

Inquiry into the quality of
healthcare at Yarl's Wood
immigration removal centre

20 – 24 February 2006

by HM Chief Inspector of Prisons

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1: Executive summary

- 1.1 In February 2006, Her Majesty's Chief Inspector of Prisons (HMCIP) was asked by the Immigration and Nationality Directorate (IND) to carry out an inquiry into the overall standard of healthcare at Yarl's Wood immigration removal centre (IRC), with particular reference to the medical case management of one (later extended to two) detainees¹.
- 1.2 The review team found evidence that individual healthcare staff sought to offer committed and caring treatment. Basic healthcare provision was usually adequate for those detainees who stayed for only a short time. Nurses were experienced in primary care and took responsibility for a specific area of healthcare, for example, asthma care and sexual health. The full time locum doctor was conscientious and there was evidence that he acted in the best interests of his patients.
- 1.3 However, underpinning systems were inadequate and the healthcare service was not geared to meet the needs of those with serious health problems or the significant number of detainees held for longer periods for whom prolonged and uncertain detention was itself likely to be detrimental to their well being. This was true for detainees in general and for the care of the two specific detainees whose care had prompted the review.
- 1.4 Structurally, the management arrangements for healthcare were complex. The healthcare provider had experienced a significant turnover of contract managers over the previous six months. Within Yarl's Wood, the healthcare manager worked under a complex set of managerial arrangements, and received inadequate clinical support. She had worked hard to develop good relationships with external healthcare providers but these were largely informal and ill defined, and it was not easy to establish where responsibility for specific service delivery lay.
- 1.5 The delivery of healthcare was undermined by a lack of needs assessment, weak audit and clinical governance systems, inadequate staff training (particularly in relation to trauma) and insufficiently detailed policies and protocols, for example with regard to food refusal and the health needs of people on re-feeding programmes. Mental health care provision was also insufficient.
- 1.6 In the opinion of the review team, the inadequacy of healthcare systems in the IRC was compounded by the unresponsiveness of the IND to clinical concerns about an alleged history of torture or adverse medical consequences of continued detention. When clinical concerns were raised, the information was not systematically addressed or actioned. Nor was independent medical opinion sought or adhered to.
- 1.7 The clinical review adds weight to a growing concern among medical and other commentators that the increased use of immigration detention raises serious concerns about the mental health of detainees, particularly in cases of prolonged detention of uncertain duration and where detainees arrive with underlying health problems.²

¹ See Appendix A for terms of reference

² For example: *Fit to be detained*, Bail for Immigration Detainees and Médecins sans Frontières, May 2005; *Report of the inquiry into the disturbance and fire at Yarl's Wood Removal Centre*, Prisons and Probation Ombudsman, October 2004; *A second exile: the mental health implications of detention of asylum seekers in the United Kingdom*, Pourgourides, CK, Sashidharan, SP, Bracken PJ, North Birmingham Mental Health Care Trust, 1996; *Detention of refugees*, Fazel M, Silove D, British Medical Journal, February 2006

2: Background

- 2.1 Yarl's Wood is a purpose-built, privately run IRC contracted by IND to provide detention facilities to hold asylum seekers and others subject to immigration control. It is run in accordance with the Detention Centre Rules (SI 2001 No.238), standards issued from time to time by IND and contractual arrangements agreed between IND and the contractor, Global Services Limited (GSL). At the time of the inspection, it held families and single women only. It provides 24-hour healthcare, with a small inpatient unit, and receives detainees with healthcare needs which cannot be managed in other centres.
- 2.2 Yarl's Wood opened in November 2001 but was closed following a disturbance and fire in February 2002. After extensive rebuilding, it re-opened incrementally from September 2003 until it reached full operational capacity (405 detainees) by the beginning of 2005. It became the main centre for holding women and families with children. Not all occupants were simply awaiting removal at end of process. Up to a third of the single women were detained at the initial stage of a claim for asylum, for fast-track processing. Under the fast-track process, an asylum applicant could be interviewed, receive a decision and have an appeal against refusal determined at the on-site hearing centre within a couple of weeks.
- 2.3 The accommodation in Yarl's Wood consists of four units in a large, two storey H block. The spine has a long reinforced corridor, with the accommodation around six internal courtyards. Two of the units (Avocet (130) and Dove (110)) hold female detainees. Bunting (42) provides the female induction unit and Crane (123) the family unit. Kingfisher holds detainees removed from association or in temporary confinement (rules 40 and 42, Detention Centre Rules). The healthcare centre is centrally located and accessed off the main corridor.
- 2.4 On the first day of the review 259 people were held. The last full inspection by HM Chief Inspector of Prisons had taken place in 2005 and we noted two significant differences in the nature of the population since that report. First, in 2005 the centre received an average of 319 detainees a month; by 2006 the average was 681 per month. Second, in 2005 only 5% had been detained for three months or more; by 2006 this had risen to 11%. While many were only detained overnight for removal from a London airport the next day, a third had been there more than a month, and seven women had been detained at Yarl's Wood for between six and 18 months. As the centre was often not the first place of detention, the total length of detention could be considerably longer than that indicated on Yarl's Wood records. To find out how long people had been detained overall required going through every file individually.
- 2.5 The centre chaplain commented on the anxiety of some of the women and resultant erratic behaviour:

"Life here is condensed into the time of removal, so every day is crucial yet filled with boredom and routine. There is a desperate need for information, advice and trust. After a long period in detention without any resolution many become frozen into despondency. This has to be recognised to see why they sometimes behave bizarrely. Staff do their best. For staff in general, the centre is like a human clearinghouse. It is not designed to accommodate dealing with the range of different stresses. There is a failure to take responsibility for individuals within the moving process. If attention is not paid to individual circumstances, there are risks. People here have few outlets for stress. Suicide and self harm (SASH) forms are going up.³ I keep

³ At the time of the February/March 2005 HMCIP inspection three SASH F2052SH self harm monitoring forms were open, at the beginning of the February 2006 inspection 12 SASH were open, with three on constant watch.

sending concerns to the IND contract monitor or doing letters for bail applications, but there is resistance to interrupting the removal process. Then there is the culture of mistrust, with all the inherent dangers; an attitude of 'These people will try anything to stay' generates resistance to wanting to see anything more. There is no clear strategy when people start losing the will to live."

(Rev. Larry Wright, head of religious affairs)

- 2.6 A sense of powerlessness and isolation contributed to the despondency of some detainees. This was alleviated to some extent by the diligent religious affairs team. In addition, one of the GSL custody officers had recently been appointed welfare officer. A source of independent support, encouraged by GSL, was the voluntary Yarl's Wood befrienders group, who gave generously of their time and money to meet immediate needs, providing an important outlet to anxiety among detainees.
- 2.7 During the previous year there had been several expressions of concern about healthcare at Yarl's Wood IRC from a number of quarters, including visiting clinicians, befrienders and the local MP. Concerns intensified following a hunger strike by a number of detainees during August and September 2005 and the deterioration in health of two Ugandan women, Ms A and Ms B.
- 2.8 The Director of IND Detention Services approached the Healthcare Commission, the General Medical Council, and the National Clinical Assessment Service to request a clinical review. They considered the matter to be outside their remits. HMCIP agreed to conduct an independent inquiry using inspectorate healthcare specialists, an IRC inspector and an external specialist (see Appendix B).
- 2.9 The team looked at healthcare management and delivery in Yarl's Wood, and the links between management of healthcare and management of detention. Specifically the task of the team was to inquire into:
- The overall standard of healthcare provided by Veritas at Yarl's Wood, with particular reference to the support and treatment of detainees with mental and traumatic stress disorders.
 - In particular, issues raised by the clinical management of Ms A and Ms B (two detainees) while at Yarl's Wood.
- This was to include examination of records, discussions with staff and detainees, consideration of effective links with outside bodies and services, and discussion with other relevant parties.
- 2.10 Although the inquiry team focused on the experience of two detainees, it also examined other records, and considered a number of other individual cases. The full terms of reference are at Appendix A.
- 2.11 The main findings are grouped under the two headings of management issues and the delivery of care. Recommendations are included in the text and summarised at the end.

3: Main findings

Management

Management of healthcare in immigration removal centres (IRCs)

- 3.1 Seven of the ten IRCs are privately run and healthcare is provided by private contractors, as is the case at Yarl's Wood. IND contracted GSL to run the IRC and they in turn, sub-contracted healthcare to another private company, Veritas. This company was formed in 2002 to provide healthcare for people held in police custody. It took over the provision of healthcare services at Yarl's Wood from Primecare, another private company, in December 2004. Many of the existing healthcare staff transferred to the new company.
- 3.2 Unlike public sector prisons, private establishments (including IRCs) were not subject to the recent transfer of healthcare funding from the Home Office to the Department of Health, with subsequent provision of healthcare by the NHS. One consequence of this was that Veritas, as an independent healthcare provider, understood that it had no requirement to register with the Healthcare Commission, within the regulatory scheme laid down by the Care Standards Act and related legislation. As a result, Veritas had not been subject to independent scrutiny or regulation of clinical care by the Healthcare Commission.
- 3.3 Healthcare Commission staff visited briefly in November 2005 to gain an understanding of the healthcare facilities and services provided at Yarl's Wood with a view to the service being registered as an independent healthcare establishment. The Healthcare Commission subsequently recommended that registration should be applied for. This had not occurred at the time of the inquiry although steps were being taken to register IRC providers.⁴

Recommendations

- 3.4 IND and the Department of Health (Prison Health) should expedite arrangements for healthcare provision in immigration removal centres to be commissioned by the National Health Service.
- 3.5 All healthcare provision in IRCs should be registered with the Healthcare Commission and their specified standards of care should be implemented as a matter of urgency.
- 3.6 The inquiry team visited the centre between 20 and 24 February 2006. This was a week after a short HMCIP inspection to follow up progress on recommendations made in the 2005 inspection report. During the inquiry, the team spoke to many people, within Yarl's Wood and outside, as well as making direct observations of clinical care. In addition to documented discussions, the team took every opportunity to speak informally with as many detainees as

⁴ The Commission for Healthcare Audit and Inspection was formed by the Health and Social Care (Community Health and Standards) Act 2003 and is tasked with promoting improvement, assessing performance and handling complaints.

possible. They also reviewed written evidence including policy documents, correspondence, clinical records, clinical reports and immigration files.

- 3.7 GSL, Veritas and IND cooperated fully with the inquiry. The team also obtained full cooperation from NHS and independent clinicians involved in the care of detainees.

Management of detention by the Immigration and Nationality Directorate (IND)

- 3.8 Both internal and external management arrangements and responsibilities for detainees are complex. From a detainee's perspective they were almost impossible to understand. This is represented diagrammatically in Figure 1 below.

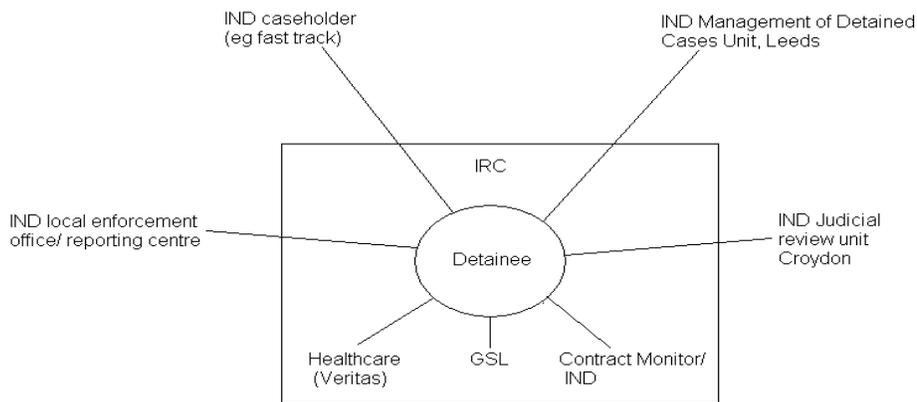


Figure 1. Management and responsibility complexity from a detainee perspective

- 3.9 Detainees' casework was scattered around the IND estate, and elements of an individual case could be concurrently located in different places: for example, the port of entry, a specialist caseworking section within IND, the local reporting centre or enforcement office responsible for detaining them, and, after a period in detention, IND's Management of Detained Cases Unit (MODCU) in Leeds. What each office had on file varied according to their task, with a synopsis on the shared casework information database (CID). This diffused ownership of, and responsibility for, individual case management.
- 3.10 In the case of one of the hunger strikers hospitalised in August 2005, the IND team at the IRC were uncertain whom to inform. They first contacted MODCU in Leeds, who said they were only doing monthly reviews and they should try 'fast track'. Yarl's Wood immigration staff then contacted Harmondsworth IRC fast track team, who denied responsibility, because they dealt only with male detainees. Eventually the caseholder was located at IND's judicial review unit in Croydon, who, a month into the hunger strike, said, 'no one had told them of food refusing'.

- 3.11 Yarl's Wood's channel of communication to IND caseworkers was via an on-site team of immigration staff: a contract monitor, two deputies, three immigration officers, one administrative officer and a temporary worker. The team had been reduced and their role was being redefined. They were to pass information between the centre and caseworkers located elsewhere, without themselves being involved in casework.
- 3.12 Detention Centre Rules (rule 9) and IND policy required that every detained person be provided with written reasons for detention when first detained and thereafter at least monthly. MODCU took responsibility for most monthly detention reviews after 21 or 28 days' detention. These were issued in English only and were often served by internal mail, without face-to-face explanation, interpretation or opportunity to query.
- 3.13 IND's detention criteria (chapter 38 of the operational enforcement manual) has a limited list of persons considered unsuitable for detention. It includes 'those suffering from serious medical conditions or the mentally ill' and 'those where there is independent evidence that they have been tortured'.
- 3.14 The inquiry found that IND officers responsible for detained cases did not always apprise themselves of detailed information about medical conditions. The periodic reviews of detention did not systematically weigh all relevant considerations and detainees, who often had no legal representative to monitor their interests, were not kept properly informed of what was happening. There was no system to seek the opinion of an independent medical specialist and in some cases IND caseworkers, with no declared medical qualification, appeared to be making their own clinical judgments (see paragraphs 3.60-3.70 and recommendations 3.71-3.76) .

Management of healthcare at Yarl's Wood

- 3.15 The management arrangements for healthcare at Yarl's Wood were complex and lacked robust clinical accountability and governance mechanisms. Veritas did not, at the time of the inquiry, employ a full time clinical director, relying instead on part time clinical advisers (six or seven doctors and nurses country-wide). The part time director of nursing was only available for 20 hours a month for all Veritas healthcare services. We were informed that recruitment of full time director of nursing was under way.

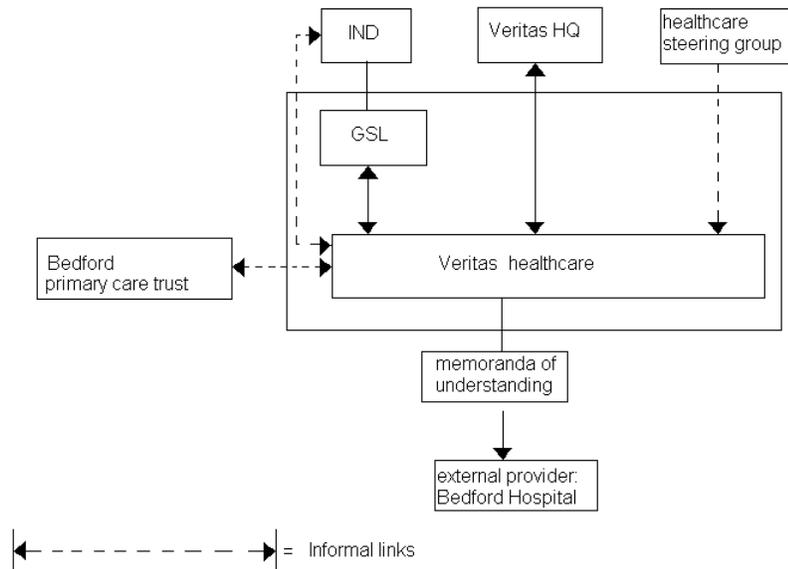


Figure 2. Healthcare management arrangements

- 3.16 Direct line management from Veritas of the healthcare team was via a regional contract manager. Three different managers had had responsibility for healthcare at Yarl's Wood in the six months preceding the review. The current regional manager was not a clinician and had only been in post one month.
- 3.17 Consequently, the healthcare manager, who herself had only been in post in that role for six months, had insufficient professional support, with little or no access to external clinical supervision. As well as her line management from Veritas, she attended senior management team meetings and had direct access to the centre director, though the contract delivery was overseen by the head of central services.
- 3.18 The healthcare manager was an active member of the immigration detention estate healthcare steering group, an informal body which met quarterly and provided peer support. The steering group had been instrumental in developing estate-wide protocols and policies but many of those we saw were sketchy and in need of updating.

Recommendations	
3.19	The clinical leadership available to the healthcare manager should be increased to ensure sufficient expertise for clinical support and advice.
3.20	The lines of accountability for healthcare management should be clarified, with regard to IND, GSL, the local NHS primary care trust, and the immigration detention estate healthcare steering group.

- 3.21 Clinical audits were not taking place at the time we visited and we were concerned at the lack of detailed policies and protocols for conditions and situations that might be expected among the client group held at Yarl's Wood.

Recommendation

- 3.22 Detailed clinical protocols should be developed in the management of common and important clinical problems. These should take account of guidelines developed by the National Institute for Health and Clinical Excellence (NICE) and other regulatory and professional bodies and should be formulated locally in multi-professional team discussions. As a minimum, there should be detailed clinical protocols for the management of the following:
- a People on hunger strike and subsequent re-feeding
 - b The management of rape survivors
 - c Post traumatic stress disorder and depression
 - d Head injury sequelae
 - e Psychosis
 - f Identification of tuberculosis, including contact tracing
 - g Malaria prophylaxis (prior to removal)

- 3.23 Nursing staff told us that they had informal peer supervision but there was no record kept of the issues discussed. Nor did the healthcare manager routinely receive Medicines and Healthcare Products Regulatory Agency alerts, Chief Medical Officer circulars or information on new guidelines from NICE.

Recommendations

- 3.24 The healthcare manager should ensure that the team receives routine alerts and guidelines from the Medicines and Healthcare Products Regulatory Agency, the Chief Medical Officer and the National Institute for Health and Clinical Excellence. These should be considered in multi-professional team meetings and both receipt and team consideration should be logged.
- 3.25 All staff, including the healthcare manager, should have individual professional supervision. Senior staff should be able to access appropriate external supervision, preferably within the same professional group.
- 3.26 Continuing professional development was not comprehensive. While some of the nurses had completed a variety of clinical training, including in diversity and suicide and self-harm prevention, there had been no cardio-pulmonary resuscitation or fire training in the last 13 months. There was no specific continuing professional development for the doctors and no staff had received specific training in the care of victims of torture. Nursing staff told us that they had peer supervision. However the sessions appeared to be informal and no records were kept of issues discussed.
- 3.27 A standards self audit had been completed in April 2005. Relatively few areas were non-compliant, but among these were some key areas, including training staff to care for torture victims. There was no evidence of a re-audit or what action had been taken to remedy the shortcomings. There was no evidence of a training needs analysis.

Recommendations

- 3.28 Healthcare staff should receive appropriate training in the care of both adults and children with a history of torture or trauma.
- 3.29 Healthcare staff should be issued with 'Medical investigation and documentation of torture: a handbook for health professionals.'⁵
- 3.30 Regular training needs analyses should be undertaken and there should be a routine induction for all clinical staff.

3.31 A health needs assessment to identify the health needs of the detainee population had not been undertaken since Veritas took over the contract 14 months previously. The review team were assured that the new Veritas regional manager was undertaking this work, although the degree to which Bedford primary care trust (PCT) staff would be involved in order to maximise available local resources and expertise was unclear. We were concerned by the lack of aggregated management information that would inform a health needs assessment and subsequent service development. Staff reported that the detainee population had changed since Veritas took over the contract, with many displaying more complex needs than expected and significant numbers staying longer than anticipated. These changes had clear implications for staff numbers, skill mix and training.

Recommendations

- 3.32 There should be an annually updated health needs assessment of detainees, prepared jointly with Bedford primary care trust.
- 3.33 Staffing levels and skill mix should reflect the needs of the population, based on the outcome of the health needs assessment.

3.34 There was a long-standing relationship between Yarl's Wood and the commissioners of local healthcare (previously Bedford Health Authority and now Bedford primary care trust (PCT)). When the IRC first opened, there had been a liaison group with representation from both the IRC and the health authority. This lapsed following the fire and a new local healthcare steering group was introduced after the reopening. The local steering group met quarterly, was well attended and had broad representation including senior staff from Bedford PCT, Veritas, GSL and Bedford hospital. Although the PCT had no statutory duty to do so, it was engaged with healthcare at Yarl's Wood and the relationship had been cited as an example of good practice by the Department of Health (Prison Health), who oversee healthcare delivery in custodial settings. A joint children's sub group had been set up to deal with child protection issues.

3.35 Despite the good relationship, the PCT was unaware when the healthcare contract changed from Primecare to Veritas and there was no contract or memorandum of understanding between the PCT and either GSL or Veritas to clarify management relationships.

Recommendation

⁵ Published by the Human Rights Centre, Essex University, and supplied by the Foreign and Commonwealth Office to all British embassies.

3.36 Memoranda of understanding to define services provided and management responsibilities should be established between GSL, the local primary care trust and Veritas.

3.37 Relationships with Bedford hospital (accident and emergency, outpatient clinics and mental health services) were considered to be good, although mainly informal. Memoranda of understanding were in place for both adult and children's services. However, these were largely procedural – for example, dealing with risk assessment and the use of handcuffs – and did not specify the levels or types of service to be provided. Consequently, it was not easy to establish where responsibility for specific service delivery lay.

Recommendation

3.38 Pending formal transfer of the commissioning of healthcare to the NHS, there should be formal service level agreements with local NHS providers and agreement about clinical information sharing. The service level agreements should include detailed specifications for the following:

- a infection control and communicable diseases advice
- b mental health services
- c secondary healthcare, including the specific needs of detainees refusing food, detainees known or suspected to have a sexually transmitted disease including AIDS, detainees with acute medical conditions requiring urgent hospital assessment/admission, and detainees requiring outpatient monitoring and support for chronic medical conditions (eg diabetes and hypertension)
- d specialist pharmacy advice and provision of anti-retroviral and other specialist treatments, unavailable in the local pharmacy

Delivery of care

Brief summary of the care of Ms A and Ms B

3.39 The review team considered the diagnoses and medical care of Ms A and Ms B in considerable detail. It is inappropriate to describe their medical conditions in detail, although these were taken into account in formulating the recommendations. What follows is a brief background summary.

3.40 Both Ms A and Ms B had pre-existing medical problems. Ms A was initially detained at the time she claimed asylum, in order to have her claim determined under the fast-track process. This process took up the first two weeks of her detention, during which she was largely unrepresented. Ms B was detained after her asylum claim was refused, when she reported to an IND reporting centre. Both Ms A and Ms B gave reports of exposure to violence, including torture. In both cases, routine rule 35 letters, notifying IND where detention might be injurious to health (see paragraphs 3.67-3.70 and Appendix D), were sent to the immigration authorities, although there is no evidence that these produced any reaction. They spent eight and nine months respectively in detention. Attempts to remove them failed because they refused to comply. There is evidence of deterioration in mental health after these failed attempts to remove.

- 3.41 In detention, both women were reported to have gone on hunger strike for more than a month, ending with their hospitalisation. During the hunger strike, they were seen almost every day by healthcare staff. Towards the end of the hunger strike, they were probably being advised inappropriately to re-feed in Yarl's Wood. One seems to have been denied pain-killing medication while on hunger strike. In hospital they were re-hydrated; appropriate re-feeding was commenced and they were returned to Yarl's Wood.
- 3.42 As discussed elsewhere in this report, re-feeding, after a prolonged hunger strike, can be problematic. The immigration detention estate had no detailed clinical protocol about the management of hunger strikes and re-feeding. On occasion, the detainees' compliance with healthcare advice was erratic: both stated they would rather die than eat. Ms A was hospitalised on three further occasions.
- 3.43 In Ms A's case, IND set – and served – removal directions notwithstanding two letters from the centre doctor reporting her deteriorating condition, and a statement that 'prolonged further detention is likely to lead to a deterioration in her state of mind...An attempt to deport her now...would almost definitely render her unfit to fly by the time she got to the aeroplane'. Removal directions were only cancelled after two further letters from the centre doctor stating that she was not fit to be detained and not fit to fly.
- 3.44 In Ms B's case, her low state of mind may have been adversely affected by the death of her previous room-mate and by the increasingly onerous burden of caring for Ms A who became her room-mate after she returned from hospital for the third time.
- 3.45 Ultimately, at different times, the two women were granted temporary release, subject to restrictions, following which Ms A remained in hospital. They suffered deteriorating health problems which the centre's healthcare staff struggled to cope with. During this period, healthcare staff also struggled with a range of competing opinions, regarding their diagnosis and care, from different sources. Usually these opinions, reported by second opinion doctors and by doctors involved in preparing legal reports, were not directly recorded in the case-files. There seemed to be no means whereby clinical concerns were systematically considered in review of detention by IND, which had ultimate responsibility for the detainees.

Delivery of care: general

Reception into detention

- 3.46 There was a small but adequately equipped healthcare room in the IRC reception area, located between the female and family admissions sections. It operated for 24 hours a day, seven days a week. Nurses were called to reception as and when required. Arriving detainees were usually seen by a nurse within two hours and given a health assessment which included baseline physical measurements.
- 3.47 We were told that the health assessment should take 20 minutes but often lasted only 10 minutes or so. The assessment was not used to inform a clear nursing action plan in all cases.
- 3.48 Some detainees arrived with a large bag of medications taken at some point over the preceding years. We were told that if the nurse admitting them was able to understand what they were taking, and when, they were given medication on the night of admission until they saw the doctor the following day. The remaining medication was put in a plastic bag in a filing cabinet in the reception healthcare room. There were no documented risk assessments.

Recommendations

- 3.49 The initial healthcare assessment should lead to formulation of a clear nursing action plan. This should include routine consideration and documentation of provision of medication (including own medication) on arrival, need for further clinical assessment, emotional needs, information needs, and specialist referral.
- 3.50 There should be formal documented risk assessments to enable detainees to have medication in possession if appropriate, including before being seen by a medical practitioner.
- 3.51 The core document arriving with detainees – often the only document arriving with them - was IND's IS91 authority for detention. It included a small section for medical or other risk factors. On most documents seen in Yarl's Wood reception this section was left blank. The section could be supplemented with further pages with a check list of factors relevant to risk. More recently IRCs had adopted a new folder, a detainee transferable document (DTD), into which the IS91 was inserted. The DTD folder enabled centres, and escorts, to add their own information, to assist escorts and other detention centres when people were moved. This was a good idea because detainees were frequently moved. However the DTD was not opened or completed in every case and the quality of entry remained erratic. Immigration staff did not appear to contribute to the DTD.
- 3.52 Where detainees were transferred from police custody, information recorded in police custody records, including any medical assessments by the forensic medical practitioner, were not transferred with them. In a reception sample considered during the HMCIP inspection which preceded the inquiry, half of the single women arriving at Yarl's Wood had initially been detained in police stations, for an average of between one and two days. It seemed likely that at least some would have seen a doctor, but without custody records this information was not available.
- 3.53 There was confusion about how much information about medical conditions should be reported on the IS91, an open document. Some stated 'medical needs', with the detail provided in a sealed envelope to be opened by healthcare staff only. However, most short term holding facilities through which detainees passed had no on site healthcare. This meant that information essential to the detainee's wellbeing could go unnoticed for some days. In other cases, sensitive information was written inappropriately on the form. On one of the files seen, 'HIV+' was marked on the IS91 for all to see.
- 3.54 In one of the cases we looked at, the detainee's chronic poor health was known, her address was known (it was accommodation provided by the Home Office's National Asylum Support Service) and she was reporting regularly to an IND reporting centre, as required. Nonetheless a decision was made to detain her immediately at the reporting centre, rather than allowing her first to return home, where she would have been able to gather all her medication and other essentials. As a consequence, the anxiety of unexpected detention was considerably aggravated because she did not have her medication, had not eaten that day in conformity with her diet plan, had only the clothes she was wearing, and was worried about medical appointments she could not keep. She was not able to contact people, after detention, for some time. Some of her medication was later collected, in her absence, but not all of it.

Recommendation

- 3.55 When a decision is made to detain people with known health problems or other special needs, they should generally be detained at home, or allowed to return home, to collect all necessary medication, and other items essential to their or their children's immediate needs.

Interpretation

- 3.56 The reception assessment forms were available in a few different languages, and there was a short health questionnaire in more languages.
- 3.57 If a detainee could not speak or understand English, a family member, another detainee, or staff member was used to interpret. Staff could use a telephone interpretation service but this was limited by pressure in the centre to keep costs down. The lack of interpreters was a very serious deficit. We considered it to be at least inadequate and possibly bad clinical practice to rely on officers, relatives, other detainees or even Language Line, especially in complex and highly sensitive situations, such as the disclosure of torture or in the assessment of a woman who may have been raped.

Recommendations

- 3.58 The range of languages in which reception health assessment questionnaires are available should be regularly reviewed, and expanded if need be, to meet the needs of the detainee population.
- 3.59 Particularly for interviews that require confidentiality, such as risk assessment, disclosure of sexual assault and psychiatric interviews, detainees who are not fluent in English should be interviewed in the presence of a professional interpreter. A telephone interpreting service should be used only if clinically appropriate.

Fitness to detain

- 3.60 Rule 35 of the Detention Centre Rules requires health services to alert the detaining authorities if detention or continued detention might be injurious to health, and specifically if there is an allegation of torture or evidence of suicidal intent. Relevant Detention Centre Rules are at Appendix C. Healthcare staff are required to inform the centre manager, who in turn is to inform IND.
- 3.61 According to Detention Services Policy Unit interim operational instruction 05/3305, of 17 August 2005:
- ‘The principal purpose of generating such reports is to ensure that any allegation or evidence that a detainee may have been the victim of torture, is brought to the attention of those with direct responsibility for authorising, maintaining and reviewing that person’s detention. It remains the case that independent evidence that a person has been the victim of torture should weigh heavily against detention, and that such a person would not normally be suitable to be detained.’
- 3.62 The inquiry found that this was implemented at best procedurally, not substantively. Standard questions during reception healthcare screening included whether there was a history of torture; and this could also come to the attention of healthcare staff at a later date. Like some other removal centres, Yarl’s Wood healthcare used a pro forma letter stating that the named

detainee 'claims to be a victim of torture'. A sample 'rule 35 letter' is at Appendix D. Centre staff said that two to three rule 35 letters were issued each week. There was no section on the pro forma for additional comment and the detainee was not necessarily interviewed to provide this information. There was no system to communicate other areas of concern raised under rule 35.

- 3.63 Healthcare sent the pro forma letter to the centre manager and to the IND contract monitor; the centre manager sent his copy to the contract monitor; the contract monitor sent it to the IND case-holding office. A copy was left on the detainee's file but no central record was kept by GSL managers, healthcare or immigration staff, to enable monitoring and follow-up. Indeed, there was no systematic follow-up. Yarl's Wood immigration staff said that rarely, if ever, did they receive a response from the caseholder. At the same time, there was evidence of inappropriate, informal contact between healthcare and immigration staff about fitness to detain with little record of what was said or arrangements for follow-up.
- 3.64 When we examined a number of immigration files, containing reviews of detention, those reviews seemed remote and uninformed. There was little sign that emerging and often deteriorating medical conditions were properly taken into consideration in decisions about continuing detention. The team came across cases where medical reports had been submitted but were barely addressed, even in the monthly detention review letters which were supposed to reassure detainees that their detention was under continuous consideration; and of on-site medical advice being ignored.
- 3.65 There was no system to seek the opinion of an independent medical specialist and in some cases IND caseworkers, with no declared medical qualification, appeared to be making their own clinical judgements.
- 3.66 As noted in paragraphs 3.40-3.45, both Ms A and Ms B were the subject of rule 35 letters which were forwarded to the IND caseholder. In neither case did we see evidence of any response from the caseholder to the centre, nor of any follow-up from the centre to the caseholder. Neither detainee appeared to have been informed.
- 3.67 The case of Ms A is illustrative. Following her arrival at the IRC for fast-track processing she described a history of torture and continuing pain as a result. A rule 35 letter was sent to IND, to which there was no apparent response on the file. The following day she was interviewed in accordance with the fast-track asylum determination process. A solicitor was present during the interview. He asked for her to be taken out of the fast-track as she had suffered torture and he intended to refer her to the Medical Foundation for examination and report. She remained in the fast track. There was no apparent referral to the Medical Foundation. She did not see the solicitor again after the interview. She tried unsuccessfully to find another solicitor, but had no representative and no medical report for her appeal, which failed. She continued to report pain resulting from torture. A second rule 35 letter was sent to IND some time later by a second removal centre. Following her return to Yarl's Wood a third rule 35 letter was sent. When she became ill, requiring hospitalisation, and new solicitors requested temporary release in the light of her deterioration, the IND caseworker refused but did confirm receipt of the last two rule 35 letters dated some months previously. Although the inquiry team saw no evidence that the content of the three rule 35 letters over the previous six months had been addressed, the writer stated: 'This clearly demonstrates that your client's case has received immediate and appropriate attention as soon as these issues were raised by your client'. This was the only acknowledgement of rule 35 letters in all the files seen.
- 3.68 Following her hospitalisation (for the third time) the IND case note said:

'phone call from YW stating appt admitted under MHA [Mental Health Act] to hospital...under no circumstances should this woman be TA'd [granted temporary release]. If she is sectioned, then she can remain there until she is fit enough to be released back to immigration detention'.

- 3.69 Subsequently, the detainee's monthly detention review, issued by a separate IND office, addressed to her at the Mental Health NHS Trust, stated 'The current position of your case is as follows: Arrangements will be made to remove you from the United Kingdom once a flight and medical escorts can be secured, and you will be notified when this will be. Your case has been reviewed. It has been decided that you will remain in detention.' There was no assessment of the medical reports submitted.
- 3.70 In another case, after a month in detention, one woman attempted to hang herself in Yarl's Wood and she was put on suicide and self-harm monitoring. Her behaviour became increasingly bizarre. After four months in detention she made a second suicide attempt. Her IND file recorded 'no clear evidence of mental illness', but a few days later she was moved to the local mental health trust under section 48 of the Mental Health Act. Soon after, in response to solicitors' representations, the IND caseworker replied, 'Should your client be released into the general populace without sound of mind [sic] the effects could be disastrous. We believe that the continued detention of your client given the current circumstances, to be the safest option available. This view is protective of the interests of both your client and the general public'. This view was not substantiated by reference to any history of dangerous behaviour or any medical opinion. During five months' detention no attempt had been made to remove her as IND was still investigating whether she could be removed.

Recommendations

- 3.71 Health professionals should document and refer to IND all medical or psychological conditions that affect fitness to detain.
- 3.72 Detainees subject to review concerning fitness to detain or travel should not be removed pending the outcome.
- 3.73 All communications between healthcare staff and IND about fitness to detain or travel should be in writing and kept on the detainee's file.
- 3.74 The Immigration and Nationality Directorate (IND) should promptly investigate and consider any illnesses or conditions affecting a detainee raised under rule 35 of the Detention Centre Rules. This process should be documented. The detainee and the IRC, including healthcare, should be notified of the outcome within a short timescale.
- 3.75 There should be a panel of independent specialist doctors to provide a clinical assessment where substantial allegations have been raised under rule 35 of the Detention Centre Rules.
- 3.76 Immigration removal centres should be required to keep a central folder of rule 35 letters, with any response from the case-holder. Timely responses should be sought and this should be subject to regular audit.

Primary care

- 3.77 The centre had no permanent full-time doctor. A locum doctor worked full-time from Monday to Friday. The present locum had worked at Yarl's Wood for over a year and provided

professional, good quality clinical care. When we interviewed Ms A in hospital in the course of this review, the locum doctor was one of the few people at Yarl's Wood whom she could remember and she spoke positively of him. Three male doctors from a local general practitioner practice provided medical cover including out of hours and weekends. We were concerned that the lack of a substantive post could compromise continuity of care. There was no female GP readily available to women at Yarl's Wood. Notices in the healthcare centre indicated that women could request to see a female doctor although this appeared to be a rare event.

Recommendation

- 3.78 Steps should be taken to ensure continuity of medical care, for example by recruiting a substantive medical practitioner.
- 3.79 There was a G grade registered general nurse healthcare manager and 10 other nurses, two of whom were team leaders. The contract with GSL required there to be a minimum of three nurses on duty each weekday and two at weekends. Generally three nurses were on 12-hour day shifts and two were on 12-hour night shifts. In addition the team leaders and healthcare manager were on duty from 8.00am to 5.00pm each weekday. Recruitment procedures were slow because of the need for new staff to undergo Criminal Records Bureau checks and ISCAT⁶ screening.
- 3.80 Some detainees had unrealistic expectations of healthcare. For example, some wished to see a doctor rather than a nurse regardless of their complaint, or expected an appointment the same day for non-urgent conditions, a standard which would not be expected of GPs in the community. In fact detainees usually saw healthcare within 24 hours of application and waiting lists for specialist treatment were relatively short.
- 3.81 New detainees and others who needed to see the doctor were given appointments for the next day's clinic and then brought to healthcare by custody staff at the relevant time. Although the healthcare centre was located in the middle of the IRC, detainees always had to be escorted there. Single women were seen in the mornings and families were seen in the afternoon. Nurses held daily triage clinics but did not follow formal triage algorithms. These were about to be introduced. There was a registered nurse in the clinic with the doctor and another nurse was available to undertake any necessary treatment. The review team considered that having a fully qualified nurse acting as the doctor's chaperone was not necessarily the best use of resources.
- 3.82 Each of the nurses took responsibility for a specific area of healthcare, for example, asthma care, diabetes care, breast care and pregnancy. Detainees were referred to the relevant nurses, who then managed their own caseload, but there were no regular clinics. The nurses called individual detainees to see them, when they were on duty and had time. Staff recognised that there was a need for more regular clinics and these needed to include cervical screening, as some women stayed for several months.
- 3.83 A skill mix review, including consideration of the use of healthcare assistants in the medical sessions, might help to free up the specialist nursing staff to run regular nursing clinics.
- 3.84 We observed a recently arrived female detainee both in reception and while being seen by the GP the following day. She was treated with respect. A past history of depression which the

⁶ Immigration Service Certification and Accreditation Team

nurse had noted on reception was followed up by the GP. The detainee had also complained of various physical pains for which the GP made a thorough and careful examination.

Recommendations

- 3.85 There should be a skill mix review and this should include consideration of the greater use of healthcare assistants working alongside the general practitioners.
- 3.86 Nurses with the relevant skills and competencies should be enabled to run regular specialised clinics.

- 3.87 A dentist visited the detention centre once a week and saw between four and six patients each week. The waiting list was no more than 10 days. The dentist undertook treatment including extractions. A detainee in need of emergency dental treatment could be taken for treatment to a local dental practice during weekdays. An optician and podiatrist visited as required. Pharmacy services were provided by a local pharmacy (Lloyds).
- 3.88 A midwife from Bedford hospital visited weekly to provide ante-natal care and follow up as required. Detainees attended the hospital for scans.
- 3.89 Detainees were referred to the local health services as necessary. The centre had a good rapport with the local sexual health clinic (Bridge House) and reported that it could get appointments for detainees within reasonable timeframes. We were told that there was sometimes difficulty getting clinical information from Bridge House, although this was probably based on heightened confidentiality and the special needs of a service dealing with sexually-transmitted diseases. There was no clinical protocol at Yarl's Wood for the assessment and management of rape survivors, or protocols for the assessment of HIV and other sexually transmitted diseases
- 3.90 Healthcare staff had good working relationships with the local consultant in communicable diseases. Detainees were tested and treated for tuberculosis if they presented with clinical symptoms. Infection control advice was available on an informal basis but this relied on goodwill and the work of the staff to develop and maintain an informal relationship. This was not adequate as a long term solution (see recommendations at paragraphs 3.22 and 3.38).
- 3.91 Detainees who needed to attend outside hospital appointments were risk assessed by both healthcare staff and custody officers, before being escorted to the appointment. At least one of the escorting staff was female. Escort records indicated that detainees were rarely handcuffed when attending hospital appointments.

Mental health care

- 3.92 There was insufficient provision for mental health care on site. There were only two mental health trained (RMN) nurses both of whom generally worked night shifts. Mental health assessments therefore often took place in the evening. We noted that the doctor had not met either of the RMNs. Primary mental health care was limited.

Recommendations

- 3.93 There should be a minimum of one registered mental health nurse on each shift during the 24 hour operating period. The grade structure should allow internal professional supervision for more junior members of the team.
- 3.94 Primary mental health care services should be developed to ensure that detainees receive a comprehensive service.
- 3.95 There should be regular mental health team review meetings to include the doctor and counsellor, as well as visiting healthcare providers.

- 3.96 Although nurses in reception noted if a detainee volunteered a history of mental health problems, this did not go as far as the NICE (post traumatic stress disorder) guideline that recommended:
'For programme refugees and asylum seekers at high risk of developing PTSD consideration should be given...to the routine use of a brief screening instrument for PTSD as part of the initial refugee healthcare assessment. This should be a part of any comprehensive physical and mental health screen' (NICE Guideline for PTSD, 2006).

Recommendation

- 3.97 National Institute for Health and Clinical Excellence guidelines including those for post traumatic stress disorder should be implemented at Yarl's Wood.

- 3.98 A consultant forensic psychiatrist visited when requested, under private arrangements with Veritas, usually at the weekend. He worked at the local medium secure unit (the Orchard Unit). Detainees did not have routine access to local general or specialist psychiatric services, for example a community mental health team. There was no provision of child and adolescent psychiatry. Detainees were unlikely to present with the level of risk appropriate to a forensic/medium secure service and would probably benefit from access to a range of service responses.

Recommendations

- 3.99 There should be a service level agreement with local NHS provider trusts to ensure detainees also have access to:
- a general psychiatrists and psychologists familiar with trauma reactions, for both adults and children
 - b child and adolescent mental health services.
- 3.100 Access to tertiary mental health services, including access to a forensic consultant psychiatrist, should be commissioned by the local primary care trust as part of the overall mental health commissioning arrangements.

- 3.101 Although the establishment was funded for 1.5 whole time equivalent counsellors, only one counsellor was in post, as 'coordinator of counselling services'. She had 1.5 hours a month of external supervision. This is the minimum recommended by the British Association for Counselling and Psychotherapy. Anyone could refer a detainee. The counsellor undertook

solution-focused therapies and coping strategy work and saw four to five detainees per day. There had been 61 referrals in the eight months prior to the review.

- 3.102 The team understood that the target client group for the counsellor was adults who were able to converse in English and who had mild to moderate depression or problems adjusting to the centre or to possible removal. This approach seemed to be in line with NICE guidelines for depression, which recommend that in 'both mild and moderate depression, psychological treatment specifically focused on depression (such as problem-solving therapy, brief CBT (cognitive behavioral therapy) and counselling) of 6 to 8 sessions over 10 to 12 weeks should be considered'. (NICE Guideline for Depression, 2004). However, it does not cater for the needs of families, people who are not able to converse in English, or those with other emotional problems. The inquiry team welcomed plans to develop group work in addition to the individual work.

Recommendations

- 3.103 There should be a review of the counselling service with a view to expanding the range of therapeutic modalities.
- 3.104 Counselling should be available to all who need it, regardless of language.
- 3.105 Professional interpreters should be available to facilitate counselling for those with inadequate knowledge of English.
- 3.106 The counsellor, or counselling team, should have access to a level of clinical supervision above the recommended minimum bearing in mind the range and level of stress within the centre population.

- 3.107 While the counselling service functioned well, accountability and management arrangements were informal and unclear. There was a lack of routine contact between counsellor and the mental health nurses (who generally worked on night shifts) although there was more frequent contact with the doctor. The counsellor maintained separate documented records, and did not usually record in the clinical file that the detainee had been seen.
- 3.108 The counsellor and other staff saw detainees at risk of suicide and self-harm (SASH). SASH meetings were held on Tuesday afternoons although this was at a time when the doctor was not available due to his clinical commitments.

Recommendations

- 3.109 There should be regular mental health team review meetings to include general practitioner, mental health nurses on day shifts and counsellor(s) as well as visiting healthcare providers.
- 3.110 The counsellor should record attendance and any serious issues for communication in the detainee's multi-professional clinical record.
- 3.111 Suicide and self-harm review meetings should be scheduled to permit the appropriate people to attend, for example the doctor, mental health nurse(s), and chaplain.

Detainees refusing food and fluids

- 3.112 Custody staff monitored and recorded detainees who refused food or food and fluids.
- 3.113 Purchases made at the centre shop as well as meals taken were recorded. Any detainees observed not to be eating were notified to healthcare staff and the immigration staff on a daily basis. Healthcare staff saw the detainee to determine the reason for not eating.
- 3.114 The following case typified the care offered. One of the women who began refusing food at the end of July was seen and given appropriate advice by healthcare. Three days later a nurse referred her to the doctor as an urgent appointment the same day because she was worried about her low mood. She was prescribed an antidepressant, referred to a mental health nurse and put on SASH monitoring for several days. A series of detailed conversations with her were recorded on the residential unit records and some custody officers appeared to have established a good rapport with her and recorded their concerns. She refused to see the counsellor, having found a previous appointment unhelpful. Healthcare staff then saw her every day, with one exception, until her transfer to hospital. She was given detailed advice, sometimes with the assistance of a friend who helped to translate, and the level of observation was increased, but she was resistant to attempts to persuade her to cooperate.
- 3.115 The clinical policy was sketchy and there was no re-feeding protocol. An IND Detention Services Order, 7/2004, outlined the need for informed consent and assessment of capacity before providing treatment, as well as the status and form of an advance directive (ie a document stating the kind of care a patient would like to have if he or she became unable to make medical decisions).⁷
- 3.116 The order suggested a medical appointment after 24 hours, to record base line weight, assess underlying mental and physical illness, explain the consequences and offer appropriate care, which might include arranging an immigration interview to discuss any grievance. It also required healthcare and immigration staff to maintain a full written record.
- 3.117 Where detainees who have been refusing food and fluid decide to resume eating and drinking, serious medical complications may ensue: for example they may become deficient in one of the B group vitamins, thiamine. Re-feeding in such a circumstance can precipitate the brain syndrome Wernicke's encephalopathy and lead to long term damage. People who have had a significant period of food and fluid refusal require careful medical monitoring before and during re-feeding. This is beyond the range of medical services usually available in any primary care setting. It requires prompt access to specialist dietetic advice and rapid blood chemistry results. However, the IND guidance was procedural and there was no detailed guidance on the clinical treatment of detainees who refused food and fluid and no detailed re-feeding protocol following a hunger strike.
- 3.118 The review team found adherence to the principles of medical ethics espoused by the World Medical Association and the British Medical Association. However, options for treatment may have been impaired because of lack of trust by detainees in the healthcare service and its practitioners, especially if it was seen as an arm of the detaining authority. We also found

⁷ The World Medical Association 1975 Declaration of Tokyo requires that consent be informed and prohibits force feeding of hunger strikers. British Medical Association policy is that detainees who are able to form a rational judgement about the consequences of a hunger strike should not be fed artificially without consent. Where it is clear that a detainee intends to continue the strike until death, refusal must be respected after the loss of capacity and he or she must be allowed to die with dignity.

evidence of an inappropriately informal approach to re-feeding even for people who had apparently been refusing food for a substantial period.

Recommendations

- 3.119 A clear management policy for the care of detainees who refuse food and fluids should be developed for IRCs, based on IND guidelines, and subject to audit.
- 3.120 A detailed protocol should be developed in partnership with local NHS hospital services for the clinical management of detainees who refuse food and fluids, as well as those who have ceased hunger strike and require subsequent re-feeding. This should be subject to audit.

External doctors – rule 33 (7), Detention Centre Rule

- 3.121 Under Detention Centre Rules, rule 33(7), detainees were entitled to request a second opinion doctor, at their own expense. This could be the only way in which they could obtain specialist medical advice or assessment (this role differed from that of the practitioners instructed by legal representatives solely to provide independent expert evidence in connection with legal proceedings, under rule 33(11). Here the doctor would have a duty to the court and it would be for the court to determine their competence and expertise).
- 3.122 Many practitioners visited the centre solely to prepare an independent medical report on behalf of the detainee for use in legal proceedings. Their reports could be subject to legal privilege, which would constrain their ability to pass on comment to IRC healthcare staff. However, in a setting like this, it is good practice for all practitioners to record the fact of their attendance in the clinical file and communicate any significant clinical concerns briefly, verbally and in writing, to healthcare staff.
- 3.123 Rule 33(7) had given rise to some confusion. In some of the cases we considered, it appeared that there were three second opinion doctors. It was not clear how this came about. There were no detailed policies. There was evidence that both detainees and healthcare staff could receive conflicting advice from, for example, the local hospital consultant to whom a referral had been made and a visiting health professional, under rule 33(7), whose status within the medical regulatory framework was unclear.
- 3.124 In one case file it was recorded that the detainee had refused to attend healthcare for a necessary blood test until 'her doctor' (ie the second opinion doctor) had been told what the reason was. On occasions such doctors were described, both by themselves and others, verbally and in writing, as the 'patient's GP'. This was wrong and misleading. None had tried to prescribe any medication but the boundaries of this role and the expectations on the doctor and on healthcare staff were ambiguous and unclear.

Recommendations

- 3.125 A minimum set of objective criteria for the admission to IRCs of medical practitioners seeking access under Detention Centre Rules, rule 33(7) (second opinion doctors requested by the detainee) should be drawn up. The purpose of this should solely be the protection of patients. Criteria should include that the practitioner is able to provide written evidence that he/she:

- a can demonstrate their identity
- b is registered with the General Medical Council and is on the GP or specialist register as appropriate
- c is registered with a medical defence organisation
- d where necessary, is registered with the Healthcare Commission

3.126 A clinical protocol should be developed, by representatives of the immigration healthcare steering group and independent organisations working professionally with asylum-seekers, to clarify the role of the second opinion doctor and the relationship with the healthcare service, with special reference to record-keeping and clinical responsibility.

Departure from the centre

3.127 Planning of care and engagement with detainees could be adversely affected when removal was imminent. One young woman, with recorded poor health, arrived late at night tired and troubled having spent most of the day in poor conditions in a short-term holding room and escort vehicle. She explained her need for specialist advice and medication and asked to be referred to a doctor. This did not happen as she was taken for removal the next day. Her anxiety increased as the residual medication she had with her was handed to escorts and she was given no more medication. On her return to the IRC, she did not trust the healthcare staff. When a hospital appointment was made and escorts arrived, she hid, convinced she was being taken to the airport not the hospital.

3.128 A member of the nursing team saw all detainees before they left the centre. A brief medical discharge summary was given to the detainee to take with him or her. Medication prescribed at the centre to meet immediate needs was not given to the detainee but was generally attached to the escorts' documents, with medical notes, in a sealed envelope marked 'medical – in confidence'. The possessions they had brought into the centre with them were returned, including any medications, regardless of expiry date and regardless of personal risk, for example risk of suicide or self-harm. This was acknowledged to be potentially hazardous, but it was a requirement to return all property to detainees. If they were being moved to a short-term holding centre there was unlikely to be any receiving healthcare service to advise or administer medication.

3.129 There was little opportunity to plan the care of those who remained in the centre for only a short time. Often neither healthcare staff nor the detainee received much warning of removal. This precluded the opportunity to consider discharge preparation in good time, for example malaria prophylaxis. Although not all detainees were uncooperative with removal arrangements, many were in fear of being removed. Anxiety was often aggravated if they had been given no opportunity to prepare themselves. There was some evidence that IND case-holders served removal directions late to pre-empt disruption and legal challenge.

3.130 Late removal directions fuelled mistrust among detainees, who consequently were reluctant to comply when called to reception for any reason, in case it was a subterfuge for sudden removal. Many custody officers said they thought that late service of removal directions caused more problems than it solved. The anxious reaction that removal often provoked was aggravated if the detainee had no time to prepare. Staff in the centre had little time to arrange for a member of the chaplaincy team or counsellor to support the detainee, and healthcare had little time to plan discharge medication or documentation.

3.131 A further case illustrates this. One of the July hunger-strikers, without advance warning, was told to pack her things for removal that same day. The escorts were in reception. The removal

directions had been set two days previously but no one had told the centre or the detainee. In fact they were cancelled that afternoon for administrative reasons. But healthcare and residential unit records from that date recorded a marked and continuing deterioration in her mental condition.

Recommendations

- 3.132 Detainees and relevant IRC staff should be notified without delay of decisions to transfer or remove, to enable staff and detainees to take steps to safeguard health and deal with medical conditions and risk, and to minimise anxiety and mistrust.
- 3.133 Before detainees are allowed to travel with medication, particularly if they may not be seen by health professionals within a short time, discharging healthcare staff should conduct an individual risk assessment to determine whether medication ought to be allowed in possession and escort staff should be instructed accordingly.
- 3.134 Reception healthcare staff should have stickers in common languages, to be put on medications withheld and returned, informing detainees that these may be out of date and should be checked.

4: Summary of recommendations

To the Immigration and Nationality Directorate (IND) and Department of Health (Prison Health)

- 4.1 IND and the Department of Health (Prison Health) should expedite arrangements for healthcare provision in immigration removal centres to be commissioned by the National Health Service. (Paragraph 3.4)
- 4.2 The lines of accountability for healthcare management should be clarified, with regard to IND, GSL, the local primary care trust, and the immigration detention estate healthcare steering group. (Paragraph 3.20)

To the Immigration and Nationality Directorate (IND)

- 4.3 All healthcare provision in IRCs should be registered with the Healthcare Commission and their specified standards of care should be implemented as a matter of urgency. (Paragraph 3.5)
- 4.4 The clinical leadership available to the healthcare manager should be increased to ensure sufficient expertise for clinical support and advice. (Paragraph 3.19)
- 4.5 When a decision is made to detain people with known health problems or other special needs, they should generally be detained at home, or allowed to return home, to collect all necessary medication, and other items essential to their or their children's immediate needs. (Paragraph 3.55)
- 4.6 Detainees subject to review concerning fitness to detain or travel should not be removed pending the outcome of this review. (Paragraph 3.72)
- 4.7 All communications with healthcare staff about fitness to detain or travel should be in writing and kept on the detainee file. (Paragraph 3.73)
- 4.8 IND should promptly investigate and consider any illnesses or conditions affecting a detainee raised under rule 35 of the Detention Centre Rules. This process should be documented. The detainee and the IRC, including healthcare, should be notified of the outcome within a short timescale. (Paragraph 3.74)
- 4.9 There should be a panel of independent specialist doctors to provide a clinical assessment where substantial allegations have been raised under rule 35, Detention Centre Rules. (Paragraph 3.75)

- 4.10 Immigration removal centres should be required to keep a central folder of rule 35 letters, with any response from the case-holder. Timely responses should be sought and this should be subject to regular audit. (Paragraph 3.76)
- 4.11 A clear management policy for the care of detainees who refuse food and fluids should be developed for IRCs, based on IND guidelines, and subject to audit. (Paragraph 3.119)
- 4.12 A minimum set of objective criteria for the admission to IRCs of medical practitioners seeking access under Detention Centre Rules, rule 33(7) (second opinion doctors requested by the detainee) should be drawn up. The purpose of this should solely be protection of patients. Criteria should include that the practitioner is able to provide written evidence that he/she:
- can demonstrate their identity,
 - is registered with the General Medical Council and is on the GP or specialist register as appropriate,
 - is registered with a medical defence organisation,
 - where necessary, is registered with the Healthcare Commission, (Paragraph 3.125)
- 4.13 A clinical protocol should be developed, by representatives of the immigration healthcare steering group and independent organisations working professionally with asylum-seekers, to clarify the role of the second opinion doctor and the relationship with the healthcare service, with special reference to record-keeping and clinical responsibility. (Paragraph 3.126)
- 4.14 Detainees and relevant IRC staff should be notified without delay of decisions to transfer or remove, to enable staff and detainee sufficient time to take steps to safeguard health and deal with medical conditions and risk and to minimise anxiety and mistrust. (Paragraph 3.132)

To the Director, Yarl's Wood Immigration Removal Centre (IRC)

- 4.15 Detailed clinical protocols should be developed in the management of common and important clinical problems. These should take account of guidelines developed by the National Institute for Health and Clinical Excellence (NICE) and other regulatory and professional bodies and should be formulated locally in multi-professional team discussions. As a minimum, there should be detailed clinical protocols for the management of the following:
- a People on hunger strike and subsequent re-feeding,
 - b The management of rape survivors,
 - c Post traumatic stress disorder and depression,
 - d Head injury sequelae,
 - e Psychosis,
 - f Identification of tuberculosis, including contact tracing and
 - g Malaria prophylaxis (prior to removal). (Paragraph 3.22)
- 4.16 The healthcare manager should ensure that the team receives routine alerts and guidelines from the Medicines and Healthcare Products Regulatory Agency, the Chief Medical Officer and the National Institute for Health and Clinical Excellence. These should be considered in multi-professional team meetings and both receipt and team consideration should be logged. (Paragraph 3.24)

- 4.17 All staff, including the healthcare manager, should have individual professional supervision. Senior staff should be able to access appropriate external supervision, preferably within the same professional group. (Paragraph 3.25)
- 4.18 Healthcare staff should receive appropriate training in the care of both adults and children with a history of torture or trauma. (Paragraph 3.28)
- 4.19 Healthcare staff should be issued with 'Medical investigation and documentation of torture: a handbook for health professionals'. (Paragraph 3.29)
- 4.20 Regular training needs analyses should be undertaken and there should be a routine induction for all clinical staff. (Paragraph 3.30)
- 4.21 There should be an annually updated health needs assessment of detainees, prepared jointly with Bedford primary care trust. (Paragraph 3.32)
- 4.22 Staffing levels and skill mix should reflect the needs of the population, based on the outcome of the health needs assessment. (Paragraph 3.33)
- 4.23 Memoranda of understanding to define services provided and management responsibilities should be established between GSL, the local primary care trust and Veritas. (Paragraph 3.36)
- 4.24 Pending formal transfer of the commissioning of healthcare to the NHS, there should be formal service level agreements with local NHS providers and agreement about clinical information sharing. The service level agreements should include detailed specifications for the following:
- a. infection control and communicable diseases advice
 - b. mental health services
 - c. secondary healthcare, including the specific needs of detainees refusing food, detainees known or suspected to have a sexually transmitted disease including AIDS, detainees with acute medical conditions requiring urgent hospital assessment/admission, and detainees requiring outpatient monitoring and support for chronic medical conditions (eg diabetes and hypertension).
 - d. specialist pharmacy advice and provision of anti-retroviral and other specialist treatments, unavailable in the local pharmacy. (Paragraph 3.38)
- 4.25 The initial healthcare assessment should lead to formulation of a clear nursing action plan. This should include routine consideration and documentation of provision of medication (including own medication) on arrival, need for further clinical assessment, emotional needs, information needs, and specialist referral. (Paragraph 3.49)
- 4.26 There should be formal documented risk assessments to enable detainees to have medication in possession if appropriate, including before being seen by a medical practitioner. (Paragraph 3.50)
- 4.27 The range of languages in which reception health assessment questionnaires are available should be regularly reviewed, and expanded if need be, to meet the needs of the detainee population. (Paragraph 3.58)
- 4.28 Particularly for interviews that require confidentiality, such as risk assessment, disclosure of sexual assault and psychiatric interviews, detainees who are not fluent in English should be interviewed in the presence of a professional interpreter. A telephone interpreting service should be used only if clinically appropriate. (Paragraph 3.59)

- 4.29 Health professionals should document and refer to IND all medical or psychological conditions that affect fitness to detain. (Paragraph 3.71)
- 4.30 Steps should be taken to ensure continuity of medical care, for example by recruiting a substantive medical practitioner. (Paragraph 3.78)
- 4.31 There should be a skill mix review and this should include consideration of the greater use of healthcare assistants working alongside the general practitioners. (Paragraph 3.85)
- 4.32 Nurses with the relevant skills and competencies should be enabled to run regular specialised clinics. (Paragraph 3.86)
- 4.33 There should be a minimum of one registered mental health nurse on each shift during the 24 hour operating period. The grade structure should allow internal professional supervision for more junior members of the team. (Paragraph 3.93)
- 4.34 Primary mental health care services should be developed to ensure that detainees receive a comprehensive service. (Paragraph 3.94)
- 4.35 There should be regular mental health team review meetings to include the doctor and counsellor, as well as visiting healthcare providers. (Paragraph 3.95)
- 4.36 National Institute for Health and Clinical Excellence guidelines including those for post traumatic stress disorder should be implemented at Yarl's Wood. (Paragraph 3.97)
- 4.37 There should be a service level agreement with local NHS provider trusts to ensure detainees also have access to:
- general psychiatrists and psychologists familiar with trauma reactions, for both adults and children;
 - child and adolescent mental health services. (Paragraph 3.99)
- 4.38 Access to tertiary mental health services, including access to a forensic consultant psychiatrist, should be commissioned by the local primary care trust as part of the overall mental health commissioning arrangements. (Paragraph 3.100)
- 4.39 There should be a review of the counselling service with a view to expanding the range of therapeutic modalities. (Paragraph 3.103)
- 4.40 Counselling should be available to all who need it, regardless of language. (Paragraph 3.104)
- 4.41 Professional interpreters should be available to facilitate counselling for those with inadequate knowledge of English. (Paragraph 3.105)
- 4.42 The counsellor, or counselling team, should have access to a level of clinical supervision about the recommended minimum bearing in mind the range and level of stress within the centre population. (Paragraph 3.106)
- 4.43 There should be regular mental health team review meetings to include general practitioner, mental health nurses on day shifts and counsellor(s) as well as visiting healthcare providers. (Paragraph 3.109)

- 4.44 The counsellor should record attendance and any serious issues for communication in the detainee's multi-professional clinical record. (Paragraph 3.110)
- 4.45 Suicide and self-harm review meetings should be scheduled to permit the appropriate people to attend, for example the doctor, mental health nurse(s), and chaplain. (Paragraph 3.111)
- 4.46 A detailed protocol should be developed in partnership with local NHS hospital services for the clinical management of detainees who refuse food and fluids, as well as those who have ceased hunger strike and require subsequent re-feeding. This should be subject to audit. (Paragraph 3.120)
- 4.47 Before detainees are allowed to travel with medication, particularly if they may not be seen by health professionals within a short time, discharging healthcare staff should conduct an individual risk assessment to determine whether medication ought to be allowed in possession and escort staff should be instructed accordingly. (Paragraph 3.133)
- 4.48 Reception healthcare staff should have stickers in common languages, to be put on medications withheld and returned, informing detainees that these may be out of date and should be checked. (Paragraph 3.134)

Appendices

A. Terms of reference

HM Chief Inspector of Prisons to carry out an inquiry into:

- The overall standard of healthcare provided by Veritas at Yarl's Wood, with particular reference to the support and treatment of detainees with mental and traumatic stress disorders.
- In particular, issues raised by the medical case management of Ms A while at Yarl's Wood
- This will include
 - Examination of medical records
 - Discussions with staff
 - Evidence from detainees
 - Consideration of the effectiveness of links with the primary care trust and mental health facilities outside the centre
 - Discussion with other relevant parties, such as the MP, medical staff, centre visitors and detainee support groups

B. Inspection team

The inquiry was headed by Dr Tish Laing-Morton (formerly head of healthcare at the Inspectorate), assisted by:

- Elizabeth Tysoe (current head of healthcare)
- Eileen Bye, inspector
- Dr Stuart Turner, Director of the Trauma Clinic

C. Detention Centre Rules relevant to healthcare

Statutory instrument 2001 No.238

Purpose of detention centres

3. (1) The purpose of detention centres⁸ shall be to provide for the secure but humane accommodation of detained persons in a relaxed regime with as much freedom of movement and association as possible, consistent with maintaining a safe and secure environment, and to encourage and assist detained persons to make the most productive use of their time, whilst respecting in particular their dignity and the right to individual expression.

(2) Due recognition will be given at detention centres to the need for awareness of the particular anxieties to which detained persons may be subject and the sensitivity that this will require, especially when handling issues of cultural diversity.

HEALTHCARE

Medical practitioner and healthcare team

33.(1) Every detention centre shall have a medical practitioner, who shall be vocationally trained as a general practitioner and a fully registered person within the meaning of the Medical Act 1983.

(2) Every detention centre shall have a healthcare team (of which the medical practitioner will be a member), which shall be responsible for the care of the physical and mental health of the detained persons at that centre.

(3) Each member of the healthcare team shall (as far as they are qualified to do so) pay special attention to the need to recognise medical conditions which might be found among a diverse population and the cultural sensitivity appropriate when performing his duties.

(4) The healthcare team shall observe all applicable professional guidelines relating to medical confidentiality.

(5) Every request by a detained person to see the medical practitioner shall be recorded by the officer to whom it is made and forthwith passed to the medical practitioner or nursing staff at the detention centre.

(6) The medical practitioner may consult with other medical practitioners at his discretion.

(7) All detained persons shall be entitled to request that they are attended by a registered medical practitioner or dentist other than the medical practitioner or those consulted by him under paragraph (6), so long as –

- (a) the detained person will pay any expense incurred;
- (b) the manager is satisfied that there are reasonable grounds for the request; and
- (c) the attendance is in consultation with the medical practitioner.

⁸ Section 66, Nationality, Immigration and Asylum Act 2000 changed the term “detention centres” to “removal centres”.

(8) The medical practitioner shall obtain, so far as reasonably practicable, any previous medical records located in the United Kingdom relating to each detained person in the detention centre.

(9) The healthcare team shall ensure that all medical records relating to a detained person are forwarded as appropriate following his transfer to another detention centre or a prison or on discharge from the detention centre.

(10) All detained persons shall be entitled, if they so wish, to be examined only by a registered medical practitioner of the same sex, and the medical practitioner shall ensure that all detained persons of the opposite sex are aware of that entitlement prior to any examination.

(11) Subject to any directions given in the particular case by the Secretary of State, a registered medical practitioner selected by or on behalf of a detained person who is party to legal proceedings shall be afforded reasonable facilities for examining him in connection with the proceedings.

Medical examination upon admission and thereafter

34. (1) Every detained person shall be given a physical and mental examination by the medical practitioner (or another registered medical practitioner in accordance with rules 33(7) or (10) within 24 hours of his admission to the detention centre.

(2) Nothing in paragraph (1) shall allow an examination to be given in any case where the detained person does not consent to it.

(3) If a detained person does not consent to an examination under paragraph (1), he shall be entitled to the examination at any subsequent time upon request.

Special illnesses and conditions (including torture claims)

35. (1) The medical practitioner shall report to the manager on the case of any detained person whose health is likely to be injuriously affected by continued detention or any conditions of detention.

(2) The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

(3) The medical practitioner shall report to the manager on the case of any detained person who he is concerned may have been the victim of torture.

(4) The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.

(5) The medical practitioner shall pay special attention to any detained person whose mental condition appears to require it, and make any special arrangements (including counselling arrangements) which appear necessary for his supervision or care.

36. Notification of illness or death

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37. Medical examinations required in the interests of others

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44. Compulsory testing for controlled drugs and alcohol

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PART V – PERSONS HAVING ACCESS TO DETENTION CENTRES

Authorisation for access

53. No person shall have access to a detention centre unless authorised by statute or the manager or the Secretary of State.

D. Example Rule 35 letter
