Medical Justice
working for health rights for detainees
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Response to consultation on Detention Services Order 05/2016: 'Care and Management of Pregnant Women in Detention', August 2016

Dear Sir / Madam,

We welcome the opportunity to comment on the Detention Services Order on the 'Care and Management of Pregnant Women in Detention'.

This policy is being revised in the context of Stephen Shaw's review finding that detention '*has an incontrovertibly deleterious effect on the health of pregnant women and their unborn children*[1]*'*. The Royal College of Midwives stated in their submission to the review that '*women who are pregnant are uniquely vulnerable in so far that they (and their babies) will always have specific, and sometimes serious healthcare needs which are time-critical and may impact on health outcomes*'[2].

Medical Justice believes that pregnant women should not be detained in immigration detention. We welcome this new policy as an important step forward. However, we do have a number of concerns about the guidance which are set out below.

We are grateful to the Royal College of Midwives (RCM) for sight of its comments on the Detention Services Order. We share the RCM's concerns and endorse the recommendations made in their response.

Comments on the Detention Services Order

1. An introductory paragraph should be added, re-stating the purpose of the policy – to minimise instances of pregnant women being detained and to ensure all involved have regard to the welfare of pregnant women, and stressing the importance of the new duty to have regard to the woman's welfare.

2. **Paragraph 2**: Given the '*incontrovertibly deleterious effect'* detention has on the health of pregnant women and their unborn babies, it is not acceptable that the DSO does not apply to women detained at the border.

3. **Paragraph 4**: The starting point for the time limit of detention is the later of either the point of detention or the point the Secretary of State is first satisfied that the woman is pregnant. This provision creates a risk that women could be detained for prolonged periods of time before a pregnancy is confirmed. It therefore needs to be made clear that there would there should normally be no reason to disbelieve a woman who reports she is pregnant and in many

[1] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/490782/52532_Shaw_Review_Accessible.pdf.

[2] As quoted in Stephen Shaw's report.

cases it will be clearly visible. If confirmation is required, a pregnancy test must be offered straight away- there should be no delay.

4. **Paragraph 6**: The provisions in paragraph 6 should apply to both women with a known and a suspected pregnancy.

5. **Paragraph 8**: Pregnant women should never be held in facilities where it is not possible to make adequate provision for their needs. The phrase 'where practicable' should therefore be removed from this paragraph.

6. **Paragraph 10**: Pregnant women should not be transferred between centres during the night. If there is no other option, then the woman should be released.

7. **Paragraph 27**: Clearly confidential medical information cannot be shared in this situation without the consent of the pregnant woman. When asking for consent it is crucial that the purpose and implications of providing consent are properly explained to the women in a language she can understand. Consent forms should be specific to the information shared and the purpose for which it is being shared.

8. Any centre where pregnant women are held must ensure that sufficient staff are available to take the woman to hospital if required. It is not acceptable for trips to hospital to be delayed because of unavailability of transport or escorting staff.

9. **Paragraph 33**: The provision of antimalarial medication to pregnant women is complex. It is rightly a matter for healthcare, but given the implications for fitness to fly and therefore for decisions on detention, it would be helpful to provide some parameters here. Public Health England Guidelines for the Prevention of Malaria in Travellers from the UK 2015 advises pregnant women not to travel:

> "*6.2 Pregnancy Pregnant women are advised to avoid travel to malarious areas. In the event that travel is unavoidable, the pregnant traveller must be informed of the risks which malaria presents and the risks and benefits of antimalarial chemoprophylaxis. Pregnant women have an increased risk of developing severe malaria and a higher risk of fatality compared to non-pregnant women. Diagnosis of falciparum malaria in pregnancy can be particularly difficult as parasites may not be detectable in blood films due to sequestration in the placenta.*"[3]

Those who have lived in the UK for a period of time will have lost their exposure-related partial protection and are therefore at higher risk.

For pregnant women, there is a limited range of anti-malarials available. Some anti-malarials have serious potential side effects and cannot be safely taken during certain stages of the pregnancy or by people with specific current or historic medical problems.

The timing of a planned removal must be such that the anti-malarials will be effective by the time the person is removed. Pregnant women may well be at risk of contracting malaria when

[3] https://www.gov.uk/government/publications/malaria-prevention-guidelines-for-travellers-from-the-uk.

they first arrived since they may be homeless and not have anywhere to hang their mosquito net. Mosquito nets should also be provided.

Detainees who cannot safely take anti-malarials, and who would be removed to high-risk malarial areas, are not fit to fly during their pregnancy and must not be detained.

10. **Paragraph 35:** Detention interrupts a woman's maternity care – initially, when the woman is detained and often again when the woman is released. To minimise the disruption caused pregnant women should be given the option of being released to the area where they were previously living so that they can resume maternity care there. They should not be housed in temporary accommodation in hotels or initial accommodation hostels given the barriers to accessing maternity care from these types of addresses. Healthcare records, including scan and blood test results and any records from the local maternity unit must be provided whenever a woman leaves an IRC (whether to be removed or released).

11. If, for operational reasons, travel cannot be arranged during the day time, pregnant women should be offered the option of being accommodated at a local hotel for one night with travel arranged for the next day.

12. **Paragraph 37**: We welcome the introduction of multi-disciplinary meetings to develop removal plans. It is crucial that these meetings take place prior to the woman being detained to avoid unnecessary detention. With the woman's consent, information on any medical or welfare concerns should be sought prior to the meeting. In many cases it is clear from the outset that a woman would be unfit to fly- it would therefore be entirely indefensible to subject her to a damaging period of detention for the purpose of removal. Similarly, there may be specific dates (eg dates of important scans) that should be avoided.

13. **Paragraph 39:** An audit by Medical Justice found that pregnant women in detention are much more likely to have complex pregnancies than the average woman. NICE guidelines classify 'recent arrival as a migrant', 'asylum seeker or refugee status', and 'difficulty speaking or understanding English' as examples of 'complex social factors'.[4] Therefore, relying on IATA guidance for uncomplicated pregnancies as the basis for assessing fitness to fly is not appropriate. Individualised assessments are needed. This should be done prior to detention to avoid inappropriate detention, and kept under review throughout detention. Where a woman is reporting to the Home Office prior to detention, this could be done by asking her to seek her midwife's or doctors' advice and bring a letter to her routine reporting appointment. Assessment of fitness to fly must include consideration of whether anti-malarials are required and whether they can be safely prescribed.

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[4] https://www.nice.org.uk/guidance/cg110