Written evidence submitted by Dr Hilary Pickles and Professor Richard Coker (COR0036)

This seeks to address aspects of 'How the Home Office and its major contractors are working together to ensure the safe and effective operation of contracted services is maintained, particularly where these services affect vulnerable people'. It concerns those detained under immigration powers and builds on evidence others have already provided to the committee. It is also relevant to the current inquiry by the Justice Committee in so far as it relates to the impact on prisons of those held there under immigration powers.

1. If the overall aim is to minimise the avoidable death and suffering from this pandemic, there has to be exceptional justification for placing anyone at excess risk of infection. Otherwise, this becomes an issue not just for them, but also for the wider public with whom they could be competing for access to the over-stretched NHS. Healthcare staff and other essential workers are rightly being applauded for remaining at the front line, but there are others at increased risk of being infected where there is neither necessity nor personal choice. They are held not through any court judgment but under immigration powers, some in immigration detention centres (IRCs), with others remaining in prison after serving their time.

2. It is well recognised that there are extra challenges for controlling the spread of infection in places of detention[i]. Communities like prisons and IRCs are high risk for spread of covid-19 because:
   - Many people are held in small spaces, such that social distancing is very difficult
   - Hand washing as recommended is problematic, since sinks are few and hand steriliser rarely available for inmates, and soap not always available
   - Cleaning standards are generally poor
   - There are many hard surfaces upon which shed virus could remain active
   - Ventilation is often poor
   - Even if visitors are now banned, staff need to move in and out daily, so can introduce infection (as well as carry it back to their families and risk seeding clusters of infection in the wider population)
   - The recommended cohorting of presumed infected detainees has not been proven to be effective with covid-19, and would be undermined both (1) by those with subclinical or preclinical infection but without symptoms still being capable of shedding virus and (2) by those whose symptoms are not from covid-19 and so being put at risk.
   - Cell-sharing is still common. However, even with physical surrounding of a much higher standard, the outbreaks in cruise liners demonstrate that covid-19 can spread easily even with passengers restricted to their own cabins[ii]. So there should be little comfort from holding high risk prisoners/detainees in single cells[iii]
   - As well as being difficult to apply, public health advice about how best to avoid infection may well not be available in a language and format accessible to all detainees and prisoners[iv]

3. Among the recognised risk groups for having severe disease, those aged over 70 are not expected to be held in IRCs, but there are no data on the ages of those held in prisons under immigration powers and many prisoners are over 70. Whilst the UK recommends stricter social distancing for the over 70s, the US has 65 as its cut-off[v]. Many in IRCs are in their 50s

and 60s, at higher risk than younger people. None now in IRCs should be in that very high risk group for severe disease who need to be shielded[vi], although there is anecdotal information suggesting otherwise[vii]. There is no information on those held in prisons. Others at higher risk from covid-19 have hypertension, diabetes, heart disease and less severe asthma, some of which may be recorded on disease registers by prison healthcare, but these registers are less reliable in IRCs where most detainees are transient. Within IRCs , but not prisons, there is a system for reporting those whose physical health may be at risk from continued detention (rule 35(1)) or of suicide (rule 35(2)), but this is little used. This means there is no existing register of those most at risk from covid-19. The Home Office Adults at Risk policy means even those judged by healthcare likely to have their health deteriorate in immigration detention can continue to be held[viii]. Medical Justice and other NGOs active in the field are aware of high-risk individuals still being held in IRCs.

4. The majority of prisoners and immigration detainees are male, shown to carry a higher risk of severe disease with covid-19. Ethnic monitoring suggests a disproportionate number of prisoners as well as immigration detainees will be from those ethnicities now recognised as higher risk of severe covid-19[ix] . Many are also suffering from mental illness which for immigration detainees is recognised to increase with time held in detention[x]. There are no data on the impact of the pandemic on the mental health of those held inside, but increased anxiety might be expected, with the inability to follow national public health guidance and from the new measures being taken by staff to keep their distance. There will also be concern about family who cannot be helped and maybe not even contacted and they will lack access to social support mechanisms[xi]. Those in IRCs are allowed access to simple mobile phones, but reception is reported as poor for some of those now being kept in their cells. Access to legal and independent medical advice has been limited. The extra futility of immigration detention when no international removals are possible will not have gone unnoticed. IRCs are bad for mental health at the best of times, now being exacerbated by the pandemic.

5. The NHS is so hard-pressed that health professionals who have been working away from the front-line have been asked to step up. Immigration detainees and prisoners have access to healthcare, with many of the doctors being GP principals who also practice outside. Rather than needing extra support brought in[xii], they would be free to devote more time to their other NHS patients, were they not expected to attend high-risk environments like prisons and IRCs. Nurses in prisons and IRCs are more usually employed there full time, but they also would be more helpful to the national effort in the mainstream NHS. Some level of prison service will need to continue for the most dangerous prisoners, and no doubt already-vetted custodial and well as healthcare staff would be welcomed there to back-fill vacancies were they able to be redeployed from closed IRCs.

6. At the time of writing, there has been little testing undertaken of either staff or inmates, and only anecdotal reports of covid-19 infected individuals. An outbreak in Heathrow IRC in early March 2020 could be conveniently labelled as influenza in the absence of testing[xiii]. However, more widespread testing is to be available in weeks, and this might be expected to show many of both staff and prisoners/detainees are or have been infected. Then what? It would not be unreasonable to ask for all staff and not just those from healthcare to be able to be tested and have routine PPE[xiv]. What that would do for those who are incarcerated but as yet uninfected is unclear.

7. There is an obvious way out of this dilemma, which involves action before more widespread testing raises the political temperature about those inside. Accelerate the release or at least bailing of as many as thought safe, as has indeed been recommended internationally as well as for the UK[xv]. For those held under immigration powers, just as their incarceration can take place by administrative order with minimum bureaucracy, release could also take place readily and it is hard to justify doing otherwise. Those remaining inside would then be just the most dangerous convicted prisoners, in less-overcrowded premises where the infection and other risks can be better handled even with fewer staff.

8. For all immigration detainees and many prisoners, incarceration needs to stop. This must happen without any further delay for the sake of those detained, the staff being expected to manage them and the wider public.

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