What are the medical risks of forced deportation to failed asylum seekers and how can they be prevented?

Painting Title: ’24 Hour Removals’

Source: Medical Justice Report‘Outsourcing abuse: The use and misuse of state-sanctioned force during the detention and removal of asylum seekers’

“Having a home, a place where we belong, a place where we feel safe is something most of us take for granted.”

Angelina Jolie, Goodwill Ambassador, World Refugee Day 2010

Word Count: 2,993

Contents

Definitions

Refugee – a person who "owing to well founded fear of being persecuted for reasons of race, religion, nationality, membership of a particular social group or political opinion, is outside the country of his nationality and is unable or, owing to such fear, is unwilling to avail himself of the protection of that country; or who, not having a nationality and being outside the country of his former habitual residence as a result of such events, is unable or, owing to such fear, is unwilling to return to it."[1]

Asylum seeker – "someone who has lodged an application for protection on the basis of the Refugee Convention or Article 3 of the ECHR." [2]

Destitution – the impoverished state asylum seekers are left in after their financial and housing support has been withdrawn following a refusal of refugee status.

Immigration removal centre (IRC) – detention centres where asylum seekers may be kept pending decisions on status or deportation. Asylum seekers can be detained at any time during their application under the Immigration, Asylum and Nationality Act 2006.

Enforced Removal – the enforced deportation of an asylum seeker from the host country.

Voluntary Return- where an asylum seeker returns to their country through a Government assisted scheme.

Abstract

Background

Asylum seekers are currently one of the most socially excluded groups in the U.K. and Government policy over the last few years has become increasingly focussed on the criminal justice system. Many reports of abuse of asylum seekers have surfaced in the press recently, particularly in relation to enforced removals, where asylum seekers are deported to another country. Injuries and even deaths have been reported.

Aim

To investigate what the medical risks, including physical and mental health, of enforced deportation are and what can be done to minimize or prevent these risks.

Method

Journals were searched using PubMed, Medline and Cinahl databases and appraised using the CASP assessment method. Search terms used included: (refugee*, asylum seeker* and deportation). Articles from newspaper websites and reports and statistics from relevant organizations and websites were also used, found through internet search engines. 1 qualitative study on the physical risks of enforced removals and 1 editorial article commenting on the psychological and physical risks of forced deportation were identified.

Results

Asylum seekers being deported often suffer from psychological disorders such as Posttraumatic Stress Disorder (PTSD). Physical risks associated with flying such as limb thrombosis can occur during deportation. Improper restraining methods used by security guards escorting asylum seekers during deportation can result in serious injuries to asylum seekers.

Conclusion

More research needs to be done in this area to provide more data. Only acceptable restraint methods should be used by security guards when escorting asylum seekers during enforced removals, and if an enforced removal fails, a medical examination should be provided to the asylum seeker immediately afterwards and funding for legal action should be provided where appropriate. Special consideration should be taken when deciding whether to deport asylum seekers with mental health problems and asylum seekers should be advised on the physical risks, such as limb thrombosis, associated with flying.

Introduction

To investigate the medical risks of forced deportation, it is important to have an understanding of the global and national situation regarding refugees and asylum seekers. The estimated global population of refugees was 10,396,500 at the end of 2009, according to the latest available UNHCR statistics,[3] The majority of refugees are "internally displaced persons", who seek refuge in neighbouring countries, and the remainder migrate to different continents. In 2009 in the U.K., 30,675 people are reported to have applied for asylum.[4] 280,000 failed asylum seekers are estimated to live in the U.K., the majority in destitution.

It is quite complex to understand how the asylum system works in practice in the U.K. The basics are that an asylum seeker arrives in the U.K. and has to apply for refugee status under the 1951 United Nations Convention Relating to the Status of Refugees (see refugee definition above), either at the border or at a the Home Office's screening unit in Croydon. The asylum seeker is assigned a case owner and attends a first meeting. There is then an Asylum Interview upon which a decision for granting refugee status is based. The Home Office aims to make this decision within 6 months, during which the asylum seeker may be kept in detention. If the application is refused, the asylum seeker is offered to return to their country of origin under the Voluntary Return Program or is forcefully removed. However, there is a right to appeal against the decision. If refugee status is granted, the person is granted an initial 5 years to stay in the country.[5]

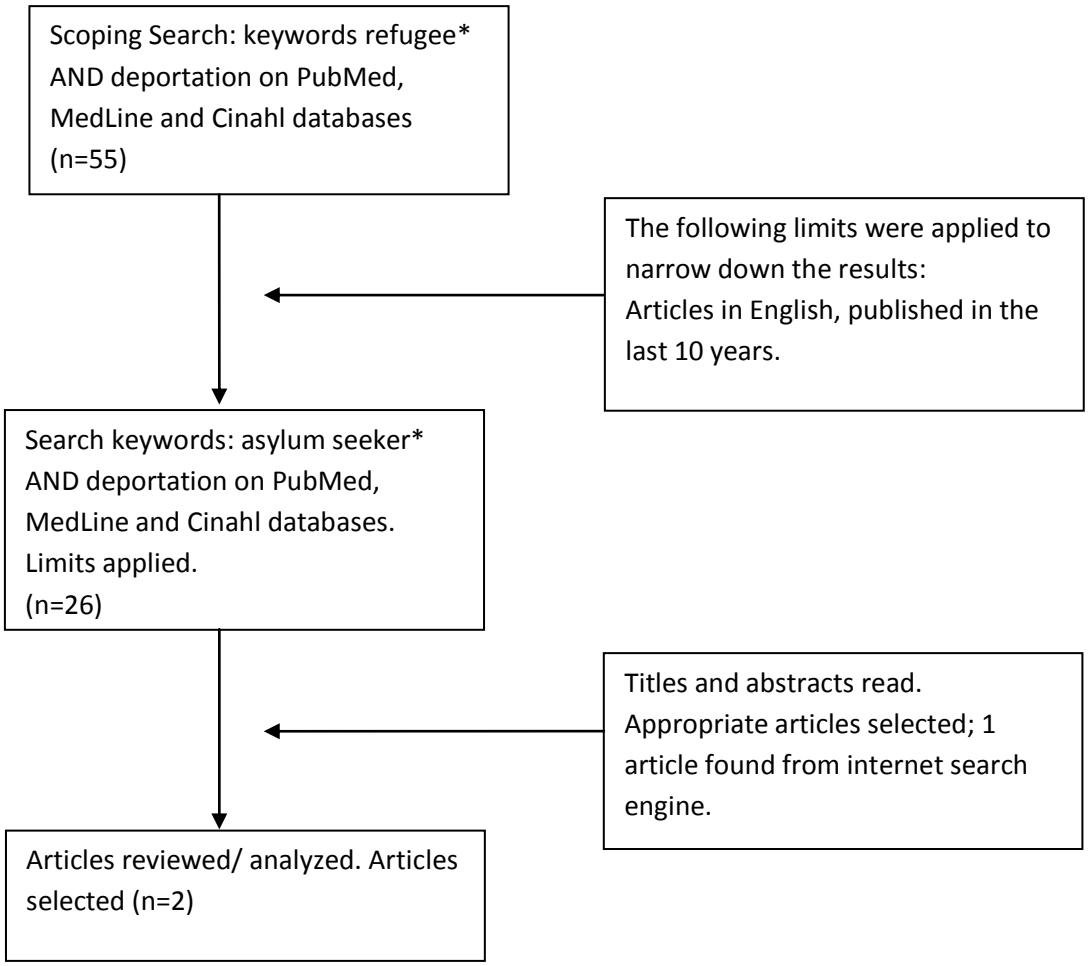
Asylum seekers can apply for financial and housing support through NASS (National Asylum Support Service). They however have no choice in where they can live, and are dispersed around the country depending on where there is available accommodation.[6] After a final refusal, asylum seekers are given 21 days to leave their accommodation provided by NASS, and are then either left destitute or are deported.[7]

In 2009, 11,365 asylum seekers were deported either through enforced removals or voluntary departures.[4] Recently there have been many alleged accounts of abuse during enforced removals in the media, resulting in injuries or death to the asylum seekers being deported. One example of this was the death of Jimmy Mubenga, who appears to have been asphyxiated after being forcibly restrained by guards contracted to carry out Home Office deportations, whilst being deported to Angola on a British Airways flight.[8] Police action is being carried out in relation to this case.[9]

Alleged cases of abuse of asylum seekers during deportations are commonplace. A report titled 'Outsourcing Abuse', carried out by Medical Justice, contains nearly 300 cases of abuse against asylum seekers. One case is that of Noreen Nafuna, a woman in her 30s from Uganda. Excessive force and violence was used during the attempt to transfer her to her seat on the aeroplane that she was going to be deported on. The injuries she sustained as a result of this were 'pain and stiffness to the neck, pain in chest and back, bruising to left thigh and abdomen, handcuff injuries and swelling to the right eye'. At the time this case was published, she was facing re-detention and deportation.[10]

Method

The following search strategy was used in finding articles to review for the research question:



The inclusion criteria for the articles were that they had been published in the last 10 years and that they were in English.

The exclusion criteria for the articles were if they were deemed to not be relevant to the research question.

The qualitative study was critically appraised using the CASP assessment tool. The ten questions used in this tool were applied to the study and the study satisfied most criteria.

Other information was gathered from websites and organizations that work with refugees and asylum seekers and are listed in the reference list.

Results

One of the articles identified was a commentary by Austrian authors on the psychological and physical risks that asylum seekers face during flight deportations. It found that the physical risks involved in flight deportations include dehydration, pulmonary embolism, thrombosis, respiratory problems and transmission of tuberculosis. In terms of psychological risks, it stated that many refugees are traumatized and suffer from PTSD (Post Traumatic Stress Disorder).[11]

The other article reviewed was a qualitative study of 14 failed asylum seekers in the U.K. who were interviewed and medically examined by doctors after alleging to have been subjected to excessive force during attempted enforced removals. [12] They were identified by solicitors and visitor groups at Immigration Removal Centres who referred the cases to the Medical Foundation for the Care of Torture Victims. Referrals were taken on based on how soon after the attempted removal the referrals were sent. This was done in order to prevent loss of clinical signs, such as bruising and swelling. Six doctors carried out medical examinations of the asylum seekers and documented their results in objective medical reports. These examinations were intended to be carried out within 5 days of the alleged incidents during the enforced removals. However, this was not always possible due to logistics in receiving the referrals and arranging the visits of the doctors.

Below is a table showing how long after the incident the medical examinations took place.

Days between alleged incident and examination	No. Of Cases
5	2
7	3
8	2
11	2
12	1
13	1
15	2
21	1

This means the mean average no. of days between the alleged incident taking place and a medical examination being undertaken was 10.3 days.

Out of the 14 asylum seekers involved in the study, 12 were male and 2 were female, and all were black. The table below shows their nationalities.

Country of Origin	Number of Asylum Seekers
Uganda	2
Ivory Coast	1
Guinea Conakry	2
Liberia	1
Guinea-Bissau	1
Nigeria	2
Tanzania	1
Ghana	1
Togo	1
Jamaica	1
South Africa	1

Four of the participants in the study had been subjected to torture in their country of origin, and two of these reported that the mistreatment experienced during the attempted enforced removal had led to a deterioration of their psychological state and had brought back memories of their previously experienced torture.

The methods of restraint used by the guards during the attempted enforced removal are listed, as described by the asylum seekers: "being dragged along the ground, being kicked or kneed, being punched – including to the head and face, being elbowed, having the thumb forcibly bent back, pressure being applied to the angle of the jaw, pressure exerted on the neck, being sat on (thorax and abdomen), and assault to the genitals."

None of the 14 asylum seekers were sedated during the attempted removals.

In at least 3 of the cases dangerous or unjustifiable force was used during restraint.

In 12 of the 14 cases, handcuffs were used to restrain the asylum seeker. In eleven of these cases, they were improperly used.

In 6 cases physical assault took place in transit back to the Immigration Removal Centre after the attempted enforced removal had been abandoned. Types of assault reported include punches, elbowing, slapping and kicking.

6 of the 14 asylum seekers reported being subjected to verbal abuse from the guards. In 3 cases, the verbal abuse was of a racist nature.

Below is a list of complaints reported by the asylum seekers immediately after the alleged incidents:

- loss of consciousness;
- swelling of the wrists, painful wrists;
- numbness of fingers, weakness of the hand;
- hip pain on weight-bearing;
- pain in the chest on inspiration;
- cut to the forehead;
- painful knee, swollen knee;
- bruising and scratches;
- neck and back pain, limited neck movement;
- pain on swallowing and inability to eat solid food;
- pain in the jaw and painful bite;
- tooth coming loose, bleeding from the mouth;
- pain over the cheek bone;
- pain in the abdomen;
- testicular pain;
- difficulty passing urine;
- nose bleed.

The doctors examined the injuries suffered and determined whether they corroborated with the physical abuse reported. Below is a summary of the type of findings in the cases:

injuries to limbs:
 cuts over the wrists from handcuffing;
 nerve injuries from handcuffing;[16]
 marked tenderness to the base of the thumb with limited range of movement – possible fracture or soft tissue injury;
 abrasions to the shins from being kicked;
 knee effusion (fluid in the knee causing swelling) and medial ligament tenderness following forced twisting of the knee.

injuries to head, neck and face:
 sprained neck from having neck forcibly flexed (head pushed down);
 bony tenderness over the cheekbone from a punch to the face;
 abrasion over the cheekbone from being dragged along the ground;
 lip laceration (splitting) from having head pushed down against the ground;
 bruising under the jaw and tenderness over the larynx from fingers being
pressed to the throat;
 laceration over the temple from having head banged against hard object.

injuries to torso:
 tenderness or swelling over rib, sternum (breastbone) or pectorals from pushing, punching or kicking, variously;
 swelling and tenderness in the scrotal area from having scrotum squeezed;
 abdominal wall tenderness from a punch to the abdomen.

Discussion

Findings of the studies reviewed

The article that is a commentary on the psychological and physical risks of flight deportation suggests a number of recommendations to reduce the medical risks involved in the process. For traumatized refugees and refugees with PTSD, it suggests caution with forced removal as it could deteriorate their condition and the required treatment might not be available in their home country. For physical risks it also makes a number of suggestions. For physically immobilizing patients, it suggests that physicians should be allowed to prescribe tranquilizers

when medically appropriate, and with the patient's written consent. To avoid thrombosis, it suggests advising refugees to move their lower limbs during the flight, and for patients at high-risk of thrombosis or pulmonary embolism, low-dose aspirin as a preventative measure. Drinking sufficient fluids before the flight is suggested to avoid dehydration. It recommends that asylum seekers with an oxygen saturation rate below 92% should undergo a formal hypoxic test to ensure that they can compensate for the change in altitude, and that asylum seekers with an arterial oxygen pressure below 6.6kPa should have supplementary oxygen supply. The last finding is that extra precaution should be taken in flights that last longer than 8 hours to prevent the spread of Myobacterium tuberculosis.[11]

The qualitative study that was concerned with the medical examination of 14 failed asylum seekers after attempted enforced removals using excessive force suggested the following findings after analysis of the medical data. The first finding was that normal restraint methods are misused, often with the intention of causing harm to the detainee. The second finding was that some forms of force used against detainees, such as punches and kicks aimed at the head and face, cannot be deemed strictly necessary or reasonable use of force in any situation, particularly when administered after already being restrained. The third finding was that physical abuse continues in vehicles taking asylum seekers back to immigration removal centres after the initial enforced removal attempt fails. The final finding was that racist verbal abuse was commonly used during attempted enforced removals.

Below is a summary of the conclusions and recommendations that the study drew from these findings[12]:

1. Immediate Medical Examination following a failed forced removal:
   Some clinical signs, particularly injuries resulting from improper use of handcuffs, can be difficult to see if the medical examination is carried out a few days after the incidents take place. Hence it is important that a medical examination is carried out immediately when the asylum seeker is returned to the immigration removal centre.

2. Reports of malpractice and injuries from healthcare staff:
   After a medical examination, if there is evidence that inappropriate or disproportionate force has been used against a detainee, this should be reported.

3. Review of force used:
   Excessive force and verbal abuse is not allowed under Detention Centre rules governing the actions of custody officers. Incidents where excessive force is used have to be logged and should include medical evidence from the examination that is recommended above.

4. Safety of force used and restraint techniques:
   Force used and restraining techniques used on the asylum seekers in this study resulted in serious injuries. A review of how these techniques are used should be carried out, and should only be carried out where absolutely necessary.

5. Training on how handcuffs are used:
   In this study handcuffs were used improperly and a third of the detainees suffered nerve damage as a result of this. Training should be provided to those involved in the removal process to ensure that they are aware of the correct method of applying handcuffs and how to minimize risk of injury whilst applying and using them.

6. Race awareness Training
   Racist verbal abuse during attempted removals was one of the findings of the study. Training should be provided to highlight the unacceptability of racism and its part played in the aggravation of abuse of detainees. Staff involved in attempted enforced removals found to be racist should be sanctioned.

7. Abuse in vehicles
   Areas such as vehicles used in transporting detainees contained no independent witnesses and abuse was common in these areas. CCTV monitoring should be in place to prevent this.

8. Non-removal while legal action is pursued
   Detained asylum seekers should be allowed to stay in the UK while evidence is gathered and legal action is pursued, which they have a right to do where they have been harmed. As well as being important to the individual concerned, it is important so that future assaults can be prevented.

9. Funding of legal action
   Often the asylum seekers in question lack private resources to be able to fund a legal claim. It is important that public funds are made available to prevent future assaults on detainees – this is in the interest of the public as well as the individual.

Limitations of the studies reviewed

There were a few limitations of the article that was a commentary. Firstly, there was no data directly relating to deportations in the article. The authors did acknowledge this however, and called for more research in the area. Another limitation was that it was an Austrian article. Austria's asylum system is different to the UK's and so it is difficult to make direct comparisons between the two systems. The physical risks that are mentioned during flights apply to the whole population and aren't specific to the asylum seeking population. However, they are considerations that are perhaps somewhat relevant to asylum seekers. Another reservation I had about the article was that it referred to people being deported as refugees, which was rather confusing as the term refugee in the UK means that the person has been granted permission to reside in the country.

There were also some limitations in the qualitative study. First of all, the sample size was only 14 people, which is pretty small. However, the fact that all the cases showed repeated patterns seems to show that the sample was representative of instances where enforced removals are stopped after abuse occurs. A lot of the results were also based on accounts by the detainees who were being abused. This could lead to inaccuracies in reporting due to traumatisation or a vested interest in trying to claim refugee status or get the perpetrators of the violence prosecuted. However, the medical examinations showed that the injuries suffered corroborated with the type of alleged violence in the detainees' accounts, suggesting that their accounts were quite accurate. Another limitation in the study is that despite the aim of having all the medical examinations and interviews carried out 5 days after the alleged incidents, this was only achieved in two instances. This would mean that some injuries, such as bruises, swellings and cuts from improper use of handcuffs, may have been difficult to detect in the medical examinations. The authors did address this in their report however, by making the recommendation that medical examinations of failed asylum seekers should be carried out at immigration removal centres immediately after the attempted enforced removal has failed.

The two articles were published in 2003 and 2004, and so there is a danger that they are out of date now. However, this doesn't appear to be the case as there have been at least 11 more alleged cases of abuse during enforced removals since the death of Jimmy Mubenga on 12th October 2010, according to Medical Justice.[13]

Findings of my review

The review looked at 2 articles which looked at the psychological and physical risks of enforced deportations of failed asylum seekers. The psychological risks were that mental health would deteriorate during enforced removals, particularly in cases where the asylum seeker suffered from PTSD or had been previously tortured. Hence where it is shown that the asylum seeker has a serious mental health problem and would not be able to access care in their home country, it would be advisable to not deport them to prevent their mental health from deteriorating. The physical risks included generic problems that apply to flying, such as thrombosis, and injuries where escort officers applied excessive force during enforced removals. The outcome of this is that advice and steps should be taken to prevent and minimize the problems associated with flying. In relation to physical risks where escort officers are alleged to have abused detainees, as outlined above in the 'Findings of studies reviewed' section, reviews of acceptable restraint techniques should be carried out, medical examinations should be carried out immediately after an alleged incident has taken place and asylum seekers should be given more opportunity to take legal action following alleged abuse, so as to prevent future cases of abuse and so that justice will prevail.

Limitations of my review

The review was only based on 2 articles. The articles were quite different in nature. One was a commentary based on no specific evidence of enforced deportations and compiled by Austrian authors, and the other was a qualitative study of a small sample of failed asylum seekers in the UK who claimed to have been abused during attempted enforced removals. There is very little literature on the medical risks of enforced removals, perhaps due to ethical and political considerations, and so it is very difficult to conclude anything as there is very little data or evidence to base these on.

Conclusion

1. More research needs to be carried out in this field as there is very little evidence or data available.

2. Greater access needs to be granted to healthcare professionals to ensure that asylum seekers are receiving treatment for their physical and mental health needs.

3. Reviews of restraint methods should be carried out to ensure that asylum seekers aren't physically abused during enforced removals, and in instances where there is alleged abuse medical examinations should be provided immediately afterwards and funding for legal action if necessary.

4. Assessment of an asylum seeker's health should be carried out to ensure that they are well enough to be deported and steps should also be taken to ensure that their healthcare needs are met when they are in their home country.

Personal reflection

Having met and spoken to asylum seekers at the various placements, I was shocked how government policy can be so inhumane, and sadly, often has the backing of the population. It was very humbling to see and hear the realities of what it is actually like to be an asylum seeker and see beyond the negative stories that are often printed in the tabloids. The people I talked to had suffered a lot in their home countries. They were very humble and grateful for what they had despite all the difficulties they had gone through and continued to go through in attempting to get refugee status. Even in the UK it appeared that they continue to suffer as they live in impoverished conditions, are stigmatised by others and are always living in fear of not knowing if they will be granted permission to stay in the UK. It definitely reinforced my belief in the core principles of the NHS and the welfare state– that healthcare should be freely available to everyone.

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Appendices

Acknowledgements

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Timetable

Activity	Date
Course Induction	24th January
Visit to LCIP	25th January
Visit to ALM	26th January
Visit to Welsh Refugee Council	27th January
Visit to Fade Library	28th January
Scoping searches and Finalizing Research Question	28th January – 1st February
Presentation Day	4th February
Research and Write up of SSM	2nd February – 10th February
Lecture Day	7th February
Hand in SSM1	11th February

Universal Declaration of Human Rights (1948)- Articles relevant to asylum seekers and their treatment in the U.K.:

Article 3: 'Everyone has the right to life, liberty and security of person'.

Article 5: 'No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment'.

Article 9: 'No one shall be subjected to arbitrary arrest, detention or exile'.

Article 14: 'Everyone has the right to seek and to enjoy in other countries asylum from persecution'.

Beauchamp and Childress' Four Principles for Medical Ethics:

Respect for autonomy: respect for 'self-rule that is free from both controlling interference by others and from certain limitations such as an inadequate understanding that prevents meaningful choice.'[14]

Nonmaleficence – 'One ought not to inflict evil or harm.'[14]

Beneficence – 'moral obligation to act for the benefit of others'. [14]

Justice – 'fair, equitable and appropriate treatment in light of what is due or owed to persons'.[14]

The most important of these principles in relation to asylum seekers is justice. Failed asylum seekers in England, Scotland and Northern Ireland do not have access to secondary care unless they pay for it, which they simply do not have the money for. Often asylum seekers also do not receive the same treatment as others because of language barriers, dispersal or poor understanding of the way the U.K.'s healthcare system works.

GMC Guidlines: Good Medical Practice: Duties of a Doctor[15]

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
* Protect and promote the health of patients and the public
* Provide a good standard of practice and care
    - o Keep your professional knowledge and skills up to date
    - o Recognise and work within the limits of your competence
    - o Work with colleagues in the ways that best serve patients' interests
* Treat patients as individuals and respect their dignity
    - o Treat patients politely and considerately
    - o Respect patients' right to confidentiality
* Work in partnership with patients
    - o Listen to patients and respond to their concerns and preferences
    - o Give patients the information they want or need in a way they can understand
    - o Respect patients' right to reach decisions with you about their treatment and care
    - o Support patients in caring for themselves to improve and maintain their health
* Be honest and open and act with integrity
    - o Act without delay if you have good reason to believe that you or a colleague may be putting patients at risk
    - o Never discriminate unfairly against patients or colleagues
    - o Never abuse your patients' trust in you or the public's trust in the profession.

You are personally accountable for your professional practice and must always be prepared to justify your decisions and actions.