International Protection Bill 2025 – Submission on behalf of Safetynet Primary Care

Safetynet Primary Care is a medical charity, funded largely by the HSE, to provide Primary Care to people with no other access, and to provide Health Screening to recently arrived Protection Applicants. We have much experience in this area and are fortunate to have long-standing excellent working relationships with many other organisations that provide health and social care and other supports to Protection Applicants. This submission is based on many years of experience of providing front-line care, both acute and continuing, and highlights issues that we have learned are very important to the people we provide care to.

We have limited comments to areas directly relating to health and healthcare, which is our area of expertise.

We are very glad to see the current system being reviewed and hope that changes will allow the human rights and dignity of Protection Applicants to be respected in ways that they are currently not.

There are three problems that we face regularly that impact very much on the health and well-being of the Protection Applicants that we see, that don't appear to be addressed in this iteration of the proposed Bill:

1 - Access to Medico-Legal reports
Many people would benefit from having a medico-legal report to support their application. People are sometimes too traumatised, and often don't have enough medical knowledge to adequately articulate the health problems they are suffering from. Safetynet does not have capacity to provide these reports. There are very few services/doctors who do and there is therefore a very long waiting-time for someone to get one. If the application process is speeded up, which would be very welcome, many more people will not be able to get a medico-legal report in time for their interview. Consideration should be given to significantly increasing the capacity in Ireland for this – perhaps by significantly increasing funding to eg Spirasi, or by establishing a service whereby doctors and psychologists are directly employed by the State for this purpose.

2 - Accommodation
It goes without saying that no Protection Applicant should be left roofless. A different problem that we often face is the transient nature of accommodation offered. We very regularly have to get involved in either trying to stop a person being moved to accommodation in another part of the country, or in trying to get their care transferred when we find out they have been moved. An example is a man who was blind (could see light and outlines) and regularly attending an Eye Clinic in Dublin. We were contacted by a local politician to say he was being transferred from a Dublin hotel to tented accommodation in Co.Clare the next day. The hotel staff and the politician had tried to get the move stopped, without success. After 6 months in Dublin, the man had established a degree of independence having learned his way around his accommodation and the local area. To have moved him to tented accommodation would have completely incapacitated him, and interrupted the treatment that was preserving what remained of his sight. Thankfully, IPAS responded to my email and the move didn't go ahead. It was fortunate that the politician had my phone number and that I had access to the man's medical record – too precarious a system to be relied on.
We need a system whereby people with significant health problems are not moved at short notice, and where the knowledge and experience of accommodation staff is given more credence when such transfers are planned.
The standard of accommodation provided varies a lot, and food provided is often a significant problem in relation to health. People with Diabetes cannot follow a low carbohydrate diet. Lactose intolerance is very common in some populations and the dairy-heavy Irish diet causes health

problems. Food is such an important part of culture, that eating unfamiliar food with little choice really affects people's well-being adversely.

3 - Deportation Orders – the loss of access to healthcare.

This is a problem that we are seeing increasingly often now. When someone is issued with a Deportation Order, they are no longer entitled to use their Medical Card, or to use the generic Medical Card that can be used to prescribe for all Protection Applicants. This means for most people that they cannot get medication – including medication such as insulin without which a person would quickly become very ill and die.

Safetynet has other generic medical cards that we can use for the people under our care, but for people outside Dublin or who attend a different GP service, they have no access. This is inhumane, and likely to result in higher costs for the health service, when people's conditions deteriorate and they end up needing acute hospital care.

Head 18: Preliminary Health Checks.

(1) Applicants subject to screening shall be subject to a preliminary health check to be carried out with registered medical practitioners with a view to identifying applicants with –
(a) acute medical care, and

Comment 1 - 'Registered Medical Practitioners' – should state 'suitably qualified registered medical practitioners' preferably on the Specialist register for General Practice, or eligible to be so registered.

Comment 2 – (a) should read 'a need for acute or essential medical care'. Not all essential medical care is acute, but leaving some conditions untreated for even a few weeks can lead to deterioration in a condition such that it becomes acute or leads to irreversible damage.

3 – 'Applicants subject to screening shall have access to emergency health care and essential treatment of illnesses.'

Comment 3 – above should read 'Applicants shall have timely and meaningful access to necessary healthcare and essential treatment of illnesses and health problems'. It is our experience that there are occasions when care might be available, but a PA cannot access it because of a lack of transport, funds, childcare, or other barrier.

(5) The results of the preliminary health check shall be made available to the applicant as soon as practicable and shall be accessible to the Minister, competent authorities, and the Second Instance Body, where applicable.

Comment 4 – the confidentiality of all PAs must be respected. Consent to share the results of any health check should be sought, and in the absence of consent, information only shared where required under legislation eg under section 38 of the Health Act 1947. Fear of negative consequences (however unfounded) often means that people do not disclose significant health conditions, to their detriment and to the detriment of our health care system, when conditions progress/deteriorate and require hospital admission etc.

It should be clear in this section that the State will provide the Preliminary Health Checks.

Head 24: Screening form
Provide that:

(1) The Minister shall complete a form in respect of applicants who have been screened, containing the following
(d) information on the preliminary health check carried out in accordance with head 18, including where, based on the circumstances concerning the general state of each individual applicant, no further health check was necessary

Comment 5 – as before, only information for which consent has been given, or information required under existing Public Health law, should be included

Head 48: Requirements for personal interviews
heads 47, 33 and 36 shall, whenever necessary for the purpose of ensuring appropriate communication during a personal interview, be provided by the Minister or Minister with the services of an interpreter. (3) To give effect to heads 47, 33, and 36, the Minister shall— (a) ensure that the persons who conduct the personal interviews are sufficiently competent to take account of the personal or general circumstances surrounding the application, including the applicant's cultural origin or vulnerability, insofar as it is possible to do so, and (b) in the case of interviews to which subhead (2) applies, select interpreters who are able to ensure appropriate communication between the applicant and the person who conducts the interview. (4) The requirement in subhead (3)(b) shall be regarded as complied with if interpretation is provided in a language that the applicant may reasonably be supposed to understand and in which he or she is able to communicate.

Comment 6 – issues other than language need to be taken into account when providing interpreting. The gender, cultural group, and possible community association of an interpreter are sometimes absolute barriers to meaningful communication, and need to be taken into consideration.

Head YY – Age Assessment

Comment 7 – There are references to an as-yet not published Head regarding Age Assessment. Situations where there is doubt about the age of an Unaccompanied Minor (commonly referred to as age-disputed minors) are a very significant area of concern for us, for a number of reasons – the vulnerability of and damage caused to young people accommodated with adults and without adequate support; lack of access to education; extreme difficulty in accessing secondary healthcare (especially psychiatric care) for people whose given date of birth makes them a minor, but who are not in the care of Tusla / do not have a responsible adult. We are cognisant of the fact that there is no means by which it is possible to accurately assess a young person's age, and also of the vulnerability of other young people if an adult is inadvertently accommodated with them. A middle ground needs to be found, where young people are given the care they might plausibly need, while protecting other young people. This might include a prolonged period of observation/assessment during which the young person is in the care of Tusla.
We ask that when this Head is drafted, we again have an opportunity to review and submit comment.