Joint Submissions of the Immigration Law Practitioners' Association and Medical Justice to the Independent Chief Inspector of Borders and Immigration's Review on Adults at Risk in detention

A. Introduction

1. This is the joint response of ILPA and Medical to the call for evidence by the ICIBI in relation to the Home Office's working of the Adults at Risk ('AAR') process. ILPA is a registered charity and a professional membership association. Medical Justice is a registered charity providing independent medical advice, assessment and reports to immigration detainees.. We welcome this opportunity to submit evidence based on the casework experience of ILPA members and cases referred to Medical Justice.

2. When the Government announced the introduction of the "adults at risk" concept into decision-making on immigration detention, it was with the clear presumption that people who are at risk should not be detained. The purpose, as stated in a note published by the Government in March 2016[1] was that *"fewer people with a confirmed vulnerability will be detained in fewer instances and that, where detention becomes necessary, it will be for the shortest period necessary."* The Government had stated that it was meant to build upon and improve the previous policy framework under paragraph 55.10 of the Enforcement Instructions and Guidance Chapter 55. **However, for reasons detailed below, it is ILPA's and Medical Justice's view that, the Adults at Risk framework has to date failed to achieve this objective and even more worryingly, seems to have led to more vulnerable people being detained and for longer periods of time, contrary to the stated intention of the Government.**

3. The submissions are structured as follows:

   3.1. Failures in Detention Gatekeeper and detention reviews / case progression panels;
   3.2. Failures in the operation of Rules 34 and 35 of the Detention Centre Rules;
   3.3. Lack of and / or ineffectiveness of alternative reporting mechanisms for identifying detainees who are 'at risk';
   3.4. Absence of structured process for identifying immigration detainees who are 'at risk' in prison;

[1] See *Annex B: Detaining individuals for the purposes of Immigration Control – Consideration of Risk Issues* published on 1 March 2016.

3.5. Assignment of evidence levels to adults 'at risk';

3.6. Approach to balancing exercise / immigration factors;

3.7. Special cases:

3.7.1. Victims of torture;

3.7.2. Victims of trafficking;

3.7.3. Mentally ill and mentally incapacitated detainees;

3.7.4. Vulnerability catch-all provision under the AAR policy

3.8. Operation of the Removals Policy in respect of adults 'at risk'

4. Case studies addressing the identified thematic issues of concern are annexed to these submissions. ILPA and Medical Justice have also had sight of the case studies identified by Garden Court Chambers, all of which also serve as examples addressing the concerns outlined above and discussed in more detail below.

B. Failures in Detention Gatekeeper and detention reviews / case progression panels

5. There are three main concerns under this heading:

5.1. the inability of the current system to screen for vulnerability and prevent the detention of individuals who are at risk of harm in detention;

5.2. lack of transparency as to the way the Detention Gatekeeper and case progression panels operate; and

5.3. insufficient independent scrutiny of decisions to detain and maintain detention.

6. The Detention Gatekeeper ('DG') and detention case progression panels were introduced further to the recommendation in Steven Shaw's first review of more independent oversight over detention decision-making and reviews.

7. The DG team was set up in June 2016, designed to ensure a consistent approach to decision-making on detention. One important purpose is 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."*[2] However, we are concerned that this is an entirely internal and opaque process operated by the very department which is seeking to detain individuals for the purposes of immigration

[2] https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2017-04-21/71612/

enforcement and removal. There is, on its face, an inherent lack of independence in this screening mechanism.

8. Very little information is available as to who the DG team consists of, what their training and qualifications are and to what extent they operate in practice at an arm's length to immigration enforcement teams. There is also no publicly available information about what the DG is required to have regard to when considering whether a person may be particularly vulnerable to harm in detention so that detention powers should not be exercised.

9. Structurally, the DG screening mechanism is not set up to identify potential vulnerabilities as there is no in-built safeguard for seeking independent clinical input into the range of indicators of risk identified in the Adults at Risk statutory guidance at paragraph 11 or any alternative way to assess vulnerability in a person who does not obviously fall within one of those indicators of risk. This is because the DG screening process takes place prior to a prospective detainee entering the detention estate. Thus the supposed safeguards for identifying potentially vulnerable detainees in detention - the Rules 34 and 35 processes under the Detention Centre Rules 2001 – will not yet have been triggered. Whilst those mechanisms operate in practice in a deeply flawed way (see below), they do provide a means within the system for ensuring the possibility of independent clinical input into the identification of vulnerabilities in prospective detainees. There is no comparable safeguard in the DG screening mechanism.

10. The prospective detainee and their legal representative (if there is one) are not invited to make representations to the DG in advance of a decision to detain. No inquiries are made to the prospective detainee to ascertain their up to date personal circumstances, including in relation to their physical and mental health and developments in their immigration situation. As currently operated, the DG is entirely reliant on whatever information that is made available to them by the relevant Home Office casework team.

11. It has been our experience that the DG is often not provided with a full picture of what is already known about a detainee. Views of professionals who are involved with prospective detainees, including hospital psychiatrists, probation officers and social workers are very rarely, if ever, sought. Documentation relating prospective detainees' vulnerabilities, as set out in psychiatric hospital and prison records and / or social services records, are also not

sought, even when the prospective detainee is, at the point of the DG screening, detained in a psychiatric hospital or under the intensive care of social services. The effectiveness of the DG as a screening mechanism is thus limited by and dependent on the quality of evidence and information provided by the very Home Office casework team which is seeking to take enforcement action against the individual. Unless the Home Office caseworker is comprehensive in the information provided to the DG and / or has access to up-to-date medical records or reports, it is highly likely that either:

11.1. vulnerabilities will not be identified to the DG at all;

11.2. where indicators of vulnerabilities are identified, they will not be accompanied by professional evidence and thus will at best be treated by the DG as 'at risk' level 1 / self-declared evidence of vulnerability, which according to the Home Office's Adults at Risk statutory guidance, is afforded very limited weight; or

11.3. in some of the casework we have seen, information is routinely either ignored or disregarded in the DG's screening consideration in favour of immigration enforcement even where it is obvious that the prospective detainee is particularly vulnerable to harm in detention.

12. These multiple problems with the effectiveness of the DG screening mechanism can be illustrated by the annexed case studies of 'Q', 'T', S' and 'J'. The ICIBI's attention is also drawn to the particularly egregious examples of failures in the DG screening mechanism identified by two ILPA members (at paragraphs 29 and 31) to the Joint Committee on Human Rights in its recently published report on Immigration Detention.[3]

13. In respect of foreign national offenders ('FNOs'), the DG screening mechanism is even less effective. It is our understanding that the DG's view of likely vulnerability of a prospective FNO to detention is merely advisory, and can be overruled if a Criminal Casework Director rejects a recommendation that a detainee should not be detained or should be released.

14. These problems are unfortunately replicated in the context of case progression panels. Again, these panels are an internal process of the Home Office. There is no publicly available information about who sits on the panel, what their qualifications are and when the panel becomes involved. Detainees are not informed of their existence or informed of

[3] https://publications.parliament.uk/pa/jt201719/jtselect/jtrights/1484/1484.pdf

when their review takes place so that representations and evidence can be submitted by the detainee and / or their legal representatives. The panels are therefore, like the DG, entirely reliant on information provided by the Home Office casework team. Panel meetings and recommendations are not referred to in Monthly Progress Reports to detainees. Detainees are not otherwise informed of any decisions or recommendations made by the panel and will be entirely unaware that the panel has met at all in respect of their cases, until or unless they obtain a copy of their Home Office file. Our experience is that decision-making is often made on an incorrect or incomplete understanding of the factual situation applicable to the detainee.

C. Failures in the operation of Rules 34 and 35 of the Detention Centre Rules;

15. Under the structure of the Detention Centre Rules there is a requirement in Rule 34(1) that each IRC must complete a physical and mental assessment of each detainee within 24 hours of their arrival. This provides an important first opportunity for healthcare to notify the Home Office of any issues of vulnerability relevant to the decision to detain right at the start of the period of detention. Rule 35 concerns an ongoing obligation for IRC GPs to inform the Home Office of any: (1) detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention; (2) suspicions of suicidal intentions of any detained person; and (3) detained person who may be a victim of torture.

16. The courts have repeatedly emphasised the central importance of the Rules 34 and 35 processes as safeguards to ensure that vulnerable individuals are identified and not inappropriately detained, most recently in the *Medical Justice* case in October 2017.[4] If these processes do not work effectively, detainees would have to fall back on lawyers and organisations like Medical Justice to bring concerns and information about them to the attention of the Home Office, with the result that very many torture survivors and other vulnerable individuals would be missed and / or delays to the identification of their vulnerabilities and consideration of their release. This is unacceptable because it shifts the onus onto detainees to prove their vulnerabilities in circumstances where it is and should be the responsibility of the Home Office to operate a safe detention system capable of identifying those who are vulnerable.

[4] [2017] EWHC 2461 (Admin).

17. The efficacy of the Rules 34 and 35 procedures have long been the subject of criticisms by the ICIBI and the Independent Chief Inspector of Prisons, the Courts and more recently by Stephen Shaw in his two reviews. We remain concerned that despite awareness of these concerns, the processes continue to operate in deeply flawed ways which inhibit the identification of vulnerable detainees for the purposes of consideration of their release from immigration detention. Our main concerns are as follows:

    17.1. The routine failure to arrange Rule 34 medical assessments and its consequence;
    17.2. The delays / long waiting lists for Rule 35 assessments;
    17.3. Poor quality of Rule 35 reports;
    17.4. Failure / Delay in completing Rule 35(1) and Rule 35(2) reports;
    17.5. Refusal / failure to complete Rule 35(3) reports on account of restrictive 'torture' definition

C.1. Routine failure to arrange Rule 34 medical assessments and its consequences

18. Rule 34 has always required medical assessments to be carried out within 24 hours of a detainee entering the immigration detention estate and be completed by a medical doctor. However we have consistently seen in the casework of ILPA members and Medical Justice a persistent failure to arrange for Rule 34 medical assessments to be carried out at all and in any event promptly within the prescribed timescale (or anywhere close to it). This problem dates back before commissioning responsibility was shifted to NHS England, but has persisted notwithstanding a change in the commissioning body.

19. As stated at the outset, the Rule 34 medical assessment is an important first opportunity for vulnerable detainees to be identified if not already screened out by the DG. A medical history of the detainee's physical and mental health should be taken and a physical and mental state examination should be carried out. This is an early opportunity, within a clinical environment, to identify physical scarring that may be indicative of past torture or ill-treatment, and mental health symptoms and past history that may make someone vulnerable to harm in detention. The Rule 34 medical assessment is also the crucial tool by which detainees who may require a report under Rule 35 of the Detention Centre Rules 2001 are identified.

20. The Home Office has sought in litigation to defend the failure to conduct Rule 34 medical assessments by pointing to initial healthcare screening conducted with a detainee when they

first get inducted into the detention estate. However, these initial health screenings are cursory and not designed for the purposes of taking a proper medical history of the detainee so that concerns about their potential vulnerability can be identified. There is no standardised screening assessment tool in use across the immigration detention estates; this creates inconsistencies as to what information is captured by such screening tools depending on where the detainee is held. NHS England itself identified this in 2015 as a problem that needs to be addressed but to date, so far as we are aware, no steps have been taken to produce standardised screening assessments [5] Initial assessments normally consistent of closed yes / no questions and are heavily reliant on self-reporting. They are also frequently administered at a time when the detainee is likely to be distressed, frightened and preoccupied with immediate circumstances / shock of being detained; or because the detainee was not asked questions relating to whether he or she had been subject to ill-treatment or torture. Moreover, such health screenings are carried out by nursing staff who are not qualified to undertake the sort of medical assessment required under Rule 34.

21. Recently, the ineffective operation of the Rule 34 process was heavily criticised by the High Court in *R (KG) v SSHD* [2018] EWHC 1767 (Admin). In that case, the detainee was a victim of torture who was not provided with a Rule 34 medical assessment at all at two detention centres, Campsfield and Harmondsworth. He was only subsequently provided with a Rule 35(3) assessment identifying him as a victim of torture more than a month after he was first detained. The High Court affirmed the mandatory nature of the duty to arrange for a Rule 34 medical assessment and the requirement for this assessment to be undertaken by a medical doctor. The High Court held that a failure to follow the requirements of Rule 34 and to ensure that an examination takes place within 24 hours of admission undermines the process prescribed for the identification and release of victims of torture and other vulnerable detainees. On the facts, had the Rule 34 been done in a timely manner as is required under the rule, KG would have promptly been identified as a potential victim of torture, leading to a Rule 35(3) assessment which would have provided compelling evidence for his release from immigration detention. Indeed, when a Rule 35(3) report was later provided, KG was released.

22. Although that case was decided only on its facts, KG's experience echoes those of clients of both ILPA members and Medical Justice. Although the partnership agreement between

[5] NHS England (2015) Health and Wellbeing Health Needs Assessment Programme: Immigration Removal Centres and Residential Short Term Holding Facilities. NHS England: London.

the Home Office, NHS England, and Public Health England make clear the obligation on all parties to ensure adequacy of timely healthcare in immigration detention, the failure to complete Rule 34 reports are now routine and mean that vulnerable detainees who have not been screened out by the DG do not get identified at the earliest opportunity once they enter the detention estate.

C.2. Delays / Long waiting lists for Rule 35 assessments

23. It is the experience of ILPA members and Medical Justice that in the past, when a Rule 34 medical assessment identified potential vulnerabilities, a Rule 35 assessment usually followed on immediately. In recent years, the two processes have somehow been delinked such that even where a need for a Rule 35 report has been identified, it is not done straight away. Instead, detainees are placed on a waiting list to be seen by a GP for a Rule 35 assessment. This undermines the very purpose and effectiveness of Rule 35, which is to identify detainees who should not be detained at the earliest opportunity.

24. The problems caused by the split in the Rule 34 and Rule 35 process are presently aggravated by the long waiting lists for Rule 35 assessments. These backlogs have consistently been documented by government agencies. See for example:

    24.1. The 2016 Independent Monitoring Board report on the Heathrow IRCs:[6] *"Average wait times throughout the year have been around 2 weeks, although maximum wait times have exceeded a month on occasions, which is unacceptable."*

    24.2. The 2017 Independent IMB annual report on the Heathrow IRCs:[7] "There can be a backlog of these requests because of a lack of GP availability."

    24.3. The 2016 HM Inspector of Prisons report on Colnbrook IRC:[8] "However, detainees waited up to three weeks for a rule 35 assessment, which was too long."

25. Medical Justice is aware that the current backlog, as at February 2019, for a Rule 35 report at Harmondsworth IRC is about 3 to 4 weeks.

[6] At page 14, available at ***https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2017/06/Heathrow-IRC-2016-.pdf***

[7] At page 19, available at ***https://s3-eu-west-2.amazonaws.com/imb-prod-storage-1ocod6bqky0vo/uploads/2018/04/Heathrow-IRC-2017-AR.pdf***

[8] At para 2.56, available at https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2016/07/Colnbrook-Web-2016.pdf

26. The backlog is not only a present and ongoing problem, it has persisted for more than four years. The significant adverse effect of the wait times is self-evident as it means that vulnerable detainees are not identified in a timely manner at the earliest opportunity, and those unsuitable for detention remain exposed to the harm of being detained for a longer period of time as a result of the waiting lists. See for example the case of 'Z' referred to in the annex. Z is a victim of trafficking who attempted suicide when served with a removal window. His failed suicide attempt did not precipitate a Rule 35 assessment. Nor did his disclosure of forced labour exploitation when he was trafficked. He referred himself for a Rule 35(3) report by approaching the detention healthcare centre. It was not until Medical Justice contacted the healthcare unit to ask what had happened to his request that he was given an appointment date. He was only provided with a Rule 35 assessment 17 days after his request. That assessment not only identified him to be a victim of torture, it also identified him as likely to be harmed by continued detention. He was released a few days after the Rule 35 report was completed.

27. The concerns regarding the Rule 35 backlogs are particularly serious in those IRCs where the Home Office operates the Detained Asylum Casework ('DAC') process. According to the Home Office's *Asylum Claims in Detention* policy[9], where a Rule 35 report indicates that a person is an adult at risk who would be particularly vulnerable to harm in detention, that detainee should not be included in and / or should be removed from the DAC process. This is predicated on the principle that it would be inappropriate to subject detainees with indicators of vulnerabilities to a truncated asylum decision making process. This is because the detainees' vulnerabilities may adversely affect their ability to participate in the asylum process in detention; their vulnerabilities may require further investigation which cannot and should not be carried out whilst they remain in detention; and they may have complex claims related to their vulnerabilities that require externally corroborative evidence which cannot be obtained whilst they are detained.

28. The DAC process normally operates on a 28-day time scale from claim to decision. The current wait times for a Rule 35 report at Harmondsworth IRC are about the same. It is unrealistic to expect a detainee and / or their legal representatives to be in a position to obtain medical evidence of their vulnerabilities via an alternative means to Rule 35 within the 28 day DAC timescale; the Rule 35 assessment process is the only realistic mechanism

[9] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/646438/Asylum-claims-in-detention-v4.0EXT.pdf

for identifying vulnerabilities in a detainee. Yet the current wait times make it near impossible for vulnerable individuals to be identified *before* an asylum decision is made within the DAC process. The wait times thus create inherent risks that adults at risk will not be identified and removed from a process which they may not be able to effectively participate in.

29. Staff shortages and resources have often been cited as an explanation for the backlogs. Whilst this may well be the reason, it is our view that these staff and resource shortages do not excuse the backlog. Rule 35 is a crucial safeguard against the inappropriate use of detention powers on those who are particularly vulnerable to harm in detention. It is, in reality and for all practical purposes, the *only* clear mechanism for effectively identifying vulnerable detainees as defined under the Adults at Risk framework. (See further Section D below as to the lack of alternative reporting mechanisms). Thus it is in our view vital that the Rule 35 process operates in a manner that is capable of achieving that purpose. Resources cannot be a defence to the existence of a wait list when this concerns the deprivation of a person's liberty and there is a mandatory and non-derogable responsibility on the Home Secretary to arrange a safe detention system, this responsibility being fortified by Parliament's introduction of the Adults at Risk framework. We are not alone in raising these concerns. The British Medical Association in a 2017 report, *Locked up, locked out: health and human rights in immigration detention*[10] expressed concerns over staff shortages and problems with recruitment and retention negatively affecting the health and well-being of detainees and the timely and accurate identification of vulnerable detainees.

C.3. Poor quality of Rule 35 reports

30. The templates for Rule 35 reports have, in our view, improved. Importantly the templates do direct doctors not only to address the physical and mental conditions of the detainee identified in the course of the clinical examination but also to comment on the likely vulnerability to harm in detention. When these new templates were first introduced in September 2016 alongside the introduction of the AAR framework, they were not being widely used across the immigration detention centres and therefore medical doctors were not addressing all the issues that were required of them under the AAR policy. In our experience, the templates have now generally been adopted across the detention estates and,

[10] https://www.bma.org.uk/news/media-centre/press-releases/2017/december/doctors-concerned-health-needs-of-migrants-and-asylum-seekers-cannot-be-met-in-immigration-centres

in general, the templates have contributed to improved quality of Rule 35 reports. However we remain concerned about the quality of Rule 35 reports.

31. The utility of the reports in identifying and explaining vulnerabilities and their impact on continued detention is only as good as the information obtained by medical doctors in the course of assessments they carry out. It is our experience that too often, Rule 35 assessments are completed without the doctor taking a proper medical history of the detainee's physical and mental health and personal circumstances. In the absence of Rule 34 medical assessments, these physical and mental state examinations become necessary as the Rule 35 assessment becomes the first and only opportunity for such important information to be recorded in the detention medical records. Yet full physical examinations are routinely not completed, nor are mental state examinations. We do not know whether this is because (1) doctors are not directed to do so; (2) the time allocated for Rule 35 appointments is insufficient; or (3) no actual interpreters are provided for these assessments (sometimes telephone interpretation is used but this, in our view is less effective in the context of Rule 35 assessments which require detainees to divulge sensitive and intimate details about their past and their medical conditions). We suspect it is a combination of these factors that contribute to the absence of proper physical and mental state examination. Again, it is our view that whilst these factors may explain the absence of proper physical and mental examinations, they cannot excuse the failure to carry out such examinations, particularly as (1) too often Rule 34 medical assessments are not carried out; (2) there are no other established avenues by which such information can be elicited from the detainee; and (3) information gained from physical and mental state examinations are, in our view, quite fundamental to informing clinical views of vulnerabilities.

32. Rule 35 reports, when produced, are, in our experience, frequently formulaic and use stock phrases without proper engagement with the individual detainee's presentation or indication of any proper examination to inform these conclusions. For example, Medical Justice has noticed that at Yarl's Wood, Rule 35 reports frequently include a standard phrase stating that a person is currently stable, yet this clinical view is expressed with no indication that any actual mental health assessment had been carried out and can be inconsistent with other entries in the medical records. At Harmondsworth, Rule 35 repots frequently refer to the same few psychological problems (such as flash backs and low mood), which in our view suggest that they only ask about these particular symptoms and do not carry out a full mental health assessment. The body map that is intended to record scarring is not always

completed or completed with an accurate documentation of the scars, which suggests that a full physical examination is not always carried out. This correlates to information given to ILPA members by their clients when they are asked about their experience of the Rule 35 assessment.

33. Although the Rule 35 template now specifically direct doctors to address the impact of detention on the detainee, the absence of a mental state examination too often means that (1) the question of impact is not addressed at all or (2) the answers given are stock answers without proper explanation of the actual impact experienced by the detainee.

34. Stephen Shaw, in his first review, documented concerns by Rule 35 doctors that their reports and clinical assessments are too often rejected as independent evidence of torture and the concerns they do express in the Rule 35 reports as to the detainee's vulnerability to harm in detention are not listened to. We have not seen any active steps to addressing this. We have set out below our concerns about the Home Office's approach to Rule 35 assessments. Whilst we understand that this will inevitably influence doctors' approach to Rule 35 assessments, it is an unacceptable state of play given the important role that Rule 35 assessments play in identifying vulnerable detainees and its role in potentially securing these detainees' release from immigration detention.

C.4. Failure / Delay in completing Rule 35(1) and Rule 35(2) reports

35. Although historically the focus on the Rule 35 process has been on limb 3, relating to victims of torture, the other two limbs of Rule 35 also play important roles in identifying those who are or are likely to be vulnerable to harm in detention. They are however grossly underused. Appendix 2 to these submissions contains the breakdown of Rule 35(1), (2) and (3) reports for two years, covering the period preceding the implementation of the AAR framework and the most recently available 12 months. These are compiled from quarterly figures published by the Home Office.[11] The contrast between the use of Rule 35(3) and Rules 35(1) and (2) is self-evident from those figures.

36. The figures do not, in our experience, accurately reflect our clients' actual experience in detention and suggest that the Rule 35(1) and (2) mechanisms are significantly underused.

[11] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/760222/IE_Q3_2018_Published_.ods

That is, in our view, problematic because these are the mechanisms by which health concerns are meant to be promptly raised with the Home Office, with an important purpose of ensuring that the Home Office address its mind to whether in the circumstances detention can justifiably be maintained or whether the individual needs to be released from immigration detention because of their vulnerabilities.

37. In respect of those posing suicide risks or attempting suicide but failing, it is our experience that Rule 35(2) reports are seldom drawn up. Although detainees are frequently placed on supervision and monitoring under ACDT (Assessment and Care in Detention Team), the responsible caseworker at the Home Office is not automatically informed. The Rule 35(2) mechanism, on the other hand, *mandates* that concerns about suicide risks be informed to the Home Office so that this information can form the basis of a prompt review of whether detention should continue.

38. Similarly, the failure to raise Rule 35(1) concerns about individuals for whom detention is likely to be injurious is of grave concern for the obvious reason that particularly vulnerable detainees are therefore not being identified and removed from detention on account of its impact on their mental and physical well-being. Rule 35(1) reports are the obvious mechanism in the detention system for obtaining level 3 evidence of 'risk' which under the AAR policy affords the strongest presumption against detention. In practice, as can be seen from the published data, very few such reports are completed and almost exclusively in cases of serious physical disabilities or where significant harm has already occurred. Rule 35(1) reports are sometimes completed by psychiatrists contracted to provide care at the detention centre for severely mentally ill clients, however Medical Justice have been told anecdotally by healthcare staff that psychiatrists have been advised that they are unable under the Detention Centre Rules to complete Rule 35 reports. Medical Justice's case examples of 'A', 'V', 'C', 'B' and 'LT' are illustrative of the common case work experiences of ILPA members.

C.5. Refusal / Failure to complete Rule 35(3) reports on account of restrictive 'torture' definition

39. Although the AAR statutory guidance rightly identifies a list of indicators of being 'at risk', the Rule 35(3) mechanism has not been amended to reflect the broader 'at risk' categories. As explained in Section D below, there is at present no effective alternative reporting mechanism for identifying detainees who are 'at risk' if they do not fall within the ambit of the 'torture' definition under Rule 35(3).

40. We consider that the failure to amend Rule 35(3) to encompass the broader 'at risk' indicators was a significant missed opportunity to ensure this statutory safeguard is capable of identifying those falling with any of the range of at risk indicators. The failure to include a more comprehensive Rule 35 for encompassing all 'at risk' indicators makes the ambit of the 'torture' definition all the more important.

41. The definition of 'torture' was not, until July 2018, set out in Rule 35. The legal definition of 'torture' used for the purposes of Rule 35(3) was that stated by the High Court in *R (EO and Ors) v SSHD* [2013] EWHC 1236 (Admin).[12] In that case, the High Court positively rejected the Home Secretary's adoption of the definition of torture contained in the UN Convention Against Torture ('UNCAT') on the basis, as found by the Judge that the purpose of Rule 35 (and the detention policy) is to protect those who are particularly vulnerable to the adverse effects of detention. The identity of the perpetrator – being a state actor or not – is irrelevant to this. Someone who has suffered severe pain or suffering from a non-state actor may equally be vulnerable to harm to detention as someone whose suffering was caused by a state actor.

42. Yet despite this clear finding on the issue, the Home Secretary attempted again to introduce the UNCAT definition of torture for application to detention and Rule 35 reports in September 2016. This was successfully challenged by Medical Justice by way of a judicial review application on the basis that the UNCAT definition focuses narrowly on acts instigated by or carried out with the consent or acquiescence of public officials and was likely to be applied in a manner which excludes victims of ill-treatment by non-state actors. This rendered the AAR policy less protective for victims of torture than the previous policy under EIG 55.10. As was held in *EO*, the crucial determinant of torture-related vulnerability to harm in detention is the experience of powerlessness when the severe pain and suffering are inflicted, and not the identity of the perpetrator. Also, Medical Justice was concerned that it would be very difficult for doctors and caseworkers to ascertain what constituted 'acquiescence of public officials'.

[12] See [82] of the judgment: 'torture' in the detention policy *"means 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."*

43. Medical Justice's judicial review application was allowed by the High Court in October 2017[13] and the Judge agreed that the narrower UNCAT definition of torture was unlawful and contrary to the stated objective of the AAR policy which is to ensure vulnerable people are accurately identified and either not detained or detained for shorter periods. The Judge also found that it was irrational to expect a detention centre doctor to reach a judgement on whether a detainee's account meets the UNCAT definition, because it would require the doctor to make legal and political judgements beyond his or her expertise as a doctor.

44. In the 3 months period from 12 September to 7 December 2016 when the UNCAT definition was applied to Rule 35(3) reports, the impact was significant. The percentage of detainees entering detention who received rule 35 reports fell sharply. This was not down to the positive impact of the DG (which concerns we have already set out in Section B above). It was clear that the issue was with the restrictive nature of the torture definition excluding those who otherwise would have obtained a rule 35 report from obtaining one. The percentage of detainees receiving a rule 35 report increased again once the more restrictive definition was suspended. These statistics, in our view, serve to illustrate the importance of the Rule 35 safeguard and the detriment caused to detainees of not being able to access the safeguard.

45. Further to the Medical Justice litigation, the Home Secretary was required by the Court to review and reissue amended AAR guidance that did not include the UNCAT definition of torture. This was done in March 2018, through statutory instruments laid before Parliament,[14] which introduced a definition of torture into a new Rule 35(6). That definition states that:

> *"(6) For the purposes of paragraph (3), "torture" means 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".*

46. The definition was introduced without proper consultation with all relevant stakeholders, including medical professionals at the Royal Colleges and the British Medical Association. The draft definition was only circulated to a select number of non-governmental organisations, including Medical Justice, but the timescale for responding was very limited. When the NGOs requested that the consultation be open to a wider group of stakeholders in view of the importance of the definition of torture to the operation of Rule 35(3), this

[13] *R (Medical Justice) v SSHD* [2017] EWHC 2461 (Admin).
[14] Detention Centre (Amendment) Rules 2018 (SI/411/2018), Immigration (Guidance on Detention of Vulnerable Persons) Regulations 2018 (SI/410/2018) and the Short-Term Holding Facilities Regulations 2018 (SI/409/2018).

request was declined. The Equality and Human Rights Commission ('EHRC'), who acted as an intervener in the Medical Justice judicial review, was excluded from the circulation list and was not invited to provide its views as to whether the definition was compliant with the statutory equality objectives under section 149 of the Equality Act 2010. During the course of the truncated period of consultation, Medical Justice and other organisations who were invited to provide their views, all raised concerns about the new definition remaining one which is narrow and exclusionary. In particular, Medical Justice raised concerns about the use of the phrase 'powerless to resist' which had no clinical or legal foundation and thus was a phrase that again requires doctors to make judgments on legal and factual matters which fell outside their competence as medical practitioners. Medical Justice requested the Home Secretary to withdraw, or at least defer implementation of the new definition of torture pending a proper consultation on the issue. This request was declined and the definition was brought into force on 2 July 2018.

47. This new definition has been the subject of a second judicial review application brought by Medical Justice on the grounds that the 'powerless to resist' criterion is not relevant to the accurate identification of vulnerable detainees. . In particular, Medical Justice is of the view that:

47.1. The new definition is narrow and exclusionary. This is because the victim must prove that he or she is under control of the perpetrator; and as a result of that control, he or she is "*powerless to resist.*" The control, according to the new definition, must be so substantial that the victim cannot resist.

47.2. The parameters of what constitutes "*powerless to resist*" are unclear. There are no objective criteria by which to ensure that this is assessed and determined consistently. The accompanying policy on the torture definition does not explain the ambit of "*powerless to resist*" and refers instead to a description of "situations of powerlessness."

47.3. The significance of the definition of "*torture*" is that it is the only indicator of risk for which there is an adequate reporting and evidence gathering mechanism.

47.4. The new definition is complex and has no legal nor clinical foundation and involves doctors in making judgments on legal and factual matters that are outside of their competence as medical practitioners and compromises their independence and the doctor-patient relationship.

48. In September 2018, the High Court granted Medical Justice permission to pursue its judicial review challenge. Currently the claim has been stayed until July 2019 on the basis that the Home Secretary will agree to:

48.1. amend the Detention Service Order on Rule 35 and the AAR Caseworker Guidance to make clear beyond doubt that to satisfy the new definition of torture in Rule 35(6), it is sufficient to show that there was a situation of powerlessness and that there is no difference between 'powerless to resist' and 'powerlessness'.

48.2. Consult broadly on proposals to amend the Detention Centre Rules and consider responses to the consultation raising concerns about the torture definition.

48.3. Lay amendments to the Detention Centre Rules by July 2019, including to reflect the clarification in (1) above, subject to there being sufficient Parliamentary time;

48.4. Prepare a further equality impact assessment related to the amendments to the Detention Centre Rules.

49. To date the AAR caseworker guidance and the Detention Services Order have not yet been amended. We remain concerned about the additional requirement to show 'powerlessness' to meet the 'torture' definition because this imposes an additional evidential hurdle on the detainee.

50. The cases that we have come across since the new definition came into operation on 2 July 2018 confirm our concerns that the new definition of torture operates in an exclusionary manner, leading to some torture survivors who are highly vulnerable to being harmed in detention not being identified and excluded from the protections of the Rule 35 process and the AAR framework. In particular, and worryingly we have come across a number of victims of torture being denied a Rule 35(3) report by doctors in detention on the basis that they are deemed not to meet the new definition of torture. Examples of this have been referred to in the annexed case studies. We do not know how many individuals were, as a result of the new definition of torture, refused a Rule 35(3) report. The Home Office's Detention Services Order on Rule 35 has, annexed to it, an Annex D precedent letter which doctors are supposed to provide to detainees when they are refused a Rule 35 assessment. We have, however, come across cases where the Annex D letter was not provided to detainees. There is therefore little consistency on the practice of how detainees are informed about a refusal.

51. We are aware that in a response to a Freedom of Information Act request made by Freedom from Torture, the Home Office confirmed that it does not record statistics on the use of Annex D letters. We are not aware of any other formal mechanism by which refusals to complete a Rule 35(3) report are recorded. There is therefore apparently no formal way of monitoring the way in which the new definition has been and is operating and the scale of cases that may be excluded from the definition as a result of the requirement to show 'powerlessness' (or 'powerless to resist', which still remains, at present, the statutory criterion in Rule 35(6)). We have only become aware of cases where detainees were refused a Rule 35(3) when Medical Justice or the legal representatives obtain the medical records and notice the refusal recorded in the records. By the time this is discovered, the detainee will have been in detention for a further period of time in circumstances where they may well be someone who are vulnerable to harm in detention but who have not yet been identified because of the restrictive way in which the torture definition operates.

52. We are aware that when the new definition came into force in July 2018, the Home Office also undertook a review of existing Rule 35(3) reports made prior to the new definition coming into force and decided, in many cases, that the detainee no longer met the new torture definition even though they had previously been accepted to be a victim of torture and an adult at risk. In each of the cases cited in the Appendix it was only after intervention by the detainee's legal representative that the Home Office reinstated the individual's status as an adult at risk and considered the request for their release properly in the light of the AAR framework.

D. Lack of and / or ineffectiveness of alternative reporting mechanisms for identifying detainees who are 'at risk'

53. Other than the Rules 34 and 35 processes, there is no other effective alternative mechanism by which vulnerabilities and risks presenting in detainees can be reported to the Home Office by detention healthcare staff. This means that unless a detainee is identified by way of Rule 35(3) as a victim of torture, it is highly likely that their vulnerabilities and indicators of risk will not be identified and alerted to the Home Office for the purposes of decisions concerning whether detention should continue. In the first Medical Justice claim regarding the UNCAT torture definition, the Home Office suggested that IS.91 RA Part Cs and other informal processes can be used to identify vulnerable detainees. However, this suggestion was rejected by the High Court as a suitable and equivalent substitute for the effective operation of the Rule 35(3) safeguard.

54. For completeness, Part Cs and other alternative reporting mechanisms are inferior because:

54.1. They can be sent by anybody, including healthcare staff who are not doctors, IRC custodial staff and Home Office staff. Rule 35 reports, if not written by an IRC doctor, must be approved and sent on the instruction of a doctor.

54.2. The Rule 35 templates are structured so as to capture the information needed by Home Office caseworkers to attach weight to a Rule 35 report. In contrast, the IS91 RA Part C form contains an open invitation to record anything that is relevant to a detainee's risk status and is used to communicate risk issues that do not relate to vulnerability (e.g. risk to others, aborted removals because of obstructive behaviour). There is no specific guidance to healthcare staff as to what level of information needs to be included in an IS91 RA Part C form or how it should be formulated. Our experience has been that IS91 RA Part C forms, when completed, seldom contain all the information necessary to address the evidential thresholds (discussed below at Section F) required by the AAR framework. They are not designed for this purpose.

54.3. It can be seen, therefore, that the quality of information in an IS91 RA Part C form is likely to be inferior and that, as a consequence, Home Office caseworkers are likely to attach less weight to it. For example, merely reporting a detainee's claim to have been a victim of torture would fall to be treated as level 1 evidence, whereas a doctor's reasoned opinion based on clinical assessment and observation, using the structure of the Rule 35(3) template, that a detainee may be a victim of torture will be at least level 2 evidence.

54.4. Rule 35 reports must be copied to detainees and Rule 35 responses must be copied to detainees and IRC doctors. There is no equivalent requirement for IS91 RA Part C forms to be copied to detainees. This makes it difficult if not impossible for detainees to challenge erroneous decisions and means that doctors are not aware if their concerns have been addressed (the Rule 35 process allows doctors to escalate their concerns if they consider that caseworkers have not addressed them in the Rule 35 response).

54.5. Unlike Rule 35 reports, they do not trigger a mandatory detention review with mandatory timescale for reports to be forwarded to the immigration officer responsible to review detention (24 hours) and provide a response to the detainee in writing (2 working days).

E. Absence of structured process for identifying immigration detainees who are 'at risk' in prison

55. Recommendation 22 of Stephen Shaw's first review was for Rule 35 of the Detention Centre Rule to apply also to detainees held in prisons. This was rejected by the Home Office on the grounds that a broadly equivalent provision (Rule 21) exists in the Prison Rules. This rule provides that medical officers must report to the governor on the case of any prisoner whose health is likely to be injuriously affected by continued imprisonment or any conditions of imprisonment. In Mr. Shaw's second review, he expressed scepticism as to whether Rule 21 of the Prison Rules was capable of acting as an adequate substitute. His reasons were that there were fewer full-time healthcare staff in prison to make assessments and less regular contact with detainees given the larger prison population numbers. He also noted with concern the absence of data on how often Rule 21 was used in prisons and expressed his suspicions that it was "rare in the extreme."[15] Mr. Shaw expressed concerns that prisoners held under immigration powers may well be subject to wider vulnerability issues which are unlikely to be picked up by Rule 21.

56. We respectfully agree with Mr Shaw's analysis. We would add that the language of Rule 21 mirrors that of Rule 35(1). It does not and cannot accommodate the requirements under Rule 35(3) to identify victims of torture. As was noted in the Medical Justice judgment, the High Court found the equivalent Rule 35(1) to be an inadequate alternative reporting mechanism for those who fall outside the narrow torture definition on the basis that Rule 35(1) has a different focus to Rule 35(3). It contains a significantly higher threshold than is needed for consideration of risk following a self-declaration of an indicator of risk. In addition, the accompanying Rule 35 Detention Services Order, with pro forma Rule 35 reports, does not apply to detainees held in prisons. Similarly, there are no processes in place to ensure that Rule 21 reports reach detention caseworkers; and no instructions setting out how reports should be responded to and timescales.

57. It is regrettable that when amending Rule 35 to include the new definition of torture under sub-section (6) that the rule was not also amended in line with Mr. Shaw's recommendation to extend the safeguard to those detainees in prison. The Home Office's contention that the AAR framework applies to detainees in prison does not provide an answer, particularly if

[15] See para 2.44 of Stephen Shaw's second review.

there is no comprehensive mechanism in prison for ensuring the consistent identification of vulnerable detainees held in prison.

F. Assignment of evidence levels to adults 'at risk'

58. Whilst the indicators of risk in the AAR framework (paras 11 and 12 of the statutory guidance) are wider than the categories in previous policy, EIG 55.10, the Home Office moved away from a category-based policy to a policy where vulnerability is assessed on a case by case basis on the basis of the available evidence. An invention of the AAR framework is the ranking of the value of the evidence that a person is an adult 'at risk' from Level 1 to 3.

    58.1. Evidence at level 1 (self-declaration of indicators of risk by a detainee) is afforded very little weight, resulting in most detainees who self-declare an indicator of risk without providing further evidence, nevertheless being detained or remaining detention.

    58.2. Evidence at level 2 has to be based on professional evidence that the detainee is an adult at risk. This is afforded greater weight. Rule 35(3) reports are now, under the AAR policy, in the main treated as Level 2 evidence.

    58.3. Evidence at level 3 also has to be based on professional evidence but must show, in addition to the detainee being an adult at risk, that a period of detention would be likely to cause harm to the detainee. Our experience in practice is that harm must be likely within a relatively short period. If this is available, it is to be afforded significant weight.

59. Whilst we do not disagree that it is right to acknowledge those who self-declare as being at risk instead of dismissing their self-declaration, we are concerned that in practice, the ranking of evidence level of risk has led to a dilution in the protection that the categories-based approach under the previous EIG 55.10 policy provided.

60. In practice, self-declarations of indicators of risk are given very little weight and do not lead to proper consideration of release on account of self-declarations. Nor do they precipitate further inquiries in detention, including via the Rules 34 and 35 mechanisms to ensure that the self-declaration is investigated. Thus someone who has self-declared but has not been provided with a Rule 34 medical examination or otherwise booked in for a Rule 35 assessment will remain a self-declared adult at risk; it is doubtful whether this confers

any additional protection that the general presumption of liberty applicable to all detainees . This makes the Level 1 recognition rather pointless.

61. As for the Home Office's approach to Level 2 and Level 3 evidence, it is now only those cases in which the professional evidence shows that detention would be likely (i.e. on a balance of probabilities) to cause harm that will be treated as Level 3 evidence. This gives rise to several quite fundamental problems:

62. First, whilst the "satisfactory management" criterion was removed from a number of indicators of risk, as recommended by Mr. Shaw, the requirement for evidence that detention would probably be harmful is in substance a back-door way of retaining the 'satisfactory management' criterion. In this way, Level 3 appears on the face of it, and in practice, to operate a threshold equivalent to the test under Rule 35(1), i.e. a detainee must be someone "whose health is likely to be injuriously affected" by detention. This is despite the High Court in the Medical Justice case finding this to be contrary to the correct interpretation of the statutory language and purpose of the AAR framework.

63. Second, the requirement that there must be evidence of likely harm caused by detention in order to secure the strongest protection against detention has the effect of shifting the onus on the detainee to show that there is some prospective risk before they are afforded the highest level of protection under the AAR policy. This misses a fundamental purpose of the AAR policy, which is meant to be preventative so that detainees are not put in a position of having to be exposed to actual or risk of future harm before they are afforded the strongest protections against further detention.

64. This also represents a significant dilution of the protections afforded under the AAR policy, particularly in respect of those who have Rule 35(3) reports confirming clinical concerns that they are victims of torture. Under the old EIG 55.10 policy, where a person was provided with a Rule 35(3) report that constitutes independent evidence of torture they would be afforded the strong presumption that they are not to be suitable for continued detention save for in *very exceptional circumstances*, the latter being a high hurdle to meet if detention is to be justified. As stated in *EO and Ors*, such an approach importantly accepts (and we say correctly) that *"those who have suffered torture in the past are disproportionately adversely affected by detention."* Under the AAR policy, it is our experience that if the Rule 35 report does not specify that the detainee is unfit for detention

or that detention has caused a deterioration, the Home Office will treat the report as Level 2 evidence only. Applied in this way, the Home Office is not only requiring evidence of likely harm being caused by detention but requiring actual harm to have been caused in order to treat a person as a Level 3 case.

65. Those with Rule 35(3) reports are now no longer presumed to face likely harm in detention. Rule 35(3) reports are normally only treated as Level 2 evidence, and thus a victim of torture would have to additionally show likely future harm caused by detention in order to be afforded the strong presumption against detention. In creating these evidence levels, the Home Office has in effect removed the high bar against detention of 'very exceptional circumstances', which represents a significant weakening of protections against the inappropriate detention of vulnerable persons under the AAR framework.

66. We consider that the policy, operated in this way, is contrary to the statutory purpose of section 59 of the Immigration Act 2016, and contrary to the statements made by the Government in Parliament of seeking to use the AAR framework to build on and improve the previous framework under EIG 55.10.

G. Approach to balancing exercise / immigration factors;

67. The problem with the evidence levels can be illustrated further by the way in which the AAR policy permits 'at risk' evidence to be balanced against immigration factors. Under the previous categories-based approach, set out in EIG 55.10, a person falling within one of the identified categories was presumed not to be suitable for detention (and thus should be released) save in "very exceptional circumstances." This threshold has been described by the High Court as a high hurdle to overcome if detention is to be justified.

68. The terms of the AAR policy approach to the balancing exercise permits Home Office case workers far greater scope in how they deal with immigration factors in Level 2 cases, and arguably Level 3 cases, than the requirement for very exceptional circumstances in EIG 55.10.

69. The focus in assessing whether there were very exceptional circumstances under EIG 55.10 was on the risks of re-offending and harm, the risk of absconding and whether removal would take place in a very short period of time. Unexceptional non-compliance issues such as illegal entry as an asylum applicant, non-compliance with reporting, non-compliance

with offers of voluntary return, would not, on their own, be sufficient to constitute *"very exceptional circumstances"* for displacing the strong presumption against detention under the old policy.

70. Under the new policy, however, in Level 2 cases, the AAR statutory guidance states that detention may be justified where either: (1) the date of removal is fixed and is within a reasonable timescale and the individual has failed to comply with voluntary return opportunities; (2) "they present a level of public protection concerns that would justify detention", "for example if they meet the definition of 'foreign criminal'" (usually, a sentence of 12 months or more), or (3) there are negative indicators of non-compliance which suggests that the individual is highly unlikely to be removable unless detained.

71. It is plain that on its terms this is a significantly lower threshold than the very exceptional circumstances under EIG 55.10. The starkest example is the explicit policy that detention of an adult at risk with level 2 evidence can be justified where a detainee has committed a criminal offence which was punished with a sentence of 12 months or more. Under EIG 55.10, there would need in addition to be a risk of re-offending and harm for detention to be justified. [16] Furthermore, previous breaches of immigration law, a refusal to leave voluntarily and previous breaches of conditions fall to be treated as negative indicators of non-compliance that have, in our experience, been treated as sufficient to outweigh professional evidence of vulnerability and justify detention, whereas these factors would not have qualified as very exceptional circumstances under EIG 55.10.[17]

72. In level 3 cases, the AAR policy states that detention may be justified if the detainee has in the past been subject to a 4 year or more custodial sentence or presents "a current public protection concern". However, as stated, under EIG 55.10 the fact of a previous criminal conviction would not qualify as a very exceptional circumstance, there would in addition need to be a risk of re-offending and harm.[18]

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[16] For example, *OE's* case discussed at paras 133-158 of *EO and Ors*.

[17] See *AM (Angola) v SSHD* [2012] EWCA Civ 521 at paras 34 and 35, where AM had falsely obtained a visitor's visa, had refused voluntary return and lodged late challenges to removal, had been disbelieved in the asylum process and had failed to report on a number of occasions.

[18] See *BA v SSHD* [2011] EWHC 2748 (Admin) where a 10 year sentence of the importation of Class A drugs was held not to qualify as very exceptional circumstances. At para 182 the judge stated: "…since what is being balanced are the factors in favour, and against, the detention of a person who may be unsuitable for detention, the policy must mean that the assessment of risk is to be done on an individual basis, and not by reference to what Mr Kellar referred to as, in effect, "an instruction" to detain those who have committed serious offences."

73. In practice, we are concerned that the fact of being a Foreign National Offender more generally has effectively come to be treated as a trump card, including in level 3 cases or where there is evidence of actual or likely deterioration in mental or physical health. For example, on the first main page of the AARCG, it states: "If the evidence suggests that the length of detention is likely to have a deleterious effect on the individual, they should not be detained unless there are public interest concerns which outweigh any risk identified. *For this purpose, the public interest in the deportation of foreign national offenders (FNOs) will generally outweigh a risk of harm to the detainee*" (emphasis added). This can also be seen in the way that the AAR policy focuses on static factors (immigration history, fact of offending) rather than conducting a dynamic assessment of the risks of absconding, harm or re-offending (e.g. by reference to probation OASYS assessments or pre-sentence reports).

H. Special cases:

H.1. Victims of torture

74. In addition to the concerns raised above at Sections F and G in respect of the operation of evidence levels and its application to Rule 35(3) reports regarding victims of torture, we also have the following further specific concerns regarding the detention of detainees with independent evidence of torture:

75. First, we are concerned that the Adults at Risk policy treats Rule 35(3) reports, in particular, as normally only Level 2 evidence of risk. As already indicated above in Section F, we are concerned about the additional evidential requirement of likely harm caused by detention before a detainee can be afforded the strongest presumption against detention. This is of particular concern in respect of those who have a Rule 35(3) report which previously would be treated as independent evidence of torture and thus mean the detainee is unsuitable for continued detention save in very exceptional circumstances. On the current approach to evidence levels, the relegating of Rule 35(3) reports to Level 2 evidence of risk represents a significant downgrading of the important status of a Rule 35(3) report and its operation as a critical safeguard against the detention of vulnerable persons.

76. Second, we are concerned that Rule 35(3) reports have been rejected by the Home Office as evidence of the detainee being at risk on the basis of adverse credibility matters. For example, we have seen a Rule 35(3) report in respect of a rape victim rejected on the basis that this was not previously raised. This is of concern and ignores the Home Secretary's own policies which recognise that there may be a variety of good reasons for delayed

disclosure by victims of rape or other gender based violence. Yet in the context of a response to a Rule 35(3) report, the Home Office seldom addresses its mind to these well-recognised principles and instead summarily rejects Rule 35(3)s on the basis of delayed disclosure damaging the detainee's credibility.

77. Under the previous EIG 55.10 policy and the Detention Services Order on Rule 35, the Courts have held that the question of credibility was irrelevant to whether a Rule 35(3) report constituted evidence of vulnerability in the form of independent evidence of torture. The Courts held that credibility concerns could be taken into account when considering whether detention was justified in the light of immigration and other factors, but even then only if the same or similar medical evidence had been considered by the decision maker. [19] The AAR policy now provides for Rule 35(3)s to be rejected even as clinical evidence of torture where there are credibility concerns. We are of the view that this aspect of the AAR policy has a meaning or is operated by the Home Secretary in a way that is inconsistent with case law and guidance under EIG 55.10 and represents a dilution (rather than improvement) on the safeguards for vulnerable detainees.

H.2. Victims of trafficking

78. Victims of trafficking should be considered adults at risk under the AAR policies. Pending the completion of the formal identification process under the National Referral Mechanism ('NRM'), the Home Office accepts that they cannot be removed. The NRM requires that a referral be made formally by a designated First Responder (the Home Office, police or another statutory public body or certain charities) in order for the formal identification process to be triggered. Although the Home Office is the most likely public body encountering a potential victim of trafficking in detention, it has been our experience that unless and until a legal representative or a detainee support group makes representations that the detainee exhibits indicators of trafficking to the Home Office, an NRM referral is frequently not made by the Home Office. The focus tends to be on immigration enforcement even though the circumstances in which the victim finds themselves in a precarious immigration situation may be manifestly linked to their trafficking. The pro

[19] See *R (AM (Angola) v SSHD* [2012] EWCA Civ 521, *R (EO & Ors) v SSHD* [2013] EWHC 1236 (Admin) and *R (BA and ST) v SSHD* [2016] EWCA Civ 458; the Detention Rule 35 Process policy stated: "In some cases where the rule 35 report is accepted as independent evidence of torture, there may nevertheless be further information which renders the overall account of torture wholly incredible. Such information may form the basis of an assessment that there are very exceptional circumstances making detention appropriate. For instance, it may be right to detain in very exceptional circumstances if, despite there existing independent evidence of torture, there is a court determination which was made with sight of a full medico-legal report and which dismisses the account of torture…"

forma for asylum claims made in detention includes a specific question about trafficking. We therefore find it difficult to understand the frequent failure to make an NRM referral.

79. It is our experience that the NRM referral forms are made, they are routinely not treated as Level 2 professional evidence that the detainee is an adult at risk by virtue of being a potential victim of trafficking. The Home Office's practice appears to be to maintain detention of a victim of trafficking until at least a first stage decision has been made that there are reasonable grounds to believe that the person is a victim of trafficking. It is not clear to us why the Home Office does not treat NRM referral forms to be equivalent to Level 2 evidence of risk. In our view it clearly constitutes professional evidence of someone meeting an indicator of risk. Yet routinely no detention review is carried out on an NRM referral being made. The AAR policy does not mandate a detention review to be carried out, unlike in Rule 35(3) cases. Some trafficked victims will be picked up through the Rule 35(3) process. But that does not, in our view, sufficiently ensure that all victims of trafficking are consistently treated as adults at risk and are afforded to protections intended under the AAR policies.

80. Further to a positive Reasonable Grounds decision, the Home Office's policy in principle requires the release of a victim of trafficking save where there are public order concerns. On the face of it the policy appears to be highly protective of victims of trafficking, the public protection threshold appearing to be a high one. However, in practice, it is our experience that the Home Office routinely treats unexceptional non-compliance issues as public order issues so that a victim who entered the country illegally could be detained on a contention that they pose a risk to public order even though their method of entry may be directly related to their trafficking. This approach has been criticised by the courts. In *EO and Ors*, the High Court observed that what is meant by "public order" is a "very high rather than routine risk that a detainee will abscond…" This interpretation – 'very high risk' - was more recently affirmed in *R (EM) v SSHD* [2016] EWHC 1000 (Admin). Despite successive court judgments on the meaning of 'public order' we continue to find victims of trafficking with positive Reasonable Grounds decisions being maintained in detention on the basis of a misapplication of the 'public order threshold' and without any regard to the balancing exercise approach set out in the AAR policy and applicable to other AAR cases.

H.3. Mentally ill and mentally incapacitated detainees

81. Immigration detention cannot be used to detain someone for their own well-being.[20] Where there is a reasonable suspicion that someone may lack mental capacity "to participate" in decisions, the Home Office is, like other statutory authorities, is required to arrange for a detainee to have a capacity assessment compliant with the Mental Capacity Act 2005. Yet, the AAR policies are silent on how mentally incapacitated detainees are to be protected when this cohort is perhaps the most vulnerable because they are less able to access legal advice or other assistance about their treatment or the decisions to detain them. Nor are they able to seek and secure evidence from a professional to demonstrate their vulnerabilities so as to benefit from the protections of the AAR policies. This major lacuna in the detention policies and the system as a whole in respect of this cohort of highly vulnerable detainees is stark and reflects the lack of protection overall for the mentally ill in the immigration detention system.

82. This was recognised recently by the Court of Appeal,[21] which found the lack of provision of advocates to assist mentally ill detainees to make representations about decision to detain, segregate and on medical treatment in detention put them at a substantial disadvantage compared to other detainees in breach of the duties under the Equality Act 2010. VC a man with severe mental illness was also found to have been unlawfully detained in breach of policy and the duty of enquiry for many months during which his mental health significantly deteriorated. In another case,[22] the Court found unlawful the Home Office's failure to make inquiries into a detainee's capacity when medical records suggested that his erratic behaviour indicated a lack of capacity to make decisions about his welfare, treatment and ongoing detention.

83. These cases are not anomalies. They contain many of the errors that resulted in 6 other cases in findings of breaches of Article 3 ECHR arising from the unlawful detention of those with serious mental illness that was the subject of inquiry in Shaw 1. We continue to represent clients with similar profiles including ones where release from detention was done without any safeguarding plan to ensure their welfare and best interests are protected in the community. To date little appears to have been done to rectify the unlawful failures in the system identified in VC and MDA. There continues to be:

[20] R (AA) v SSHD [2010] EWHC 2265 (Admin) at [40]

[21] VC v SSHD [2018] EWCA Civ 57

[22] R (MDA) v Secretary of State for the Home Department [2017] EWHC 2132 (Admin)

83.1. failure to implement any system by which any or any adequate enquiries are made into the nature and severity of mental illness and the mental capacity of detainees in decisions relating to the detention and treatment, care and welfare, in detention;

83.2. lack of provision of an advocate or other appropriate adult to assist mentally ill and / or incapacitated detainees;

83.3. failure to act fairly and reasonably to arrange suitable bail accommodation for a detainee for whom there is no longer a prospect of removal promptly or at all;

83.4. failure to comply with policies requiring multi-agency cooperation with health and social care to manage the safe release of vulnerable detainees into the community with appropriate accommodation, care and health input;

83.5. lack of arrangements for detainees to access necessary mental health assessments and treatment in detention.

84. We are concerned that segregation continues to be used to manage mentally ill detainees. There are delays in transferring for appropriate treatment in hospital. Individuals who have been hospitalised are often re-detained under immigration powers despite clear knowledge of their mental illness. There is a failure to do proper hospital discharge; when discharge meetings are held, the focus is too often on the immigration status of the individual rather than how their needs related to their mental health are to be managed.

85. In January 2018, significant changes were made to immigration legislation revoking powers to grant individuals temporary admission and subjecting all persons who are subject to immigration control and without leave to remain to immigration bail. The bail powers set out in Schedule 10 of the Immigration Act 2016 require the Home Office to impose at least one bail condition. The absence of any discretion not to impose bail conditions gives rise to serious problems for the mentally ill and mentally incapacitated. No consideration is paid to whether the incapacitated immigration detainee released on immigration bail has the capacity to comply with the bail conditions imposed on them. The sanctions for breach of bail include criminal sanctions as well as re-detention. This is self-evidently particularly draconian for incapacitated detainees. We are concerned that the statutory powers permit no flexibility in this respect and is in breach of statutory equality duties.

H.4. Vulnerability catch-all provision under the AAR policy

86. Steven Shaw, when recommending the expansion of categories of vulnerability under EIG 55.10 also recommended a catch-all concept of vulnerability in recognition of its dynamic

nature so as to ensure more (not fewer) detainees are identified even if they do not easily fit within one of the listed indicators of risks. However, it is our experience that without an effective Rule 34 process, a comprehensive Rule 35 process and effective alternative reporting mechanisms, such vulnerabilities are often missed by the Home Office because they are not identified or because the Home Office says they fall outside of the AAR policy, for example, victims of ill-treatment that do not qualify as torture or sexual/gender-based violence.

I. Operation of the Removals Policy in respect of adults 'at risk'

87. Since 2015, the Home Office has been able to inform someone they are *liable* to removal, and then remove that person at any given point during a three-month removal window. The removal window runs from the time the notice of liability for removal or deportation decision letter is served. If, however, a removal window has not expired, it can be extended by way of a further notice for a further 28 days. This is a change to the former legal obligation of issuing "removal directions" which would specify the date, time and flight number of the removal, with minimum notice periods.

88. We are concerned that removal windows result in practice in those subject to them not being able to obtain legal advice and representation in time to challenge their removal. Immigration decisions continue to be made and served during the removal window with removal potentially taking place on the same day without further notice. For detainees who may be medically unfit to fly the lack of a specific removal date means fitness to fly cannot be assessed accurately and in an up-to-date manner. Being subject to no-notice removal adds to the uncertainty and predictability inherent in immigration detention and further aggravates the negative mental health effects of detention.

89. The Home Office's removals policy specifies that adults at risk with Level 2 or Level 3 evidence of risk should not be subject to removal windows, but they are, in our experience, often, issued removal windows. In addition, delays in Rule 35 assessments and reports mean that detainees remain on removal windows and may be subject to removal before their Rule 35 assessment takes place.