

Torture and the UK's 'War on Asylum'

Medical Power and the Culture of Disbelief

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Abstract This chapter explores medical power in the UK's 'war on asylum', examining how medical expertise has been undermined in the asylum process when this expertise is utilised to add weight to asylum seekers' claims to have experienced torture. It examines how there have been attempts to narrow the definition of torture in ways which exclude people from the protections to which torture survivors are entitled. It explores the extent to which medical power has been complicit in riding roughshod over existing safeguards to prevent further harm to those who have experienced torture, and also, crucially, how this form of power has been and continues to be challenged.

Keywords Immigration detention. Torture. Asylum seekers. Border control. Medical power.

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1 Introduction

When the now 'iconic' images of shackled, humiliated and dehumanised detainees in the Abu Ghraib prison complex in Iraq were broadcast globally, in the mid-2000s, the relationship between medical power and torture in the 'war on terror' was also thrust sharply into focus. Graphic images of coalition troops photographing and posing in front of hooded, naked prisoners forced into a 'human pyramid', and of people made to wear animal collars, indicated a regime in which degradation had a defining role. The photograph of a soldier gloating over the corpse of a man who had died as a result of torture was just one picture of a network of interrogation camps in which detention by coalition forces could be fatal. Yet if there were any expectations that the presence of medical personnel may have checked this violence, these were shattered by the fact that clinicians – in some cases at least – were integral to its practice. "It is now beyond doubt that Armed Forces physicians, psychologists, and medics were active and passive partners in the systematic neglect and abuse of war on terror prisoners", wrote Steven Miles in 2009 (Miles 2009, X). And as he continued, this involved providing interrogators "with medical information to use in setting the nature and degree of physical and psychological abuse during interrogations". It involved monitoring "interrogations to devise ways to break prisoners down or to keep them alive" (2009, X). It involved pathologists holding back death certificates and autopsy reports in order to minimise the number of fatalities or cover up torture-related deaths as deaths by natural causes (Ibid). Procedures including "cramped confinement, dietary manipulation, sleep deprivation, and waterboarding" were among the practices that were "at times [...] legally sanctioned due to medical supervision" in the context of the "war on terror", according to Hoffman (2011, 1535). He continued to suggest that doctors are not just important to "modern torture methods", they are "irreplaceable".

The role of medical power in the practice of torture has been subjected to sustained critique in the context of the "war on terror". However, what follows examines the relationship between medical power and torture in the context of what has been depicted – metaphorically – as another (although to some extents related) 'war': the 'war' on asylum. According to the UNHCR (UN, UNHCR 2017, 3), between 5 and 35 per cent of those asylum seekers who have been granted refugee status have survived torture. And focusing on the UK as a case study, this chapter examines the institutional and legal structures prohibiting torture and inhuman and degrading treatment, particularly as they apply to those subject to immigration control in this context. But further, it also examines the ideological and political conditions within which claims by those seeking asylum that they have been subjected to torture prior to arrival can be (and

have been) ignored, downplayed and denied. It examines how medical expertise has frequently been undermined in the asylum process when this expertise is utilised to add weight to asylum seekers' claims to have experienced torture. It examines how there have been attempts to narrow the definition of torture in ways which exclude people from the protections to which torture survivors are entitled. But it also explores the ways in which segments of the medical profession have been complicit in riding roughshod over existing safeguards to prevent further harm to those who have experienced torture, thus potentially compounding its effects. In particular, it examines claims that in certain contexts clinicians have administered dangerous 'care' in order to ensure the removal of people from the UK, despite them claiming that they - or their family members - face serious harm and persecution on arrival as a result of this.

In a historical discussion of medical involvement in torture, Giovanni Maio (2001, 1609) has noted that from its earliest incarnations one of the features of torture has been its use as an "oppressive instrument used in the preservation of power". Furthermore, whilst methods of torture have certainly "developed", and continue to do so, he argues, this "function" of torture is "especially relevant today" (1609). This chapter argues that the (mis)treatment of those in the UK who say they have been tortured preserves and is bound up with a particular manifestation of state power: the aims, rationale and dictates of immigration control. Its claims are perhaps much more mundane than the forms of direct medical complicity in torture alluded to above. But they are nonetheless important. For it is argued that the acts of omission and *commission* documented in this chapter expose the tensions between the rights of certain 'categories' of migrants to be afforded adequate clinical care on the one hand, and the goals and aims of immigration control itself on the other. This poses profound questions about the functions of clinical care and the ethical duties, responsibilities and obligations of clinicians, it is suggested. But as this chapter also crucially explores, this is a form of power that many within the medical profession have historically challenged, and continue to do so.

2 A 'War' on Asylum?

Metaphors of a 'war' on asylum in the UK are, of course, open to accusations of hyperbole. There has never been a direct declaration of 'war' on asylum by British governments (as aggressive and vitriolic as much rhetoric certainly has been). And given that neither has there ever been its formal instigation - at least in its narrowest sense - why do scholars refer to a 'war on asylum' as a term at all (see for example, Burnett 2015; Kundnani 2007; Philo, Briant, Donald 2013; Web-

ber 2006)? Indeed, more to the point, is this even a helpful metaphor to do so? We argue it is; and the reason for this is that we suggest it goes at least *some* way to contextualising the (mis)treatment of those who have been (or claim to have been) subject to torture or indeed may face it. As such, before examining the infrastructural framework with regard to torture and the asylum system, the following briefly examines the extent to which an ideological construct of a 'war on asylum' has punctured understandings of such issues in the UK. Indeed, without wanting to be reductive – and certainly without wanting to suggest that this is not contested –, it nonetheless argues that such discourses cannot be ignored when examining policy frameworks with regard to the treatment of asylum seekers, not least with regard to torture.

2.1 Tropes of Invasion

It is well established that dominant discourses, portrayals and representations of those subject to immigration control in the UK have frequently been underpinned by a *language* of threat, combat and violence. Perhaps the most high-profile example of this in recent years is the infamous *Sun* article by the columnist Katie Hopkins, in 2015, in which she stated that “What we need are gunships sending these boats back to their own country!” with reference to migrants attempting to reach Europe by the Mediterranean Sea. According to Hopkins, “these migrants” are “like cockroaches [...] built to survive a nuclear bomb”; and she continued to suggest that “Once gunships have driven them back to their shores”, their “boats need to be confiscated and burned on a huge bonfire”.¹

Such was the level of vitriol in this column that it prompted an intervention by the United Nations High Commissioner for Human Rights, Zeid Ra'ad Al Hussein. As he suggested, the depiction of people as “cockroaches” echoed language used by the Nazis in the 1930s and also prior to the genocide in Rwanda in the 1990s. However, from his perspective, although particularly venomous, this column was nonetheless symptomatic of “decades of sustained and unrestrained anti-foreigner abuse, misinformation and distortion” by segments of the British media.² Indeed, since the 1990s, at least, an “asylum invasion complex” has intensified in certain media discourses in the UK, according to Tyler (2013). And as Kundnani (2001, 46) has docu-

¹ Katie Hopkins, “Rescue Boats? I'd Use Gunships to Stop Migrants!”, *The Sun*, 17 April 2015.

² <https://www.ohchr.org/EN/NewsEvents/Pages/DisplayNews.aspx?NewsID=15885&LangID=E> (2019-11-07).

mented in a powerful analysis of this process, one newspaper editor in the late 1990s depicted asylum seekers as the “scum of the earth” who were “targeting our beloved coastline”, before appealing to his readers to “clear the backdraft of a nation’s human sewage”. Whilst in turn, content analysis of media coverage in 2008 highlighted how asylum seekers were frequently depicted as a “threat”, a danger and as harbingers of criminality (Khan 2012, 68).

Now of course, this is not to underplay the extent to which narratives are resisted. Not all media is the same, and there have been attempts to counter such tropes (for earlier discussion with regard to this, Smart et al. 2005). However, when set against this backdrop, a British newspaper cartoon appearing to liken Muslim migrants to vermin in 2015,³ for example, or headlines calling for the army to resolve the Calais “illegal immigrant crisis”,⁴ ought not to be seen as isolated events. Rather, they are part of a pattern of coverage about which significant concerns have been expressed over many decades (Smith, Deacon 2018). In Philo, Briant and Donald’s (2013, 33) content analysis of media coverage of asylum seekers and refugees in 2011, for instance, they noted repeated references to natural disasters when discussing migration, including references to being “swamped”, of “soaring” numbers of people, of “waves”, of “masses” and of people “flooding in”. Meanwhile, in 2015, a report prepared for the UNHCR examining press coverage of the “migration crisis” in five EU states (Sweden, Germany, Italy, Britain and Spain) noted that “coverage in the United Kingdom was the most negative”. Although some UK coverage was “sympathetic”, it suggested, the “right-wing press in the United Kingdom expressed a hostility towards refugees and migrants which was unique” (Berry, Garcia-Blanco, Moore 2015, 10).

In such a context, then, the point is not just that Hopkins’ column above is indicative of long-standing hostile outlook with regards to migration. So too is her demand for a violent response. Perhaps this has been at its most transparent with regard to migrants in Calais, France, who in at least some cases may have wanted to travel to the UK. Calais occupies a particular place in discourses around irregular migration to the UK, and is frequently held up as a ‘weak point’ in British immigration control. As such, when the ‘jungle’ camp in Calais was demolished by French authorities in 2016, this was presented by some segments of the British media as a victory in an ongoing war of attrition. Indeed, as Bhatia (2018) has noted, this was championed as “The battle of Calais” by one paper, which continued to de-

³ Aubery Allegretti, “Daily Mail Cartoon Comparing Refugees To Rats Is ‘Islamophobic’”, Richard Burgon MP Claims”, *The Huffington Post UK*, 19 November 2015. URL <https://bit.ly/2BX7i0k> (2019-10-30).

⁴ James Slack et al., “Calais: Send in the Army”, *Daily Mail*, 20 July 2015.

scribe the destruction of destitute migrants' accommodation and in some cases possessions as a victory over "invaders", as well as "illegals, transgressors and security threats".

Moreover, while such 'invasion' metaphors have certainly been resisted, it is also important to recognise that in some contexts they have not just been confined to media discourses, but have also been both reproduced and took their lead from political and establishment figures. Writing in the *Daily Mail* in 2001 about his time as Deputy Prime Minister between 1996-97, for example, Michael Heseltine noted that he came to three "stark conclusions" about asylum seekers. "The first is that a very large number [...] are cheats, quite deliberately making bogus claims and false allegations in order to get into this country", he suggested. The second "was that the demands on scarce housing and medical care made by dishonest 'economic migrants' (were) likely to stretch the patience of voters". Whilst the third was that "the problem of phoney asylum seekers was likely to grow as the impression spread that this country was a soft touch".⁵ Meanwhile, speaking to the Home Affairs Select Committee in 2006 about suggestions that the Home Office was not "fit for purpose", former Home Secretary Jack Straw suggested that the "fundamental problem" was not "the quality of the staff". It was "the nature of the individuals it has to deal with [...] They are dysfunctional individuals many of them - criminals, asylum seekers, people who do not wish to be subject to social control" (cited in Mulvey 2010, 445). As above, the issue here is not just that *some* political figures, in *some* particular contexts, have *sometimes* made political capital from articulating asylum seekers as a threat. Nor, in fact, is it that there has been (and continues to be) a certain level of symbiosis between media and elite discourses around asylum and irregular migration. The issue is that if the metaphor of a 'war' on asylum has some conceptual relevance, it is because in both discursive *and* in practical ways there is a body of evidence to suggest that individuals' rights and access to human rights have been suspended or disregarded with regard to policy in this context - including with regard to the treatment of torture. It is to this that this chapter next turns.

⁵ Cited in John Grayson, "The Shameful 'Go Home' Campaign", *IRR News*, 22 August 2013. URL http://www.irr.org.uk/news/the-shameful-go-home-campaign/#_edn8 (2019-10-30).

3 Torture, Health Needs and the 'War' on Asylum

In the UK, torture is prohibited under section 134(1) of the Criminal Justice Act 1988, which defines it as the infliction of severe pain or suffering by a public official in the "performance or purported performance of his public duties". Further, the right to be free from torture is embodied in a range of international human rights instruments including the Universal Declaration of Human Rights (UDHR) (1948), the International Covenant on Civil and Political Rights (ICCPR) (1976) and the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment (CAT) (1987) (for discussion, Redress 2018, 7). Article 3 of the Human Rights Act 1998 protects an individual from mental or physical torture, inhuman and degrading treatment or punishment, and deportation/extradition to a place where there is a real risk of facing any of the above. It also obliges states to intervene to stop these rights being breached, to not rely on evidence obtained through torture and also to investigate allegations of these rights being breached (Liberty 2010). As such, whilst the above is certainly not exhaustive, it nonetheless outlines certain key principles regarding the prohibition of torture or degrading and inhuman treatment; and within these, the right to be free from torture is absolute. However, in the context of the 'war on asylum', there have been concerns repeatedly raised that these protections have been undermined in a range of interrelated ways, of which several are necessary to examine briefly here.

3.1 The Culture of Disbelief

First, a widely-cited 'culture of disbelief' among at least some of those involved in decision-making processes with regard to asylum cases has intensified, eroding protections against torture in the process. In 2010, for example, a case worker in one UK Border Agency locale alleged that staff involved in deciding asylum claims humiliated, degraded and tricked applicants whilst simultaneously taking pride in refusing applications. It was claimed that there was a toy gorilla in the office - colloquially known as a 'grant monkey' - which was put in the decks of those who accepted claims as a badge of shame. Moreover, the whistleblower suggested that applicants were denied basic safeguards (such as interviews being recorded), with one senior employer allegedly going as far as stating "If it was up to me I'd take them all outside and shoot them". These claims (aside from the presence of the stuffed toy) were denied by the UK Border Agency after an investigation (UK Border Agency 2010). But there can nonetheless be little doubt that over the last few decades an increasing proportion of claims have been initially refused, even in the Home Office's

terms, wrongly. For example, between 1984 and 2017, the proportion of claims initially refused almost trebled, from around 23 per cent to 68 per cent. Yet in 2017, some 37 per cent of asylum appeals against negative decisions were allowed (Blinder 2019; Sturge 2019, 7). In turn, these appeal rates must be set against a concerted attack on the *right* to appeal, which has significantly undermined the ability to engage with the appeals process at all.⁶

Second, this culture of disbelief has fundamental implications with regard to those who claim to have survived torture; for even when clinicians provide medico-legal reports suggesting that applicants may have been subject to torture, these claims have nonetheless frequently overridden by caseworkers. This was made clear in the starkest terms in 2016, when Freedom from Torture (set up in 1985 as the Medical Foundation for the Care of Victims of Torture) examined the case files of a sample of 50 asylum seekers that it worked with, who said they had experienced torture and whose claims had initially been refused. According to their data, in 74 per cent of these cases, caseworkers substituted their own opinion for that of the clinicians with regard to the cause of injuries. In 54 per cent of the cases, the worker demonstrated a poor understanding of the Istanbul Protocol with regard to torture claims.⁷ And in *every single case*, the caseworker applied the wrong standard of proof with regard to torture (Freedom from Torture 2016, 14-15). To put it differently, suggestions that applicants had experienced torture by those with medical expertise were routinely, and erroneously, overridden by those without. What is more, this is not just confined to caseworkers in initial claims. When Tamil asylum seeker 'KV' appealed against a refusal in 2011, for example, he submitted medical opinion stating that scarring from having heated metal rods applied to the skin were "highly consistent" with his account of torture. However, the Asylum Tribunal dismissed this appeal, and the Court of Appeal went as far as saying that the clinician had "trespassed" into the role of decision maker. It was consequently left to the Supreme Court, in *KV (Sri Lanka) v Secretary of State for the Home Department* (2019), to rule that the lower courts had overruled the clinician wrongly, and that it was in fact part of a clinician's role.⁸

⁶ Jo Wilding, "Revealed: Legal Advice for Asylum Seekers Disappearing Due to Legal Aid Cuts", *The Conversation*, 15 November 2017. URL <https://theconversation.com/revealed-legal-advice-for-asylum-seekers-disappearing-due-to-legal-aid-cuts-86897> (2019-10-30).

⁷ Under the Istanbul Protocol, which was adopted by the United Nations in 2000, physicians should indicate whether lesions are "not consistent" with the trauma described, "consistent with", "highly consistent", "typical of" or "diagnostic of".

⁸ *KV (Sri Lanka) (Appellant) v Secretary of State for the Home Department (Respondent)* (2019), Supreme Court, UKSC 10, On appeal from: [2017] EWCA Civ 119. URL <https://www.supremecourt.uk/cases/docs/uksc-2017-0124-judgment.pdf> (2019-10-30).

Indeed, whilst there may well be between 5 and 35 per cent of refugees who have been subjected to torture, there is in all likelihood a further, unsubstantiated number of people who have been subjected to torture but not been granted some form of protection. Some, no doubt, have been returned to countries from where they initially fled: a fact that was not lost on the UN Committee Against Torture in June 2019 in a damning report which noted how the UK failed to publish any data regarding the number of people removed who have said they face torture in the destination country (UN Committee Against Torture 2019, 10-12). When “credible medical evidence of past torture” is “arbitrarily rejected”, it stated, this results in the “arbitrary denial of asylum claims made by victims of past torture” (2019, 10-12). Others, however, are frequently forced into complete destitution – joining the hundreds of thousands of people denied access to many mainstream services, unable to access housing and like all those in the asylum process, not allowed to work. It is somewhat ironic, to say the least, that those who have survived torture are pushed into this situation. For when Section 55 of the Nationality, Immigration and Asylum Act 2002 introduced provisions to make asylum seekers who had not claimed asylum as soon as “reasonably practical” after they had arrived in the UK to be made destitute, the High Court ultimately ruled that it violated Article 3 of the Human Rights Act as inhuman and degrading treatment (Webber 2014, 96-100). With regard to ‘refused’ asylum seekers though, the practice has only since intensified.

4 Torture and the UK ‘Detention Estate’

What the above indicates then is that the culture of disbelief cited does not just manifest itself through decision-makers within the asylum system, it is also frequently given legitimacy and structured within distinct policy measures which enable it to flourish. Perhaps the clearest manifestation of this has been with regard to immigration detention. Around 24,700 people entered immigration detention in the UK in 2018. And in the Detention Centre Rules (which came into force in April 2001 and were amended most recently – at the time of writing – in 2018) there are explicit provisions to guard against the detention of torture survivors (Detention Centre Rules 2001⁹). In particular, Rule 35 of these rules operates as a mechanism through which doctors in Immigration Removal Centres (IRC¹⁰) must report on detainees whose health may be “injuriously affected” by either continued detention or the conditions of detention, along with those suspected

⁹ <http://www.legislation.gov.uk/ukSI/2001/238/contents/made> (2019-11-07).

¹⁰ We use the terms IRC and detention interchangeably.

of having “suicidal ideations”. The Rule 35 report is passed on via a Home Office team at detention, to a casework unit/caseworker managing the individuals’ case. The report is in theory supposed to ensure that detainees at risk are brought to the attention “of those with direct responsibility for authorising, maintaining and reviewing detention” (Home Office 2019, 20). Whilst in turn, this report can – and indeed in many cases *should* – trigger the individual in question’s release. As such, although torture is certainly not the only “category” covered in this schema (for example, it also covers having been a victim of sexual or gender-based violence and human trafficking, among other things; Home Office 2019, 20), given the above-mentioned number of detainees who potentially may have been tortured it is a key safeguard with regard to significant human rights abuses.

4.1 Failures of Rule 35 in Identifying Torture Victims

Whilst the principle behind Rule 35 is quite clear, its operation is far opaquer – at best. In 2012, the charity Medical Justice documented in detail the extent to which Rule 35 is overridden, ignored and ultimately frequently ineffective in its own stated terms, analysing the medical records of 50 immigration detainees who should theoretically have been covered under its remit (Tsangarides 2012). First and foremost, the report identified a lack of scrutiny, monitoring and accountability within the Rule 35 process, and this resulted in vulnerable individuals being routinely detained. Second, it uncovered that the definition of ‘torture’ was not adequately offered within the Rule 35 guidance, and neither was it clear as to how caseworkers should interpret and respond to the information contained within the report. Third, the majority of healthcare teams in IRCs were contracted out to private healthcare providers (although these teams nonetheless had to comply with Home Office’s *Detention Services Operating Manual*; Home Office 2005). Despite the importance of the guidance, authorities consistently failed to conduct internal audit of the functioning of the Rule 35 process. Furthermore, the healthcare providers were not subjected to robust clinical accountability, and the safety and quality of their care was not scrutinised by independent medical bodies. Since its creation, Rule 35 has been severely criticised. For instance, over a decade ago, the Joint Commission on Human Rights highlighted the disjoint between the policy and practice – the report stated:

We are not satisfied that the quality of healthcare currently provided to asylum seekers in detention is fully compliant with international human rights obligations, in particular the rights to freedom from inhuman and degrading treatment and to the enjoyment

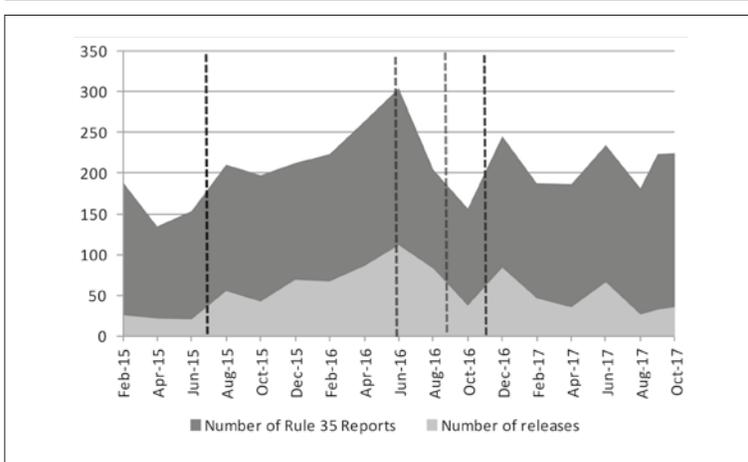


Figure 1 Total Rule 35 Reports vs. Number of Releases (source: Shaw 2018, 38)

of the highest attainable standard of physical and mental health. We are particularly concerned about gaps in care for people with HIV and with mental health problems. It is not clear that procedures for identifying and supporting torture victims work in practice. We recommend that the Department of Health establish a policy for supervising the health services that are available in detention centres, and that the standard of services should be monitored. (Joint Commission on Human Rights 2007, 101)

The above recommendations appear to have been largely ignored by the Home Office, and to this date there continues to be a system wide failure in identifying and protecting vulnerable subjects. More recently, in 2018 (and after previously highlighting inconsistencies within the Rule 35 process in 2016), a report compiled by Stephen Shaw, the former Prisons and Probation Service Ombudsman, once again expressed a strong concern and lack of confidence in the Rule 35 mechanism (Shaw 2016). It alluded to the fact that assessment was routinely rejected by the Home Office for minor inconsistencies. Furthermore, Shaw (2016, 49) identified that clinical staff were not competent enough to interpret “what constituted torture”. Of course (and as mentioned earlier), these also indicate a widely prevalent culture of disbelief and denial, and Shaw argued for a significant cultural shift in casework areas. The above figure shows the number of Rule 35 reports completed versus small numbers of individuals released.

The **fig. 1** also directs the attention to the extent of neglect and abandonment of vulnerable people. There are a number of individuals who do not appear in the above figure, as they slip through the Rule 35 assessment altogether. This may be due to medical practitioners not being able to identify torture, assessments being conducted by an unqualified person, or the production of report consisting of descriptive and inconclusive information. In Bhatia's (2014), a voluntary sector psychiatrist explained:

I must have seen over 600 people in detention over last 5 years... 150 had medical 'care' which was disastrous, and individuals needed urgent medical attention. All the rest were almost an exception i.e. wrongfully detained... very recently I attended two torture cases: in one case, the Rule 35 report mentioned "no signs of torture" and I counted 15. The other one at Yarl's Wood [IRC] stated "no scars" and I counted 30 scars, 30! [emphasis added by the interviewee]. On many occasions detention authorities have taken weeks to respond to the external [charity sector] doctor's reports, causing further damage to the detainee's health. They just don't seem to recognise what's going on... I will give you another recent example: I attended a torture victim, who was 'tasered' [shot by taser gun] in her country of origin. The detention centre nurse, with the help of an interpreter, had written over 4 pages worth of notes and not mentioned about any of the scars and concluded that "she was not tortured". Well, to start with, it should have been a doctor examining the detainee according to the detention rules - which describes that "medical practitioner shall..." which by the legal definition is a doctor on the medical register and not a nurse. (interview with Dr Aaron in Bhatia 2014, 184)

There have been several proposed amendments to immigration and asylum legislation in order to counteract the above systemic failures and culture of disbelief, of which two will be briefly outlined here: the first asking for exemption of torture victims from detention, and the second for a requirement to detail specific action taken for each Rule 35 Report. However, both these amendments were rejected and instead a decision was taken by Home Office to improve the operational guidance (Tsangarides 2012). As noted throughout this section, this has clearly not been sufficient. Moreover, in another recent report released in 2018, the Chief Inspector of Prison sampled ten Rule 35 assessments, out of which nine had detailed the evidence of torture. Nevertheless, the Home Office maintained detention of all but one of these examples. Needless to say, this amounts to the unlawful detention of torture victims, and causes the re-traumatisation of survivors (see § 5). According to figures released under the Freedom of Information Act, the Home Office were challenged in the Court on

numerous occasions and paid nearly £10million in compensation for wrongful detention between 2011 and 2013.¹¹ This figure increased to approximately £16million between 2013 and 2017.¹²

4.2 Failures of Adults at Risk Assessment

The 2016 Shaw Report found that “many practices and processes associated with detention are in urgent need of reform” (Shaw 2016, 91). The Conservative government publicly accepted the broad thrust of the report and subsequently introduced an “Adults at Risk” policy. The policy sets out a framework for identifying different levels of vulnerability by using a series of risk categories. Under the policy, the Rule 35 report is completed by medical practitioners and sent to the Home Office workers, who then need to conduct an assessment based on the report and release individuals. Whilst on the surface this appeared to be a streamlined and robust process, the approach was filled with flaws and often failed to identify vulnerable people altogether. In 2018, the charity Bail for Immigration Detainees (BID) released a report based on 30 detainees’ casework files, analysing the success of this policy in identifying and protecting individuals (BID 2018). Eighty per cent of their sample were defined as being “at risk” by a medical practitioner. The diagnosed conditions and vulnerabilities were most commonly Post-Traumatic Stress Disorder, depression and suicidal tendencies, with two thirds recorded as being torture victims. However, the Level 3 (high risk) category was rarely designated even to the most vulnerable of clients (which in part explains the disparity in release of vulnerable individuals even if their Rule 35 is completed, highlighted in **fig. 1**). Only one detainee was designated as a Level 3 risk and subsequently released. BID further stated that Home Office decision makers (who are *not* medically qualified) were conducting the Adult at Risk assessment. Historically, the individual health concerns are considered secondary, when compared to the immigration control imperatives. The Home Office is yet to release accurate figures of how many ‘at-risk’ individuals were removed from the United Kingdom – in the 12 month period before and after the implementation of the Adults at Risk policy. As such, this begs the question: how many of these individuals were victims of torture, or individuals experiencing active suicidal ideation and serious mental distress at the time of removal?

¹¹ “Compensation Paid Out for Unlawful Detention from 2011 to 2013”, *Home Office*, 22 October 2014. URL <https://bit.ly/32Zn47h> (2019-10-30).

¹² May Bulman, “More than £500m Spent on UK Immigration Detention Over Four Years”, *The Independent*, 5 February 2018. URL <https://bit.ly/2pg8EB1> (2019-10-30).

The other major issue with the policy was that it significantly narrowed the definition of torture. The Home Office drew upon the United Nations Convention Against Torture (UNCAT) definition, which was previously rejected in the case of *R (on the application of EO, RA, CE, OE and RAN) v Secretary of State for the Home Department* [2013] EWHC 1236 (Admin).¹³ The UNCAT definition was restrictive and it excluded categories of victims of non-state severe ill-treatment who are equally vulnerable to harm in detention as victims of state torture. In 2017, a case was brought against the Home Office by seven individuals affected by the policy. The Home Office was challenged for its use of this restrictive definition on the basis that it carried unacceptable risks for individuals who were unsuitable for detention, but would not be identified or protected. As such the consequences could be significantly detrimental. A judgement was passed in favour of the seven individuals affected by the policy that lacked “rational or evidence base”,¹⁴ and the narrowing of definition was deemed unlawful.

5 Detention, Re-Traumatisation and Repatriation Medicine

The detention centre was the second torture that I had... the first was in DRC and was physical, the second one was psychological.

My time in detention was a nightmare... I found myself having the worst flash backs [of my time in] prison in Cameroon... It was the same event repeating itself twice in detention... I am traumatised... When I see uniformed people I get so frightened. My health is getting worse. My time in detention is something I won't wish my enemy to experience. The whole atmosphere is one of panic.

I was so depressed in detention... it reminded me of torture in Cameroon, they beat me and caused nerve injury to me.

I am traumatized from torture from my country and now feel I am being punished again. (Research Participant; Tsangarides 2012, 46)

No [any other] human being should be treated like that, you suffer in the hands of those who you think will offer support and keep you safe. There are so many victims of torture in there but the

¹³ <https://www.landmarkchambers.co.uk/resources/cases/r-on-the-application-of-eo-ra-ce-oe-and-ran-v-secretary-of-state-for-the-home-department-2013-ewhc-1236-admin> (2019-10-30).

¹⁴ “High Court Rules Government Redefinition of Torture in Immigration Detention Policy is Unlawful”. *Medical Justice*, 10 October 2017. URL <http://www.medicaljustice.org.uk/high-court-rules-government-redefinition-of-torture-in-immigration-detention-policy-is-unlawful> (2019-10-30).

system does not even have time to detect that from the detainees. People do suffer from their origin country and flee to face another torture. Detention in my point of view, it is a torture itself. (Research Participant; Tsangarides 2012, 46)

The UK continues to project itself as a beacon of human rights and refugee protection and having appropriate safeguards. However, as evidenced throughout this chapter, the migration control regime and treatment of at-risk people suggests otherwise. Detention is one of the most contentious areas, not only due to the fact that UK is the only European region to subject people to indefinite confinement – but also because detention is inherently unhealthy (Bosworth 2016) and historically the procedures and practices to safeguard vulnerable people have in many cases miserably failed. For torture victims, the very process of detention can result in re-traumatisation and the exacerbation of mental distress, and as such it is little surprise that individuals experiencing treatment in confinement as describe a “second torture”.

Torture is a reason why Rule 35 is triggered; however, as Bhui argues (quoted in BID 2018, 24), torture is also one of the few reasons why it could be considered. He draws cases to explain that, 60 people who had been considered to be at risk of self-harm, of whom half had been considered to be at high level of risk and placed under constant supervision by the staff, were not offered Rule 35 assessment on suicidal ideation. Indeed, the treatment of victims of torture and those experiencing severe mental distress in IRCs indicates a sheer lack of willingness to protect people from further harm. In Bhatia's research (2014), it was noted that medical negligence and denial of care had serious repercussions. The individuals were not processed correctly and medical staff did not take prompt actions – thereby, amplifying individual suffering – as the following psychiatrist argued:

Detainee was suffering from a serious underlying medical condition; however, s/he continued being detained. I'll tell you what was most shocking – S/he was on anti-epileptic medication which ran out. S/he was then transferred from prison to Yarls Wood [IRC], where the nurse is supposed to see them within 2 hours – which eventually happened. The nurse then mentions in the report that “detainee CLAIMS to be epileptic”. They made no effort to obtain the medical file from the prison, which they should have done, nor did they provide anti-epileptic medication, which they should have done... She ended up having four fits attacks in that month, before they recognised that she might as well be epileptic. The individual was eventually released and received refugee status, and then filed a case for wrongful detention with the help of her lawyer... medical negligence in the detention centre was extra ordinary... (interview with Dr Aaron in Bhatia 2014, 188)

There are also cases where the severity of individual condition is known to the health practitioners, and yet they are not treated adequately and appropriately, and given medication only to somewhat 'manage' their condition. This is done so as to continue detention, even if it has a disastrous health outcome for the person. As a charity manager mentions in Bhatia's research (2014):

Over last 3 months we had two cases, both suffering acute psychosis and one of them almost turned like a vegetable. His condition was that bad. [Individual was] on average 3 years in detention, because they couldn't deport him to Zimbabwe. He was refused bail over 5-6 times and his condition turned very bad.... [continues] the other man was kept in detention for 2 years. The detention centre staff knew that he was suffering from psychosis for over a year and his condition turned so bad that he could not even give us instructions. We had to eventually close his file for some months. And then he gave us a call again at some point asking for help. We eventually arranged for Human Rights solicitors, and bailed him last month... Surprisingly we had a medical report from the Home Office stating that he is schizophrenic - then why was he detained? (interview with Dr Aaron in Bhatia 2014, 187)

It is in this context that Burnett (2010) has questioned whether medical care within the detention estate can be conceptualised as a sub-optimal form of *repatriation medicine*. Here, the role of medical expertise is not so much treatment as the facilitation of immigration control. Immigration controls have constantly attempted to reduce asylum seekers from ontological beings to ontic beings, a mere object of security, power and control. And in this regard, at least in some cases, medical power and expertise within the detention has been mobilised in attempts to remove people from the UK. In 2010, for example, research conducted on the experiences of 141 children and young people in the detention estate identified that at least 50 were facing removal "without being adequately protected, [that] were administered with the wrong drugs prior to removal, or were removed without being adequately immunised" (Burnett 2010, 26). As this research documented, some children were being given inappropriate malarial prophylaxis - known to have potentially dangerous side-effects - in order to ensure that they could be removed on certain flights. Indeed, according to one parent, her child was left coughing up blood as a result.

This is not to suggest that these children and young people had necessarily all arrived in the UK as a result of the experience or threat of torture. Indeed, while some had faced threats prior to arrival, many had been born in the UK itself. It is to say, however, that in some cases their parents said they had experienced torture prior to arrival in the UK; and in all cases said they feared for their life if

they were to be returned. At the very least, this raised questions that remain of central relevance about the role of medical power and the ethical duties of clinicians in the context of immigration and asylum policy, not least with regard to torture.

6 Conclusion

As the sociologist Zygmunt Bauman argued, “[o]ne is tempted to say that were there no immigrants knocking at the doors, they would have to be invented [...]. Indeed, they provide governments with an ideal ‘deviant other’” (Bauman 2013, 56). This chapter has examined how the creation of a “deviant other” in the context of a metaphorical war on asylum has had significant material impacts. Central to its focus has been the undermining of provisions against torture in a myriad of ways, but with specific reference to medical power. It is no secret that a significant proportion of those seeking asylum have experienced torture, and yet it is clear that provisions to protect against this have frequently been undermined. That this can be traced to both the individual actions of caseworkers and clinicians as well as broader political drives and policy documents indicates something about the ways in which institutional practices are located within broader structural frameworks. To put this in another way, measures to combat this must organise on both micro and macro levels at once.

The consequences of not doing so are clear. The damage done to those who have survived torture in the context of this ‘war on asylum’ has time and time again proven to be catastrophic. It has intensified the harms of torture and compounded its effects. Yet whilst this chapter has argued that medical power is a key terrain upon which such damage can be wrought, it is also essential to acknowledge that it is also a key terrain upon which it is being resisted. It is within such networks, in conjunction with those from migrant communities and those who have sought asylum, that attempts to uphold protections against torture are being connected to attempts to resist the state power embedded in the ‘war on asylum’ itself.

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