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Detained and Denied

The clinical care of immigration detainees living with HIV

When the doctor knew that we were HIV positive he had a weird look on his face, "like oh no" we felt bad and rejected by his looks

I wanted to commit suicide.

Yes when I transferred from Brook house IRC at Gatwick to Hammondswoth near Heathrow, I had to go for nearly 4 weeks without my Medication as the healthcare at Brook house did not bother to dispense it.

7. Are you aware of any examples where people harmed themselves whilst in detention?

yes. A man killed himself in detention.

The long term detention has made my children to afraid of the police, their have sleepless nights, lost of appetite, their think that their are not human beings anymore, their have no future and their think that we are criminals.

Medical Justice

Medical Justice is a network of doctors, lawyers, ex-detainees, and detention centre visitors. It is the only organisation dealing with the denial of adequate healthcare from immigration detainees in the UK. We believe that the harm being caused by immigration removal centres is so widespread that the only solution is to close them down. In the interim, we work to reform the institutions and to stand up for the rights of those incarcerated within them.

Medical Justice currently receives approximately 1,000 referrals a year, arranging for independent doctors to assess detainees, investigate inadequate healthcare provision, give medical advice and challenge the denial of medication and care. Medical Justice also carries out research activities based on this case work, as well as policy work and litigation in order to secure lasting reforms and change.

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We would also like to pass on our gratitude to Aidan Griffin for his research assistance.

A special thank you must go to Emma Ginn, Theresa Schleicher and Emma Stevens whose work and collegiality has provided the impetus for this report.

Our biggest debt of gratitude must go to the individuals who allowed us to reproduce their experiences in this report. As these accounts show, these experiences have frequently been harrowing and, in some cases, particularly detrimental. Numerous people agreed to their inclusion in this report in the hope that what has happened to them in detention will not happen to anyone else.

Forewords

Mary, an ex-detainee

I welcome this new report by Medical Justice and hope that it will be widely read and that UKBA will act on the recommendations. The research highlights the way people like me are not treated like human beings in detention.

As well as being HIV positive I'm an insulin-dependent diabetic and need to eat regularly. I was released from detention after four days. I felt very weak because I had had very little food and no medication during my detention. Interrupting my HIV medication had consequences for my health.

I was scared that I was going to die in Yarl's Wood when they refused to give my medication. It was as if they were turning off my life support machine. The way they treated me was inhuman. I felt as if I was a criminal. I was traumatised for a long time after my release.

Mary, 55, fled Uganda after she was persecuted for her opposition to the government. She suffered torture by soldiers including rape and later discovered that she had been infected with HIV. She claimed asylum in the UK and in November 2007, was detained at Yarl's Wood Immigration Removal Centre.

Mary has now been granted indefinite leave to remain.

*Names have been changed to preserve anonymity

Jenny Willott MP

Before I entered Parliament, I worked for charities working with some of the most vulnerable people in the UK and the rest of the world, including UNICEF. I strongly believe that the measure of our society is how we treat the most vulnerable.

This is especially true of people who are seen as 'other' or 'lesser' by some in society. Immigrants and asylum seekers are often vilified in the media and sadly far too many people see those who have come, for whatever reason, to try and seek a better life in the UK as not worthy of our support.

This report shines a shocking light on the type of treatment to which this mindset has led. HIV/AIDS is a horrific condition which destroys families and devastates lives. We are so fortunate in this country to have the capacity for treatment and care that is simply unavailable in many parts of the developing world. That this treatment should be denied to someone because of their immigration status should be unimaginable in a society which prides itself on its commitment to human rights.

In 2009 NAT/BHIVA recommended that those in immigration detention with HIV / AIDS should receive the level of care they would from the NHS, and it is extremely worrying that this is still not happening. The clinical care in detention centres is currently so poor that it is a dangerous place for someone with HIV. Health and wellbeing is affected and lives are even being shortened. That is unacceptable.

The UK must now live up to our responsibilities. We must look after those who have come here fleeing persecution and seeking a better life. Not only do we have obligations under international treaties, but we have the moral obligation to protect the health and rights of those that come to our shores.

Case Study 1 – a woman tries to end her own life in immigration detention

PM was born in Sub-Saharan Africa. She came to the UK after being harassed by her late husband's family. Approximately one year after arrival her health began to deteriorate and, a few years later, she was diagnosed with HIV. She claimed asylum, but this was refused. Despite taking regular antiretroviral (ARV) drugs her physical health remained poor and she began to suffer from various psychological problems.

In 2009, after being in the UK for almost a decade, PM was arrested and detained in Yarl's Wood Immigration Removal Centre (IRC). She became increasingly depressed. Healthcare notes in Yarl's Wood, from the first two months of her detention, indicate that she was tearful, unable to sleep and had a reduced appetite. Three months after being detained she tried to kill herself by taking an overdose of her HIV medication and drinking fabric conditioner. As a result she was transferred to a local psychiatric ward. Whilst held in this ward she did not receive all of her HIV medication for six days. About three weeks after her suicide attempt, she was informed that she was to be deported.

PM was assessed by Dr Indrajit Ghosh, a specialist registrar in GUM/HIV, whilst still detained in 2010. As he stated:

There were no written documents in her medical records about her time in psychiatric hospitalisation, or statements on which medication she got during that period. In any case [PM] needs to be reassessed by an HIV clinic about her current immune situation: First due to the suicide attempt and her mental health situation and second due to the reported treatment interruption from the patient.

As he continued, the provisions of the NAT/BHIVA advice on removal had not been taken into consideration. PM did not have a letter for a future treating clinician, medical notes indicated that she had been given only one month's supply of ARV medication, and she had not been given the contact details of trusted HIV organisations were she to be removed. Dr Ghosh made clear that:

As [PM] has not been treated in [the destination country] before, it is vital that she has enough medication to tide her over while she accesses a clinic which can treat her and so avoid missing any medication... even one or two missed doses of HIV medication can seriously compromise efficacy of therapy and lead to drug resistance.

PM found out that her removal had been cancelled while she was shackled in handcuffs, moments before the plane was due to fly. Medical records from the same day, before the failed removal attempt, note that she was 'very tearful'.

Some weeks later, PM was released from detention. She was subsequently assessed by Professor Cornelius Katona who has prepared over 250 expert medical reports on the mental conditions of asylum seekers. He is an Honorary Consultant Psychiatrist at the East Kent Partnership Trust, Emeritus Professor of Psychiatry at the University of Kent, and Honorary Professor of Psychiatry at University College London.

In his assessment, he expressed concerns that PM would be unable to access specialist care if she was to be removed. He stated:

In my opinion [her] depressive symptoms would be likely to worsen significantly if she were forced to leave the UK. She has recently made a serious and potentially life-threatening suicide attempt only a few weeks ago and continues to have frequent, persistent and intrusive suicidal thoughts. When I asked her how she would cope if she had to return to [her destination country] she was silent for several seconds and then replied very softly 'I won't lie to you. I would just take my life straight away. I don't want to suffer'.

PM is still in the UK. She told Professor Katona that she felt 'ashamed of how I am'.

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Executive Summary

This report presents the findings of an investigation into the clinical care of immigration detainees living with HIV in the UK. In June 2009, concerned about the provision of healthcare for immigration detainees with HIV, the National AIDS Trust (NAT) and the British HIV Association (BHIVA) produced a document (the NAT/BHIVA advice) which sought to ensure that the standard of care for detainees would be the same as what would normally be expected in the NHS. What follows shows how, and why, this advice has been spurned.

The detainees featured in this report all faced removal to countries where they would potentially be unable to continue treatment for their HIV infection. Most (over 90%) were born in Sub-Saharan Africa, or born to parents originating from Sub-Saharan Africa: a region which is a focus of international AIDS prevention efforts. Over two-thirds of new infections with HIV, and AIDS related deaths, have been in Sub-Saharan Africa in recent years. Yet only approximately one-third of the population have access to antiretroviral (ARV) medication. Notwithstanding variations between different countries, health systems in the region are, in some areas, inadequately resourced and close to collapse.

Given such disparities in the availability of adequate HIV treatment and compounded by the fact that the vast majority of the people, whose cases are featured in this report, claimed that they had fled from persecution and violence it is unsurprising that many detainees were terrified at the prospect of being deported. As in the UK, they faced potential stigmatisation and marginalisation and some people, as emphasised in Case Study 1, were so frightened that they tried to end their own life.

The UK is the 5th richest country in the world and envisages itself as a key partner in the international effort to prevent and reduce HIV/AIDS. Our report though shows that, despite this rhetoric, the treatment of people detained for immigration purposes has been so detrimental that it may have left them requiring complex clinical care for their HIV infection. UK law and policy nonetheless allows for the removal of people to countries where this level of care is unlikely to be available.

This report argues that the treatment of people with HIV, detained for immigration purposes, is perpetuating a health crisis. Our findings indicate that detaining individuals with HIV puts them at a level of risk that is so severe that they should never be detained.

About this report

This report features the cases of 35 people who were being detained at some point in the 18 months

between June 2009 and November 2010. Medical Justice handled each of these cases. Medical Justice is the only organisation in the UK investigating inadequate healthcare provision in immigration detention. Independent doctors visit and assess detainees and the organisation facilitates the provision of legal advice. Approximately 1,000 cases are handled a year and the findings of this report are taken from this work. The report draws on medical and legal evidence, testimonies from detainees and ex-detainees, and information generated through the provision of case work. The medical evidence used in this report comes from the work of eight independent expert clinicians who assessed the detainees whose cases are featured: Dr Frank Arnold, Dr Miriam Beeks, Dr Richard Dillon, Dr Indrajit Ghosh, Dr Charmian Goldwyn, Dr Rachel Hill-Tout, and Professor Cornelius Katona.

Key findings

• The detainees in this report

35 individuals were featured in this report. The majority of the detainees and ex-detainees in this report were aged between 30 and 39 when Medical Justice supported them. 80% of the sample (28 people) are female. There were a small number of children and teenagers. 46% of the sample (16 people) were released from detention after Medical Justice intervened in their case (in some, but not all, cases as a result of the actions of Medical Justice) and 16 people were removed from the UK. Three people (8% of the sample), as of November 2010, were still detained. 12 people had been detained more than once, or previously either imprisoned or held in police cells.

69% of the sample (24 people) had been detained for a total period of longer than one month when they were seen by Medical Justice and 15% (five people) for longer than one year.

• The diagnosis of HIV infection

Despite the commonly held assertion that people frequently come to the UK in order to access the NHS, 28 of the detainees whose cases are featured here (80% of the sample) discovered their HIV infection after their arrival. Some individuals only learned of their HIV infection after they were screened in detention. Several people reported contracting HIV after being sexually assaulted.

• Failures to act on the NAT/BHIVA advice

The 35 individuals whose cases are featured here suffered from a total of 79 failures to apply distinct provisions of the NAT/BHIVA advice. These breaches occurred throughout the detention process: on

arrival, in detention, and during attempted and actual deportations. Records from our investigation revealed that:

- **Failures by detention centre staff to carry out adequate investigations and procedures, when a detainee arrives in detention, expose detainees to unnecessary risk.**

Nine people (35% of the sample) suffered from failures by detention centre staff to apply provisions of the NAT/BHIVA advice relating to arrival in an Immigration Removal Centre (IRC). These included failures to contact previous treating clinicians and obtain medical records, failures to arrange appointments with HIV specialists, and failures to ensure continuity of care.

- **Interruptions and disruptions in antiretroviral therapy occur repeatedly in detention.**

21 people (60% of the sample) experienced disruptions in their medication as a result of failures by staff in detention centres to provide drugs, failures to facilitate external appointments, failures to ensure that people were given medication en route to detention centres, and administrative errors. One person was given a significant overdose of her medication in detention. Three people were so afraid of being deported that they hoarded their drugs and, subsequently, attempted to overdose in an effort to end their own lives.

- **When detained, people may be subjected to clinical practices which are demeaning, degrading, and which in some cases may have worsened their condition.**

23 people in this study (66% of the sample) had their right to quality primary and secondary clinical care (in ways other than those set out above) violated. These included practices putting people at risk of contracting opportunistic infections, failures to adequately investigate symptoms indicative of HIV infection, failures to respect the confidentiality of detainees and failures to carry out or pass on the results of tests to determine resistance to particular medications. Some people were forced to undergo consultations whilst handcuffed to escorts: a procedure which, in certain IRCs, seems to be common.

- **Detainees have been removed, or have experienced attempted removals, with less than a three month supply of ARV medication (recommended in the NAT/BHIVA advice) and whilst potentially not medically 'fit to fly'.**

26 people (74% of the sample) were subjected to deportation attempts which, according to our records, breached the provisions of the NAT/BHIVA advice on removal. Detainees were given little or no medication. They were often not provided with information for future treating clinicians or given information about HIV organisations in their destination country. Numerous detainees faced removal despite concerns about the efficacy of their medication.

Failures to apply the provisions of the NAT/BHIVA advice occurred for a number of reasons. The UK Border Agency (UKBA) has legally challenged attempts to enforce a requirement that detainees should be given a three month supply of ARV medication when removed. Yet our investigation reveals that, in some parts of the country, UK residents living with HIV would normally be dispensed with that amount of medication after seeing a HIV specialist. Within detention it appears that individuals employed by the UKBA or its contractors act, in certain circumstances, in ways which may endanger detainees. At the same time, the institutional structures of clinical care are unable to ensure quality and consistent management of HIV infection.

Recommendations

This investigation exposes a series of failures to provide adequate and consistent clinical care for immigration detainees living with HIV. Below, we set out our recommendations for the government.

Individuals who have been diagnosed HIV positive should not be detained for immigration purposes. The government should:

1. Make a public announcement that detainees living with HIV will not be detained.
2. Amend policy to include a provision which states that people who have been diagnosed with HIV will not be detained for immigration purposes.

In order to ensure that individuals with HIV are not detained, adequate screening procedures for HIV should be put in place within IRCs:

1. All detainees should be seen for health screening within 24 hours of arrival in an IRC. This screening should have an option for voluntary HIV testing.
2. If an individual has HIV then they should be released back into the community in such a way that ensures consistency of care.

Medical Justice is particularly concerned about the removal of people to countries where they may have difficulty maintaining access to ARV medication. However, if a person is leaving the UK, steps should be put in place to ensure that they have medication, are medically stable, and are equipped with relevant information following the provisions in the NAT/ BHIVA advice that individuals should be provided with:

1. A letter for their future treating clinicians
2. Three months' supply of medication
3. Contact details of trusted HIV support organisations in their destination country
4. And that an individual should only travel if their condition is stable.

An investigation should be launched into the apparent discrepancy in the availability of medication to detainees which may amount to discrimination by the NHS and the UKBA. This investigation should include:

1. Examining whether there is a discrepancy between how much ARV medication immigration detainees have been dispensed with, after seeing treating clinicians whilst detained, and how much medication residents residing within the same NHS catchment area have been dispensed with.
2. If this is proved to be the case, exploring the reasons behind this discrepancy.
3. Recommendations to help ensure such events are avoided in the future.

Introduction

Since the first diagnoses of Acquired Immune Deficiency Syndrome (AIDS) in 1981 in New York, the prevalence of the disease has increased to such an extent that it has led to more than 25 million deaths worldwide. HIV/AIDS has been described as 'one of the most destructive epidemics the world has ever witnessed'¹ and, according to the World Health Organization (WHO) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), in 2009 (the latest year for which figures are currently available) it was estimated that 33.3 million people worldwide were living with HIV.² Some 2.6 million were newly infected and there were an estimated 1.8 million AIDS related deaths in that year alone.³

67% of new recorded infections worldwide, in 2009, were in Sub-Saharan Africa. The region accounted for 69% of new infections among adults, 89% among children and 72% of AIDS related deaths.⁴ 10,600,000 people were in need of treatment and, despite efforts to improve the quality of clinical care, only 37% of the population had access to ARV medication.⁵

Within the UK, it is estimated that there were roughly 86,500 people living with HIV in 2009 of whom a quarter were unaware of their infection.⁶ Approximately 6,900 new diagnoses of HIV were recorded in 2009 and, by the end of that same year, 108,766 diagnoses of HIV had been recorded since the early 1980s. Overall, there have been over 19,000 recorded deaths of people infected with HIV in the UK⁷ and, according to the National AIDS Trust (NAT), there are a range of factors which put certain migrants, and particularly those seeking asylum, at risk of HIV infection.⁸

The UK has a highly developed system of healthcare for those living with HIV. As a result of the availability of Highly Active Antiretroviral Therapy (HAART), mortality rates, in recent years, have been relatively low.⁹ Yet despite these services for those living within the UK, and despite successions of political commitments to provide global resources and leadership in response to HIV and AIDS, the law in the UK allows for the removal of refused asylum seekers who are suffering from the infection even where it is known that this may be fatal. In the case of *N v UK*,¹⁰ referring to a Ugandan woman who fled to the UK in 1998 and who was diagnosed with AIDS soon after, her claim for asylum and appeals were refused notwithstanding a Law Lord acknowledging that removing her 'would be similar to having a life-support machine switched off'.¹¹

In this context, individuals who are living with HIV may be detained for immigration purposes to effect their removal,

and whilst their claim for asylum (if applicable) is being processed.¹² Approximately 30,000 people are detained a year for immigration purposes. Most are held in one or more of the 10 (formerly 11)¹³ IRCs (see Appendix 1) and there is also detention space in 25 'non residential' and four 'residential' Short-Term Holding Facilities (STHFs). Simultaneously, the criminal justice system may also be used to detain people. This includes prisons but, also, it is not uncommon for police cells to be used to detain those held under immigration powers.¹⁴

Those who are detained, according to the Detention Services Operating Standards Manual for IRCs,¹⁵ 'must have available to them the same range and quality of services as the general public receives from the National Health Service'.¹⁶ These operating standards put in place a set of auditable requirements which administer the statutory healthcare provisions set out in the Detention Centre Rules 2001.¹⁷ According to the former Immigration Minister Liam Byrne, healthcare in the detention estate 'is as good as it is on the NHS'.¹⁸

This report tells a different story. The findings suggest that detainees living with HIV may be put at risk as a result of the practices and processes established between the UKBA, IRCs, and sub-contractors. Collectively, these factors underpin a system of healthcare which, for the detainees in this report at least, is at times substandard and in some cases hazardous. With some parallels to the sentiments expressed above in *N v UK*, one detainee featured in this report stressed that 'being in detention without proper medical attention, to me, is equivalent to turning off a life support machine'.¹⁹

Concerns regarding the treatment of people in mainstream prisons with HIV have underpinned a plethora of guidelines, reports, and best practice manuals.²⁰ However, despite the similarities between prisons and IRCs,²¹ there is little literature which documents and analyses the experiences of, and healthcare provisions for, immigration detainees living with HIV.²² What concerns there are led to the publication of a best practice guide for the care of immigration detainees, in June 2009, by the British HIV Association (BHIVA) and the NAT.²³ This document (referred to in this report as the NAT/BHIVA advice) set out a clear and comprehensive set of clinical standards relating to the detention and treatment of immigration detainees. According to the respective Chairs of the NAT and BHIVA, when it was published it was their hope that it would be used 'widely to provide appropriate high-quality care and to support consistency, continuity of care and clinical handover during removal'.²⁴

This report has the following aims, to:

- Document the standard of healthcare for detainees with HIV;
- document breaches of the NAT/BHIVA advice, how and why it is violated, and the repercussions of these breaches;
- examine structures of accountability where detainees living with HIV do not receive adequate clinical care; and
- produce recommendations based on the above findings.

It is based on an analysis of the cases of 35 detainees with HIV whose cases have been handled by Medical Justice between June 2009 (when the NAT/BHIVA advice was published) and November 2010. Some of the detainees were initially detained prior to June 2009, and some have been detained throughout this entire period. Each of these cases involves one or more breaches of the provisions set out in the NAT/BHIVA advice.

Case Study 2 – delayed HIV tests and suicidal ideation

HT is a Zimbabwean woman who fled to the UK after her father and uncle were killed because of their political activities. She had to leave her son behind.

She arrived in the UK in 2003 and applied for asylum. After serving an 18 month prison sentence she was transferred to Yarl's Wood IRC in 2007. Prior to being detained in Yarl's Wood, HT reports that she had no health concerns. However, whilst detained, she began to suffer from multiple health problems including coughs, breathlessness, scalp and ear infections and dry, itchy skin. Furthermore, she reported numerous episodes of vaginal itching and discharge, discomfort when urinating and abdominal pain. She began to lose her appetite and for a period could only manage one meal a day.

In 2009 HT was visited and examined by Dr Rachel Hill-Tout, a Clinical Fellow in HIV Medicine. Given that HT is of Zimbabwean origin (where HIV prevalence among women is relatively high) and that she had experienced numerous health problems, Dr Hill-Tout stated that she should have been offered a HIV test much earlier than when this eventually did happen. In Yarl's Wood HT had been treated for (among other ailments) persistent hair and skin disorder, an oral fungal infection and recurrent respiratory infections: all of which could have been attributable to HIV infection. Indeed, Dr Hill-Tout reported: "It is apparent that she was becoming

increasingly unwell during her detention with multiple medical problems...many of which are attributable to her advanced HIV infection which was belatedly diagnosed in April 2009. Given the symptoms and their recurrent nature in addition to [HT]'s Zimbabwean origin where the prevalence of HIV is 15.6% an HIV test should have been offered at an earlier stage".

However, she was only given an HIV test after she requested a sexual health screening in 2009, some 17 months after being detained (and nearly three years after being imprisoned). The results of this test were positive. HT continued to report respiratory concerns; she found it difficult to breathe at night and, in response, was given an extra pillow. It appears, however, that this did little and she later suffered from chest pains, night sweats and a cough productive of yellow sputum. According to Dr Hill-Tout:

Given that by this time it was known that that [HT] had advanced HIV disease and was therefore very vulnerable to potentially life-threatening opportunistic infections a more pro-active attitude should have been taken to these symptoms of respiratory tract infection.

In an assessment with Dr Hill-Tout, HT reported that she felt that being diagnosed with HIV and being detained was some kind of punishment. She had become forgetful, had difficulty concentrating, was experiencing flashbacks about events in Zimbabwe, was feeling consistently sad and saw herself as 'worthless'. When asked about the future she replied that 'she wished she would wake up dead'. After being diagnosed with HIV, she attempted to kill herself by overdosing on ARV medication but her roommate managed to stop her. Dr Hill-Tout stated that:

[HT] demonstrates clear evidence of severe depression with suicidal ideation as well as evidence of Post-Traumatic Stress Disorder (PTSD). The PTSD symptoms are reported since she left Zimbabwe. The depressive symptoms appear to have become more prominent since her diagnosis of HIV and are almost certainly being exacerbated by her ongoing detention in Yarl's Wood IRC. Given the serious nature of her psychiatric symptoms I would recommend that she is fully assessed by a Psychiatrist and I would consider that further detention would be detrimental to her mental state.

Soon after, HT was released. She suggested that, 'the standard of healthcare in Yarl's Wood is very poor. They don't care about people. They treat people like animals...'²⁵

Chapter One – The NAT/BHIVA advice on Detention, Removal and People Living with HIV

Asylum seekers in detention often have multiple health needs and the introduction of the NAT/BHIVA advice, in June 2009, stemmed from a growing recognition of the fact that detainees with HIV were facing ‘real difficulties’ in relation to detention and removal. This advice was introduced in an effort to increase awareness amongst IRC healthcare staff of their responsibility to ensure that clinical practices in detention meet NHS standards. In doing so they set out a series of recommendations and requirements. Consequently the advice has been used in a series of injunctions which have attempted to prevent or delay deportations where the recommendations have not been upheld. However, in a test case in 2010, it was ruled that these provisions of the advice do not constitute policy and, therefore, cannot be considered ‘binding’.

Health needs of asylum seekers and the provision of medical care

The health needs of asylum seekers have been well documented. Numerous studies have drawn attention to high levels of psychological distress,²⁶ PTSD and subsequent impairment,²⁷ musculoskeletal problems²⁸ and other physical health problems which, frequently, have an impact upon a person’s ability to carry out routine day-to-day activities.²⁹ Further, as the clinicians Harris and Telfer have explained:

Some asylum seekers present with the physical sequelae of torture or other violent trauma which may not have received adequate medical attention in their countries of origin. These sequelae include malunited fractures, osteomyelitis, epilepsy or deafness from head injuries, or non-specific musculoskeletal pain or weakness... In rape victims, in addition to the psychological sequelae of rape, there may be a risk of HIV or other sexually transmitted diseases.³⁰

Given these health needs, the provision of medical services has a particularly important role. Yet numerous commentators have highlighted that the medical care of asylum seekers in the UK, has proved seemingly inadequate. In 2001 Dr Michael Wilks, a former Chairman

of the British Medical Association’s Medical Ethics Committee went as far as stating that:

There has been no real NHS planning for the health needs of asylum seekers... No thought has been given to their health needs or the social infrastructure around them and it is possible to see the whole process as an abuse of human rights in itself.³¹

Governments have responded to the health needs of asylum seekers by reducing access to some forms of healthcare in line with an individual’s immigration status. At the time of writing, people seeking asylum who are living with HIV, regardless of whether their claim has been refused or not, are entitled to free ARV therapy and HIV care (although there are some exceptions). However, at some points previously, refused asylum seekers and irregular migrants have been charged, except in emergency circumstances and where treatment was already ongoing prior to their change in immigration status.³² If a person is detained for immigration purposes they may well arrive in detention with numerous medical concerns requiring complex clinical care.

Within immigration detention the delivery of healthcare is framed by a series of relationships between the NHS and private companies. Of the 10 IRCs in the UK, seven are managed by Serco, G4S, and GEO³³ and these companies, in turn, deliver privately contracted healthcare provisions to immigration detainees. Serco, operating Yarl’s Wood and Colnbrook IRCs, provide healthcare arrangements through the use of their own employed medical staff. Brook House, Campsfield House, Dungavel, Harmondsworth, and Tinsley House IRCs all sub-contract their healthcare arrangements to different healthcare providers. Where IRCs are operated privately, the company in question commissions (and is responsible for) primary care services; the local Primary Care Trust (PCT) is responsible for secondary and tertiary services.³⁴

The origins and aims of the NAT/BHIVA advice

Regardless of the way healthcare is delivered in immigration detention, standards should comply with NHS practices and procedures. However, there have been

serious concerns about the appropriateness of detention and the structures of clinical care.³⁵ In a report by HMIP, for example, healthcare provisions in Yarl's Wood IRC were subjected to serious criticism. HMIP documented a catalogue of insufficiencies which included poor training, inadequate clinical accountability, and deficient mental health services. As their investigation explained:

[U]nderpinning 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... 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.³⁶

Other investigations have raised questions about general conditions within the detention estate. Several unannounced inspections by HMIP have raised concerns of their own, or drawn attention to complaints by detainees, about issues including overcrowding,³⁷ poor ventilation³⁸ and a lack of cleanliness.³⁹ Further, an inspection by the UKBA which looked at the quality of food in Yarl's Wood IRC, in 2009, drew attention to food being sold to detainees which was beyond its 'best before' date and chicken being served which still had feathers attached to the skin.⁴⁰

Whilst these inspections have focused on general conditions in detention and healthcare services, a number of investigations have more specifically drawn attention to particular concerns about the appropriateness of immigration detention for people living with HIV. In 2003, the All-Party Parliamentary Group on AIDS (APPGA) reported that: 'All evidence received during the inquiry suggests that removal centres are unsuitable places for people living with HIV. Detention can undermine efforts to maintain good health.'⁴¹ In 2007, the NAT also raised concerns about the provision of care after conducting a survey of healthcare managers in detention.⁴²

Informed by similar anxieties about the clinical care of immigration detainees diagnosed with HIV, in June 2009 the NAT and the BHIVA published advice on the clinical care of immigration detainees on the basis that 'the process of detention and removal has resulted in real difficulties for asylum seekers living with HIV.'⁴³

Both the NAT and BHIVA have significant experience working with individuals affected by HIV and AIDS and are widely recognised and respected for their expertise and knowledge. BHIVA was founded in 1995. It is the leading professional association of doctors working on the

treatment of HIV and, among other activities, produces a regular set of guidelines relating to the management of HIV and acts as an advisory body for other organisations and associations. The guidelines produced by BHIVA are widely recognised as authoritative. The NAT was founded in 1987 as an independent charity. It carries out a range of activities including running a policy network made up of voluntary sector organisations, producing resources to help understand the needs of those living with HIV and informing policy, practice and development.⁴⁴

The advice was produced in collaboration with IRC healthcare managers.⁴⁵ It is split into concerns with what the authors describe as the key stages within the detention process: reception, detention and removal.⁴⁶

Reception and arrival in immigration detention

Given the vulnerability of detainees, reception, as the advice states, 'is not the right time to begin complex HIV-related work.'⁴⁷ However they make clear that a health screening should be arranged within 24 hours of arrival which includes: information on the respect of confidentiality in the IRC in question; the fact that discrimination and intolerance will not be tolerated; and that the detainee is entitled to healthcare that is of equivalent standard to the NHS. Where a detainee is already on ARV therapy, the advice explicitly states that this must be maintained, either by continuing the regimen where the detainee has medication with them, or by arranging immediate access to medication if the detainee does not, (which may occur, for example, if an individual is arrested without their medication). This requires close working between the IRC and their local HIV clinic.⁴⁸

Detention

When in detention, the advice covers the fact that it is the responsibility of the IRC to ensure that the detainee has the opportunity for unbroken access to their medication. Ideally this should be through allowing the individual to keep medication in their room; where this is not possible IRC staff are responsible for ensuring that the detainee has the opportunity to access their treatment. When detainees are transferred between different IRCs, arrangements should be made to ensure that ARV access remains constant.⁴⁹

As well as a distinct need to ensure rigid adherence with ARV therapy, provisions should further be established to ensure that the 'HIV-related needs of people living with HIV include the availability and accessibility of high-quality treatment, care and support.'⁵⁰ Specifically, this relies on:

Access to high-quality and confidential clinical primary care services [and] access to high quality and confidential secondary care with expertise in HIV consistent with current UK and BHIVA standards of care...⁵¹

Again, these provisions necessitate a series of clinical

procedures which ensure that healthcare standards in immigration detention meet those which are expected within the NHS.

Removal

Where detainees are to be removed from the UK, IRC staff (in conjunction with the local HIV clinic) should ensure that adequate and unbroken treatment is maintained despite leaving the country. Primarily this is achieved by ensuring that the following conditions are met:

- the detainee is provided with a letter for future clinicians in the country where the detainee is being deported to;
- the detainee has three months' supply of medication; and
- contact details of HIV support organisations in the country where the detainee is being deported to are given to the detainee.

At the same time the IRC GP, in conjunction with local HIV specialists, should be satisfied that the detainee is medically stable and 'fit to fly'. In this regard, a range of factors should be considered including: whether the detainee is waiting for the results of an HIV test or an assessment to clarify their clinical condition; whether ARV therapy or a new drugs regimen has just been started; whether there are particular co-infections; whether the detainee has mental health issues; if the detainee is pregnant or has given birth within the last six months; and whether there are any other medical complications. This list is not exhaustive, and is provided within the advice to

indicate certain issues relevant when making a decision.⁵²

More recently, in 2010, Pierce Glynn solicitors issued judicial review proceedings on behalf of three immigration detainees living with HIV who, it was argued, had significantly suffered whilst detained. These detainees had all missed medication in detention and clinicians had failed to provide appropriate clinical care. Accordingly:

The effect of this, on their case, has been to put their health in jeopardy in ways that could have serious long term consequences for their ability to survive in the United Kingdom or in their home countries when or if they are removed.⁵³

Notwithstanding this recognition of jeopardised health, this judicial review was dismissed on the basis that, according to the Judge, the treatment of the detainees had not been 'sufficiently mismanaged'.⁵⁴ At the time of writing, an appeal is pending.

Figure 1(1) presents the key provisions of the NAT/BHIVA advice and merges these with the key provisions established by the Detention Services Operating Standards (written by the UKBA). These Operating Standards set out the procedures that should be adhered to with regard to the medical care of immigration detainees. When both are amalgamated what is presented, in diagrammatic form, are some of the main provisions which a detainee who is HIV positive *ought* to be (according to the NAT/BHIVA advice), and is (by way of the Detention Services Operating Standards) entitled to.

Figure 1(1) - an overview of key expected healthcare procedures in IRCs in the UK

Arrival		Detention		Transfer and Removal	
Medical confidentiality must be maintained throughout the detention process. The detainee must be informed that issues relating to their healthcare will remain confidential.					
The detainees should be medically screened within two hours of arrival and this screening should include an assessment for risk of self-harm/suicidal behaviour.	Detainees must have appropriate access to emergency care and treatment.		Where a detainee is transferred to another prison or IRC their clinical records must also be transferred at the time of transfer.		
	Detainees who require a medical appointment Monday – Friday must be given one within 48 hours.		If being transferred, steps should be taken to ensure that detainees living with HIV are provided with adequate medication to ensure unbroken access.		
Arrangements should be in place for a physical and mental examination by a medical practitioner within 24 hours of arrival.	The IRC must make arrangements to provide access to secondary care and specialist services.		Before removal, a detainee with HIV should be provided with a letter for future treating clinicians.		
	Healthcare provisions within the IRC must be provided by a medical practitioner and healthcare team.		Before removal, a detainee with HIV should be provided with three months' supply of medication		
In this initial 24 hour period the medical practitioner should ascertain whether a detainee living with HIV is on ARV medication. If so, they should ensure that the detainee is maintained on this ARV therapy if they have it with them. Immediate access to the regimen must be arranged if not.	The IRC must make access for 24 hour health cover.		Before removal a detainee with HIV should be given contact details of trusted HIV organisations in the destination country.		
	Detainees with HIV should have available to them high quality treatment, care, and support whilst detained.		Final judgements about whether a detainee with HIV is medically fit to fly should be made by an IRC doctor in conjunction with HIV specialists.		
The IRC should have a policy statement outlining what medical care is available, and who provides this care; this statement must be communicated to the detainee in the above examination.	Adherence to HIV medication must be maintained. Where possible detainees living with HIV should be allowed to keep medication with them. If this is not possible it is the responsibility of the IRC to ensure the opportunity for adherence.		Detainees should not travel when they are not 'fit to fly'.		
Detainees who are living with HIV should have an appointment arranged, within a maximum of one week, with the IRC GP and with a local HIV specialist.	Every effort must be made to ensure that medical appointments with healthcare providers are not cancelled.				
The IRC should obtain medical records from previous healthcare providers. Discrete records should be merged with existing clinical records.					
Medical practitioners must report to the Manager any cases where a detainee's health is 'likely to be injuriously affected by continued detention or any conditions of detention'.					
	Primary care services must be in place to provide care to detainees with mental health needs.				
	Measures should be in place to ensure the control and management of communicable diseases.				
	When handcuffs have been used in an escort, they should be removed during hospital treatment if requested by a clinician.				
When any clinical procedure is deemed necessary the detainee must be made aware of the reason, and fully informed consent must be secured.					
Detainees should have available to them adequate interpreting services.					

NB: Shaded text denotes recommendations in the NAT/BHIVA advice⁵⁵.

The standing of the NAT/BHIVA advice

The NAT/BHIVA advice, as discussed above, was written in conjunction with IRC healthcare managers and, whilst being formulated, presented on several occasions to the IRC Healthcare Steering Group.⁵⁶ According to Dr Grummitt, a member of this group and a detention centre practitioner, writing in a foreword to the advice:

This practical resource outlines clinical best practice for healthcare professionals supporting the HIV-related needs of asylum seekers during detention and in preparation for removal... For serious and often complex long-term conditions such as HIV, then there is a particular need to ensure consistent and appropriate care. We commend this resource to all those responsible for the health and well-being of detainees.⁵⁷

Despite this commendation, the advice has been the subject of dispute and the UKBA has vehemently refused to legitimise its standing. This, combined with the actions of IRC healthcare staff and management, has resulted in routine breaches of the standards stipulated in the advice, particularly in relation to removal. Consequently, since the introduction of the advice, there has been a series of judicial reviews and injunctions based on these violations. In one such case Simon Barrett, Assistant Director of the Detention Services Policy Unit in the UKBA, stated in a witness statement that:

The booklet was issued by NAT/BHIVA in June 2009. It was made clear to NAT/BHIVA beforehand that UKBA could not approve or endorse the guidance booklet in its final form. It does not, therefore, constitute UKBA policy; nor is it considered binding on UKBA. The UKBA position is that the booklet represents no more than NAT/BHIVA guidance to healthcare professionals, including those working in immigration removal centres, which they may or may not follow as they consider fit.⁵⁸

The UKBA has adopted a position which is inherently contradictory. The NAT/BHIVA advice provides guidance to clinicians about the care of immigration detainees living with HIV which, in turn, is recognised by at least one member of the IRC Healthcare Steering Group as 'best practice'. However, the UKBA has argued that it does not have the power to enforce clinicians to adhere to it. If the UKBA claims it cannot direct clinicians to prescribe, then neither should it be able to deny medication deemed essential by medical experts. Nonetheless, the UKBA's stance was endorsed in a test case in 2010.

This case involved a woman, at risk of suicide, who was to be deported to Sub-Saharan Africa. A judicial review was lodged, in part on the basis that her removal would be unlawful, as it breached the NAT/BHIVA advice. But, drawing on interim instructions in light of *N v UK*, Mr Justice Owen argued that the UKBA 'does not currently have a specific policy with regard to the provision of medication to individuals with HIV/AIDS upon removal from the United Kingdom.'⁵⁹ Further, whilst discussing that the UKBA does not have the power to direct clinicians to prescribe medication, he stated, 'I therefore consider that the claim that the claimant had a legitimate expectation that the defendant would comply with the BHIVA guidance is unsustainable.'⁶⁰

Ultimately, for clinicians, this raises a series of practical concerns about medical ethics. Clinicians are bound by a code of practice which explicitly maintains that their overriding duties should be to the best interests of their patients.⁶¹ Yet this ruling articulated that ethical medical guidance is not necessarily applied with regard to the removal of immigration detainees living with HIV. In doing so it upheld the message in *N v UK* that, where the will to deport competes with the health of people subject to immigration control, medical ethics are subjugated.

Chapter Two – The detainees in this report

The individuals featured in this report were all detained for immigration purposes at some point (if not at all times) between June 2009 and November 2010. The nationality of those included reflects, in some ways, the global prevalence of HIV/AIDS. The majority of those detained discovered their HIV infection after arriving in the UK. Numerous detainees were, and indeed in some cases still are, held for several years. Many of the detainees stated that they had fled from violence, and when detained, they frequently exhibited serious physical and psychological problems.

The age, nationality and gender of detainees and ex-detainees

The majority of the detainees and ex-detainees whose cases are featured in this report were adults aged between 30 and 39. One child was under ten and three detainees were teenagers, with one aged less than 18, when Medical Justice intervened in their case (see Appendix 3 – Figure A3(1)). The nationality of those included reflects the unequal global distribution of HIV/AIDS and the vast majority (over 90%) of the detainees were born in Sub-Saharan Africa, or born to parents who are from Sub-Saharan Africa (see Figure A3(2)). Most of the people whose cases are featured are female (Figure A3(3)).⁶²

The discovery of HIV infection, reasons for entering the UK, and previous health concerns

Perceptions of ‘health tourism’, relating to HIV and AIDS, have permeated healthcare policy and practice.⁶³ However, research conducted on behalf of the Home Office in 2002 highlighted that people seeking asylum frequently knew little about healthcare or welfare services prior to arrival.⁶⁴ The findings of this report reinforce this claim. Most of the 35 individuals were unaware of their HIV infection before they came to the UK and as Figure A3(4) shows, 28 people (80% of the sample) discovered their HIV infection in the UK. In a small number of cases people were not aware of this until they were screened in immigration detention. Some of the people in this report

contracted HIV after they were sexually abused: either in the UK, or before arrival.

33 of the people whose cases are featured in this report had claimed asylum, or were a dependent of someone who had claimed asylum, in the UK. One person had applied for leave to remain on medical grounds and one person’s immigration status was unknown. 10 people had breached the conditions of their visa, and claimed asylum after this point. Three people were part of detained fast track (DFT) procedures within which claims for asylum are processed at rapid pace.⁶⁵

Of the detainees whose cases are featured in this report, 16 were released from detention after Medical Justice intervened in their case (in some, but not all, cases as a result of the action of Medical Justice), and 16 people were removed from the UK. Three people, as of November 2010, were still detained (see Figure A3(5)).

Reinforcing the discussion in the previous chapter, that those seeking asylum may have survived particularly traumatic experiences prior to leaving their country of origin, 31 people (89% of the sample) stated that they had fled from torture and violence. This included (but was not exclusive to): rape; female genital mutilation (FGM); being chained up in prisons; being regularly beaten with various weapons; being stabbed; being bitten (by humans); being deprived of food; having family members threatened and harmed; being urinated on; and being burnt. Further, people had complex clinical needs in the UK and, prior to being detained, had been treated for illnesses, symptoms, and infections including: cervical dyskaryosis (pre-cancer); early HIV peripheral neuropathy; lymphoid interstitial pneumonia; raised blood pressure and blood sugar; shingles; brain abscesses; pneumocystis jirovecii infection; tuberculosis; bell’s palsy (paralysis of the facial nerve); depression; and PTSD.

Location of detention, and the length of time people were detained

The detainees whose cases are featured in this report were held in Yarl’s Wood, Tinsley House, Brook House, Harmondsworth, and Colnbrook when Medical Justice intervened in their case (see Figure A3(6)). 12 people

had previously been detained, imprisoned, or held in police cells.⁶⁶ Numerous people had been imprisoned for immigration offences such as working, or being in possession of false documents.⁶⁷ The 35 individuals had experienced 56 'periods' of detention in total, and previous incidences of detention are displayed in Figure A3(7). As Figure A3(7) shows, some people had previously been detained in various locations.

The individuals in this study had been detained for varying lengths of time. Figure A3(8) sets out the total length of time detained. That is, if a person has been detained previously, or has been transferred between different institutions whilst detained, the overall length of time detained is included. With regard to those still detained the length of time up until 30 November 2010 is recorded. Despite long-held assertions by governments that immigration detention is used as a 'last resort',⁶⁸ the evidence produced here correlates with that which government statistics themselves, on the contrary, exemplify: some people are detained for months and years.⁶⁹

Chapter Three – The provision of care upon arrival and in detention

The detainees featured in this report were frequently deprived of clinical care conforming to NHS standards. In some cases the management of their condition was dangerous and may have led to permanent harm. The provisions in the NAT/BHIVA advice relating to the arrival of individuals in immigration detention, and their subsequent care, have been breached repeatedly. These breaches have arisen as a result of what appears to be indifference, inadequacies, and in some cases because of established practices between government bodies, private companies, and their sub-contractors. Some detainees were held responsible for their own substandard care.

Clinical care of individuals arriving in immigration detention

Of the 35 individuals whose cases are featured in this report, the treatment of nine (or 26% of the sample) detainees breached recommendations in the NAT/BHIVA advice about arrival and reception in immigration detention. These breaches included failures to ensure that ARV therapy was continued whilst an individual was detained (discussed in further detail later in the chapter), failures to contact and obtain details from treating clinicians about an individual's HIV status, and failures to arrange appointments with relevant HIV specialists. Of the nine identified breaches seven occurred in Yarl's Wood IRC, one in Brook House, and one in Colnbrook.

Figure 3(1) – breaches of the NAT/BHIVA advice in relation to arrival and reception in immigration detention

Breach of NAT/BHIVA advice	Number of breaches
HIV medication handed over at reception, and not returned to detainee	2
Missed appointment with HIV specialist as a result of being detained	2
Failure to offer HIV test	1
Failure to obtain relevant information from a treating clinician	1
Failure to arrange appointment with HIV specialist	2
Failure to act on medical notes handed over on arrival	1
	Total: 9

Of the nine detainees, all but one was already aware of their HIV infection prior to being detained. In these cases, failures to apply adequate clinical procedures on arrival in immigration detention, in turn, often led to deficiencies in their subsequent clinical care. One person, however, did not know about her HIV infection when transferred to immigration detention. Despite a number of factors which should have precipitated a HIV test on arrival, this was not done until over a year later.

Disrupted adherence to HIV treatment regimens

Disrupted adherence to ARV treatment regimens can have serious implications. Where medication is missed, this increases the propensity to HIV related (and non HIV related) illness. Ultimately, these can be fatal.⁷⁰ At the same time missing medication can lead to an individual developing resistance to particular drugs and, subsequently, necessitate more complex combination therapy. In many parts of the world it can be particularly difficult to access certain drugs as a result of underfunded healthcare infrastructures,⁷¹ the costs of medication (and the actions of pharmaceutical companies),⁷² and in some contexts the impacts of national and international HIV/AIDS policies.⁷³ In some parts of Sub-Saharan Africa, where the majority of the individuals featured are being removed to, it is particularly difficult to continue complex combination therapy.

Certain studies have indicated that it would be more preferable not to begin an ARV regimen, than have a regimen interrupted, as the implications of missing medication can be so severe. Rather, therapy should not be interrupted at all.⁷⁴ The consequences of missing medication are discussed explicitly in the NAT/BHIVA advice, and as the document explains:

Drug combination to control HIV in the body and to protect the immune system can be life saving, although the combination can be complex and the treatment regime demanding. For example, drugs must be taken at the right time according to specific instructions. Some ARV drugs must be taken with food and others must be refrigerated. At least 95 per cent adherence to treatment is required, as even one or two missed doses can seriously compromise both the efficacy of therapy and lead to drug resistance. This means missing no more than one dose a month if a detainee is taking once-daily therapy, or two doses a month if a detainee is taking twice-daily therapy. IRC

healthcare staff should ensure that every detainee in need gets their medication each day.⁷⁵

Our research shows that interruptions and disruptions in ARV therapy occur repeatedly in relation to those detained for immigration purposes. Of the 35 detainees, 21 (60%) had experienced disruptions in their medication. These disruptions occurred for a series of different reasons, and for a range of lengths of time. However they were all precipitated, in one way or another, by their detention. A further two people stopped taking their medication, prior to being detained, when their claim for asylum reached a negative decision. One woman stopped going to her regular hospital appointments as she was afraid that staff would alert the UKBA of her whereabouts. Another woman stopped taking medication as she lost hope for the future, and decided that she would rather die in the UK than in the country to which she was facing removal. The different factors causing compromised drug adherence in detention included: clinical errors and procedural failures, interrupted care as a result of detention (including being transported to or from IRCs), and detainees proactively disrupting their own treatment regimens. These factors are discussed in more detail below.

Disrupted medication as a result of clinical errors

As a result of clinical errors and procedural failures, eight detainees missed their medication. These errors included IRCs running out of medication and failures to ensure that detainees were provided with sufficient drugs. In some cases detainees were not brought to appointments with HIV specialists in local hospitals and their treatment was consequently interrupted. One woman, who had been raped prior to arriving in the UK and was severely traumatised, was unsure about when she had, or indeed had not, taken her medication. Another woman, who was seriously ill, was given a significant overdose of her HIV medication. The length of time that people missed medication varied from days to weeks. In one case a man known to have poor short term memory was not adequately supported to ensure that he took his medication regularly.

Case Study 3 – missed appointments in detention, and attempts to blame a detainee with poor short term memory for missing his medication

MW was born in the Caribbean. He came to the UK after being granted leave to enter for six months and overstayed his visa. After being in the UK for about five years he became seriously ill and was diagnosed with HIV. Subsequently, MW lapsed into a coma and was put on a life support machine. After commencing on ARV therapy he recovered but was left with a permanent visual defect, had an area of stroke in the brain, had slurred speech and poor short-term memory. Occasionally, there were times when MW forgot to take his medication.

Some years later, in 2008, MW was sent to prison and within a few months he was served with a notice of liability to deportation. After serving his prison sentence he was transferred to three immigration detention locations and in May 2010 was sent to Tinsley House IRC. At a later date, MW was moved to Harmondsworth IRC (via two other IRCs).

Whilst detained, MW missed numerous appointments with his treating consultant (based in a local Sexual Health Clinic) in relation to his HIV infection. In 2009 his medication was changed and his consultant arranged for a follow up consultation a week later. Notwithstanding the importance of this appointment – fatal side effects could have developed as a result of the change in medication – escorts did not actually bring him to attend. According to this same consultant, MW reported missing medication in about half of the appointments that he was able to make. Attempts to remove MW from the UK were unsuccessful and, on one occasion, were prevented due to failures to supply three months' ARV medication.

MW was part of a judicial review test case regarding the legality of detaining people, for immigration purposes, who have been diagnosed with HIV.⁷⁶ He acknowledged the trouble that he had previously had in relation to regularly taking his medication and explained:

When I first went to see [my treating consultant], I explained to him that I sometimes missed my anti-retroviral medication, but this was not because I was not taking it seriously; I really want to take the medication, but I cannot remember when I have done so.⁷⁷

However, despite the fact that he was known to have previously suffered from short term memory loss, the Secretary of State's expert – Professor Gazzard – suggested that MW's missed appointments and missed medication were in, part, his own fault. Accordingly, his

history of poor adherence was highlighted and Professor Gazzard stated:

It was clear that [MW] had a previous history of poor adherence, and it could be argued that, while in detention, he was more regular in taking the medication because he was reminded of the importance of doing so by the nurses in charge. Nevertheless, because of oversleeping, he did miss several doses, although that was clearly a personal responsibility.⁷⁸

Scared of being deported to a country where he fears he will not be able to continue his ARV regime, and terrified of being separated from his family, at one point MW wrote a pleading letter to the Home Office, saying:

I regret committing the offence I committed and I am very sorry for this but deporting me will be separating me from my partner and children and separating me from my love[d] ones in the UK and that will be like taking away my life, I will have no reason to live if separated from my family and loved ones.

At the time of writing, some two years after finishing his prison sentence, he is still detained.

Compromised drug adherence on route to detention, or as a result of being raided

Seven people missed medication whilst being transported to or from IRCs, or because their treatment was interrupted by immigration detention. Three people were unable to access their medication while they were held in police cells prior to being taken to an IRC; in two cases these interruptions lasted for three days. Two people missed medication when they missed external appointments which were necessary for their continued care and, in one of these cases, a woman was detained on the same day that she was supposed to have started her treatment regimen. One person was unable to access their medication for a day when attempts were made to remove her from the UK. Further, a failure to ensure that one woman had her medication with her when she was detained resulted in disruptions to her ARV medication.

Deliberate disruptions to treatment regimes

Struggling to cope with their detention, or attempting to protest against it, five detainees proactively disrupted their own treatment. One woman, who it was thought had contracted HIV from a family member who had sexually abused her, would not take medication as she was afraid to confront her illness. Another woman, in protest against her ongoing detention and the threat of deportation, began a hunger strike which also led to missed drugs. In a desperate attempt to escape their situation, three other detainees hoarded their drugs until they had an amount which they thought would be of sufficient quantity to be fatal. Two people overdosed in an attempt to end their own lives. Another only failed to do so because she was prevented by another detainee.

Figure 3(2) – reasons for disrupted ARV medication

Reason for disrupted medication	Number of people	Proportion of the 21 people
Clinical and procedural errors	8	38%
Transporting to or from IRCs, or due to failures to meet external appointments	7	33%
Proactively not taking medication	5	24%
Unknown	1	5%
	Total: 21	100%

Consistency of care in immigration detention

23 people in this study (66% of the sample) were reportedly subjected to practices, distinct from failures to ensure uninterrupted medication, which were inadequate and insufficient. These practices violated the NAT/BHIVA advice that medical care in immigration detention should conform to NHS standards. These deficiencies are set out below.

Inappropriate and demeaning treatment

Infection with HIV leads to immune impairment that may ultimately culminate in acquiring AIDS. After contracting HIV, there may be few noticeable symptoms for many years. Nonetheless, the virus causes immune deficiency during this period. Through attacking lymphocytes (white blood cells), HIV impairs the ability of the immune system to function and, if untreated, renders an individual more susceptible to dangerous and acute infection.⁷⁹ There is a well established link between HIV and tuberculosis (TB), for example, wherein ‘HIV infection is the greatest risk factor for the development of active tuberculosis ever identified’.⁸⁰ Three people living with HIV, however, were reported to have been put at risk of contracting infectious diseases in immigration detention: a man who was removed from his family, after being accused of causing dissent by organising prayer meetings, and consequently placed with a detainee with Influenza A H1N1 (‘Swine Flu’); a woman who shared a room with a detainee who had TB; and a woman at risk of contracting chicken pox.

These three cases indicate one way in which conditions or practices within immigration detention posed significant health risks. Other cases showed inappropriate conditions which were demeaning, unethical, and exacerbated the emotional despair which many detainees experienced. In direct contravention of the NAT/BHIVA advice, three detainees were taken to appointments with their external HIV specialist in handcuffs and, in at least one case, forced to undergo consultations chained to an escort. A woman in Yarl’s Wood, meanwhile, argued that she was made to

take her medication late, and without food, as a result of practices in Yarl's Wood.

Five other people complained that their rights to have their HIV infection kept confidential were violated. One woman stated that she was made to take her medication in front of other detainees who, consequently, discovered that she had HIV. Another woman claimed that, after she had spent a few days in a hospital, other detainees knew about her HIV infection when she returned. And three other people, including a man (mentioned above) who had been placed with another detainee who had 'Swine Flu', reported either that escorts violated their right to confidentiality during failed removal attempts or Detention Custody Officers (DCOs) breached their rights to confidentiality in detention.

Case Study 4 – inappropriate conditions in detention and breaches of confidentiality⁸¹

CS and his wife, AZ, fled from Sub-Saharan Africa with their son and daughter to the UK. AZ and her daughter were both sexually abused by a family member, and the family state that they are in danger if they are returned. Both parents have numerous health problems. AZ was diagnosed with cervical cancer in the UK, and CS was diagnosed with lymphoid interstitial pneumonia. They were also diagnosed with HIV. They chose not to tell their children about their condition, so as not to frighten them.

The family were detained for less than one month in summer 2009, after being subjected to a dawn raid. As a result of the raid, the parents missed ARV medication that was being delivered to their home. Furthermore, they were only able to resume this medication two days later after arriving in Yarl's Wood IRC. The mother was also unable to continue regular medication for debilitating pain in her legs, and instead reports that she was given paracetamol.

Within Yarl's Wood, a member of staff told the two children about their parents' HIV infection: a revelation that, according to the father, 'broke their hearts'. The family were then separated when the father was put in isolation for a short time, after being accused of causing dissent during prayer meetings with other detainees.

After receiving removal directions, the father wrote a pleading letter to the European Court of Human Rights, stating that 'I will not be able to look after the children and they will end up being orphans. We will not have access to our medication and [our children]

will die young'. Similar concerns were raised by one of their previous doctors, who wrote a letter confirming that, without access to continued ARV medication in the country they were being returned to, the life expectancy of both parents was likely to be only a few years. A second doctor wrote a letter to Yarl's Wood IRC, explaining that the family should not be removed as the son, who was by this point receiving treatment for possible thrush in the mouth, needed an HIV test and as a result was not 'fit to fly'. Moreover, despite concerns about the parents' life-expectancy if they were to be deported, the family had not been provided with the three month supply of anti-retroviral medication that is recommended in the NAT/BHIVA advice.

With the mother unable to walk, due to failures to give her adequate medication for the pain in her legs, escorts reportedly racially abused and dragged her out of her wheelchair and on to an airport runway in order to effect the removal of the family. According to her husband, her children witnessed this event and looked on as the escorts shouted 'you illegal immigrant, the government is spending money on your medication and food and you are refusing to go back'. As a result of these events, the plane crew refused to accept the passenger. Soon after the family were released from detention.

After their experiences in detention, AZ became increasingly alarmed about the impacts of detention on his family. As he explained:

My daughter lost weight, became depressed and didn't eat much. My son was sweating in the night and has nightmares. He has developed heart problems since he came out of detention. [My wife] was stressed, her legs became swollen and she couldn't walk. I was stressed... The long term detention has made my children afraid of the police, they have sleepless nights, loss of appetite; they think that they are not human beings anymore, they have no future and they think that we are criminals.⁸²

After a failed suicide attempt, where she vomited an overdose of tablets, AZ and CS's daughter wrote a letter explaining how she wanted to kill herself 'in order to find peace'. A Social Worker, after assessment, noted that she was experiencing high levels of distress and anxiety and that she had also reported having repeated flashbacks about the abuse she was subjected to prior to arrival in the UK. The teenage girl was acknowledged as a young carer of her parents, and she reported to her Social Worker that she rarely invited friends to her home as she did not want to place her parents under any stress. In this same assessment, she explained that she often tries to sleep, in order to 'block out memories of the past'.

Failures to investigate symptoms which may have been indicative of HIV/AIDS, and other clinical deficiencies

Many of the detainees in this report were seriously ill. Some were suffering from HIV related illnesses and many were distressed, anxious, and as discussed earlier, in some cases suicidal. For some, their anguish had been directly exacerbated or caused by their experiences in the UK. One person who attempted suicide in prison before being transferred to immigration detention, had subsequently been restrained and handcuffed.

Not only was care in immigration detention – in certain cases – deficient to such an extent that it failed to alleviate symptoms and suffering; in certain cases it could be argued to have put the health of detainees at risk. Four people, for example, exhibited symptoms which could have been indicative of a development of their HIV infection which, according to our records, were not sufficiently investigated. One woman was coughing yellow spit, had signs of TB infection, and was at risk of numerous life-threatening opportunistic infections. Little, however, appeared to have been done to investigate these symptoms. Another woman had lost approximately 20kg in weight, had abdominal pains, and watery diarrhoea; yet she had not seen a HIV specialist in over a month.

Eight people suffered from failures by clinicians in detention to either obtain the results from, or carry out, tests which were vital for the management of their HIV infection. These included a failure to pass on, or act on, the results of tests to determine whether a detainee had become resistant to particular medications, even though the individual needed to begin a new treatment regimen urgently. Another person began a new treatment regimen, but tests were not carried out to assess the toxicity of their drugs. One man had a particularly low CD4 count,⁸³ and had missed appointments for HIV related illnesses, but claimed that clinicians in detention refused to give him the results of blood tests and instead would only give them to the UKBA.

Six people were prevented from attending appointments with external clinicians relating to the ongoing management of their HIV infection. In some cases these missed appointments occurred as a result of administrative errors or failures to pass on relevant information. However, in three cases, they may well have resulted because of the practices of G4S: a private company contracted to transport immigration detainees. An internal G4S document indicates that different forms of transporting have different priorities, with each category split further into sub-categories. There are six transporting priorities of which the first, in this list, covers incidences

where there are removal directions. Medical appointments are the fourth priority. They are considered less important than, for example, embassy appointments.

It should be noted that, in October 2010, the Home Office announced that they were not renewing their contract for escorting services with G4S after three escorts were arrested in relation to the death of a man, Jimmy Mubenga, during an attempted deportation. Instead, it was announced that Reliance Secure Task Management Limited would take over this contract from May 2011.⁸⁴

Figure 3(3) – G4S transporting priorities

PRIORITY 1	
1.1	Removal directions (RDs) within 24 hours
1.2	International flights (Bounce back)
1.3	Domestic Shuttle flights
1.4	Domestic ferries
1.5	Upper tier Operations
1.6	Middle tier Operations
1.7	Lower tier Operations
1.8	Bedwatch
1.9	Embassy Appointments
PRIORITY 2	
2.1	Removal directions 32 > 24 hours
2.2	Positioning for Charter flights
2.3	High Court
2.4	Crown Court Hearing
2.5	Magistrates Court Hearing
2.6	A.I.T Tribunal Hearing
2.7	A.I.T Bail Hearing
2.8	Interviews with police
2.9	Interviews with Immigration
PRIORITY 3	
3.1	Moves with complicated special needs
3.2	Moves that have previously failed
3.3	Moves involving ferries / flights
3.4	High profile moves not already covered in band A & B
PRIORITY 4	
4.1	Moves to and from A&E
4.2	Outpatient Appointments
4.3	Moves out of prison
4.4	Moves into prisons
4.5	Moves out of Dover Removal Centre (DRC)
4.6	Moves out of Haslar
4.7	Moves out of Lindholme
4.8	Moves into DRC
4.9	Moves into Haslar

4.10	Moves into Lindholme
4.11	Dental Appointments
4.12	Other medical appointments
4.13	Opticians appointments
PRIORITY 5	
5.1	Cross Deck Moves
5.2	Bus Routes
5.3	Holding room to anywhere
5.4	Reporting centre to anywhere
5.5	Police (RD < 36)
5.6	Police stations (remote locations)
PRIORITY 6	
6.1	Police station to 24 hour detention
6.2	24 hour detention to 24 hour detention
6.3	Police station (No RDs or RDs >36 Hour)

Other deficiencies in clinical care included a woman (already mentioned), who was given a significant overdose (approximately double) of part of her anti-retroviral medication for a number of days: an act which could be life threatening. A different woman, in Yarl's Wood, was supposed to have been started on a new ARV regimen but, nonetheless, was still being supplied with her previous medication. In numerous cases, HIV specialists were not supplied with medical notes about patients in IRCs and one such delay was reported to have lasted approximately three months. One woman, who had only recently been informed of her HIV infection, was told to begin taking medication but was given no advice about side-effects or ongoing care. Another case involved an external HIV specialist informing clinicians in Tinsley House IRC about a patient who had a kidney infection, but this knowledge was alleged to have not been acted upon. In one case a treating clinician was reported to have been told that an individual was going to remain in the UK until a particular date, but in reality was deported prior to this. As a result, the detainee was denied access to specialist medical care. In the vast majority of cases where clinical care in immigration detention was deficient the UKBA was actively trying to remove the person from the UK. This is discussed further in the next chapter.

Chapter Four – deporting detainees who are living with HIV

Resistance to the recommendations in the NAT/BHIVA advice has led to deportations which may have seriously compromised some detainees prospects of survival. Detainees have routinely been removed with little or no medication; in certain cases they have not been supplied with relevant information about their HIV infection, for future clinicians, or given any support in finding HIV specialists in their destination country.

The majority of those detainees whose cases are featured found out about their HIV infection in the UK. Consequently, it is unlikely that they had any detailed knowledge of the healthcare infrastructure, with regard to HIV, in their home country. Nor would clinical agencies have had any information about their HIV infection. However, as the previous chapter explored, people have been subjected to practices in immigration detention which may have had detrimental short and long term impacts upon their health. In certain cases, their health had deteriorated to such an extent in the UK (both whilst, and prior to, being detained) that they required complex medical care which, potentially, may not have been available in the country where they were being removed to. As the NAT/BHIVA advice maintains:

In many developing countries the range of treatment options are limited, so maintaining the efficacy of the current treatment regimen is often highly critical to the long-term survival of detainees who are removed.⁸⁵

Of the 35 people, 26 (74%) were subjected to deportation attempts which, according to our records, breached the provisions of the NAT/BHIVA advice on removal. Of these 26, 12 (46%) were released; 13 (50%) were removed, and 1 person (4%) is still detained. 23 (88%) cases where these breaches took place were in Yarl's Wood IRC. Three (12% of the subtotal) other detainees were being held at that point in Colnbrook, Harmondsworth, and Tinsley House respectively. Alongside breaches of the recommendations in the NAT/BHIVA advice, some detainees were reportedly subjected to racist abuse during removal attempts.

Case Study 5 – a woman is abused by escorts after her removal is prevented on the basis of the NAT/BHIVA advice

JC, originally from Sub-Saharan Africa, came to the UK after she was raped repeatedly by a member of her family. She had a child by him, when she was a teenager, who she was unable to bring with her when she left. She found out that she was HIV positive, in the UK, some years later when she was tested during a second pregnancy. As a result, she was initiated on ARVs to prevent transmission of the infection to her child.

After being subjected to a 'dawn raid'⁸⁶ JC and her son were detained, in 2010, in Yarl's Wood IRC. Despite the fact that JC's treating clinician had written a letter explicitly warning that her child required monitoring for his first 18 months, to ensure he had not been infected with HIV, a date was set for their deportation. A Judicial Review against the removal was subsequently issued on the basis that the provisions of the NAT/BHIVA advice on removal had not been applied. JC had not been issued with three months' medication, did not have a letter for future treating clinicians and, despite the fact that she had never been treated for HIV in the destination country, had not been provided with details of trusted HIV organisations. This Judicial Review further emphasised that JC's child had not been offered malaria prophylaxis and, given that he was born in the UK, would be extremely vulnerable to this disease.

JC and her son found out that their removal had been cancelled, a few hours before their flight, whilst they were at an airport. Upon hearing this news JC reports that she was taunted and subjected to abuse. As she explained:

[W]hen they failed to remove me... they pinched, pushed, [and] handcuffed me. My son was there crying. One of the escorts said that I should not pass him my disease, and that he knew I have HIV, in front of the other escorts. [He said] that he would deport me [and that I am] just spending taxpayers' money.⁸⁷

Following the cancellation of the removal, the mother and child were released from detention. They are still in the UK.

Removals with less than three months' supply of ARV medication

The most common forms of breaches of the NAT/BHIVA advice, in relation to removal, were related to the recommendation to provide three months' supply of ARV medication. 20 of the 26 people (77%) were either removed, or faced removal, with either no medication or less than three months' supply. Ten people were deported with insufficient medication, according to the NAT/BHIVA advice, and in some cases were deported with none at all. In one case, a judge recommended that the UKBA either find a woman who had been removed with insufficient ARV drugs and bring her back to the UK, or arrange to have three months' supply of medication flown out to her. Neither happened.

Where medication is given to someone who is going to be removed, this is facilitated by the local HIV/GUM clinic. However our records indicate that in five cases – all related to detainees in Yarl's Wood IRC – the local HIV/GUM clinic (Bridge House, located in Bedford Hospital) had not been informed of an impending removal and, as such, providing adequate medication was not possible. Even in other cases where staff members in Bridge House were aware of a removal, though, detainees were not always provided with three months' medication. In one such case, for example, the Deputy Healthcare Manager in Yarl's Wood IRC wrote down that the decision on how much medication a detainee would be given was made by the local HIV/GUM clinic and, with regard to Bridge House, this was generally 28 days. In another, a detainee was reportedly told by a member of staff in Bridge House that there were not enough funds to provide three months' medication.

Up until the test case (discussed in Chapter One) in 2010, which ruled that the provisions of the NAT/BHIVA advice on removal were not 'binding', the deportation of numerous detainees whose cases are featured here were prevented through injunctions and judicial reviews. Ten people facing removal in breach of the NAT/BHIVA advice were later released from detention back into the UK. The effect of the above ruling, however, may well mean that detainees are not provided with three months' medication in the future. This is despite, as shall be discussed in more detail below, it being common for an NHS patient 'in the community' to be discharged with a three month supply of medication (at least with regard to patients in Bedfordshire).

Concerns about stability, and other breaches of the NAT/BHIVA advice

As well as facing the prospect of being removed with what, according to the NAT/BHIVA advice, was insufficient medication, numerous detainees also faced removal when they were reportedly not 'fit to fly'. General fitness to fly guidelines are provided by the Civil Aviation Authority.⁸⁸ However, the NAT/BHIVA advice puts in place a series of specific stipulations which seek to ensure that an individual is not removed from the UK if their condition is not stable.

Our records show that nine (26%) of the 35 detainees were given removal directions despite serious concerns about the stability of their condition; in numerous cases these concerns existed in conjunction with deficiencies in the amount of medication being offered. Of the nine people where these concerns applied, the majority related to removals where the efficacy of medication was unknown. In turn, in certain cases concerns about the efficacy of ARV medication had arisen as a result of incidents and events, including inadequacy of care, which had occurred whilst an individual was detained.

Case Study 6 – missed ARV medication and an attempted removal despite concerns about 'fitness to fly'

NK fled to the UK from South Africa. She was forced to flee after family members attacked her for being in a same sex relationship. She has scars on her body, one of which is from a stab wound.

After being in the UK for about one year, NK was diagnosed HIV positive. She settled and was a student for some time. However after being in the UK for nearly ten years, in 2010, she was arrested for immigration purposes. On the way to Yarl's Wood IRC she was held at a police station for three days and, during this time, she was denied access to her ARV medication. Whilst detained she missed a medical appointment, related to her HIV infection, as she was required to attend court.

NK was assessed in Yarl's Wood, about a month after she had been detained, by an independent doctor: Dr Charmian Goldwyn. Dr Goldwyn has assessed a significant number of immigration detainees and has prepared over 140 medico-legal reports. As she stated:

[The fact that NK missed medication for three days] is considered serious (see NAT/BHIVA guidelines) and she will now need to be completely re-assessed at the local GUM clinic in Bedford (the Bridge Centre). She had been given an appointment but it clashed with her court appearance, so she had to cancel. The Health Centre is arranging another appointment, in order to take blood tests to see if she has developed resistance to any of her drugs.

Dr Goldwyn further expressed concerns that NK had been given removal directions despite the above factors and, as she continued:

In my opinion, [NK] is not fit to travel until it has been proved that the HIV virus she carries has not developed resistance to her drugs, she is stable on the medication, and she has three months' supply, a letter [for future treating clinicians], and addresses of suitable clinics in South Africa.

NK's flight was cancelled a few hours before she was due to be removed. She was subsequently released from detention. She later described the standard of healthcare in Yarl's Wood as 'very, very poor'.⁸⁹

As the case study above indicates, where attempts were made to remove people who were not stable this could have had long lasting implications for the future care, treatment, and ultimately the life expectancy of detainees. These implications could include developing resistance to drugs and, subsequently, being deported to countries which may not have had the capabilities to provide complex combination therapy (required when resistance has developed). Our records indicate that four people were removed notwithstanding warnings by clinicians that they were not stable and among these was an individual who was about to start a treatment regimen, but was removed from the UK before being given the chance. In some cases, questions about the effectiveness or continuity of medication further related to the unborn children of those who were being deported.

Case Study 7 – removal prioritised over the welfare of an unborn child

HB fled from South Africa, to the UK, in 2006. She overstayed a visa and was detained in 2007 for approximately one month in Yarl's Wood IRC. Following her release, she was given instructions to report to the Home Office on a weekly basis. In 2009 she claimed asylum and the following day, when complying with these reporting conditions, she was detained again in Yarl's Wood.

At the time that she was detained (in 2009) HB was pregnant. She had been diagnosed with HIV during the pregnancy and started on HAART to prevent transmission to the unborn child. Dr Miriam Beeks – a GP of 20 years who has been working with immigration detainees as an independent doctor for five years – carried out an assessment with HB and expressed concern about her pending removal to South Africa. She stated that HB had told her that she had less than a month's supply of anti-retroviral medication and warned that, 'it is vital that treatment is not interrupted in pregnancy in order to prevent infection with HIV in the baby'.

Dr Beeks further queried whether HB had been given adequate blood tests to confirm that her HAART was effective. As she reiterated, 'it is vital that these checks are done to ensure that the baby does not become infected with the HIV virus'.

HB was later released from detention. She stated: 'if I go back to South Africa I'll die quickly and I can't let my baby watch me die'.⁹⁰

Our records show that five adults faced removal despite concerns that doing so would put their children at risk. As in the case above, one way this was manifested was through the attempted deportation of adults where it was unknown whether medication was effectively preventing the transmission of HIV to their unborn children. Other cases involved adults who were HIV positive although their children did not carry the virus. In such cases attempts were made by lawyers to try and prevent the removal of the family on the basis that doing so would inevitably orphan the children. In some, but not all, of these cases these applications were successful.

Three of the cases where children were at risk further involved breaches of the provisions of the NAT/BHIVA advice which stipulate that those being removed should be provided with a letter for future clinicians and contact details of HIV support organisations. Seven people (20% of the total sample) faced removal without these provisions being met. In all but one of these cases, these breaches occurred in conjunction with other violations of the NAT/BHIVA advice (such as, for example, not providing a three month supply of medication). One woman, given ARV medication which would last 28 days, reports that she was told by escorts that she would not be given contact details of future clinicians when she enquired about these provisions of the NAT/BHIVA advice. Two children whose cases are featured in this report were removed from the UK notwithstanding their HIV infection. Given that they were being removed to a country where it is unlikely they would have been able to continue complex combination therapy their removal was described, by one independent doctor, as 'as good as a death sentence'.⁹¹

Figure 4(1) shows the ways in which and how often the provisions of this advice, in relation to removal, were breached.

Figure 4(1) – breaches of the NAT/BHIVA advice with regard to the removal of detainees

Breaches of the NAT/BHIVA advice	Number of people	Percentage of overall sample of detainees
Local HIV clinic in the UK unaware of removal	4	11%
Removal or attempted removal when a detainee was not medically stable	9	26%
Removal or attempted removal with less than three months' supply of medication	20	57%
Removal or attempted removal where there was insufficient information for future treating clinicians or the detainee being removed	7	20%

Conclusions

This report provides evidence to suggest that immigration detainees living with HIV have been subjected to practices which, in other circumstances, would be considered unacceptable. Our records indicate that breaches of the NAT/BHIVA advice are routine; they occur intentionally in some cases, and as a result of inadequacies in others. Taken together, these breaches amount to a system of care which is frequently detrimental to the health and well-being of those detained for immigration purposes. The UKBA claim that they are neither willing nor able to enforce the provisions of the NAT/BHIVA advice within immigration detention. However, our findings suggest this advice could, and should, be made binding immediately. At the same time though, this report indicates that the only way to ensure that individuals living with HIV are not harmed by immigration detention is to make sure that they are never detained.

The NAT/BHIVA advice was introduced with the aim of ensuring that the care that immigration detainees receive is of a standard comparable to the NHS. The cases here provide a body of evidence which indicates that this aim has not been met. Yet what this investigation further emphasises is the extent to which the UKBA and its contractors will fight against measures to enforce a minimum standard of care for those subject to immigration control.

As Figure 5(1) displays, the 35 individuals whose cases are featured here suffered from a total of 79 distinct breaches of the NAT/BHIVA advice and, it should be noted, this figure is likely to be an underrepresentation.⁹² Breaches of the advice occurred throughout the detention process: on arrival, in detention, and during removals or attempted removals. Numerous detainees experienced clinical care in detention which violated this advice in various ways.

Figure 5(1) – total breaches of the NAT/BHIVA advice

Forms of breaches of NAT/BHIVA advice	Number of incidences	Proportion of detainees experiencing particular breaches of the advice
Provisions relating to arrival and reception in immigration detention	9	26%
Interrupted access to ARV therapy	21 ⁹³	60%
Failures to ensure quality and consistent primary and secondary care (aside from interrupted ARV therapy)	23	66%
Provisions relating to deportation or attempted deportation from the UK	26	74%
	Total: 79	

Reasons for inadequate clinical care in detention

The routine breaches of the NAT/BHIVA advice emphasised in this report expose a series of deficiencies relating to the clinical care of immigration detainees. From our records we can deduce that these violations occur for a number of reasons.

1. *Some individuals employed by, or working on behalf of, the UKBA treat detainees degradingly*

Our findings suggest that, in some cases at least, there are what appear to be examples of disregard for the dignity of immigration detainees. On one level this disregard is manifested in individual acts and practices which are degrading, humiliating, and insensitive. For example, despite clear guidance demanding that confidentiality must be maintained at all times with regard to matters relating to healthcare, our records indicate that the right to confidentiality has been openly flouted. In one instance, two children found out that their parents were HIV positive when detention centre staff chose to tell them. Similarly, one man suffered the ignominy of being forced to undergo consultations with his HIV specialist whilst shackled to an escort who refused to unlock his chains. Other detainees reported that they were racially abused by DCOs and escorts.⁹⁴

2. *Certain parts of the NHS and the UKBA may be acting in a way which is discriminatory*

The NAT/BHIVA advice was introduced, in part, as an attempt to ensure that individuals being deported would be able to have enough medication and information with them so as to ensure some chance of being able to manage their HIV infection after they were returned. The UKBA have vehemently resisted such a stipulation and, in their own words, they have done so on the basis that they do not have the power, or desire, to enforce a set of minimum standards on medical professionals. Rather, as they have stated, the decision over how much ARV medication a person receives if they are removed, is at the discretion of the treating clinician and decided on a case by case basis. In this way it is inferred that the UKBA will not infringe upon the autonomy of the medical profession.

The suggestion that clinical decisions should be made by those with appropriate expertise and experience is beyond dispute. But the very fact that the UKBA has legally opposed advice on HIV, published by bodies which are widely acknowledged as experts on HIV, suggests that medical knowledge is not respected in all cases. Our records show that 16 people, or 46% of the detainees featured, were removed. Some of these removals took place despite medical experts suggesting that doing so would place them at risk of harm. In some cases former treating clinicians wrote letters explaining, explicitly, that deporting particular detainees would be likely to lead to death. Nonetheless, the individuals were still deported.

There is further evidence to suggest that, where treating clinicians in detention are recommending less than a three month supply of medication prior to a removal, this is not necessarily always based on decisions made on a case by case basis. The majority of the detainees whose cases are featured in this report were detained in Yarl's Wood IRC and in 2009 the Deputy Healthcare Manager of Yarl's Wood stated, in writing, that detainees 'normally' leave the IRC with 28 days' supply of ARV medication. Similarly, a letter written by a representative of the Foreign and Commonwealth Office, in 2009, for the attention of the European Court of Human Rights, claimed that:

UKBA policy is for an applicant to be returned to their country of origin with a 28-day supply of medication, and this is considered sufficient to comply with EHCR obligations. The UKBA is under no obligation to provide medication beyond this period.⁹⁵

However, in 2010, in response to a request under the Freedom of Information Act 2000 the Bedford Hospital NHS Trust, (which supplies the medication which detainees in Yarl's Wood receive), stated that patients, in general, who are stable on ARV medication would

normally be dispensed with three months' supply.⁹⁶ As such there appears to be a discrepancy in the provision of clinical care. Detainees are normally given 28 days' supply of medication and residents in Bedford can normally expect to receive three months' supply of medication. Not only, then, does the expectation that detainees will be given a 28 day supply of medication indicate that specific medical needs are not given adequate consideration. It also points towards a practice which is discriminatory. The rationale behind such decisions is not clear. But, as emphasised in the previous chapter, one factor may be the cost of providing medication; whereby NHS Bedfordshire wants extra funding from the Home Office to pay for the necessary treatment.

3. *Detaining people who are living with HIV inherently puts them at risk*

The various breaches of the NAT/BHIVA advice, described above, indicate examples where the substandard treatment of detainees appears to be either individually or systemically wilful. However, our findings indicate that, at the same time, the process of detaining people who are HIV positive inherently puts them at risk. Numerous people suffered from practices which constituted breaches of the NAT/BHIVA advice, for example, as a result of enforcement visits. Detainees suffered from interruptions to their medication as they were held in police cells, or because medication was not brought with them to IRCs by immigration officers. Another person missed medication during a day when there were attempts to remove her from the UK. Other people, whilst detained, missed appointments as a result of administrative errors whereby information was not passed on or shared appropriately. Our records further show that detainees have been put at serious risk of contracting dangerous – potentially fatal – infections or viruses when made to share rooms with people with TB and Swine Flu.

4. *Detention increases the likelihood of proactive disruptions of medication*

Holding people against their will, for indefinite periods, and often facing removal to a country from where they have fled, carries with it a further set of risks. Mental health problems and depression can lead to reduced adherence to treatment regimens, including the regular taking of ARV medication.⁹⁷ And, more widely, self-harm within detention is frequent. In 2009 there were 215 incidents (averaging at an incident every 1.6 days) of self-harm requiring medical attention in detention, whilst in 2008 there were 179 incidents.⁹⁸ In a number of reported examples, immigration detainees, desperately afraid of what the future held for them or their families, have taken their own lives.⁹⁹

As discussed in Chapter Three, these points are reinforced in this report. Numerous people deliberately disrupted their own medication by storing up an

amount which they considered enough to be fatal and, consequently, attempted to end their own lives by overdosing. One woman stated:

The standard of healthcare in Yarl's Wood is very poor. They don't care about people; they treat people like animals... I am aware of lots of people [who] wanted to kill themselves in Yarl's Wood. I am one of those who wanted to end my life. I wanted to commit suicide.¹⁰⁰

5. *The acceptance that immigration control overrides the need for continuous medical care pervades practices in immigration detention*

The practices within immigration detention are underpinned by an institutional framework which essentially rules that, except in the most extreme circumstances, the right to deport someone from the UK overrides the right to maintain access to life-prolonging healthcare. This principle, with regard to HIV, is upheld in case law primarily by the case of N vs UK. More recently, it has been reinforced in 2010 through a case which ruled that removing individuals living with HIV/AIDS to Zimbabwe would not breach obligations held under disability discrimination legislation.¹⁰¹ Our records, as the previous chapters show, further indicate that the subordination of health rights goes beyond those of adults, and extends to their children. Representations made on behalf of one of the women whose case is featured here, in 2009, stated that her deportation would potentially have fatal consequences due to the lack of medication in her destination country. This, in turn, would leave her young child, who was also going to be removed, without parents in a country where he had no ties and no support. In response, the Foreign and Commonwealth Office (FCO) accepted that removing the mother could have potentially detrimental consequences but continued to assert that, '[s]hould the applicant's medical condition deteriorate significantly... it is considered that there is a sufficient level of care available to the applicant's son in [the destination country]'. That is, it was accepted that the mother would potentially die, but this was considered reasonable as the child would potentially have access to an orphanage.¹⁰²

The priority given to deportation over the medical care of detainees is reflected in the transporting priorities by the private company G4S. As discussed previously, medical appointments are situated in this list below removals and below appointments relating to an individual's claim for asylum (such as, for example, Tribunal Hearings). Our records indicate that numerous

appointments with external HIV consultants were missed when detainees were simply not brought to attend.

Other cases emphasised the extent to which the pressure to remove people impacted on the quality of clinical care. A number of detainees faced removal from the UK notwithstanding serious concerns about the efficacy of their medication and whether they were medically fit to fly. And in one example an independent medical expert claimed that she was misinformed by clinicians in Yarl's Wood about the date that a person would be removed. This doctor was told that a detainee was going to be removed on a date which, in reality, was later than when the removal was planned for. As a result, this gave the impression that support did not have to be arranged immediately and, consequently, the detainee was removed with insufficient medication and whilst not medically stable.

These cases indicate an irreconcilable conflict between health rights and certain aspects of immigration and asylum policy. As has been written elsewhere medical care in detention has been described, by a practitioner working in these settings, as 'repatriation medicine'.¹⁰³ Clinicians employed privately, or administering medical care in detention, may be forced to negotiate 'dual loyalties' between medical ethics and the aspirations of the UKBA or its contractors.

6. *IRCs are not suitable for people living with HIV or the effective management of HIV infection*

Given all of the factors above, the vast majority of the breaches of the NAT/BHIVA advice, especially those occurring within the confines of IRCs, indicate that such institutions do not have the capacity to effectively manage HIV infection. The incidences documented here include failures to ensure appointments are kept with HIV specialists, failures to ensure continuity of care by obtaining relevant medical information, failures to spot signs indicative of HIV and of opportunistic infections, and failures to investigate the efficacy of ARV medication. In some cases, local hospitals were unable to provide support for an individual facing removal as they were unaware that this was about to take place. Record keeping in detention centres, according to our investigation, is frequently inadequate and in some cases led directly to insufficient clinical care. It should be acknowledged that the cases we have represented here cannot be taken to be a fully representative sample of all people living with HIV who are detained for immigration purposes. However for these individuals, substandard clinical care occurred on a scale, and in such ways, as to be almost endemic.

Costing lives: the consequences of breaching the NAT/BHIVA advice

As the evidence here has made explicitly clear, failures to adhere to the NAT/BHIVA advice have grave implications. Within the confines of IRCs these include (but are not exclusive to) risks of building up resistance to ARV medication, and significant deteriorations in individuals' physical and mental health. Beyond these confines, individuals have been deported with little or no medication, with no information about how to continue their treatment, and in many cases to places where they allege that they face violence and danger.

In a letter from Lord Attlee to Lord Avebury on 2 March 2011, Lord Attlee outlined the access to medical treatment by asylum seekers living with HIV or AIDS. He wrote: 'Nobody is denied access to necessary treatment or medication whilst detained'. However, as this report has shown, this is clearly not the case.

The political desire to increase removals from the UK may create the basis for many of the breaches of this advice. On the one hand, this advice is breached (in terms of, for example, provisions to provide adequate medication on removal) as a result of conscious decisions made by individuals working within, or on behalf of, the NHS and the UKBA. On the other hand, they occur as a result of inadequacies and deficient practices in detention. This report presents a picture which shows that this combination of factors underlines routine failures to deliver consistent and quality clinical care.

Regardless of the reasons behind these frequent violations of the NAT/BHIVA advice, what these breaches represent are examples of failures to adhere to the government's own guidelines of providing care which is of NHS equivalent standard. Despite every indication to show that some of these breaches occur as a result of the degrading actions of individual staff members this is not true in all cases. Rather, our findings indicate that IRCs inherently contain the capacity to disrupt and undermine the effective management of HIV infection.

Ultimately, these breaches carry with them a range of costs. The failure to provide adequate medication on removal may, in part, be related to a set of financial arguments about which the government body is responsible for funding drugs for detainees. In the meantime, detainees themselves pay the personal price – documented throughout this report – of a standard of care which creates fear, uncertainty, and at times potentially significant damage. The reputational costs

borne by the UK are that any claims to be upholding the rights of those who are seeking safety become more and more unsustainable. Given the routine failures to provide adequate care to those living with HIV in detention, a strategy must be put in place to ensure that individuals who are HIV positive are never detained for immigration purposes. Until this happens, our evidence suggests that people will continue to suffer from practices which may potentially prove fatal.

Appendix 1 – Immigration Removal Centres in the UK (November 2010)

Immigration Removal Centre	Location	Year it became operational as an IRC	Current management	Bed spaces
Brook House	Gatwick Airport Gatwick	2009	G4S	426 male detainees
Campsfield House	Oxfordshire	1993	The GEO Group Ltd	216 male detainees
Colnbrook (NB Colnbrook has a built in Short Term Holding Facility)	Colnbrook Bypass Harmondsworth	2004	Serco	383 male and female detainees (plus another 20 on behalf of HM Revenue and Customs)
Dover	Dover Kent	2002	HM Prison Service	314 male adults
Dungavel	Strathaven South Lanarkshire	2001	G4S	148 single males, 14 single females and eight families ¹⁰⁴
Harmondsworth	Colnbrook Bypass Harmondsworth	2001	The GEO Group Ltd	630 males
Haslar	Gosport Hampshire	1989	HM Prison Service	160 males
Lindholme	Hatfield Woodhouse Nr Doncaster South Yorkshire	2000	HM Prison Service	112 males
Tinsley House	Gatwick Airport Gatwick	1996	G4S	150 with facilities for males, females and families
Yarl's Wood	Clapham Bedfordshire	2001	Serco	405 bed spaces. 284 single females; 121 family bed spaces. ¹⁰⁵

Appendix 2 – Methodology

This report is based on information from the cases of 35 detainees, who have been diagnosed HIV positive, and detained for immigration purposes within the UK between June 2009 and November 2010. The data that is used within this report was gathered using different qualitative and quantitative methodologies. Particular attention was given to ethical considerations.

Sampling and data gathering

The 35 detainees whose cases are featured in this report were all detained at some point between June 2009 (when the NAT/BHIVA advice was introduced) and November 2010. Some of the detainees were detained prior to June 2009, but remained in detention at the point that the NAT/BHIVA advice was introduced. The individuals whose cases make up this report were all detained in one of the 10 IRCs in the UK but, in some cases, had previously been held in prisons and police cells.

A core aspect of the work of Medical Justice is the facilitation of advice by independent doctors who visit immigration detainees. Given that the sampling frame is made up of cases referred to Medical Justice, this cannot be said to be wholly representative of all immigration detainees living with HIV. It is not the intention of this report, however, to explore how often the NAT/BHIVA advice is breached from a representative sample of all cases. Rather, it starts from the position that this advice is routinely breached and, consequently, analyses how these breaches occur, why they occur and the implications of these violations.¹⁰⁶ The 35 cases are taken from a wider sample of cases of approximately 50. Cases were not included where there was insufficient evidence to substantiate any of the claims made. Often, this would have been where a case was referred to Medical Justice but the detainee was released or removed before this could be investigated.

The medical evidence data gathered from these cases stems from the work of eight separate independent clinicians: including General Practitioners, HIV specialists, and psychiatrists. These eight clinicians have all assessed the detainees whose cases are featured here either whilst in detention, through telephone consultations, or after a detainee was released from detention.

The information used can broadly be categorised in three distinct, but in certain regards overlapping ways:

- Firstly, information that has been used or generated for use within a claim for asylum or other immigration matter;

- secondly, data that has been gathered for the provision of Medical Justice case work; and
- thirdly, data that has been generated for the purpose of this report.

Data gathered for the use of, or generated for the use of an asylum or immigration case

Data drawn from sources that have been used within a claim for asylum, or other immigration matters includes a wide range of documents, submissions, reports, and testimonies. These include, for example, statement of evidence interviews, reasons for refusal, notices of removal directions, correspondence between solicitors, appeal and judicial review applications and determinations, and witness statements.

Data gathered or generated for the provision of Medical Justice case work

Data gathered for the purposes of Medical Justice case work in many ways coincides with the above, and frequently draws from information produced by Medical Justice volunteer clinicians that, in turn, has been utilised in a detainees' (or former detainee's) immigration matter. This can include Medico-Legal Reports (MLRs), and professional letters that are based on either visits to detainees, or telephone consultations. In many cases solicitors will have contacted Medical Justice to facilitate medical expertise in relation to an asylum claim.¹⁰⁷ Simultaneously, this report uses information that is gathered by Medical Justice to *facilitate* the provision of case work, but that does not necessarily come from clinicians. Data is drawn from initial information given when cases are referred to Medical Justice and this can include a non-medical assessment of symptoms, a series of concerns about a detainee's health, and an overview of key medical concerns or relevant issues (such as, for example, complaints that a detainee is receiving inadequate medical care).¹⁰⁸ Finally, this information may also include that which is gathered by Medical Justice through the case work process such as, for example, medical notes within IRCs.

Data gathered for the purposes of this report

This report further utilises information which has been gathered specifically for the purposes of this project. Primarily, this refers to information that has been provided by detainees and former detainees whose cases are featured. In certain cases detainees provided written testimonies relating to their experiences in detention in the UK. These testimonies were guided by questions which sought to follow up on issues that were unclear, or points that needed clarifying further.

Ethical considerations

A project of this nature inevitably raises a series of ethical concerns. A primary consideration within the data collection was a demand for informed consent which, for the purposes of this report, refers to the principle that where possible, subjects should be made aware of both their participation in a project and the possible implications of this involvement. Furthermore, their agreement to participation should be based on these factors.¹⁰⁹ Within the context of this report informed consent was interpreted in the above manner.

Where contact was established the full nature of the report was explained to the detainee, or ex-detainee, and an offer was made to meet personally with Medical Justice to discuss this further if necessary. The implications of participating in the report, particularly if any identifiable aspects of their case or experiences were to be highlighted, were discussed in detail. If the individual agreed to participate in the report, they were given the opportunity to consent to the use of information in the report in one of three ways:

- First, as a full 'case study'. This would mean that full, identifiable, details could be utilised within the report and that consent was provided to utilise full information from documents related to their case such as (for example, information relating to their asylum claim, and Medico-Legal Reports);
- Second, as a 'case study', above, but with the provision that names were changed for the purpose of this report; and
- Third, for the use of information but in a way that was made completely anonymous. This would ensure that any documents that were referred to relating to the case were not quoted from, and that information was presented within the report in a way that ensured that the individual in question could not be identified.

Participants were asked to sign and return a consent form. This form gave more information about the project, and provided three boxes (corresponding with the above), of which one could be ticked, to provide consent for the use of information. This form was then signed, and returned to Medical Justice. In a number of cases, particularly where contact was made with an ex-detainee who had been removed from the UK, sending and receiving consent forms in this way was not possible. In each of these cases the individual agreed to the use of fully anonymous data. If it was not possible to establish contact with a person then information was only included in a way which ensured anonymity. Seven people agreed that their experiences could be presented as case studies.

Given the immigration status of a number of those who are included in this report, and with regard to the medical focus of this report, the interests of the participants were paramount. Every effort has been made to preserve confidentiality where an individual has requested this. Where an individual has requested further medical support every effort has been made to facilitate this request.

Appendix 3 – The Tables

Figure A3(1) – age at the time of Medical Justice intervention

Age of detainee (years)	Number	Percentage
0-9	1	3%
10-19	3	9%
20-29	4	11%
30-39	14	40%
40-49	9	25%
50-59	3	9%
60+	1	3%
	Total: 35	100%

Figure A3(2) – country of origin

Country of origin	Number of people
Angola	1
Cameroon	1
Dominica	1
Eritrea	1
Nigeria	3
Malawi	14
Mozambique	1
Uganda	4
South Africa	3
Swaziland	1
Tanzania	2
Vietnam	1
Zimbabwe	2
Angola	1
	Total: 35

Figure A3(3) – the gender of detainees

Gender	Number	Percentage
Male	7	20%
Female	28	80%
	Total: 35	100%

Figure A3(4) – whether HIV infection was diagnosed before or after entering the UK

Discovery of HIV infection	Number of people	Percentage of people
Prior to arrival in the UK	5	14%
In the UK	28	80%
Unknown	2	6%
	Total: 35	Total: 100%

Figure A3(5) – destination after being detained

Destination after being detained	Number	Percentage
Released	16	46%
Removed	16	46%
Still detained	3	8%
	Total: 35	100%

Figure A3(6) – location of detention when Medical Justice intervened in cases

Immigration Removal Centre	Number of people
Brook House	2
Colnbrook	2
Harmondsworth	1
Tinsley House	1
Yarl's Wood	29
	Total: 35

Figure A3(7) – locations where people had previously been detained

Location	Number of people (out of the 12 who had been detained previously)	Number of incidences
Colnbrook	2	2
Dungavel	3	3
Tinsley House	2	2
Yarl's Wood	1	1
Police cells	2	2
Prison	7	11

Figure A3(8) – length of time in immigration detention

Length of time detained	Number of people	Percentage
Seven days or less	4	11%
Eight – 14 days	5	14%
15 – 31 days	2	6%
One – two months	6	17%
Two – four months	4	11%
Four – six months	2	6%
Six – 12 months	7	20%
One – two years	2	6%
More than two years	3	9%
	35	100%

Appendix 4 – Medical ethics statement

Medical Justice believes that HIV positive detainees should not be in detention centres. Until such times as this is changed we need to ensure that patients receive the best possible care if they are detained. Medical and nursing staff may have dual loyalty to their patient and to their employer. They may be under pressure to treat patients in circumstances which are not ideal, compromising both the care of their patients and their ethical standards.

Detainees may receive clinical care from staff employed by the detention centre or by NHS staff. No matter who employs staff, both doctors and nurses should be working under guidance from their governing bodies such as the General Medical Council (GMC) or the Nursing and Midwifery Council (NMC). Both these organisations have very clear standards which staff are expected to follow in order to remain on the professional register. While health care assistants are not required to have membership of a professional body, conduct and care of clients should be the responsibility of their employer.

The GMC guidance on the duties of a doctor states that 'Patients must be able to trust doctors with their lives and health. To justify that trust you must show respect for human life and you must *make the care of your patient your first concern*. . .'. The NMC also requires that nurses 'make the care of people your first concern, treating them as individuals and respecting their dignity'. The GMC and NMC can remove staff from their register if they do not meet required standards.

Staff have a duty of care to their patients no matter where that care is delivered. In the Principles of Biomedical Ethics, Beauchamp and Childress outline four principles which should guide the actions of staff. The first of these, beneficence, suggests that staff should act in a manner which provides benefit to their patients. If staff are aware of practices which compromise the care and wellbeing of their patients, they have an obligation to raise these concerns with their employing authority. If there is no satisfactory response, they should inform the GMC, NMC or their defence organisation.

The principal of non-maleficence requires staff to avoid causing harm to their patients. Any delay in offering the HIV test to detainees may result in the exacerbation of their medical condition. This is also true if there is a delay in access to medical or primary care services. There have been reports of patients who are established on treatment having this withdrawn or withheld when they have been detained. This may lead to the development of drug resistance and an increase in viral load and lowering of CD4 count. The British HIV Association and National AIDS Trust advice suggests that patients who are being removed to their country of origin should be provided with a referral letter for future clinicians, three months'

supply of medication and the details of a local HIV support organisation. Failure to do so may result in a break in treatment, again leading to potential drug resistance and a rebound in viral load. Some patients may find it difficult to access treatment in their country of origin. Clinicians should ensure that they are given information on how to minimise the risk of developing drug resistance by staged withdrawal of treatment. Clinicians may find themselves under pressure to sign 'fit to fly' documents for detainees who are being removed from the UK. In some cases, patients may not be well enough to travel. Clinicians should act in the best interests of their patient and refuse to sign if there is a risk that travelling would cause additional harm to them.

Providing care for HIV positive detainees may be challenging for staff. They may find themselves under pressure to act in a manner which is against the best interests of their patient. This is especially difficult if they are working in an environment where health care needs are not given priority and they feel unsupported by colleagues and other staff.

At present, there is no standard training for health care staff working with HIV positive detainees. Individual institutions organise their own induction and mentoring, which may lead to inconsistencies in standards of care. It may be useful to standardise training in order to meet the challenges of providing health care to this group. Ethical concerns could also be better addressed within a new framework. However, in order for this to work, it would need the support of all concerned.

Ensuring that standards are maintained may be challenging, with care being provided by a range of health care agencies in a number of settings. It may be useful for an independent body to be set up which could monitor the practice. There would also need to be a system in place to ensure that any concerns raised by independent monitors were acted upon. This body would have the responsibility for acting on concerns raised by health care staff via a confidential phone line.

While overall responsibility for detainees lies with the authorities, their individual health care needs reside firmly with their clinician. These clinicians should be mindful of the guidance provided by their governing bodies and ensure that the care of the patient is their primary concern. Institutional apathy to the health care needs of HIV positive detainees should be challenged by all health care professionals.

Linda McDonald
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Glossary of terms

AIDS – Acquired Immune Deficiency Syndrome
APPGA – All-Party Parliamentary Group on AIDS
ARV – Antiretroviral
BHIVA – British HIV Association
DCO – Detention Custody Officer
DOH – Department of Health
DFT – Detained Fast Track
ECHR – European Court of Human Rights
FCO – Foreign and Commonwealth Office
FGM – Female Genital Mutilation
GMC – General Medical Council
GUM – Genito-Urinary Medicine
HAART – Highly Active Antiretroviral Therapy
HPA – Health Protection Agency
HIV – Human Immunodeficiency Virus
HMIP – Her Majesty’s Inspectorate of Prisons
IRC – Immigration Removal Centre
LSC – Legal Services Commission
MLR – Medico Legal Report
NAT – National AIDS Trust
NHS – National Health Service
PCT – Primary Care Trust
PTSD – Post Traumatic Stress Disorder
RDs – Removal Directions
STHF – Short Term Holding Facility
TB – Tuberculosis
UKBA – UK Border Agency
UNAIDS – Joint United Nations Programme on HIV/AIDS
WHO – World Health Organization

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- 11 See Gill, P. (2006) *Body Count: How They Turned AIDS into a Catastrophe*, London: Profile Books, p. 162. As a result, she appealed again to the European Court of Human Rights on the basis that removal would be a breach of Article 3 of the European Convention on Human Rights but, again, this was refused. For discussion see Carter, M. (2008) 'Deportation from UK of refused HIV-Positive asylum seeker to Uganda does not breach human rights, European Court rules', *Aidsmap*, 27 May, <http://www.aidsmap.com/en/news/F3531FE4-A8F1-401F-8299-B427A9D88DB2.asp> The 'N' case emphasises that contemporary human rights jurisprudence allows for the removal of people who are diagnosed HIV positive, where this will lead to interruptions in treatment, in all but the most exceptional cases. These exceptional circumstances were already set out in case law through the case of 'D', and require the individual having deteriorated to such an extent that they have reached an 'advanced or terminal' stage of a 'terminal or incurable' illness, and where there is an absolute lack of effective treatment in the destination country. For those who do not meet this extremely high threshold, immigration control overrides their right to continue vital, life-prolonging treatment. See Bettison, V., and Jones, A. (2009) 'The integration or exclusion of welfare rights in the European Convention on Human Rights: the removal of foreign nationals with HIV after *N v UK* (Application No. 26565/05; decision of the Grand Chamber of the European Court of Human Rights, 27 May 2008)', *The Journal of Social Welfare and Family Law*, 31(1), pp. 83-94.
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- 19 Written testimony. Case Number: 28.
- 20 See for example United Nations Office on Drugs and Crime (2008) *HIV and AIDS in places of detention: a toolkit for policymakers, programme managers, prison officers and healthcare managers in prison settings*, Vienna: United Nations. It does not necessarily follow though that concerns about the experiences of people with HIV in prisons has led to a consistent level of care. This is discussed in more detail in Chapter Three.
- 21 IRCs are run similarly to prisons, they are monitored by the same bodies who monitor prisons – Her Majesty's Inspectorate of Prisons, the Prison Ombudsman, and through Independent Monitoring Boards – and they are governed by standards which are based on prison service rules. However, according to a range of government ministers and IRC managers IRCs are not prisons. For example, the Contract Director in Colnbrook IRC offered the following paradoxical analysis, that Colnbrook is 'physically built like a prison, with wings, locks, bolts and bars; this is necessary for the detainee population here. However, we're very clear that the men in our care are not prisoners. In such surroundings it's sometimes difficult for the detainees to appreciate that they are not prisoners..' Collolby, V. (Undated) 'Victoria Collolby Contract Director Colnbrook Immigration Removal Centre', *The Custodial Review*, Downloaded 30 April 2010, http://www.custodialreview.co.uk/Victoria_Colloby_Contract_Director_Colnbrook_Immigration_Removal_Centre-a-7.html For a discussion of the similarities between prisons and IRCs see Bosworth, M. (2008) 'Foreign Nationals in Prison and Detention', *Prison Service Journal*, 180, pp. 18-23.
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- 36 HMIP (2006) *Inquiry into the quality of healthcare at Yarl's Wood immigration removal centre 20 – 24 February 2006*, London: Her Majesty's Inspectorate of Prisons, p. 4.
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- 61 See, for example, General Medical Council (undated) 'Duties of a doctor', *General Medical Council Guidance on Good Practice*, downloaded 22 November 2010, http://www.gmc-uk.org/guidance/ethical_guidance/7162.asp
- 62 The distribution of HIV/AIDS, by gender, varies in different regions. In Sub-Saharan Africa it was estimated that in 2001 58% of those living with HIV and AIDS were women and in 2008, in this region, this had risen slightly to approximately 60%. Túrmen, T. (2003) 'Gender and HIV/AIDS', *International Journal of Gynaecology and Obstetrics*, 82, pp. 411-418. UNAIDS (2008) *2008 Report on the Global AIDS Epidemic*, Switzerland: UNAIDS. As has been well documented elsewhere the disproportionate distribution of HIV/AIDS, by gender, can reflect a range of factors including biological differences, violence against women, and unequal access to services. See for example Gupta, G. R. (2000) 'Gender, Sexuality and HIV/AIDS: The What, the Why, and the How', *Plenary Address XIIIth International AIDS Conference, Durban, South Africa*, 12 July; and World Health Organization (2009) *Integrating gender into HIV/AIDS programmes in the health sector: Tools to improve responsiveness to women's needs*, Geneva: World Health Organization.
- 63 The convergence of immigration and asylum, and healthcare policy within the UK is underpinned by a policy framework which has sought to delineate varying levels of access to the NHS. Such strategies are not necessarily new, and opponents of the NHS based their arguments on opposition to the idea of universal free healthcare upon its inception. However, within the first decade of the 21st Century these concerns have culminated in a series of reviews, consultations, and policies which have more coherently marked out differing levels of healthcare entitlement. Strategies introduced to reduce entitlement to the NHS, in line with an individual's immigration status, are tied directly to concerns about 'health tourism': the conception that individuals enter the UK in order to access free healthcare. In large part these concerns have been perpetuated both within and by government and, for example, as the previous government made clear in 2005, in a response to the Health Select Committee: 'The Government remains convinced that deliberate abuse of the NHS by overseas visitors, across a range of services, is not just a potential threat but a very real one and the Government must fulfil its responsibility to ensure that the NHS is protected for those who are entitled to receive it free of charge. That applies as much to HIV treatment as to any other hospital service'. Department of Health (2005) *New Developments in Sexual Health and HIV/AIDS Policy: Government Response to the Health Select Committee's Third Report of Session 2004-2005*, Cmnd. 6649, London: Department of Health, Para. 20.
- 64 Robinson, V., and Segrott, J. (2002) 'Understanding the decision making of asylum-seekers', *Home Office Research Study No. 243*, London: Home Office. Such ideas have further been heavily criticised by a series of health professionals and experts on the basis that these claims are unsubstantiated. With regard to HIV, research has indicated that: 'There is compelling and robust

- evidence that 'HIV health tourism' does not exist. Most migrants come to the UK unaware of their HIV status and do not test for HIV until an average of five years following arrival, due to a combination of factors including denial and HIV-related stigma and fear'. See National AIDS Trust (2009) *The Myth of HIV Health Tourism*, London: National AIDS Trust. Nonetheless, the concept continues to gain resonance. Whilst those seeking asylum who have not received a decision are entitled to free ARV therapy, refused asylum seekers and irregular migrants may be charged, except in emergency circumstances, and where treatment was already ongoing prior to their change in immigration status. To view legal challenges against this see Pierce Glynn Solicitors (2009) *Access to Healthcare Overview*, London: Pierce Glynn Solicitors.
- 65 For discussion see Bail for Immigration Detainees (2007) "Refusal factory": *Women's experiences of the Detained Fast Track asylum process at Yarl's Wood Immigration Removal Centre*, London: Bail for Immigration Detainees.
- 66 The fact that these particular IRCs feature in this report may reflect a number of factors. The higher proportion of people detained in Yarl's Wood may well reflect the disproportionate number of females whose cases are featured here. At the same time, the location of detention may further be a sign of the practicalities of Medical Justice case work. Given that Medical Justice case work stems from cases being referred to the organisation, on the one hand this could emphasise that the particular IRCs featured predominantly here are of particular concern with regard to the treatment of detainees with HIV. On the other, this could reflect the fact that Medical Justice is simply more likely to receive referrals of cases relating to these particular institutions.
- 67 For wider discussion on this point see Fekete, L., and Webber, F. (2010) 'Foreign nationals, enemy penology, and the criminal justice system', *Race & Class*, 51(4), pp. 1-26.
- 68 Hughes, J., and Field, O. (1998) 'Recent Trends in the Detention of Asylum Seekers in Western Europe', in Hughes, J., and Liebaut, F. (eds) *Detention of Asylum Seekers in Europe: Analysis and Perspectives*, CN The Hague: The Netherlands, p. 19.
- 69 See London Detainee Support Group (2010) *No Return No Release No Reason: Challenging Indefinite Detention*, London: London Detainee Support Group.
- 70 Siegel, L., and Sadr-El, W. (2006) 'New Perspectives in HIV Treatment Interruption: The SMART Study', *The PRN Notebook*, 11(2), pp. 8-9.
- 71 Parliamentary Office of Science and Technology (2003) *Postnote: HIV/AIDS in Developing Countries*, No. 210, London: The Stationary Office;
- 72 See for example Fiestas Viñes., Danarajan, S., Malpani, R., Kamal-Yanni, M., Saunders, P., and Atkins, S. (2007) 'Investing for life: meeting poor people's needs for access to medicines through responsible business practices', *Oxfam Briefing Paper 109*, Oxford: Oxfam International.
- 73 For discussion of the ways in which national and international policies have undermined HIV prevention and treatment efforts see Gill, P. op. cit; and Pisani, E. (2008) *The Wisdom of Whores: Bureaucrats, brothels and the business of AIDS*, London: Granta Books.
- 74 Gardner, A. (2006) 'Stop-and-Start HIV Treatment Too Risky', *HealthDay News*, 29 November, <http://news.healingwell.com/index.php?p=news1&id=536329>
- 75 British HIV Association and the National AIDS Trust (2009), op. cit, p. 10.
- 76 *The Queen on the application of TN (Vietnam), CJ (Dominica) and MD (Angola)*, [2010] EWHC 2184 (Admin), 30 July 2010.
- 77 Cited in Ibid. Para. 30.
- 78 Ibid. Para. 27.
- 79 For discussion see, for example, Poinisky, L. Harding Douglas, P. and Metroka, C. (1992) *The Essential HIV Treatment Fact Book*, New York: Pocket Books.
- 80 Scharer, L. L., and McAdam, J. M. (1995) *Tuberculosis and AIDS: The Relationship Between Mycobacterium TB and the HIV Type 1*, New York: Springer Publishing, p. 10.
- 81 This case study is also presented as 'Case Study 6' in the Medical Justice report 'State Sponsored Cruelty: children in immigration detention'. See Burnett, J., Carter, J., Evershed, J., Bell Kohli, M., Powell, C., and de Wilde, G. (2010) op. cit, p. 41.
- 82 Written testimony. Case Number: 3.
- 83 CD4 cells are one of the cells in the body which are attacked by the HIV virus.
- 84 Home Office (2010) 'New contract for escorting detainees', *Home Office News*, 29 October, <http://www.homeoffice.gov.uk/media-centre/news/escort-detainees> It should be noted that the Home Office stated that the decision to discontinue the contract with G4S was based on financial reasons, rather than the death of Jimmy Mubenga.
- 85 British HIV Association and the National AIDS Trust (2009), op. cit, p. 11.
- 86 In the official terminology such activities are referred to as 'enforcement visits'. We, however, use the more commonly accepted term 'dawn raid'.
- 87 Written testimony. Case Number: 31
- 88 Civil Aviation Authority (2008), op. cit.
- 89 Written testimony. Case Number: 28.
- 90 Written testimony. Case Number: 6.
- 91 Cited in Richardson, H. (2010) "Never nice for children" - life in a detention centre', *BBC News Online*, 17 February, <http://news.bbc.co.uk/1/hi/education/8518742.stm>
- 92 This is discussed in more detail in the methodology.
- 93 This includes 5 detainees who disrupted their own regime.
- 94 For more discussion on this point see Birnberg Peirce & Partners, Medical Justice, and the National Coalition of Anti-Deportation Campaigns (2008) *Outsourcing abuse: the use and misuse of state-sanctioned force during the detention and removal of asylum seekers*, London: Birnberg Peirce & Partners, Medical Justice, and the National Coalition of Anti-Deportation Campaigns; and Burnett, J., Carter, J., Evershed, J., Bell Kohli, M., Powell, C., and de Wilde, G. (2010), op. cit.
- 95 Written correspondence between the Foreign and Commonwealth Office and the European Court of Human Rights, 23 December 2009.
- 96 Freedom of Information Act Request Reference FOI 652. This information is publicly available at http://www.whatdotheyknow.com/request/amount_of_art_medication_given_t#incoming-118425
- 97 See for example Mellins, C. A., Havens, J. F., McDonnell, C., Lichenstein, C., Uldall, K., Chesney, M., Santamaria, E. K., and Bell, J. (2009) 'Adherence to antiretroviral and medical care in HIV-infected adults diagnosed with mental and substance abuse disorders', *AIDS Care*, 21(2), pp. 168-177; and New York State Department of Health AIDS Institute in collaboration with the John Hopkins University Division of Infectious Diseases (2006) *Adherence to Antiretroviral Therapy Among HIV-Infected Patients With Mental Health Disorders*, New York: New York State Department of Health AIDS Institute in collaboration with the John Hopkins University Division of Infectious Diseases.
- 98 See the National Coalition of Anti-Deportation Campaigns (2009) 'Self-harm in immigration detention', *NCADC News Service*, 9 December, <http://ncadc.wordpress.cpm/2009/12/08/self-harm-in-immigration-detention/>; and (2009) 'NCADC News Service Friday 13th February 2009', *NCADC News Service*, 13 February, <http://www.ncadc.org.uk/archives/13Feb.html>
- 99 The most authoritative account is provided in Athwal, H. (2006) *Driven to desperate measures*, London: Institute of Race Relations.
- 100 Written testimony. Case Number: 10.
- 101 *RS and Others (Zimbabwe – AIDS) Zimbabwe CG* [2010] UKUT 363 (IAC)
- 102 Written correspondence between the Foreign and

Commonwealth Office and the European Court of Human Rights, 23 December 2009.

- 103 See Burnett, J. (2010) 'Repatriation Medicine', *Criminal Justice Matters*, 82, pp. 26-28.
- 104 After being elected in 2010, the coalition government pledged to end the use of Dungavel to detain children, and announced that children would be screened there before being transferred to Yarl's Wood.
- 105 At the time of writing the coalition government has reneged on its promise to end the detention of children for immigration purposes. Children are still being detained in Yarl's Wood, albeit in reduced numbers. In December 2010 Deputy Prime Minister announced plans to detain children in institutions other than IRCs.
- 106 There is a wealth of literature on sampling techniques. See for example Babbie, E. (1998) *The Practice of Social Research*, 8th Edition, Belmont, CA: Washington.
- 107 See Arnold, F. (2008) 'Clinical Director's Report', in *Medical Justice Annual Report 2008*, London: Medical Justice, p. 5.
- 108 See <http://www.medicaljustice.org.uk/content/view/68/100/> for further information about the detail that may be provided when cases are referred to Medical Justice.
- 109 Jupp, V., Davies, P., and Francis, P. (eds) (2000) 'Planning Criminological Research', in *Doing Criminological Research*, London: Sage, pp. 131-133.

Its very stressful when you are going through all that when you are HIV. Its the worst moment in life when you are detained.

South-harrow police station I missed my medications for almost two days because I was told that I had to be examined by a doctor first, ~~and then~~ when the doctor came two days later, I wasn't even examined.

I missed the medication for 2 weeks. There were always telling me these no medication. Some ~~the~~ time they will say am not sick. am pretending to be sick.

On the 25th / 06 it was my appointment date, they wanted to handcuff me to hospital, when I told them its impossible for me to walk while holding my walking stick, they told me to go back to my cell, that is at Coln brooke.

Our children at first they didn't know that we were/had HIV, but they knew when we went to the detention center. The doctor asked questions about our sickness & front of our children and that broke their hearts and more stressed.

11/05/09, I was subjected to immigration raid before 6am. They came so many together with police officers and dogs and treated me like a criminal. No warrant was served, I was not allowed to take my crutches which I was using at the time, handcuffed and escorted into a waiting van. My girlfriend ~~and~~ ~~Cousin~~ who was nursing me and Cousin who came to visit because I was not well, were also arrested.

They was any outbreak of chicken pox and with my flawed immune system I asked for guarantees if I would be okay. But it took them 3 and half weeks to transfer me to Hammonds worth without my medication as I refused to sign a paper of responsibility if any thing happened to my health, as Crookhouse wanted to cover themselves up.