Home Office

Equality Impact Assessment

Demonstrating Compliance with the Public Sector Equality Duty (PSED)

Equality Impact Assessment (EIA)

- **Remember that your duty is to demonstrate that you have had "due regard" to equalities issues.**

  Useful guidance:

- Discrimination and differentiation guidance
- Equality Impact Assessments

1. Name and outline of policy proposal, guidance or operational activity

There is a body of evidence to suggest that the way in which the Adults at Risk in Immigration Detention (AAR) policy previously governed the use of external medical reports led to inappropriate release from immigration detention. This evidence is in the form of external medical reports that the Home Office considered, in many cases, to be unreliable and of a poor standard, commissioned by legal firms and advisors and prepared by a healthcare professional (doctor or psychologist) assessing their client in immigration detention.

Such reports often sought to establish that the person in detention was suffering from a mental health condition, to the level at which further detention would be likely to lead to harm. There has been a sharp rise in the number of these reports since early 2018, with a consequent increase in releases from detention and drop in returns.

The aim of the policy change is to introduce a set of standards to raise the quality and reliability of these externally sourced reports. Should a submitted report fail to meet the standards required, this could lead to a lowering of the AAR evidence

level allocated to the person or could ultimately lead to the rejection of that report as evidence under the AAR policy.

The standards act as a framework upon which casework decisions relating to detention are made under the AAR policy when external medical reports are submitted and will apply to medical reports commissioned by legal representatives on behalf of their client in detention. The standards do not, however, apply to other forms of medical evidence which may be submitted, such as letters from GPs who may have treated the person in the past, or contributions of professional evidence from professionals who may have had some interaction with the person prior to their detention. Neither do the standards apply to written information received from the healthcare team at the place of detention.

The AAR casework guidance, which sits alongside the statutory AAR guidance, has been updated to include these standards in order to promote the consistent evaluation of this privately sourced evidence wherever it is received across the detained estate.

For the purposes of clarity, this EIA will interchange the use of the term 'external medical report' and MLR, which stands for Medico Legal Report. In essence, they are the same thing, though historically the AAR policy reserves the use of the term MLR when describing a medical report prepared by certain providers; Helen Bamber Foundation and Freedom from Torture etc. Such reports will normally be prepared in support of asylum claims involving incidents of torture and will apply diagnostic criteria as established in the Istanbul Protocol when referring to physical injuries advanced as resulting from torture. The external medical reports which are the subject of this paper and policy proposal do not apply such measures, though they are often entitled 'Medico Legal Reports' (MLR). The term MLR has been practically adopted both internally and externally as a general term for these reports, without making such a distinction as is implied within the AAR policy and the term will therefore be used interchangeably within the text below.

2. Summary of the evidence considered in demonstrating due regard to the Public Sector Equality Duty.

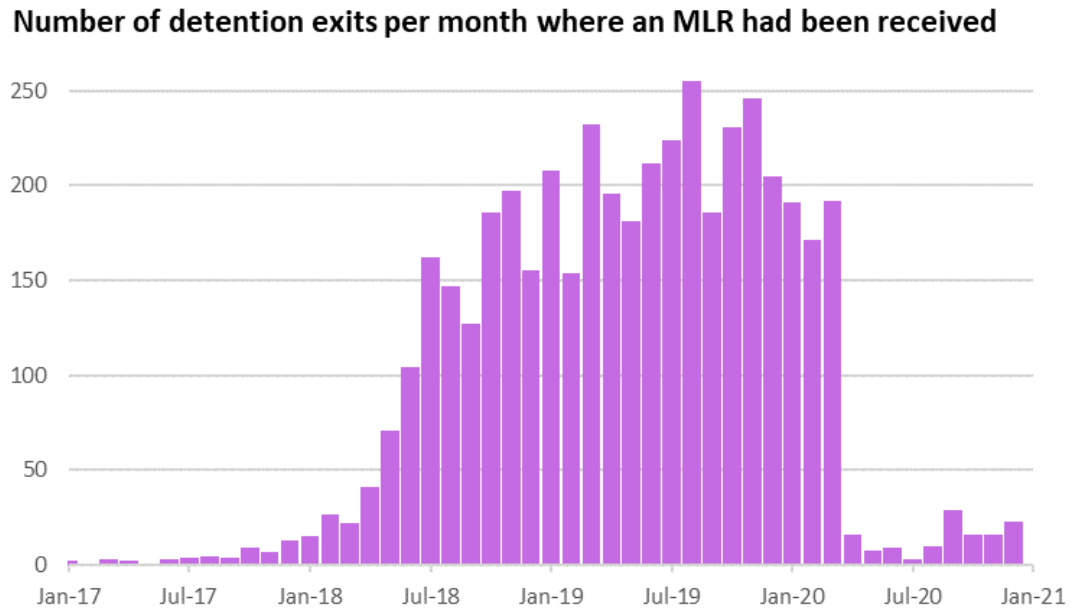
Formulation of this policy change has been made with reference to the following sources of evidence/reports:

- Home Office Analysis and Insight (HOAI) analysis, January 2021
- Detained Casework Oversight and Improvement Team (DCOIT) commissioned second opinion pilot study March 2021
- Detained Asylum Casework MLR report October 2018
- 194 case studies, of which all have been a subject of external medical reports. These individuals have all since been released from immigration detention. This total is additionally subdivided:
  132 reports which have been considered in detail

62 cases in which reports from an unregulated firm have been submitted, but have not been reviewed in detail. Data on identifiable protected characteristics only has been used

Scale and operational impact:

External medical reports were increasingly submitted in respect of those in immigration detention since the late Spring of 2018. HOAI analysis below shows the trend developing over the past few years. The significant drop throughout 2020 is due to the impact of Covid upon the detention estate and resultant steep decline in the detained population.



This activity grew strongly throughout 2019 and the HOAI figures below illustrate the prevalence of this activity associated with those detained within the UK for immigration offences.

For people who left detention in 2019	Number of detention exits	Of which, involved an MLR	Proportion of detention exits involving an MLR
People detained on arrival in the UK	7,315	215	2.9%
People detained within the UK following immigration offences	11,367	2,208	19.4%

FNOs detained from custody or from the community	5,920	107	1.8%

This level of activity has had a direct impact upon returns. The figures below illustrate the extent of that impact when activity grew in 2019 prior to the impact of Covid upon the detained population.

Year	**Number of detentions involving an MLR**	**Of which, ended in return**	**Proportion of detentions involving an MLR that ended in return**
2015	15	4	27%
2016	51	11	22%
2017	53	8	15%
2018	1254	51	4%
2019	2530	63	2%
2020	684	34	5%

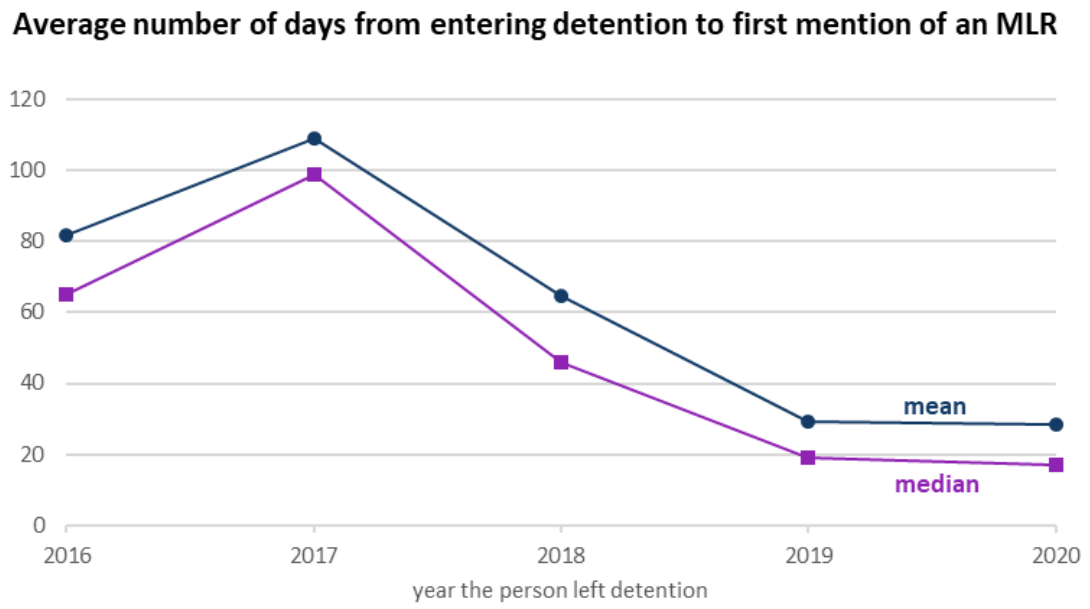
The trend has continued throughout 2019/20, with a drop off in activity since early spring of 2020, largely owing to the Covid-19 outbreak, which prompted a significant reduction in the size of the detained population.

Notable trends:

Aside from the obvious impact that the increase in the number of MLRs has had on immigration detention operations concerns have arisen from the scale of the activity and content of the reports, which has led to the need to place additional measures to govern the overall management of MLRs as external evidence within the AAR policy.

Reports are being submitted earlier in the detained process

The HOAI figures below show that the average days in detention before an MLR is received has reduced as their frequency has increased.



This analysis shows that MLR activity recorded on the Home Office database (first mention of an MLR) is happening sooner than in previous years.

A sample of 132 cases taken from 2019-20 reveals that, in 72% of cases, a medical assessment resulting in an MLR was conducted less than 2 weeks after the person entered detention. This is consistent with the trend that MLRs are being submitted earlier than previously. The same sample identified that a pre-existing mental health condition was reported/identified during questioning on encounter, or during the statutory Rule 34 healthcare check in only 9 cases (7%).

This is a concern, as it would suggest that mental health issues (which are overwhelmingly the most common health issue raised in such reports) are either, to a considerable degree, developing in detention within 2 weeks, or that they were pre-existing and not declared and/or identified upon initial arrest or health screening in detention. This issue was also picked up in the DAC report as a cause for concern[1]. The subjects are overwhelmingly single males of working age. Indeed, the 132 sample features only two females, (assessed by the same psychologist on the same day). This imbalance runs contrary to general information available on the incidence of mental health issues prevalent across the gender spectrum, which indicates that women are considerably more likely to suffer from depression, anxiety and PTSD[2]. Whilst the detention population is some 88 percent male, females are nevertheless extremely under-represented across this activity, particularly given the general expectation that they are more likely to exhibit mental health problems.

Without additional clinical evidence to support the assessment made in these MLRs one might reasonably conclude that the likelihood of so many young men, who are all fit and well, suffering harm in detention so quickly, to be very low

[1] DAC Harmondsworth MLR progress report, October 2018, page 7

[2] Gender differences in Mental Health – RAMH

indeed. In many cases, this activity is initiated too quickly to appear credible – or, at the least, it raises questions about credibility.

Given the reasonable assumption that many illegal migrants in detention wish to be released and avoid return to their home countries, there may be an alternative rationale behind the growth in the submission of MLRs: that mental health conditions are being falsely presented/reported as a means to secure release through the AAR policy.

Reports are disproportionately focused on certain nationalities.

The HOAI analysis shows that certain nationalities are more likely to be the subject of an external medical report, as illustrated below in figures taken from 2019 activity:

Number of detentions involving an MLR (2019)	Nationality	Proportion of detentions involving an MLR
1396	**Albania**	**41%**
522	India	29%
156	Pakistan	13%
146	Bangladesh	19%
310	**All other nationalities**	2%

The table shows the 2019 activity to be closely associated with Albanian nationals. As this nationality accounted for only 14% of people entering and leaving detention in 2019, this figure is clearly disproportionate. Additionally, where the data is available from the separate case by case sample, that the average length of time between the point of detention and medical assessment for this nationality was 12 days. This is at the lower end of the duration figures above and is consistent with this trend to submit this evidence earlier on in the process.

Whilst many reports cite studies arguing that detention is inherently detrimental to mental health, the level to which medical reports are concentrated around certain nationalities appears more suggestive of a strategic approach to legal representation for certain client groups, than of an endorsement of the broader conclusions of such studies. One would expect a much broader range of nationalities to be represented in the group of subjects, if the trend of submitting medical evidence is to be reflective of the conclusions of such studies.

Concerns: poor clinical practice.

A DCOIT-commissioned study into a sample of 21 MLRs was conducted by two consultant psychiatrists between December 2020 and February 2021, as part of a

pilot in which the Home Office sought second medical opinions on MLRs, reveals a number of clinical concerns related to the methods of assessment and the conclusions reached across the sample. Examples include:

- The majority of authors were unclear about limitations in their ability to make findings based on the method of assessment, treating telephone and virtual assessments on par with face to face assessments in terms of their effectiveness
- In more than three-quarters of cases the author failed to rely on objective health records and in more than half of the cases relied upon non-diagnostic self-reporting tools as the basis for their opinions
- There was insufficient exploration of hereditary background to mental health issues in more than seventy percent of cases
- Insufficient exploration of major symptoms underpinning diagnosis was a factor in more than half the cases reviewed
- In ten percent of reports, the author commented that there was no indication to suggest the individual was exaggerating or feigning his mental health problems or sufficient evidence to support malingering. However, no formal tests for malingering were conducted to verify this.
- There was insufficient exploration of self-harm risk when raised as a serious risk, as it was in more than half of the reports reviewed.
- Methods to reach diagnoses were regarded by the reviewing psychiatrists as largely questionable in all but three cases reviewed. Examples include clinical inconsistencies, or diagnoses which the clinical psychiatrists reviewing the MLRs deemed unwarranted
- There was insufficient consideration of possible mitigating treatment available in the IRC.

3A. Consideration of limb 1 of the duty: Eliminate unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Equality Act

The primary purpose of the policy change is to improve the capacity for balanced decision making on the appropriateness of maintaining immigration detention with respect to those detained people who are the subject of medical reports which have been privately commissioned by their legal representative.

Consideration has been given to whether the changes could constitute conduct prohibited by the Equality Act.

The policy would apply to all people for whom external medical reports are commissioned whilst in detention, irrespective of any protected characteristics and

would therefore not constitute direct discrimination. Consideration has been given to whether they constitute indirect discrimination, but have reached the conclusion that they do not, for the reasons set out below. It is not considered that they entail any other form of discrimination prohibited under the Equality Act.

Age

The Home Office does not detain unaccompanied children under 18, other than in exceptional circumstances, and then not in immigration removal centres. The AAR policy and thereby the new policy standards do not apply to minors. Being aged 70 or older is specified as an indicator of risk of harm in the AAR policy. Accordingly, people falling into this group will be detained only when immigration control considerations in their case outweigh evidence of their vulnerability.

A review of a random sample of 194 cases of people (all aged 18-62) who submitted external medical reports whilst in immigration detention indicated the following age breakdown:

Age group	MLR Sample	control group (DGK figures for 2019)
18-25:	50 (26.0%)	28.4%
26-30:	56 (28.5%)	23.2%
31-35:	36 (18.0%)	17.9%
36-40:	17 (9.0%)	12%
41-45:	12 (6.0%)	7.8%
46-50:	12 (6.0%)	5.4%
51-60:	10 (5%)	4.6%
61+:	1 (0.5%)	0.7%

The policy change may lead to a greater possibility that detention will be maintained, because we expect that there will be reports that do not meet the standards. Although this would only impact those who submit an MLR, it would appear to carry a greater impact to those under 35 years of age within that group, since they are responsible for some 72% of all reports. Since this is broadly similar to the control group in terms of those detained in that age group (69%), there is insufficient evidence show that such an impact would be disproportionate when looking at the age ranges of the detained population as a whole. Any impact, regardless of the age of the person is nevertheless considered to be justified as the policy change is a proportionate means of achieving a legitimate aim, to raise the quality and reliability of these externally sourced reports and ensure consistent

evaluation of the reports as evidence. Such an impact would only apply in the event that the standards were not met, which is considered within the gift of the legal representative commissioning the report and the healthcare professional writing it.

Disability

For the purposes of the Equality Act, disability is described as being: “A physical or mental impairment that has a ‘substantial’ and ‘long-term’ negative effect on an individual’s ability to carry out normal daily activities.” The Home Office does not routinely collect data on the number of people entering detention broken down by disability as defined by the Equality Act 2010.

To date, the health conditions most commonly raised through external medical evidence relate to mental health issues. Serious mental health issues, such as complex PTSD, depression, or forms of psychosis are considered as a disability, where they are long-term and imply a substantial negative impact upon the ability to function. An external medical report could also be written other health issues, including those related to physical disability.

Under the AAR policy, there is a presumption against detention for people with mental health conditions and/or serious physical disabilities, health conditions or illnesses. It remains the case that evidence of a disability, such that might be presented within an MLR, will be balanced against immigration considerations and public protection risk in accordance with the AAR policy. However, the policy change could have an impact on this group. The failure to comply with the new standards will have a range of effects upon the consideration of that evidence submitted. Where reports fail to comply and this results in the rejection, or lowering of the evidence level, the rate of release is likely to drop, where Hardial Singh principles continue to be satisfied. It is therefore considered that the policy proposal may have a disproportionate impact upon those who are regarded as having a disability due to a mental health condition.

The purpose of the policy is to introduce further means to balance the claimed vulnerability, (which often relates to a disability/mental health issue), against the legitimate aim of removing the person from the UK. It is therefore considered that if indirect discrimination were to arise, the policy change is a proportionate means of achieving a legitimate aim, to raise the quality and reliability of these externally sourced reports and ensure consistent evaluation of the reports as evidence. Safeguards are in place in the event that reports are rejected following a failure to observe the baseline standard. For example, the clinical team will always receive the report for their information to manage the care of the person in detention. The section on mitigation in section 5 below provides more detail on this.

Gender Reassignment

The Equality Act defines a transsexual person as someone who is proposing to undergo, is undergoing or has undergone a process (or part of a process) for the purpose of reassigning their sex by changing physiological or other attributes of sex. The Home Office does not collate data on the number of transsexual people entering detention. However, anecdotally the number of transsexual, transgender and intersex people in immigration detention is known always to have been very small.

Transsexual and intersex persons are listed in the AAR policy as being particularly vulnerable to harm in detention. There is therefore a presumption that transsexual individuals will not be detained until the point at which the immigration considerations are such that they outweigh any risk of harm identified if detained. In a review of a sample of 132 cases of people who had submitted an external medical report whilst in immigration detention, none had reference to gender reassignment. Whilst it is likely that the new policy will disproportionately impact those who submit MLRs (if they do not meet the standards), there is no evidence to suggest that the proposed policy change would impact disproportionately on this particular group when compared with another.

Marriage and Civil Partnership

The Home Office does not collate data on the number of people entering detention broken down by marital status. Neither has this been captured within any of the samples referred to throughout this paper. It is not possible therefore to draw any likely conclusions as to the impact of the policy change; but there is no evidence to suggest that the policy change would have any differential impact on individuals because of the status of their relationship with any partner or spouse.

Pregnancy and Maternity

Section 60 of the Immigration Act 2016 provides that a pregnant person may be detained only if their removal / deportation will take place shortly or there are exceptional circumstances to justify their detention. In either case, detention may last for no more than 72 hours although, in exceptional circumstances, this may be extended up to an absolute maximum of 7 days in total if that extension is authorised by a Minister. Data indicates that pregnant people are not being held in immigration detention for longer than the statutory limit.

Under the AAR policy, pregnancy is afforded significant weight when determining suitability for detention. In a review of a sample of 132 cases of people who submitted external medical reports whilst in immigration detention, none were identified as being pregnant. As with all protected characteristics, it would be possible for an MLR to be submitted for a pregnant person in detention. Given the possibility that the standards may not be met, and that this would lead to a

rejection, or downgrading of that evidence, it is considered that there is the potential for a disproportionate impact upon a person submitting an MLR. However, there is no evidence to show that it would have such an impact upon this particular group when compared with another.

Race

Published Home Office detention policy does not exclude any groups from immigration detention on the grounds of race or nationality. The cohort of individuals subject to immigration detention is, by definition, made up of non-UK nationals who do not have leave to remain in the UK and are therefore liable to removal. It follows therefore that a medical report could be commissioned in detention by someone who is liable for removal from the UK of any overseas nationality.

Figures taken from the HOAI data suggest that four nationalities make up the vast majority of MLRs submitted within detention (Albania, India, Pakistan, and Bangladesh). The control group by contrast gives the following breakdown of those same four nationalities as a proportion of the greater detained population as: Albania 13.2%, India 7.1%, Pakistan 4.5%, Bangladesh 2.6%, others 72.6%.

The policy changes are likely to most frequently impact people of those nationalities simply because individuals of these nationalities have submitted the great majority of MLRs, and this may well continue in the future. We have therefore considered whether the proposals could result in indirect discrimination on grounds of race / nationality.

There is the potential that where, previously, (according to the evidence from the DAC report) the submission of an external medical report was very likely to lead to a rating of AAR3 and subsequently release, a different decision may be made because of the new standards. Where the standards are not met the likely impact would be to either reject the report or downgrade the level of vulnerability from AAR3 to AAR2. This, without any further corroborating evidence of vulnerability from other sources and, leaving to one side the question of immigration factors and removability, would lead to a higher degree of possibility that detention would be maintained. However, this will only disproportionately impact the nationalities above if the same trends continue following the introduction of the standards. As noted in section 5 below on mitigation, the standards have been developed in line with industry regulators and are considered to be reasonable and achievable. It is therefore considered that if indirect discrimination were to arise, the policy change is a proportionate means of achieving a legitimate aim, to raise the quality and reliability of these externally sourced reports and ensure consistent evaluation of the reports as evidence.

Religion or Belief

Published Home Office policy does not exclude individuals from detention by virtue of their religion or belief. The Home Office does not publish data on the number of people entering detention broken down by religion or belief, though it may be possible to ascertain this information on a case by case basis.

Such research was conducted on a sample of 62 cases of people who submitted an external medical report through an unregulated legal advisor whilst in immigration detention, where data was identified regarding their religious belief. Muslim:36 (58.1%), Sikh:6 (9.7%), Hindu:3 (4.8%), Christian:1 (1.6%), Not stated:16 (25.8%)

In this case, it would follow that the majority of those submitting external medical reports are Muslim, with Sikh and Hindu a distant 2nd and 3rd. Whilst this represents a very small sample, if this assumption was extrapolated and applied to the immigration removal estate in general, figuring that four nationalities (94% of reports submitted) represent some 30% of the detained population, it is likely that the policy proposal will have a marginally increased impact upon those of the Muslim religion. However, this by no means certain and not to any measurable, or considerable degree so as to present indirect discrimination.

Sex

Published Home Office policy does not exclude individuals from detention by virtue of their gender. The same criteria apply to the detention of people of all genders, though the majority (approximately 88%) of people in immigration detention are men, as noted from the Detention Gatekeeper statistics from 2019. Based upon the sample of 194 cases submitting medical reports where gender was identified, only 2 (1%) were from women.

According to those statistics it would be reasonable to state that the change in policy would have more impact upon men, purely owing to their making up the majority of the detained population, and the greater propensity to seek and provide the Home Office with external medical reports. If indirect discrimination were to arise, it is considered that the policy change is a proportionate means of achieving a legitimate aim, to raise the quality and reliability of these externally sourced reports and ensure consistent evaluation of the reports as evidence

Sexual Orientation

The Home Office does not collate data on the number of people entering detention broken down by sexual orientation. Neither has this been captured within any of the samples referred to throughout this paper. It is not possible therefore to draw any likely conclusions as to the impact of the policy change; but there is no evidence to suggest that the policy change would have any differential impact on individuals because of their sexual orientation.

3B. Consideration of limb 2: Advance equality of opportunity between people who share a protected characteristic and people who do not share it

The Equality Act specifies that this limb involves having due regard to three specific aspects:

removing or minimising disadvantages suffered by persons who share a relevant protected characteristic that are connected to that characteristic;

taking steps to meet the needs of persons who share a relevant protected characteristic that are different from the needs of persons who do not share it; and

encouraging persons who share a relevant protected characteristic to participate in public life or in any other activity in which participation by such persons is disproportionately low.

Schedule 18 to the 2010 Act sets out exceptions to the public sector equality duty in relation to the exercise of immigration and nationality functions-s149 (1)(b)-advance equality of opportunity between persons who share a relevant protected characteristic and persons who do not share it-does not apply to the protected characteristics of age, race (insofar as it relates to nationality or ethnic or national origins) or religion or belief.

Therefore, the following protected characteristics have been considered in respect of limb 2:

- disability
- gender reassignment
- pregnancy and maternity
- sex
- sexual orientation

We consider that the proposal introduces greater equality of treatment of all people within immigration detention, as it will require that evidence submitted to establish whether the individual's health is suffering in immigration detention is both prepared to a higher standard and subjected to a greater degree of balanced consideration, which will lead to more informed caseworking decisions. The standards are intended to lead to a more thorough and consistent evaluation of evidence.

3C. Consideration of limb 3: Foster good relations between people who share a protected characteristic

The Home Office does not foresee this guidance causing detrimental relations between people who share a protected characteristic and those who do not, on the grounds that it does not apply any specific advantage to any group on the basis of their sharing a protected characteristic. The proposed policy change seeks to ensure that detention decisions are taken with equality of treatment for all those for whom an external medical report is submitted.

The Home Office does not anticipate any particular group of people holding another responsible for any perceived problems, or any group being seen to benefit unfairly on the basis of one or more protected characteristics.

4. Summary of foreseeable impacts of policy proposal, guidance or operational activity on people who share protected characteristics

Protected Characteristic Group	Potential for Positive or Negative Impact?	Explanation	Action to address negative impact
Age	Data from previous activity suggests potential for most impact in age group 18-35	This age group is most active where the policy change takes effect and any rejection of external medical evidence or reduction in the weight it is afforded owing to the standards (where these are not met) may mean that this group may be more likely to remain in detention.	The standards are reasonable; additional balance in the consideration of evidence serves as assurance that vulnerability in detention is accurately factored into detention decision making. Any negative impact is not targeted at the group and is considered proportionate to maintain an effective immigration removal system. Detention decisions will continue to be made in accordance with the wider policy framework, which includes protections for those over the age of 70. Impacts of the policy change will be monitored, including for any indication of discriminatory treatment. Those who are under 18 years of age are not within the remit of the AAR policy but benefit from other protections.
Disability	Potential to impact negatively	To qualify as disabled under the Equality Act 2010 a person must have a physical or mental impairment that has a 'substantial' and 'long-term' negative effect on their ability to do normal daily activities. Long-term in this case generally means 12 months or more. Data of previous MLR activity suggests that some of those for whom MLRs have been submitted would be considered disabled. This includes those suffering from PTSD, depression, and those	Standards introduce additional balance in the consideration of external medical evidence. It is considered likely that where people suffer from serious mental health conditions (to qualify as being disabled), this would be identified through prior or subsequent healthcare interaction, regardless of the external medical report, even if that report is rejected initially owing to the failure to meet the regulation standard. In line with Rule 34 of the Detention Centre Rules 2001, individuals

		more serious conditions which can qualify as disability.	receive a medical examination within 24 hours of entering an Immigration Removal Centre, where the examination is consented to. Additional safeguards exist within the system, including the Rule 35 and IS.91RA part C reporting mechanisms, which exist to alert detention decision makers of vulnerabilities which are detected during day-to-day interaction with people in immigration detention and enable decision makers to reassess the appropriateness of detention as necessary. The ACDT process provides a mechanism whereby those who are considered at risk of self-harm, or suicide can be closely managed within the detained environment. Notwithstanding this, any negative impact is not targeted at the group and is considered proportionate to maintain an effective immigration removal system
Gender Reassignment	None identified		
Marriage and Civil Partnership	None identified		
Pregnancy and Maternity	None identified		
Race	Data from previous activity suggests most potential impact across	These four nationalities have provided 95% of MLRs and we anticipate this may continue. The negative impact would be that people of these	The standards are reasonable; additional balance in the consideration of evidence serves as assurance that vulnerability in detention is

	four nationalities: ALB, IND, PAK, BGD	nationalities may be more likely to remain in detention where an MLR is received if standards are not met.	accurately factored into detention decision making. Any negative impact is not targeted at the group and is considered proportionate to maintain an effective immigration removal system. Notwithstanding this, a mechanism has been introduced to monitor activity and the impact of the policy change, which includes weekly reporting of activity and outcomes. This will allow us to measure the impact, including any indication of a disproportionate impact to any particular group. In line with Rule 34 of the Detention Centre Rules 2001, individuals receive a medical examination within 24 hours of entering an Immigration Removal Centre, where the examination is consented to. We consider the independent service operated by NHS-run healthcare teams to also constitute suitable safeguards to manage any disproportionate impact, through the Rule 35 and IS.91RA Part C reporting mechanisms, which exist to alert detention decision makers of vulnerabilities which are detected during day-to-day interaction with people in immigration detention and enable decision makers to reassess the appropriateness of detention as necessary. The ACDT process provides a mechanism whereby those who are considered at risk of self-harm, or suicide can be closely managed within the detained environment. Whilst the report may be rejected or attract limited weight within detention decision making if the standards are not met, healthcare teams will be made aware of its contents and take action as appropriate.

Religion or Belief	The limited data from previous activity suggests most potential impact across two religions: Muslim and Sikh, though the sample is extremely small	The negative impact would be that people of these religions or beliefs may be more likely to remain in detention where an MLR is received if the standards are not met.	The standards are reasonable; additional balance in the consideration of evidence serves as assurance that vulnerability in detention is accurately factored into detention decision making. Any negative impact is not targeted at the group and is considered proportionate to maintain an effective immigration removal system. Notwithstanding this, a mechanism has been introduced to monitor activity and the impact of the policy change, which includes weekly reporting of activity and outcomes. This will allow us to measure the impact, including any indication of a disproportionate impact. In line with Rule 34 of the Detention Centre Rules 2001, individuals receive a medical examination within 24 hours of entering an Immigration Removal Centre, where the examination is consented to. We consider the independent service operated by NHS-run healthcare teams to also constitute suitable safeguards to manage any disproportionate impact, through the Rule 35 and IS.91RA Part C reporting mechanisms, which exist to alert detention decision makers of vulnerabilities which are detected during day-to-day interaction with people in immigration detention and enable decision makers to reassess the appropriateness of detention as necessary. The ACDT process provides a mechanism whereby those who are considered at risk of self-harm, or suicide can be closely managed within the detained environment. Whilst the report may be rejected or attract limited weight in detention decision making if the

			standards are not met, healthcare teams will be made aware of its contents and take action as appropriate.
Sex	Data from previous activity suggests most impact to males (99%) of activity	Negative impact will be increased detention if standards are not met.	The standards are reasonable; additional balance in the consideration of evidence serves as assurance that vulnerability in detention is accurately factored into detention decision making Any negative impact is not targeted at the group and is considered proportionate to maintain an effective immigration removal system. Notwithstanding this, a mechanism has been introduced to monitor activity and the impact of the policy change, which includes weekly reporting of activity and outcomes. This will allow us to measure the impact, including any indication of a disproportionate impact to any particular group. In line with Rule 34 of the Detention Centre Rules 2001, individuals receive a medical examination within 24 hours of entering an Immigration Removal Centre, where the examination is consented to. We consider the independent service operated by NHS-run healthcare teams to also constitute suitable safeguards to manage any disproportionate impact, through the Rule 35 and IS.91RA Part C reporting mechanisms, which exist to alert detention decision makers of vulnerabilities which are detected during day-to-day interaction with people in immigration detention and enable decision makers to reassess the appropriateness of detention as necessary. The ACDT process provides a mechanism whereby those who are considered at risk of self-harm, or suicide can be

			closely managed within the detained environment. Whilst the report may be rejected or attract limited weight within detention decision making if the standards are not met, healthcare teams will be made aware of its contents and take action as appropriate.
Sexual Orientation	None identified		

5. In light of the overall policy objective, are there any ways to avoid or mitigate any of the negative impacts that you have identified above?

In light of the potential impacts considered above, a number of key mitigating factors exist to minimise potential negative impact:

- All reports will be referred to IRC/prison healthcare teams for their attention, even where standards have not been met and the Home Office proposes to reject or give limited weight to that report. This will ensure that the healthcare team will be aware of the concerns raised in the report and will be able to take action as appropriate.
- As part of the development process, the standards were presented to industry regulators of both legal and healthcare fields for their endorsement. With their input and approval, it is considered that the standards are a proportionate approach to ensuring that reports are considered more carefully and that more attention is given to the quality of the report.
- To accompany the introduction of standards, relevant processes have been amended to support their operation. Legal firms will now be encouraged to request access to the IRC healthcare file in advance of the assessment, in order to provide more background for the visiting healthcare professional and lead to a more balanced assessment of their circumstances. Direct access to the IRC healthcare team will now be facilitated through the use of a pro-forma, enabling the visiting professional to make clear any specific concerns arising immediately following the assessment. This will act as a reporting mechanism to help ensure that cases of particular concern are flagged/re-flagged to the IRC healthcare team as soon as possible, providing an additional safeguarding mechanism.
- The introduction of the standards is set out in a published update to the AAR policy caseworker guidance. This provides a full explanation of the changes and provides caseworkers and stakeholders with clarity on where and how the standards apply.
- The introduction of standards has been accompanied by a training package rolled out across detained casework. This included the introduction of a detailed process for decision making where external medical reports have been submitted.

In addition to these mitigating factors, consideration has been given to whether certain aspects of the proposal would lead to an unjustified disadvantage to the person who is the subject of the external report. This would be particularly relevant with any decision to reject a report if the baseline requirement was not met (resulting in continued detention). The consideration here is whether the person

should be disadvantaged due to the actions of his/her legal representative and/or healthcare professional and their failure to comply with the standards.

However, in considering this point, the intention of the AAR policy is to provide guidance on how vulnerability should be considered in caseworker decisions on the detention of individuals. Whilst its intention was not to invite such evidence *en masse,* some several thousand privately commissioned external medical reports have been received since mid-2018, with the clear impact of a reduction in returns. As demonstrated above, the Home Office is concerned that there is evidence of poor standards of practice surrounding the submission of thousands of reports, which has led to a marked impact upon the detained operation.

These events since mid-2018 has led the Home Office to the conclusion that the consideration of these reports needs to be more robust and offer caseworkers more guidance on the standard a report must reach to be regarded as reliable evidence. The introduction of quality standards helps the Home Office to guarantee a reliable and consistent assessment of vulnerability and to ensure that the AAR policy is applied correctly to individuals whose health may be suffering in detention.

6 Review date

This Equality Impact Assessment will be reviewed by the end of 2022.

I have read the available evidence and I am satisfied that this demonstrates compliance, where relevant, with Section 149 of the Equality Act and that due regard has been made to the need to: eliminate unlawful discrimination; advance equality of opportunity; and foster good relations.

SCS sign off

Name/Title: Official - sensitive

Directorate/Unit: Official - sensitive

Lead contact: Official - sensitive

Date	10 November 2021

For monitoring purposes all completed EIA documents **must** be sent to the PSED Team.

Date sent to PSED Team: 15 November 2021