Oireachtas Joint Committee on Justice, Home Affairs and Migration

Opening Statement

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Good afternoon. I'm Nicola Perry, CEO of Safetynet Primary Care, and I am joined by my colleague, Medical Director Dr Angy Skuce. We would like to start by thanking the committee for the invitation to speak here today.

We are an HSE-funded organisation that provides health screening and medical assessments for newly arrived international protection applicants nationwide through our Mobile Health and Screening Unit. **Our detailed written submission sets out our full analysis and recommendations. Today, we want to highlight four areas where we believe the Bill could be strengthened, drawing on examples from our front-line clinical practice.**

While we welcome this Bill's reform objectives, our **experience has identified some gaps that, if addressed, would help ensure the health provisions achieve their intended purpose of protecting both individual well-being and public health.**

ISSUE ONE: THE CONSENT FRAMEWORK GAP

Head 18(5) allows medical information to be shared without consent. At the same time, Head 59(8) gives automatic access to these results for medical examination where torture or ill-treatment is alleged—even though Head 59(6) requires consent for those examinations themselves.

Why this matters in practice:

We have multiple examples of people concealing a diagnosis of HIV, fearing that this information would lead to discrimination in many areas, including their Protection Application. As a result, they went without life-preserving medication for many months, resulting in significant progression of their disease.

We recommend: Amending Head 18(5) to require informed consent before sharing medical information and ensuring independent medical practitioners conduct assessments in accordance with the Istanbul Protocol under Head 59.

ISSUE TWO: HEALTHCARE ACCESS AFTER DEPORTATION ORDERS

We are particularly concerned about this issue. Currently, when someone receives a deportation order, they lose access to their medical card immediately, and they are not entitled to avail of the Protection Applicant Medical card number. We **encounter this situation regularly in our clinical practice.**

CASE EXAMPLE 2 - Safetynet is fortunate to have the use of a generic medical card number, but we are not aware of any service outside Dublin that has the same. This means that people outside the greater Dublin area immediately lose access to

medications, leading to an inevitable deterioration in health that is unethical and could prove costly to the State. For someone with Diabetes, loss of their insulin supply will lead to hospital admission within days.

Our generic medical card also has limitations, with some medications not being available on it, including supplies for blood glucose monitoring for diabetes.

The period between the deportation order and actual deportation can extend for many months, with the likelihood of chronic conditions (heart disease, lung disease, inflammatory bowel disease) deteriorating and acute conditions such as chest infections going untreated. From a humane perspective, this is not acceptable, and from a health systems perspective, it is vastly inefficient.

We recommend **creating a provision that explicitly guarantees continued healthcare access for individuals subject to deportation orders, at a minimum,** for life-sustaining medications, communicable diseases, emergency care, and maternity care.

ISSUE THREE: ACCOMMODATION TRANSFERS AND CONTINUITY OF CARE

We have observed that short-notice transfers can create significant challenges for people with ongoing healthcare needs.

CASE EXAMPLE 3: A man who was blind was *scheduled for transfer from Dublin to Clare tented accommodation with 24 hours' notice. After 6 months of establishing independence, learning his way around, and attending a specialist eye clinic for sight-preserving treatment. Hotel staff recognised the concerns and sought assistance through various channels. We were eventually contacted, documented the medical situation, communicated with IPAS, and the move was reconsidered. Note: "This situation highlighted how care continuity depends significantly on informal connections and chance circumstances."*]

We recommend that provisions to protect medical care be taken into consideration during accommodation transfers, with formal mechanisms for accommodation staff to raise concerns about residents' medical needs.

ISSUE FOUR: MEDICO-LEGAL ASSESSMENT CAPACITY

Many applicants would benefit from Istanbul Protocol reports to support their applications, but the current capacity is limited. **Our written submission discusses this in detail.**

CASE EXAMPLE 4 - It is currently not possible for the majority of applicants (if any) to obtain an Istanbul Protocol-compliant report in 3/12. Our services are struggling to

manage demands that are beyond our capacity to fulfil, and our resources are unavoidably diverted from providing actual Primary Care. People are requesting a copy of their medical records to bring with them to their Interview, which records are a wholly inadequate substitute for a medico-legal report.

As processing timelines accelerate, we are concerned that assessment capacity may not keep pace with demand.

We recommend: Significantly increased funding to organisations like Spirasi and/or consideration of a state-funded medico-legal assessment service to ensure adequate capacity.

ADDITIONAL TECHNICAL POINTS

Our written submission and briefing paper include further recommendations on:

- Head 18(3): Strengthening "access" to "timely and meaningful access" to address practical barriers such as transport, childcare, and financial constraints.
- Head 18(1)(a): Clarifying "acute medical care" to include "acute or essential medical care"—addressing conditions before they deteriorate.
- Head 48(10): Ensuring specialised assessment by independent practitioners with trauma expertise when determining fitness for interview.
- Qualification requirements for medical practitioners conducting health checks.
- Food provision in accommodation to address medical dietary needs (diabetes, lactose intolerance, allergies).
- Age assessment procedures for unaccompanied minors.

CONCLUSION

The content of our statement and subsequent submission is informed by our daily clinical experience working with this population. We are committed to working with the state and other agencies to ensure healthcare access across procedures.

We thank you again for the opportunity for this discussion today.