



# Food and fluid refusals in immigration removal centres

## Detention Services Order 7/2004

**BUILDING A SAFE, JUST AND TOLERANT SOCIETY**

**Detention Services Policy Unit**

# DETENTION SERVICES ORDER 7/2004

## Food and fluid refusals in immigration removal centres: Guidance

### Preamble

This Order describes the procedures that must be adopted for handling food and fluid refusal by detainees. Such food and fluid refusal should be consistent, continuous and of a degree which may cause harm. The procedures apply to all removal centres. They are modelled on procedures that are already in effect in prisons and have been drawn up in consultation with the Department of Health.



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### PART A

### Introduction

1. Before the doctor provides treatment for a detainee who is refusing food and/or fluid, the doctor should ensure that he/she has the detainee's consent to do so. For the detainee's consent to be valid, the person must:

    - Have the capacity (be "competent") to take that particular decision (see Part B)
    - Be acting voluntarily (not under duress from anyone)
    - Be provided with enough information to enable them to make the decision

2. The law presumes that an adult has the capacity to take his or her own healthcare decisions unless the opposite is proved.

3. Seeking consent should usually be seen as a process, not a one off event. Detainees who have given consent to a particular intervention are entitled to change their minds and withdraw their consent at any point if they still have the capacity to do so. Similarly, they can change their minds and consent to an intervention which they have earlier refused. It is important to let each detainee know this, so that they feel able to tell the Doctor or other healthcare professional if they change their minds.

4. Legally it makes no difference whether detainees sign a form to indicate their consent, or whether they give consent orally or even non-verbally. However if consent is given it is important in practice that a written record is made of the detainee's instructions.

5. Detainees with the capacity to take a particular decision are entitled to refuse treatment being offered, even if this will clearly be detrimental to their health. Administering medical treatment to a person with full mental capacity in the absence of consent amounts to common assault.

6. Detainees need to have enough information before they can decide whether to consent to, or refuse treatment. In particular, they need information about:

    - The benefits and the risks of proposed treatment
    - What the treatment will involve
    - What the implications of not having the treatment are
    - What alternatives there may be
    - What the practical effects on their lives of having, or not having, the treatment will be

7. Adults with capacity have the right to refuse life-sustaining treatment, both at the time it is offered, and – by making an "advance directive" (see Part C, paragraph 2.1) – in the future. Where a detainee's refusal to give his consent has been expressed at an earlier date, before he became unconscious or otherwise incapable of communicating it, especial care may be necessary to ensure that the prior refusal of consent can still properly be considered as applicable.

8. If a competent detainee has made an advance directive, whilst they remain competent their views should be monitored to ensure that the directive continues to reflect their wishes for their future treatment when they have lost capacity to reach a decision for themselves. A competent person may withdraw or amend any advance directive that he has previously made.

9. Where a detainee is refusing food and/or fluids, is judged to lack capacity, and has not made an advance directive, doctors must consider administering whatever treatment is in the detainee's best interests.

**Status of this Guidance**

10. In addition to information about advance directives and how they should be presented to a detainee who is reusing food and/or fluid, this paper provides guidance about the procedures that should ideally be followed in any case of a detainee refusing food and/or fluids. The legal status of these two documents is different and it is important to clarify this difference.

11. Where a detainee has made an advance directive, the wishes expressed in this directive must be honoured. It is a legal requirement to obtain a patient's consent to treatment.

12. It must be acknowledged that there may be occasions when, assuming a serious question arises about the competence of the detainee, the situation facing the medical team may be so urgent and the consequences so desperate that it is impracticable to attempt to comply with this **guidance**. In such circumstances it must be remembered that this note is procedural guidance. Where delay may itself cause serious damage to the patient's health or put his/her life at risk then formulaic compliance with this guidance would be inappropriate.

## PART B

### Assessing capacity

The doctor should ensure that he/she makes as objective a judgement as is possible, based on the principle that the person should be assisted to make their own healthcare decision if at all possible.

The Courts have stated that for people to have the capacity to take a particular decision they must be able to:

- comprehend and retain:
    - information material to the decision
        - especially as to the consequences of having or not having the intervention in question, and
    - use and weigh this information in the decision-making process.

## PART C

### Food and fluid refusals: General guidelines

1.1 When a detainee is known to have refused food and/or fluid for over 24 hours they should be offered a routine medical appointment. If the detainee appears unwell an urgent appointment should be offered on clinical grounds. If the detainee prefers an appointment with a nurse this should be arranged.

1.2 The purpose of the initial appointment, which is in most cases not an urgent appointment, is to ensure that the detainee

- Has no undiagnosed mental illness causing the refusal
- Has no physical illness causing the refusal
- Understands the consequence of their action
- Is offered care from any appropriate source
- Has base line weight recorded and is advised of any interference of the food/fluid refusals with other medical problems or medication

1. 3 Informed decision making by the detainee is central to the consent process. The health professional at this initial stage must therefore outline the risks and consequences of refusing food and/or fluids over time. Consideration should be given to obtaining a psychiatrist's assessment, particularly if there is any uncertainty over the individual's mental state.

1. 4 If the detainee is found to be physically or mentally unwell at the routine (or urgent appointment) they will be managed by the health professionals in line with normal practice.

1. 5 Detainees who are refusing food and/or fluid will be fully entitled to confidentiality, to retain responsibility for their own health wherever possible and their ability to give informed consent will be assessed by appropriately trained health care staff.

1. 6 If the health professional considers that the detainee is refusing food as a way of pursuing a grievance, s/he should arrange for the Immigration Service contract monitor or CIO (the BIA manager) to speak to the detainee as soon as possible.

1.7 Health care appointments are available to food/fluid refusers whenever they wish to make one. Such appointments are made in the usual way as any other appointments within the centre.

1. 8 Detainees who are refusing food do not necessarily require to be seen on a daily basis by health care staff. However, Immigration Service staff will

need to be regularly informed of the state of health of a food refuser after food has been refused for more than five days and will require a daily update of the state of health of any detainee who has been refusing food and fluid for more than 24 hours. It is important that Border and Immigration Agency staff maintain a full written record of events and information passed on to them.

1.9 Food/fluid refusers requiring nursing care should be managed in one of the centres with 24-hour nursing. Centres without such facilities are advised to seek the transfer of fluid refusers at 48 hours and food refusers at 14 days. Immigration Service staff should follow advice given by their healthcare advisors and, if it is agreed that the detainee should be transferred, contact DEPMU. Form IS 91 RA Part C should be completed giving full details of the food and/or fluid refusal so that the most appropriate accommodation can be arranged.

1. 10 A food/fluid refuser can be admitted to full time nursing care to remove them from peer group pressure causing prolongation of the food and fluid refusal.

1.11 On arrival at a centre with 24-hour care the food/fluid refuser will be assessed. A detailed medical history and examination is appropriate. If they are not immediately in need of nursing care they will be managed in the main centre until such time as admission to the centre's healthcare beds is clinically indicated

1.12 When a food or fluid refuser becomes physically unwell as a consequence of their food/fluid refusal their health needs will be met by the health care staff as far as the food and fluid refuser allows.

1.13 At no time should undue coercion to eat or drink be applied.

1.14 Detainees who are refusing food and/or fluid should be encouraged to maintain family contact.

1.15 Admission to a NHS facility will be under the direction of the health professional in charge

1.16 It is likely to be unlawful to treat a detainee should they lose consciousness if their previous, clearly stated intention was to continue food/fluid refusal to death. Please see the following section about advance directives.

**Advance directives**

2.1 A detainee who is currently competent may wish to make a *"living will"* or *"advance directive"* specifying how they would like to be treated in the case of future incapacity. Where a detainee refusing food/fluids wishes to make such an advance directive, they may want their own legal adviser to draw it up. This is acceptable. Alternatively, a model version is attached to this Order.

2. 2. Detainees are unlikely to be aware of the ability to make an advance directive. As soon as a detainee begins to refuse food and fluids, and after a detainee has refused food for five days, he/she should be made aware of this facility. It is preferable that both the health professional and the BIA manager (either the contract monitor or the CIO) are present when the ability to make an advance directive is being explained to the detainee. The purpose of an advance directive should be spelt out to the detainee, as well as the fact that once an advance directive is made, whether written or oral, the detainee has the right to reverse this decision at any time during which they retain competence.

2.3 Case law requires that previously expressed wishes regarding medical treatment made by a detainee who is not, at the time of the treatment, in a state to express his wishes, shall be taken into account. An advance refusal of this kind is only valid if made voluntarily, by an appropriately informed person, with full capacity. Failure to respect such an advance directive may result in legal action against the practitioner.

2.4 Ideally the directive should be made in writing, signed by the detainee and the health professional determining capacity. However, it should be noted that it is not legally necessary for the refusal to be made in writing or formally witnessed. An oral directive must be followed if sufficient evidence of it, its terms and validity exist. As in the case of a written directive, a suitably qualified health professional will need to assess whether or not a person is competent to give an oral directive. A record of an oral directive should be made and formally signed by the health professional determining capacity.

2.5 Other forms of care, provided they are consistent with the terms of the directive, should continue to be provided. Basic or essential care includes keeping the detainee warm, clean, and free from distressing symptoms such as breathlessness, vomiting, and severe pain. However, some detainees may prefer to tolerate some discomfort if that means they remain more alert and able to respond to family and friends.

2.6 BIA are under no duty to administer treatment to a food/fluid refuser who has made a valid advance directive and a court declaration is not needed to establish this.

**Role of the health professionals**

3.1 Where a competent detainee refusing food and/or fluids is also refusing medical treatment at a time when a doctor judges it is becoming necessary, whether or not an advance refusal of treatment has been made, the doctor must explain the consequences of these refusals to the detainee, in the presence of another healthcare professional. These explanations must include the following information:

- That the deterioration in their health will be allowed to continue without medical intervention unless they request it;

- That continuing food/fluid refusal will lead to death. This must include a description of the process of dying in terms of pain, what can be offered to ameliorate those symptoms and the physical effects of refusal of nutrition;

- That prolonged food and fluid refusal which does not result in death may lead to permanent disability and organ damage.

3.2 It is important that this information is provided in a form that the detainee can understand. This may involve using an interpreter and every effort should be made to obtain the services of an interpreter as soon as possible. Should the detainee wish to use a fellow detainee or member of his/her family to interpret the doctor's explanation then this would be acceptable.

3.3 The doctor must:

- Write a full record of what has been said to the detainee, and the doctor, the second healthcare professional and the interpreter, if used, must sign to say that they were present when this advice was given. The doctor may wish to repeat this procedure from time to time;

- Consider the appropriateness of transferring the detainee to the healthcare centre at Harmondsworth, Colnbrook or Yarl's Wood;

- Inform the BIA Manager (the contract monitor or CIO) that this stage has been reached and request that the detainee is transferred to Harmondsworth, Colnbrook or Yarl's Wood as appropriate.

## Role of the BIA manager

4.1 A detainee who is refusing food and/or fluids may be using this as a way of pursuing a grievance.

4.2 It will be for the BIA contract monitor or CIO (the BIA manager) to establish whether there is a grievance and what this may be. The BIA manager must ensure that the detainee will be supported in pursuing a grievance through all legitimate channels (eg the BIA, legal representatives, the centre manager or the Visiting Committee). Detainees using food/fluid refusal as a means of protest may be prepared to eat and drink once they have access to an alternative means of pursuing a grievance. The BIA manager will wish to check every couple of days that the detainee's grievance/concern is being pursued.

4.3 The BIA manager must explain to the detainee, in the presence of a second IS officer, that continued food and fluid refusal:

- will not lead to the progress of the detainee's immigration or asylum case being halted or delayed;
- will not lead to removal directions being deferred;
- will not lead to permission to stay in the UK;
- will not lead to release from detention in order to prevent death.

4.4 The BIA manager must write a full record of what has been said to the detainee, and both the manager and the second BIA officer must sign to say that they were both present when this advice was given. The BIA manager may wish to repeat this procedure from time to time.

4.5 It is important that this information is provided in a form that the detainee can understand. This may involve using an interpreter and every effort should be made to obtain the services of an interpreter as soon as possible. Should the detainee wish to use a fellow detainee or member of his/her family to interpret the BIA manager's explanation then this would be acceptable.

**Reporting**

5.1 If the procedure outlined above is carried out correctly it will be the case that at all times the BIA manager will be aware of the current state of health of any detainee who is refusing foods and fluids.

5.2 The BIA manager must ensure that the Detention Service Operations Support Unit is kept informed in line with the Unit's instructions for reporting incidents. It is the Unit's responsibility to ensure that Senior Managers and Ministers are informed as appropriate and it is vital that the advice the Unit receives is accurate and current.

Detention Services
December 2004

**IMMIGRATION DETENTION: ADVANCE DIRECTIVE**

| | |
|---|---|
| **PORT REF.** | |
| **DC REF.** | |
| **HO REF.** | |

I, [*name* ] currently detained at [ ] Immigration Removal Centre, wish to state the following:

1. [I do not intend to eat]*.

2. [I do not intend to drink or otherwise receive fluids]*.

3. I do not wish to receive any treatment.

4. I do not consent to the administration of nutrition or hydration or any form of medical treatment whether resuscitation or otherwise designed to keep me alive, in the event that there is a deterioration in my condition

   - [unless there is a loss in consciousness]* [and/or in the event of a loss of consciousness]*
   - [unless I sustain any injury to my person howsoever caused] *[and/or in the event that I sustain any injury to my person howsoever caused]*.

5. I do/do not* consent to any medical or nursing care designed to keep me comfortable and free from pain in the event of serious deterioration in my condition [*If there is consent to some care, give details of any particular care that is offered and accepted by the detainee*].

6. It has been explained to me that if I refuse treatment in this manner, that my medical condition could deteriorate, that I could be in a great deal of pain, that I could lose consciousness and that I could die as a result of the refusal to consent to treatment.

7. I have read and had the contents of this directive read over to me [in [*language*], a language I understand] and I fully understand its contents and its effects.

8. I have been advised to take legal advice from an independent legal adviser on the contents and effect of this Directive. I have carefully reflected on the terms of this Directive, and have been advised to discuss its terms with my next of kin before signing it.

9. I am aware that I can change my mind and revoke this Directive at any time if I remain capable of making decisions about my medical treatment.

**Signed …….**

**Date of Birth ……**

| **Witness A** | **Witness B** |
|---|---|
| **Name:**<br>**Signature:** | **Name:**<br>**Signature:** |

| | |
|---|---|
| **Address:** | **Address:** |
| **Ideally one of the two witnesses should be the healthcare professional determining capacity** | |

** Delete as appropriate*