Additional Written Evidence submitted by Medical Justice (COR0117)

About Medical Justice

Medical Justice has been helping people held under immigration powers to document their scars of torture and challenge instances of inadequate health care since 2005. We work with over 80 volunteer clinicians and 100 volunteer interpreters, and handle between 700 and 1,000 referrals per year.

As well as our work with individual detainees, Medical Justice also undertakes research, advocacy and litigation on immigration detention policy to bring about wider systemic change.

Summary

Medical Justice submitted written evidence to the inquiry on 25 March and 21 April 2020. This is Medical Justice's third submission and should be read as supplemental to the two previous submissions.

We remain concerned that the continued use of Immigration Removal Centres (IRCs) during the COVID-19 pandemic is putting people's lives at risk. **We reiterate our recommendation that the Home Office should release all those held under immigration powers in prisons and close all IRCs with immediate effect.** In addition, they must provide anyone who lacks an appropriate release address with appropriate alternative accommodation so that they can self-isolate, and with financial support, regardless of immigration status**.**

There is an implicit admission that COVID-19 risks spreading more aggressively within IRCs/prisons than within the community as evidenced by: (a) the standing guidance from Public Health England (PHE) on outbreaks in secure settings; (b) the special guidance from PHE on covid-19 in secure settings; (c) the attempted identification of those detainees at higher, and not just very high, risk of severe disease as in the panel reviews carried out by Home Office in late March 2020; (d) the issuing of PPE to many staff and; (e) the recent availability of testing for staff.

Failure to eliminate this increased risk through the release of all those held under immigration powers to shelter in suitable accommodation in the community puts the lives of detainees and staff at risk. It is also weakens the protection of the NHS and thereby puts the wider public at risk.

Instead, the Home Office appears to be relying on policies which aim to mitigate the risk, an approach which has proved ineffective in containing the virus in the context of cruise ships, for example. As staff travel to and from work in secure settings they form a conduit of infection between the institutions, their families and the wider community, potentially spreading infections. So far, Medical Justice are aware of three confirmed cases in three different IRCs. However, in the absence of testing and reporting, the true number of

infections is likely to be much higher. No information has been provided on the number of staff infected, symptomatic or tested.

It is clear that all remaining detainees must now be released. The continued reliance on detention under immigration powers is not an inevitable policy, as demonstrated by the release of a sizable proportion of detainees in recent weeks. None of those who remain in detention are currently serving custodial sentences. They are held instead for the administrative convenience of the Home Office.

As long as detainees continue to be held in IRCs, Medical Justice is worried not only about the risk of infection, but also about the negative impact that the conditions of detention and the restrictions imposed as a response to COVID-19 are having on the health and wellbeing of detainees. We are also concerned by the potential unlawfulness of their ongoing detention. Across IRCs we are seeing reduced access to communication, healthcare and legal advice. In addition, there are considerable differences between the responses taken in different centres which may contribute to putting some detainees at greater risk or disadvantage. This inconsistent and unequal treatment seems rooted in different interpretations of, or divergence from, Public Health England advice.

Detailed evidence

1. Understanding PHE guidance given to IRC providers and Home Office

a. We would encourage the Committee to seek clarification on the advice given by PHE to IRC providers and the Home Office. Medical Justice is only aware of two publicly available policy documents:

i. *"COVID-19: prisons and other prescribed places of detention guidance."* Ministry of Justice and Public Health England. Updated 26 March 2020. https://www.gov.uk/government/publications/covid-19-prisons-and-other-prescribed-places-of-detention-guidance/covid-19-prisons-and-other-prescribed-places-of-detention-guidance

ii. *"Guidance on social distancing for everyone in the UK".* Public Health England. Updated 30 March 2020. https://www.gov.uk/government/publications/covid-19-guidance-on-social-distancing-and-for-vulnerable-people/guidance-on-social-distancing-for-everyone-in-the-uk-and-protecting-older-people-and-vulnerable-adults.

b. We would also encourage the Committee to clarify whether PHE has issued any additional policy documents to providers and/or the Home Office that elaborate or provide further clarification on the two documents above.

c. It is also important to understand:

i. Whether PHE advice has shifted over time, and if so, what has been driving this shift?

ii. When were new guidelines issued?

iii. Has separate guidance been issued by PHE at a local level e.g. by local Health Protection Teams?

iv. How have operational practices changed (if at all) in response to this advice? For example:

1. The PHE guidance on COVID-19 in places of detention makes no mention of social distancing yet this is now a major component of the various providers' policy inside of detention. Has further advice been issued by PHE on social distancing and practical measures to be taken inside of detained settings?

2. The PHE guidance on COVID-19 in places of detention relies on cohorting of symptomatic cases. However, with growing awareness that asymptomatic individuals can transmit the virus, this brings into question the reliance on cohorting in the absence of reliable testing for infectivity. Cohorting still seems to play a major role in how providers are dealing with symptomatic detainees. In the absence of testing, cohorting introduces the possibility of detainees who are symptomatic but are not positive for COVID-19 being isolated with those who are positive – thus increasing the risk of exposing already ill detainees to additional infection with COVID-19 – without doing much to control infections which may be spread by un-symptomatic individuals. Has PHE updated its advice to providers and Home Office on cohorting in light this?

3. The release of a significant proportion of detainee has enabled a shift to single cell occupancy. However, was this shift to single occupancy was done in response to specific advice from PHE about cell sharing constituting a risk? If so, when was this advice given and the change implemented?

4. Providers are reporting that they are providing staff with masks. Was the wearing of masks by staff related to advice

from PHE, and if so when was this advice given? Why are not all IRCs responding in the same way?

2. Operational differences between IRC providers

a. The written evidence submitted by IRC providers to the inquiry thus far confirms Medical Justice's experience of significant variety in the operational procedures between different centres.

b. It is also important to note that the responses have changed considerably over time, and sometimes vary from day to day, and thus the answers given only provide a particular snapshot of the situation at the time of writing of the letters. For example, at one point all detainees held in Brook House IRC were locked in their cells only to have this restriction lifted a day later.

c. The absence of evidence from HM Prison and Probation Service on the conditions in Morton Hall IRC are notable. Was a similar letter sent and has an explanation been sought for why no answers have been provided?

d. The considerable degree of divergence in approach between different centres is particularly worrying in light of continued transfers and new detentions (as highlighted in Medical Justice's supplemental evidence of 21 April 2020), as well as the reduced oversight and scrutiny from IMB, HMIP and others (see Section 4).

3. Operational differences in detail

a. We will address some of the most concerning areas of divergence below. This should not be read as an exhaustive list.

i. **Provision of PPE to detainees**

Mitie (who run Harmondsworth and Colnbrook IRCs) and GEO (who run Dungavel IRC) have stated that they are providing facemasks to detainees who are in isolation, but not to the general population of detainees.

Serco (who run Yarl's Wood IRC) have stated they are providing facemasks and gloves to all detainees.

G4S (who run Tinsley House (currently empty) and Brook House IRCs) make no mention of PPE for detainees.

ii. Provision of PPE to staff

The use of PPE by staff may limit the transmission of infection from staff (who are arriving from the wider community each day) to detainees. It is therefore important to understand the extent of PPE provision to staff, and their use of it. While staff at all centres are being provided with PPE, there are differences between centres in the precise equipment provided.

It is also important to recognise, however, that the use of PPE by staff may raise levels of anxiety amongst those held in IRCs. It may also create a barrier to detainees feeling comfortable enough to disclose important medical information, such as histories of past trauma or other vulnerabilities, for example during the initial health screening.

iii. Health screening of detainees

Serco and GEO have each stated that they are carrying out daily health checks of all detainees, including taking temperatures. The submissions from Mitie and G4S show they are relying on detainees themselves to identify whether they or others are symptomatic.

GEO is the only provider to mention a daily mental health check.

Daily health checks of all detainees seem an obvious way for providers to monitor the physical and mental well-being of people still held in detention at this time. The mental health checks introduced by GEO seem particularly important.

However, it must be pointed out that such checks do not eliminate the risk of infection, as there is growing evidence that asymptomatic individuals can also spread the disease. Relying on checks may therefore give providers a false sense of security in terms of their success in controlling the spread of the virus in IRCs.

iv. Levels of freedom of movement/association and social distancing

All providers stress the need for social distancing in their submissions.

In addition, G4S and Mitie are restricting detainees to their own wings. Mitie refers to the concept of each wing as a specific 'household" of 30 detainees. This is a measure utilised in pandemic flu planning but is only thought to be effective if there is little pre-symptomatic transmission, which is now not thought to be the case with COVID-19. We suspect that the grouping of detainees into large 'households' in wings of IRCs at Heathrow and Brook House is effectively an admission by the providers that the two metre distancing rule is simply not achievable in an IRC. Further, the notion of limiting contact between wings is potential undermined by the

large amount of shared hard surfaces in communal areas around the centre.

None of the providers appear to adequately recognise the ongoing risk of transmission created by the movement of staff between wings, and between the centre and the wider community.

v. Isolation of symptomatic detainees

All centres rely on isolation of symptomatic detainees in a specific wing and ensure that staff who engage with those in isolation do so with PPE. However, GEO is the only provider to have facilitated isolation in single rooms with en-suite toilet and shower facilities (thereby avoiding use of shared bathroom facilities) and to be minimising exposure by designating a single member of custodial staff and nurse to interact with the individual through an intercom system.

vi. Information provided and translation of such materials

Most of the providers describe relying on officially translated NHS materials in order to communicate guidelines to detainees. Most also describe using Big Word or other equivalent telephone interpretation services.

With regards to the later, it is not clear how such services can be used safely at this time – if a telephone is being shared between staff member and detainee, this risks virus transmission; if the conversation is taking place over a speaker phone, this risks compromising confidentiality.

G4S specifically describe two worrying approaches in their response – a) sourcing materials from around the world, which risks not repeating official NHS advice and b) using fellow detainees as interpreters, which again potentially compromises confidentiality.

vii. Testing of symptomatic detainees in IRC

The approach to testing in the centres seems entirely confused between different providers.

Mitie reports that Central and North West London Foundation Trust will arrange testing if someone becomes symptomatic. There has been no further clarification of how this testing will be carried out and whether all symptomatic cases are systematically tested.

Serco states that PHE only advise testing upon admission to hospital. However, it also reports having had a confirmed case at Yarl's Wood.

To the best of our knowledge the person in this case was not hospitalised. It is therefore not clear how or where the test was carried out.

GEO say they do not routinely test but have access to test kits which they can use.

G4S say that where someone is symptomatic, PHE will advise them on whether or not to test.

The inconsistency of approaches to testing contributes to the general lack of clarity about the true levels of infection in IRCs. Medical Justice is aware of three confirmed cases in three different IRCs but the real figure is likely to be much higher, particularly given that transfers into and around the detention estate are continuing. Data on numbers of symptomatic detainees, as well as infections in staff, must also be reported to be able to get a clearer picture of the situation inside IRCs.

viii. Cleaning

Again, the approach here is not standard across the centres.

GEO and Serco state that all cleaning activities are carried out by professionals, with detainees only being given supplies to clean their own rooms.

Mitie and G4S state that wings are continuing to be cleaned by detainees as usual. They point out that this is a way to keep detainees 'occupied'. However, given the seriousness of the COVID-19 outbreak, it is questionable whether the 'occupying' detainees should be prioritised over ensuring adequate hygiene standard e.g. through the use of appropriately trained cleaning staff. This is particularly concerning given that poor hygiene has been a common feature in IRC inspection reports for many years.

Medical Justice has also received frequent reports from detainees held in Harmondsworth and Colnbrook IRCs that they are being asked to clean with only very basic PPE (gloves), in what they experience as dangerous conditions.

ix. Healthcare

Providers report that healthcare services are running as normal.

However, Medical Justice clients report that they are experiencing reduced access to healthcare services and that some medical consultations are being carried out over the phone.

As noted at Section 3(a)(iii), Serco and GEO are taking a more proactive approach, with every detainee being checked on daily basis, including having their temperature taken. G4S state that they are checking vulnerable detainees daily. Mitie and G4S are relying on detainees themselves to identify whether they or others are symptomatic.

GEO is the only provider to mention mental health preparedness and the provision of one-to-one counselling.

G4S claim that the "level of medical service available to detainees at Brook House exceeds what could be expected in the community". However, Medical Justice questions this assertion as we regularly raise concerns about the quality of healthcare services in IRCs, including those run by G4S. Moreover, it should be noted that people held in IRCs do not have access to A&E or walk in pharmacy services as they would in the community.

Medical Justice's clients at Brook House IRC have reported that in order to book a medical appointment, a detainee must fill out an appointment form that includes a section titled 'reason for seeing the doctor'. The form, which is not put in any form of sealed envelope, must then be handed to a guard to deliver to healthcare. Such an arrangement clearly breaches medical confidentiality and may be deterring people from accessing the healthcare they need. We are also concerned that it may be particularly difficult for detainees who do not speak English or who cannot read or write.

Medical Justice is also concerned that not all people with COVID-19 comorbidities are being identified by healthcare. We have recently had several clients in this situation. It is important to note that we have repeatedly warned over many years that the mechanisms to identify and report vulnerabilities in detention, including Part C Forms and the Adults at Risk policy, are wholly inadequate and poorly suited for this task.

We are also continuing to see detainees with COVID-19 comorbidities in detention. For many the 'solution' offered by providers is that they self-isolate in their rooms. However, evidence taken from cruise ships has shown that the virus was still able to spread despite people confined to their rooms. It is therefore clear that such shielding measures are not adequate to protect vulnerable detainees.

x. Screening prior to leaving IRC

None of the providers are testing those leaving the centre.

There have been reports of risks to staff and detainees involved in forced removals where detainees resist, necessitating very close proximity and associated risk of infection for both parties – all with limited PPE.[1]

xi. Vulnerable detainees

Again, the understanding of the policy on vulnerable detainees seems partial and the providers diverge significantly in terms of their approach.

Serco state that they offer all vulnerable detainees a single room and PPE. However this is something they are offering to all detainees, so it is not clear how they are tailoring their approach when someone has been identified as vulnerable.

G4S state that vulnerable detainees have been offered accommodation on a separate wing where they would only cohort with other vulnerable detainees, all of whom have a care plan. However, it is not clear how this provides protection, since those with vulnerabilities may also have COVID-19 and it may be spread by those who are asymptomatic.

GEO state they are discussing all identified adults at risk in weekly meetings and are relying on the Rule 35 process to flag vulnerabilities.

It is important to note that, while the use of single rooms may help to limit the spread of infection, it potentially introduces other risks around social isolation, risk of suicide and self-harming and increased anxiety for many. Detainees only have access to a non-camera phone without internet access so are very isolated. Providers say they are putting in place Skype access but it is not clear how this is being facilitated.

xii. Access to facilities

Limits to access have been introduced across the centres to facilitate social distancing. However, we have concerns about the impact of these restrictions.

[1] Mark McGivern, 'Immigration workers say they are forced to move asylum seekers without PPE - despite deportation flights being grounded' *The Daily Record* (Glasgow, 13 April 2020). Available at: https://www.dailyrecord.co.uk/news/scottish-news/forced-removals-leave-immigration-workers-21856249

Some centres report that faith leaders are no longer visiting the centre and in some centres video conferencing or pre-recorded services are being provided. This may be particularly important during Ramadan, for example. Medical Justice is concerned that such a change constitutes one less external visit to the centre and less observation of conditions inside – particularly in relation to those who may be held in segregation where the faith leader is one of the daily visits expected (under rule 40 and 42).

The restricted access to IT rooms reported by providers has a direct impact on detainees' ability to start or continue legal cases and challenge their own detention. Moreover, Detained Duty Advice surgeries are now taking place by phone only, further restricting access to legal representation.

Medical Justice has also received reports from detainees held at Harmondsworth IRC that they cannot use the centre's fax machine themselves. Instead they must rely on officers to take the documents to the fax machine and send the faxes for them. This potentially compromises both legal and medical confidentiality, as a detainee may need to send both types of records as part of their case.

Providers state that detainees have been given an extra £10 phone credit per week. However, phone signal is often very poor in many detainees' rooms, and this further complicates access to legal representatives, independent medical practitioners and social support from friends, family and NGOs.

It is very worrying to see that Serco classes the welfare provisions in their facility as something which could be discontinued without much impact on the running of the centre. One would have thought that particularly under these circumstances welfare provision would be vital to detainees.

Mitie submit in their material that all organisations had already stopped visiting by the time visits were stopped. This is simply not true: Medical Justice had an appointment booked with a client for the day after the ban on visits came into effect. As a result of the ban, the centre cancelled the appointment.

4. Lack of oversight and scrutiny

a. We are particularly concerned about these differences – and the situation more generally in detention – given the reduction of external, independent monitoring of IRCs and prisons by Her Majesty's Inspectorate of Prisons

(HMIP) and the Independent Monitoring Board in light of the Covid-19 pandemic.

b. On 20 April 2020 HMIP announced it was introducing an alternative approach to inspections, involving new "short scrutiny visits" that will look at a limited number of key areas.[2] It is clear that this new methodology equates to a reduction in scrutiny levels.

c. On 30 March 2020 the IMB announced that, given ongoing restrictions, it had developed "remote methods of providing some independent assurance at a time of heightened concern for prisoners and detainees".[3] From 30 March until 3 May 2020, the method consisted only of "dedicated email addresses" to which detainees could send their concerns. On 4 May 2020 the IMB announced it had also introduced a new freephone "hotline" in IRCs, where detainees can leave a voicemail message about their concerns.[4] An IMB member will apparently then respond to the detainee, usually by phone. A timeframe for this response has not been given.

d. We do not consider the IMB's response adequate in the circumstances. We are particularly concerned by the lack of monitoring of segregation units, one of IMB's most critical functions. We also believe that many detainees will struggle to use the new email addresses and "hotline", in part because of restricted access to internet/computers resulting from social distancing requirements at centres, as well as language and/or literacy barriers. Detainees may also feel uncomfortable leaving a record (either by email or voicemail) of their complaint, due to a fear that this may be later used against them in some way. It is also concerning that for a period of over a month i.e. before the hotline was set up, email was the only method by which detainees could contact the IMB.

e. Medical Justice has also received reports that fewer visits by IRC GPs are taking place. IRC GPs are in a position to raise concerns about the treatment of detainees and to whistle-blow. The reduction in their visits is therefore cause for further alarm.

f. It is also not clear whether monitoring visits from the organisations that commission healthcare in detention (the Home Office and NHS England) are still taking place, and if so, whether any new metrics are being collected on healthcare provision during this crisis.

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[2] HM Chief Inspector of Prisons, *Alternative approach to scrutiny of immigration removal centres during the COVID-19 pandemic* (HMIP 2020). Available at: https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/03/Short-scrutiny-visit-briefing-document-for-IRCs-for-website.pdf.

[3] 'Coronavirus/COVID-19: Update from IMB National Chair' (IMB, 30 March 2020). Available at: https://www.imb.org.uk/coronavirus-covid-19-update-from-imb-national-chair/

[4] 'Freephone messaging service launched for people in immigration detention' (IMB, 4 May 2020). Available at: https://www.imb.org.uk/freephone-messaging-service-launched-for-people-in-immigration-detention/.

5. Need for more information

a. As was noted in our submission of 21 April (see Section 5(b)) the lack of transparency and communication from the Home Office is out of line with that of other departments such as the Ministry of Justice. On 24 April 2020 PHE published a detailed briefing on the modelling and changing response to the COVID-19 situation in prisons.[5] This document offers the kind of analysis and detail we would expect to see when evaluating the response in a detained setting. We are unaware of any similar analysis being conducted in relation to those held under immigration powers and those held in IRCs specifically.

b. In addition, it is important to know whether providers are talking to each other about the various responses in IRCs. If these conversations are taking place, have they been facilitated by the Home Office, or are providers initiating them themselves? If they are not taking place, how are best practice and lessons learned being shared?

May 2020

[5] Dr. Éamonn O'Moore, *Briefing paper - interim assessment of impact of various population management strategies in prisons in response to COVID-19 pandemic in England* (PHE, 2020). Available at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/882622/covid-19-population-management-strategy-prisons.pdf