C. Immigration control factors

“An individual should be detained only if the immigration factors outweigh the risk factors...” The weight that is placed on various immigration control factors differs depending on the evidence level .

A level 1 adult at risk can be detained if one of the following immigration control factors applies:

- ⇒ the date of **removal can be forecast with some certainty** and if this date is within a **reasonable timescale**;
- ⇒ **any public protection issues** are identified;
- ⇒ there are **indicators of non-compliance**

A level 2 adult at risk can be detained if one of the following immigration control factors applies:

- ⇒ the **date of removal is fixed**, or **can be fixed quickly**, and is **within a reasonable timescale** and the individual has failed to comply with reasonable voluntary return opportunities, **OR** if the individual is being detained at the border pending removal having been refused entry to the UK;
- ⇒ they present a **level of public protection concerns** that would justify detention **OR** there is a **relevant national security OR other public protection concern**;
- ⇒ there are **negative indicators of non-compliance** which suggest that the individual is highly likely not to be removable unless detained.

A level 3 adult at risk can be detained if one of the following immigration control factors applies:

A person can be detained if one of the following applies:

- ⇒ removal has been set for a date in **the immediate future**, **there are no barriers to removal**, and escorts and any other appropriate arrangements are (or will be) in place to ensure the safe management of the individual's return **and** the individual has not complied with voluntary or ensured return.
- ⇒ the individual presents a **significant public protection concern**, **OR** if they have been subject to a **4 year plus custodial sentence**, **OR** there is a **serious relevant national security issue OR** the individual **presents a current public protection concern**.

*The definition of ‘torture’ has changed since the implementation of the AAR policy in September 2016 as the Courts found the definition initially contained in the policy to be unlawful. Refer to *Medical Justice v SSHD [2017] EWHC 2461 (Admin)*.

Appendix 2: Vulnerabilities present in the IRC sample and the prison sample

IRC sample	
Vulnerability	n
Depression:	12
Anxiety:	3
PTSD:	10
Bipolar:	1
Victim of torture:	19
Blind:	1
Victim of modern Slavery:	1
Victim of trafficking:	1
Hypertension:	1
Suicidal/ self-harm:	5
Rape/ sexual abuse:	2
FGM:	1
Type 2 diabetes:	1
Schizophrenia:	2
Overeating:	1
Past drug abuse	2

IRC sample			
	Detainee	Type of Vulnerability	Level Risk
1.	JB	Victim of torture Depression PTSD	2
2.	GE	Depression Anxiety Victim of torture	No AAR assessment
3.	LL	Victim of torture	No level given
4.	OI	Victim of torture Depression Anxiety PTSD Bi-polar disorder Type 2 Diabetes	No level given
5.	FG	Depression PTSD Victim of torture	2
6.	SE	Schizophrenia PTSD Depression Suicidal	No level given
7.	KA	Victim of torture victim	2

		Depression PTSD Trafficking victim	
8.	HD	Depression Suicidal (4 suicide attempts, on hourly watch by IRC staff due to self-harm concerns)	2
9.	MK	Victim of torture	2
10.	VB	Victim of torture	No AAR assessment
11.	TD	Victim of torture Victim of child abuse Suicidal	1/2
12.	WA	Victim of torture Insomnia Anxiety High blood pressure Hypertension	2
13.	DI	Victim of modern slavery Victim of torture Depression	2
14.	RF	Depression Blind Victim of torture	2
15.	UC	Victim of torture	2
16.	EH	Depression PTSD Victim of torture	2
17.	CJ	Victim of torture PTSD	2
18.	PH	Victim of torture	2
19.	NJ	Schizophrenia Suicidal Rape Sexual exploitation Past drug abuse	No AAR assessment
20.	IC	Serious brain trauma Past drug abuse	2
21.	QG	Rape FGM PTSD Victim of torture (on the basis of the rape, although this was	1

		rejected by HO)	
22.	BK	Victim of torture Depression Self-harm PTSD	3
23.	AL	Depression Over eating Victim of torture	2

Prison sample			
	Detainee	Type of Vulnerability	Level Risk
1.	AD	Severe depression Repeated psychosis episodes Paranoid personality disorder HIV	No AAR assessment
2.	XA	Schizophrenia Bipolar disorder	No AAR assessment
3.	BE	Psychotic disorder Manic episode anxiety Intrusive thoughts	2
4.	CF	Depression Anxiety Heart condition	No AAR assessment
5.	ZC	Depression with psychotic features Suicidal PTSD Hallucinations Victim of torture	No AAR assessment
6.	YB	Schizophrenia Bipolar Disorder Comorbid mental illness Illicit substance and alcohol misuse Suicidal	No AAR assessment
7.	DG	Schizophrenia Depression PTSD	No AAR assessment

Appendix 3: The definition of torture and the AAR policy

The applicable definition of torture has changed over the course of the AAR policy since Shaw and has been the subject of legal challenge. In September 2016, a new torture definition was introduced (previously it had been defined by caselaw):

“any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed or is suspected of having committed, or intimidating or coercing him or a third person, or for any reason based on discrimination of any kind, when such pain or suffering is 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.” (Article 1 of the UN Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (UNCAT).) It includes such acts carried out by terrorist groups exploiting instability or civil war to hold territory.”

NGOs, including BID, advised against this definition as it was drafted in UNCAT for the purposes of prosecuting state perpetrators of torture, rather than identifying vulnerability in individuals. The Courts agreed, and the definition was found to be unlawful in the Medical Justice case (*Medical Justice v Secretary of State for the Home Department* [2017] EWHC 2461 (Admin)). The Home Office reverted to the definition of torture set out in the EO case (*EO and Others v SSHD* [2013] EWHC 1236 (Admin)), that is:

“any act by which severe pain or suffering, whether physical or mental, is intentionally inflicted on a person for such purposes as obtaining from him or a third person information or a confession, punishing him for an act he or a third person has committed, or intimidating or coercing him or a third person, or for any reason based upon discrimination of any kind.”

while it developed a definition that aligns with the Medical Justice ruling.

New statutory instruments came into force in relation to the torture definition at the time of writing (2 July 2018), which defined torture as follows:

“any act by which a perpetrator intentionally inflicts severe pain or suffering on a victim in a situation in which— (a) the perpetrator has control (whether mental or physical) over the victim, and (b) as a result of that control, the victim is powerless to resist.”

The revised definition of torture requires the individual to meet multiple limbs and is excessively complex. It requires medical practitioners and Home Office decision-makers to go beyond their expertise, which we consider will lead to its arbitrary application. It is anticipated that the new definition will be the subject of another legal challenge.

BID and other NGOs maintain that the current categories of “torture” and “victims of sexual or gender based violence” should be combined and replaced with a more inclusive category modelled on the UNHCR detention guidelines, namely ‘victims of torture or other serious, physical, psychological, sexual or gender based violence or ill-treatment’. This would avoid decision-makers drawing unnecessary or artificial distinctions between ill-treatment, abuse and torture for the purpose of identifying vulnerability in detention.

