MILLION

Planning better outcomes and support for unaccompanied asylum seeking children - A response by 11 MILLION led by the Children's Commissioner for England, supported by the Children's Commissioners for Scotland, Wales and Northern Ireland.

31st May 2007

This document is aimed at:

* The Borders and Immigration Agency
* Children and young people that 11 MILLION has involved in preparing this response
* Organisations working with young asylum seekers

"Please do not waste our lives please – we R children"
Young asylum seeker

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1 Who are we?

11 MILLION is a national organisation led by the Children's Commissioner for England, Professor Sir Al Aynsley-Green. The Children's Commissioner is a position created by the Children Act 2004.

Our mission

We will use our powers and independence to ensure that the views of children and young people are routinely asked for, listened to and that outcomes for children improve over time. We will do this in partnership with others, by bringing children and young people into the heart of the decision-making process to increase understanding of their best interests.

The Children Act 2004

The Children Act requires the Children's Commissioner for England to be concerned with the five aspects of well-being covered in *Every Child Matters* – the national government initiative aimed at improving outcomes for all children. It also requires us to have regard to the United Nations Convention on the Rights of the Child (UNCRC). The UNCRC underpins our work and informs which areas and issues on which we focus our efforts.

Our long-term goals

Children and young people see significant improvements in their wellbeing and can freely enjoy their rights under the United Nations Convention on the Rights of the Child (UNCRC).

Children and young people are more highly valued by adult society.

Spotlight areas

'Asylum and trafficking' is one 11 MILLION's 'Spotlight' areas for 2007/8. These are areas in which we will influence emerging policy and debate.

2 Introduction

This response has been written by 11 MILLION led by the Children's Commissioner for England, and refers mainly to English legislation and guidance. The response has been viewed and supported by all of the UK Children's Commissioners. The Commissioners for Scotland and Wales will be making an additional response to the consultation which will address the issues in their own national or regional context.

We aim to make our reports easy to read for people without specialist knowledge of policy areas. See section 8 for a list of words and abbreviations used in this document that might need further explanation.

The four Children's Commissioners for each part of the United Kingdom were established under separate statutory arrangements and have differing powers. However, all the Commissioners use the United Nations Convention on the Rights of the Child (UNCRC) to underpin their work with children and young people. We are all committed to listening to children and young people and giving a voice to their concerns. We believe that the British Government's reservation to the UNCRC – which mainly affects those children who come to the UK seeking asylum - inhibits these children from realising the universal rights established under the UNCRC and in doing so breaches one of its most important articles – that of non-discrimination. Many of the proposals outlined in the current consultation widen the 'rights gap' between children who are citizens of the UK and those who are seeking its protection and would have a negative impact on outcomes for children.

'I believe the new laws are very selfish minded and will not benefit the Government in the long run therefore a lot of young people will suffer'
Young asylum seeker

Asylum seeking children and young people who are separated from their parents or customary care givers are a 'particularly vulnerable group' [1]. Like other young people, although they are often reflective about their past, their homes and their loved ones, their lives are more bound up with their present struggles and their hopes for the future.

These children tell us that their initial feelings of relief at arriving in a place of safety are often shattered as they encounter obstacles at being believed – whether about their age or about their reasons for leaving their country - and about accessing the things they need to make their lives safe, worthwhile and fulfilling. Overwhelmingly, they tell us that the uncertainty surrounding their future causes them great difficulties and makes it hard for them to integrate or settle.

Arrangements for care under the *Children Act 1989* mean that, typically, these children's most pressing physical needs are met (when they are

[1] Committee on the Rights of the Child, General Comment No.6 (2005) "Treatment of Unaccompanied and Separated Children Outside their Country of Origin" – paragraph 4.

‘accepted’ as a child) – in that they are provided with accommodation and financial support. However, the quality of the care they receive from Children’s Services Authorities is very variable and many of their wider needs as children are not adequately met by the various agencies they are required to negotiate.

Our view is that at least part of the problem is the inadequate levels of funding provided to local authorities to care for these children both under the Home Office grant to the under 18’s and the DfES grant to the over 18’s. We recommend that adequate levels of funding are provided for both groups to allow local authorities to meet their legal obligations under the *Children Act 1989* and related legislation.

Unaccompanied children in the UK also do not benefit from the appointment of a legal guardian to represent their best interests. The Home Office has consistently stated that this is not necessary as their best interests can be represented by their social workers along with the ‘safety net’ of the Children’s Panel of Advisor’s. The Children’s Commissioner does not accept that these arrangements are adequate. In our experience many children under social services care are not even appointed their own social worker and the children’s panel, while providing an excellent service, is unable to meet the demand for its services and has no statutory role. We recommend the proposals in this consultation are underpinned by the appointment of a legal guardian for every unaccompanied child as recommended by the United Nations Committee on the Rights of the Child.[2]

In preparing this response 11 MILLION, led by the Children’s Commissioner, has consulted four groups of young asylum seekers in different areas of England. Some had obtained permanent status, but most had been given only temporary permission to stay in the form of ‘Discretionary’ or ‘Exceptional’ leave to remain. The vast majority were either currently being looked after by a local authority or were still receiving help under ‘leaving care’ arrangements. In all, we spoke to around 40 children and young people. We are very grateful to all of them for their insightful contributions and comments on the proposals. We sincerely hope that the Home Office will also listen to what these young people have been telling us. **All the quotations from young people in this response have come from these consultations unless otherwise stated**. We have not attached names or ages to the quotations in order to preserve anonymity.

[2] Ibid, paragraph 33

3 Scope of the paper –
Our response to paragraphs 1-9 in Planning Better Outcomes and Support for Unaccompanied Asylum Seeking Children

We welcome the definition of an unaccompanied asylum seeking child adopted in the consultation document. In September 2006, the UK Children's Commissioners responded to the Joint Committee on Human Rights enquiry into the treatment of asylum seekers. One issue we highlighted was that the Home Office did not consider asylum seeking children to be unaccompanied if they were being cared for by *'an adult who is responsible for them'* as distinct from an adult who is responsible for them *'by law or custom'.* The latter definition more closely matches the internationally accepted definition used by United Nations High Commission for Refugees (UNHCR), the Committee on the Rights of the Child and in a number of European Union (EU) Directives.

The old Home Office definition put children at risk in various ways. Siblings judged to be over 18 were sometimes inappropriately left to care for their younger brothers or sisters within the adult asylum support system. Children were exposed to being cared for by adults whom they may not have known in their country or origin or who had trafficked them into the UK with inadequate safeguards in place to check their suitability as carers.

We hope that the definition adopted in the consultation document will reduce the risks to children. However, this will only happen if the Government ensures that the same definition is used throughout the Borders and Immigration Agency (BIA) in all its functions. This will require changes to the Asylum Policy Instruction on children. In particular, funding guidance to local authorities should reflect the definition adopted in this consultation.

'What's the difference between a young asylum seeker and a young indigenous person?'
Young asylum seeker

In terms of the consultation proposals, the initial assessment by a social services authority should take into account that some unaccompanied children (by the definition used here) will be best cared for by other family members already present in the country[3] and not necessarily in specialist authorities. This will have implications for social work services even where outside of a specialist authority.

We take it as given that young asylum seekers matter every bit as much as other young people in the context of meeting the five outcomes of the *Every Child Matters* framework but question the emphasis in Chapter 1 on their 'different and particular needs'. Asylum seeking children whom we talked to are very clear on this point:

[3] This is in line with guidance given in the CRC 'General Comment No.6 (2005) *"A child who has adult relatives arriving with him or her or already living in the country of asylum should be allowed to stay with them unless such actions would be contrary to the best interests of the child. Given the particular vulnerabilities of the child, regular assessments should be conducted by social welfare personnel."* – paragraph 40.

“What’s the difference between a young asylum seeker and a young indigenous person?”

“Do not treat them in different way to your child.”

“To compare British young people and refugee young people, the issues may not be the same, but they are at the same level. It terms of the psychological affects of whatever experience, it’s the same level.”

The ‘issues’ are different mainly because asylum seeking children have to negotiate an immigration system – although we accept that many asylum seeking children will have additional needs arising from their experience of trauma. In all other respects, asylum seeking children have needs that they share in common with other children – either in or out of the care system: to be loved, cared for, appreciated and valued for their unique talents and aspirations and to be treated with respect. Such needs are universally accepted and have been translated into the rights that are contained in the United Nations Convention on the Rights of the Child. The starting-point for meeting their needs and acknowledging their rights is to consider them as children first and foremost. This implies flexibility both in care planning *and* in the immigration processes.

We agree that many of the proposals highlighted in the DfES Green Paper *Care Matters: Transforming the Lives of Children and Young People in Care* apply equally to this group of children. Those proposals, of course, relate only to children in care. We are very concerned by what we see as a growing trend to remove asylum seeking children from the formal care system at the earliest opportunity and provide them with a lesser level of service under the ‘leaving care’ arrangements of the *Children Act 1989* between the ages of 16-18. We do not accept that these are appropriate arrangements or that asylum seeking children understand what it means to be ‘de-accommodated’ in this manner. Such arrangements may also be unlawful in certain circumstances. We are concerned that if unaccompanied asylum seeking children are ‘de-accommodated’ and therefore taken out of the care system they will not benefit from the helpful proposals in *Care Matters.* We therefore recommend that all unaccompanied asylum seeking children remain ‘looked after’ (in the formal care system) until they are 18 years old unless fully informed consent can be obtained to a different care route.

4 Why improvements need to be made - Our response to paragraphs 10-21 in Planning Better Outcomes and Support for Unaccompanied Asylum Seeking Children

We are not opposed in principle to placing unaccompanied children in a limited number of specialist authorities although the children and young people we talked to had a mixed response to this proposal and some expressed their anxieties concerning integration, racism and the administrative competence of the Home Office.

‘‘If young people have to be moved it should happen quickly, because if you arrive somewhere you can get attached very quickly to a place and the people there.”

“If they keep moving you around, there will be no integration.”

“If you change address, they often send you stuff to the wrong address, then you don’t receive important letters, and don’t reply to them and that can be very damaging to your case.”

“The further North you go, the more racism there is, because all they see there is what the media says.”

“When I go up north, they all look at me, and I think ‘I just want to go home!’ It’s not like that here in London.”

The argument for more planned geographical distribution through the transfer of placements into specialist authorities could provide a backdrop for greater consistency of provision and aid the development of specialist services. However, greater consistency in the numbers being supported in each specialist authority will not in itself resolve the issue of inconsistent service provision.

Paragraph 16 of the consultation says that: *“We are also aware that, notwithstanding the statutory guidance on the issue, there is considerable variation in its interpretation, in terms of whether authorities continue to support young people through either the provisions of section 17 or section 20 of the Children Act 1989.”* (Emphasis added)

Unfortunately, the guidance referred to[4] –is *not* ‘statutory guidance’[5] If consistency of service provision is to be realised then there needs to be *statutory* guidance issued to local authorities.

[4] In England, Local Authority Circular (2003) 13

'If you change address, they often send you stuff to the wrong address, then you don't receive important letters, and don't reply to them and that can be very damaging to your case.'
Young asylum seeker

We are greatly concerned that some local authorities continue to routinely provide services to separated asylum seeking children under section 17 rather than section 20 of the *Children Act 1989,* apparently ignoring the current non-statutory guidance.

In order to improve consistency of service provision, we recommend that either the current guidance is made subject to section 7 of the Local Authorities Social Services Act (LASSA) 1970 or that new statutory guidance is issued. We also recommend that equivalent statutory guidance be issued for Scotland, Wales and Northern Ireland if local authorities within these regions are to become specialist authorities.

Finally, we think that the grant provided by the Home Office to local authorities for the care of unaccompanied asylum seeking children should be made contingent upon services being provided in accordance with the guidance. The current guidance makes it clear that the 'default' position in respect of the care arrangements for unaccompanied asylum seeking children is section 20 of the *Children Act 1989.* Local authorities who indicate in their grant claim that they are supporting children under any other provision of the Act should have their grant for each such child withheld until they can demonstrate that *informed consent* has been given by the young person to this alternative route of assistance including a full understanding of the implications for 'leaving care' provision and continued oversight of their case by an independent reviewing officer.

[5] 'Statutory Guidance' is subject to section 7 of the *Local Authorities Social Services Act 1970* which requires councils to act under the Guidance of the Secretary of State unless local circumstances indicate exceptional reasons not to.

5 The journey through the asylum and support system - Our response to paragraphs 22-57 in Planning Better Outcomes and Support for Unaccompanied Asylum Seeking Children

Sponsoring key messages in countries of origin - Paragraph 23

There is not a consultation question relating to this section of the paper. We are disturbed by the 'key message' that *'we must safeguard the asylum system from abuse'*. 'Safeguarding' in the context of a document relating to children must be about meeting duties to the child, not about protecting the system from children. Most children we talked to reacted with dismay to this proposal and felt it reflected an inappropriate and inaccurate understanding of what led them to seek asylum:

"Some people have a reason to come to the UK. No one thinks England is heaven. Everyone wants to go back. If I had no problem I'd go back then."

"I didn't expect the best in the UK. When you have a gun to your head, I wanted to save my life. I would have come under a train – any way at all."

"It's outrageous. I feel like crying, I want to put my head in my hands and just cry."

"It could have affected me. I didn't choose to be in a war or to come here – I was a child. It's not a choice, you don't choose, you don't make the decisions. Sometimes your own government makes the decisions not to let you back into your own country."

"This says 'you're stealing from us' to me. It's insulting."

"It's so full of themselves. It assumes that this country is what everyone is looking for."

"Before I came I didn't even know what England was, let alone dream about it."

"It's degrading."

These responses show us that the underlying assumption that permeates the consultation – that these children do not really have protection needs and that their claims are therefore 'abusive' – is utterly misconceived. The historic failure of the asylum determination system to

properly account for asylum seeking children's protection needs must be at the heart of reforming the current arrangements.

There is a further point that if any campaign in countries of origin to prevent children from reaching the UK takes the form of preventing them from travelling (as was the case with Roma from the Czech Republic some time ago), then children and young people will be put at further risk by placing them more firmly in the hands of people smugglers. The 'best interests' principle requires the Government to allow access to the territory of the UK.[6] As the children's views show, many do not see travel to the UK as a 'choice' but leave in extreme circumstances to seek safety.

Initial assessments, including age determination - Paragraphs 24-31

This section of the document has two core proposals which try to address the issue of determining the age of an asylum applicant. Only one of these is subject to a consultation question – the legitimacy of using compulsory dental X-rays or other medical examination to 'improve' age assessment. The other 'improvement' is the co-location of social workers at major ports of entry and asylum screening units. This must be regarded as a 'fait accompli' given that no response is sought. In our view this idea is seriously misguided and we urge the Borders and Immigration Agency (BIA) to re-examine their commitment to it in light of the forthcoming publication of research by the Immigration Law Practitioners Association *When is a child not a child? Asylum, age disputes and the process of age assessment.*

The Children's Commissioner's view on this matter is informed by the guidance given by the Committee on the Rights of the Child[7] which states that *"the assessment must be conducted in a scientific, safe, child and gender-sensitive and fair manner, avoiding the risk of violation of the physical integrity of the child; giving due respect to human dignity; and, in the event of remaining uncertainty, should accord the individual the benefit of the doubt such that if there is a possibility that the individual is a child, she or he should be treated as such."*

Proposal 1: Co-location of social workers with immigration staff

The 'co-location' of 'specialist' social work teams at ports of entry and Asylum Screening Units to 'work alongside immigration officials' in order to facilitate instant age assessments is an unacceptable approach. There is wide agreement within social work that an age assessment should be conducted in the context of an initial assessment of need. These places are not an appropriate setting for a detailed and sensitive initial assessment of need to take place. Children are not in a position at this stage of the process to understand what is required of them let alone the differing roles of immigration officers and social workers.

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[6] CRC, General Comment No.6, paragraph 20.
[7] Ibid, paragraph 31 (i)

"On arrival – main thoughts are you are in a new country don't know what to answer. Don't know why you are being asked questions. Might say nothing. Might be scared."

This is how the young people we spoke to reacted to the idea of co-located social workers:

"It doesn't work having Social Workers in the Home Office. With hundreds of young people coming in every day – imagine that you see so many people, how will you know what age each person is? If you see it over and over, you just become like a machine."

"Working in that context (with the Home Office) you'd just assume already that they are NOT under 18. That would be the starting point."

'It's outrageous. I feel like crying, I want to put my head in my hands and just cry.' Young asylum seeker

We agree with these views. Inevitably, any process of age determination at ports or screening units would be constrained by the pressure of resources and numbers of applicants present on the day. Conducting assessments in circumstances where there would be considerable pressure to conclude them within timescales that meet with a Home Office driven agenda in respect of the New Asylum Model is not acceptable.

Some young people were baffled by the idea that anyone should want to lie about their age while others, on reflection, tried to understand the Home Office perspective:

"Why would someone change their age? Before I came I never heard about changing age."

"Some people may lie about their age. I'm trying to see the Home Office point of view here, but you have to find the right way to deal with it. But this way, you are made to feel like a criminal. Is that the right way of doing it?"

The children and young people we spoke to were also aware of the how their own experiences may make them appear older than British children of the same age and agreed that a visual assessment was not a good way of assessing age:

"Where I come from the sun is hotter, wrinkles come quicker – sun ages the skin."

"People have had a hard life - living under a hot sun."

"Not a good idea to look at someone's face to guess their age."

"I think every day about how to make my life better. I think about my country. I am 'aged' by the experiences and processes I've been through. English young people have it easy – they are big babies."

Proposal 2: The use of medical procedures to assess age

We have four main objections to the use of medical procedures such as dental assessments to assist with the assessment of age:

i) The fundamental misunderstanding in believing that an X-ray of teeth or of the skeleton can give an 'accurate' chronological age of a child. There is substantial normal variation in the speed with which young people attain sexual and skeletal maturity. The proposed X-rays demand specialist interpretation, and it is naïve to argue that they can determine the child's chronological 'age' – all X-rays can do is indicate the degree of skeletal maturity that has taken place. The 1999 Guidelines by the Royal College of Paediatric Health which reject this suggestion still hold good today. The 'research' mentioned in the consultation exercise should be open to professional scrutiny if the Home Office decides to go ahead with this approach. We are certain that the weight of professional opinion is strongly opposed to the approach suggested[8].

ii) We question the ethics of subjecting children to an invasive investigation that is of no therapeutic benefit to them.

iii) We also query whether consent from extremely vulnerable and potentially traumatised children, most of whom speak or understand minimal English, can be properly given. The coercive proposal that a refusal to undergo an X-ray should 'strongly inform the final decision on

[8] We have appended two items in support of our understanding that professional opinion is against this proposal. The first is an article by Neil Cameron *'Estimation of Chronological age in Children'* which first appeared in *Science and Public Policy* in February 1982 and which the author forwarded to us. The second is a personal letter to the Commissioner by Professor Peter Hindmarsh, Professor of Paediatric Endocrinology at the Institute of Child Health responding directly to the proposed use of dental and bone assessment in the Consultation document.

age' makes a mockery of the idea that consent can be genuinely given. As Professor Hindmarsh[9] puts it:

> "*..Given the age of the child in question any examination would require a process of informed consent to be followed and this would require detailed explanation of the investigation proposed along with an acknowledgement that the examination was of no benefit to the individual concerned. It is doubtful given the environment in which these examinations are proposed to be undertaken that informed consent could be obtained in a manner which we would recognise as part of Good Clinical Practice."*

iv) Paragraph 29 of the consultation suggests that such an X-ray would provide the opportunity to assess dental health. This is in our view tricking the young person since the prime motive would be to assess their age rather than offer them treatment.

Many of the children and young people we spoke to reacted with dismay and fear at these proposals while a smaller number saw it as better than visual assessment.

"You are scaring me"

"It means they don't want to accept any new refugees – best to close the country down"

"It's obvious that what they are trying to do is not accept anyone."

"I'm not scared by the idea"

''We don't care – you can't tell by looking at people's faces"

The majority of the young people we spoke to had real concerns about the proposal for X-ray examinations:

"If you've been physically abused, raped, in your country, the whole idea of someone going through your body – it's horrible."

"Isn't it against human rights? We're talking about children here, aren't we?"

"The physical changes of each individual are different. How reliable are these tests anyway?"

[9] See **Appendix 2** - letter from Peter Hindmarsh to the Children's Commissioner, 29th May 2007

“If they say that if you refuse it then you won’t be believed, then that’s not really a choice is it?”

“Are young people informed of this? About what it means if they refuse?”

“Where is this going to happen? Because if it’s the Home Office doing it, they could just make up the results to reduce costs.”

“Scared – what the heck is that?”

“Not told what it is for.”

“No interpretation – might think they want to take teeth!”

“Might be scared – don’t know what is going to happen.”

“Dentists might judge you (be prejudiced) and say you are older.”

“You can’t dispute a doctor if he says you are older.”

We share the view of the recommendations in the forthcoming report from the Immigration Law Practitioners Association (ILPA) that where the ‘benefit of doubt’ can not be given, then an age assessment should take place at a regional age assessment centre by social workers and a range of other professionals. A key feature of the arrangement is that the local authority that would be responsible for the ongoing care of the young person should not be involved in the age assessment process.

Transfer to specialist authorities - Paragraph 32 – 34

We have stated earlier that we are not opposed in principle to transfer to specialist authorities but it is clear that a great deal more work needs to be done to see how this would work in practice. For example, would a child landing in a rural area or small town be transferred first to an ‘assessing authority’ and then to a ‘specialist authority’? Three moves in a short space of time are likely to be very unsettling for a child.[10] There is also the broader and unresolved question of how moving children from one authority to another fits in with the rigid timescales of the children’s segment of the New Asylum Model (NAM) and the requirements to attend various events – screening, first reporting events, the asylum interview and the decision interview. We believe that there is a strong argument for NAM processes to be put ‘on hold’ where it is known that a child will be transferred to a specialist authority relatively quickly. The NAM process could then start once the child is settled in the specialist authority. This would also have the advantage of

[10] “ In order to ensure continuity of care and considering the best interests of the child, changes in residence for unaccompanied and separated children should be limited to instances where such change is in the best interests of the child.” – CRC, general comment No 6 (2005) , paragraph 40.

providing time for the resolution of any age dispute prior to entry into NAM and would help with making sure that the child had access to legal representation.

The assessment of longer-term care needs is not a single act and the question of where this assessment takes place (either before or after transfer) is therefore unhelpful. Rather assessment is an ongoing process that should take place both when the young person first arrives and then once the young person has been placed to ensure that the placement is suitable and meets the needs of the particular individual.

If a decision is made by the 'initial' authority that a placement in semi-supported accommodation is 'suitable', there must be arrangements in place following transfer to ensure that that assessment is still valid in the context in which the child or young person finds him or herself. We firmly believe that it would be exceptional for a local authority to accommodate an unaccompanied child other than under section 20 of the *Children Act 1989*. It would be inappropriate for an initial authority to arrive at a decision to assist a child under section 17 and transfer the individual on that basis.

Assessment of need and placement -Paragraph 35 – 37:

Decisions on where a child is placed must be made according to need rather than on a pre-determined age of 16. We do not think there is a role for the Home Office in making decisions about children's placements. This must be done by child care professionals, whose job it is to take into account the wishes and views of the young person and act in their best interests. We are concerned at the implication in question 6 that the Home Office see a role for themselves in the management of placement decisions. The current grant arrangements whereby children under 16 are funded at a higher rate than children over 16 already means that there is enormous pressure on children to leave their foster placements when they are not ready to do so. We have seen a number of examples of social workers colluding in the process of removing children from foster placements at age 16 with the stated reason being the financial constraints on them. We believe that the current grant arrangements lend themselves to social workers making decisions on foster placements which are financially driven rather than directed by what is in the child's best interests. The proposal in the consultation appears to us as an attempt to institutionalise this poor practice and is contrary to the guidance given by the United Nations Committee on the Rights of the Child.[11]

The young people we talked to felt that they were often forced into independence too early. Others were particularly concerned with how independent living sat with any schedule of examinations they might be taking:

[11] Ibid – paragraph 40

“It should be the choice of individuals when they leave foster care. They are hugely stressed on exams and learning English, stressed through not knowing if you can stay, dealing with legal jargon that you don’t understand, being advised one thing be your social worker, another thing be the Home Office… and then told to live independently – where do you breathe?”

“It should be the young people’s choice, and foster parents, and social services, together, to say if they are ready to live independently.”

“When you’re 16, living alone, you’re so vulnerable to get involved in all sorts of things; drugs, crime, dangerous activities, – this has an implication for the whole of the UK.”

“Moving to live on your own drains you out.”

“The only network they have is with their foster family.”

“You should let children finish their education before moving them from the places they are in.”

Others questioned whether this was discriminatory in relation to children from the UK in care. In the light of the options presented in *Care Matters* suggesting that a child might have a veto on being moved from foster care prior to age of 18, they might be correct:

“**Does this apply to all young people in care, or just asylum seekers?”**

“There are two different laws.”

The Asylum Application - Paragraph 38 – 47

The consultation document *‘accepts that the process of determining asylum applications from unaccompanied asylum seeking children needs to be improved’* and this is to be welcome. In 11 MILLION’s news release in response to the launch of this consultation, we said: *‘The historic failure of the asylum determination system to properly account for separated children’s protection needs mean that these proposals present a high risk strategy which jeopardizes the Government’s commitment to safeguarding children.’* We expand on what we meant by this below.

We are concerned about the proposed procedural changes to the way asylum claims from children are handled. Some of the changes may be

welcome, but we do not yet have the evidence to say so with any degree of certainty. We accept that the old system of submitting evidence via the Statement of Evidence Form was inadequate and has not served children well. This is reflected in the low numbers of children recognised as refugees referred to in the consultation. However, the dramatic rush to interviewing all children over the age of twelve appears not to have arisen from any evidence based research or consideration of alternative approaches. There may be real problems in interviewing children as young as twelve – particularly if they have been traumatised by their experiences. Re-traumatising children through the interview process is a distinct possibility. We would like to see an independent evaluation of the New Asylum Model's (NAM) children's segment started as soon as possible. However, we firmly believe that *procedural changes alone* are insufficient to fully get to grips with children's protection needs.

It is not enough to make procedural changes without at the same time ensuring that a child sensitive approach is adopted to the *substance* of the claim. As United Nations High Commission for Refugees (UNHCR) have recently put it: *'[children's] special vulnerabilities require an age sensitive approach to be adopted in relation to substantive aspects of refugee law as well as procedures. If not, the risk of failing to recognize child specific forms of persecution or underestimating the particular fears of children is high.'*[12]

In incorporating the EU Qualification Directive[13] into domestic legislation the Government failed to address the issue of 'child specific persecution'. Article 9 (2) of the Directive describes the form that 'acts of persecution' might take in order to qualify under the 1951 Refugee Convention. Article 9 (2) (f) refers to *'acts of a gender-specific or child specific nature'*. [14]

Following a period of consultation, the Directive was implemented through changes to the Immigration Rules and through secondary legislation[15] . Despite transposing every other 'act of persecution' from the Directive word for word, the regulations omitted any reference to Article 9(2) (f). This cannot have been an oversight since it was specifically mentioned in the Children's Commissioner's response to that consultation. We have never received a reason why gender and child specific acts of persecution were omitted in this way. We therefore remain to be convinced that the Government has fully accepted that child specific acts of persecution fall within the Refugee Convention. While we welcome mention of 'child specific persecution' in the recent

[12] Nicholson FT, 'Refugee Protection in International Law' , page 57
[13] Council Directive 2004/83/EC
[14]UNHCR: Nicholson FT, Refugee Protection in International Law considers that "The range of potential [Refugee Convention] claims with an age dimension is broad, including forcible or under age recruitment into military service, family or domestic violence, infanticide, forced or under-age marriage, female genital mutilation, forced labour, forced prostitution, child pornography and trafficking."
[15] UNHCR: Refugee or Person in need of International Protection (Qualification) Regulations 2006

Asylum Policy Instruction on children, this does not have the same legal force as the Regulation.

There needs to be a marked improvement in knowledge and skills in handling children's cases by *all* the specialists involved in the decision-making – this means not only NAM 'case-owners' but legal representatives, immigration judges and higher judiciary. While we know that the Home Office is playing its part by developing specialist training courses for NAM case-owners, the changes implemented or proposed in relation to the asylum process must be given time to settle down. We must see evidence that the new system for processing children's claims are working for them. We believe that there is an acute and serious danger that if the New Asylum Model does not deliver better decision-making, we will see a situation where children and young people with real protection needs are disenfranchised from the care and support they require following a refusal of their claim.

To date, the policy of granting 'Discretionary Leave' to those whose asylum claims fail has at least offered a 'safety net' in the absence of good quality decisions. Proposals to restrict or abandon that safety net should only go ahead – and will only go ahead with the support of professionals involved with children – if it can be demonstrated that decision-making in children's cases has been transformed. We are not currently convinced that there is the infrastructure and knowledge-base in place amongst decision-makers and lawyers dealing with these cases to warrant the approach to children at the 'end of the line' suggested in this consultation.

The re-assessment of limited leave following a refusal to grant asylum or Humanitarian Protection must be considered in the context explained above. One option suggested is 'shorter periods' of limited leave. Currently, the law prevents those granted a period of leave of a year or less from appealing the decision to refuse them asylum[16] (although an appeal right is triggered if further leave 'aggregating' to more than a year is then granted). Introducing 'shorter periods' of a year or less would exclude children from an immediate right of appeal against the refusal of asylum. This cannot be right and would also appear to conflict with the declared aim of the consultation to bring 'finality' to the asylum process so that children and social workers supporting them can begin planning for the young person's future. Why the speedy decision making of the NAM process if an appeal – the real final decision – is *designed* to be delayed by granting short periods of leave?

The same issue impacts on the decision that has already been taken to time the grant of Discretionary Leave to expire at age 17 and a half. This has the effect of disenfranchising any child whose asylum claim is refused after age 16 and a half from an appeal at the point of refusal. In order to have a first appeal before an Immigration Judge, a young person of this age on refusal of asylum – quite a high proportion - will now either: a) have to apply to extend their period of Discretionary

[16] Nationality, Immigration and Asylum Act 2000, section 83

Leave when it expires at age 17 and a half and wait for the extension application to be refused or; b) wait until removal directions are set.

Designing a system to ensure that a child can only appeal in the first instance in the last month or so before their 18th birthday or shortly afterwards is not in their best interests and is not in the interests of social workers who will be expected to be involved in planning for the child's future even before a first appeal has been heard. This is a badly thought out policy and it is hard not to draw the conclusion that it is an attempt to address concerns over leaving care costs. However, it does not even have the merit of doing this as we explain further on.

Another suggestion in the consultation is that '*no granting of limited leave at all might be the appropriate option for the post 16 age group'*. While this would have the benefit of permitting an appeal against refusal of asylum, the consequences need to be spelt out clearly by the Government. As we understand it many of the opportunities currently available to this group would be lost under this proposal. This would include the entitlement to a national insurance number, the right to work, vocational training, work-based learning and entry to employment schemes as well as an end to access to the benefits system on reaching 18 years old[17]. The only lawful means of support would be via the *Children Act 1989* – and then only until the age of 18 and not beyond. Further Education between the ages of 16-18 may be the only option a failed unaccompanied asylum seeking child with no leave would have. This would not be appropriate for all of the 16-18 age group and limits the options for care planning and for equipping young people with skills for any planned return. It will certainly lead to an increase in illegal employment and young people putting themselves at risk. We think there will also be an increased risk to the wider community through criminal or illegal behaviour. We therefore think the proposal of 'no leave' for the 16-18 group who have failed in their asylum claim should not be implemented unless other ways can be found to restore the current entitlements that would otherwise be lost.

The effect on access to Further Education must also be closely considered for this group. Currently the rules employed by the Learning and Skills Council (LSC) [18] allow unaccompanied minors aged 16-18 and supported by a social services department to be classed as 'Home Learners' for tuition fees purposes. Learner eligibility for LSC funding in Further Education is established at the point at which the learner enrolls onto a programme. This means that if at the time of enrolling a learner is considered to be eligible, s/he will remain eligible for the rest of the programme. *FE colleges are however expected to check, when a learner enrolls on a course, whether that learner has sufficient leave remaining enabling him/her to finish the programme.* We are very concerned that those attempting to gain entry to A-Level courses at FE or sixth-form college will be stopped from doing so if they have no

[17] Currently children accommodated under section 20 of the Children Act 1989 can not access benefits until age 18. Those assisted under section 17 are entitled to if they have any kind of leave to remain.
[18] LSC Funding Guidance for Further Education 2006/7

formal grant of leave. This would be devastating to the many young people who are hoping to build their life chances through obtaining an education and entry qualifications to higher education. It would also engage UNCRC both in respect of the right to education and because it would discriminate against this group under Article 2.

The UK Children's Commissioners believe that no further changes to the leave policy should be implemented until an independent review of the children's segment of NAM has taken place and been evaluated. Furthermore, a separate evaluation of the effects of any proposed changes to the current leave policy on the employment, training and education opportunities of young people needs to be conducted.

One key change the Government should make is to section 83 of the *Nationality, Immigration and Asylum Act 2002*. An amendment to section 83 will be brought forward when the *UK Borders Bill* reaches the House of Lords that would restore an immediate right of appeal to those refused asylum but granted a period of leave of one year or less. We believe this to be a sensible and practical amendment that will assist children and social workers by bringing an earlier resolution to the asylum application.

The uncertainty that children feel about their status is clearly an important issue for them as is the perceived arbitrary nature of the decision-making process. All the current proposals on changes to the limited leave arrangements can only increase that uncertainty:

"Waiting for the future – uncertainty – I can't make any plans."

"The uncertainty is very difficult – it's better to get a refusal than to have to wait with the uncertainty."

"If we're entitled to stay we should get a decision quickly."

"Cases are not treated equally – two people can have the same situation yet one is accepted and one is refused."

We do not accept the premise of the consultation question, '*In what other ways can care planning be better aligned to immigration considerations?'* 'Immigration considerations' are not a fixed entity as the proposals on leave demonstrate. The current proposals and new policy around Discretionary Leave make any kind of care planning considerably more difficult for the social work profession and for children.

While we accept that immigration considerations will play a role in care planning we would like to see 'immigration considerations' aligned in a more flexible way with care planning arrangements that reflect the rights of the child. For example, those who are enrolled on courses to equip

them with skills – wherever their future may lie - should be allowed to complete those courses without the threat of removal before finishing. Children have a right to lead fulfilling lives and equip themselves for adulthood. The Government must ensure that the proposals do not put obstacles in the way of children fulfilling their potential.

The question *'What further guidance is needed on managing the needs and expectations of unaccompanied asylum seeking children whose asylum claims fail?'* is clearly directed at local authorities. Any guidance would need to clearly explain the legal implications of the child's 'leave' situation and its impact on the various entitlements outlined above. Social workers are bound by their own set of professional ethics which inform the way in which they relate to their clients. These must be respected.

It is our observation that many unaccompanied asylum seeking children have a relatively low level of understanding of the asylum processes they go through and particularly in relation to Discretionary Leave. Better and easier to understand information in format such as DVD rather than complex text could be provided to children about the possible outcomes of their asylum application and the implications that flow from those outcomes. There is also a clear role for the child's immigration lawyer in explaining this. Further discussion is needed to work out who is best placed to deliver this information and at what point in the process.

Return to the country of origin – Paragraphs 48-52

The consultation refers to returns of both children under 18 and young people who have reached 18. We reiterate the point that, in the face of a new and untested asylum determination procedure, there may be many children and young people whose protection needs are not recognised. From the viewpoint of the child who has a subjective fear of returning which has not been accounted for or recognised, either forced or voluntary returns will not be considered an option. This is what the young people we spoke to told us:

"I don't want to be forced to go back. "

"Why make people go back when they are scared."

"Every day hundreds die in Iraq, 4,000,000 Iraqis have left – if it's safe why are people leaving – everyone should accept Iraqi refugees."

"Young people come to this country not because of money but protection of their lives. Returning them home may lead to harming themselves."

"Some people claiming asylum did not have the chance to study

for many reason. If they send them back what will be there? He might end up by being a rebel or drug dealer."

"If send home many people they hurt themselves."

"I know life in Britain better than life in Afghanistan. I go to the shop, go to college, and see my friends. In Afghanistan I have nothing."

"I think of this place as my home now."

"I can't go back."

As the consultation paper notes, there are big difficulties for care workers in focusing care plans around the requirement that a young person will return to their country of origin. This will be particularly the case for children who retain a real fear of returning. The alternatives are indeed 'stark' for children who decide not to co-operate with voluntary return. The consultation fails to acknowledge that the policy options already implemented or suggested in relation to Discretionary Leave entitlement make those alternatives even starker.

The return of those under 18 should not be contemplated unless the child has a legal guardian to represent them and it is in their best interests to be returned in accordance with Article 3 of the United Nations Convention on the Rights of the Child. We firmly believe that all unaccompanied children should be appointed a legal guardian to ensure their best interests are upheld. As the Government is aware, this has been recommended by the United Nations Committee on the Rights of the Child. The need for a guardian is particularly acute where consideration is being given to returning a child.

We are aware that discussions have, in the past, taken place between the Home Office and a number of organisations about returning unaccompanied children. It appears that these discussions stalled and little further discussion has since taken place. We understand that there has been an internal transfer of responsibility for this programme within Borders and Immigration Agency (BIA). In particular, we are aware that Immigration and Nationality Directorate (as was) shared plans which involved the relevant local authority being a party to any decision made with regard to the suitability of a child's return. This seems to us a realistic approach to the returns of those under 18's provided the child has also been appointed a Guardian who is able to establish whether this meets the 'best interest' test. We fail to understand why this is not now up for consultation.

Even where a child does not meet the criteria for Refugee Leave or Humanitarian Protection, there may still be child protection and safeguarding issues that would need to be weighed against return. The obvious examples are where there has been parental abuse of the child or where there is a risk that a child may be 're-trafficked'. We would have thought it essential that the child's guardian and the local authority is involved in this decision which concerns the child's welfare. This is

not BIA's area of expertise. We therefore support the idea of inter-agency planning for those children for whom return under 18 is a possibility subject to the appointment of a guardian. BIA must exercise flexibility and listen to the child care professionals and to children themselves, before any decision is made to enforce the return of a minor.

Centring 'the care plan for return' around *'employment, training and educational opportunities rather than specific cash incentives'* may not be a realistic option for many of the countries from which asylum seeking children come. Some of the young people we spoke too also thought that for some countries this may be a perverse incentive to come to the UK in order to receive the package.

Other issues when a young person reaches 18 - Paragraphs 53-57

We cannot accept that the measures introduced or planned will *'alleviate problems with excessive post 18 care costs (caused by delays in determining the young person's immigration status).'* (paragraph 54). It is planned to process any application to extend Discretionary Leave and hear and determine any appeal arising from that refusal in the 'window' between the end of Discretionary Leave at 17 and a half and the child's 18th birthday. If those time scales can be kept to, the child would be left 'unlawfully in the UK' on their 18th birthday.

As a consequence, those young people will not have access to employment, the benefits system or 'leaving care' provision under the Children Act. As the consultation correctly point out the only legal recourse to support would be under Schedule 3 of the Nationality, Immigration and Asylum Act 2002 *'in order to avoid a breach of their human rights'.* This would mean that, pending removal of the young adult, the local authority would need to bear the complete costs of housing and subsistence without the assistance of the DfES grant or housing benefit, income support or Job Seekers Allowance. The young person would be unable to contribute to his or her own living expenses as s/he would be prohibited from working. Refusal by local authorities to support the young person on 'human rights grounds' would lead to extensive litigation against them leading to even greater costs.

Furthermore, 'Section 4' support – as it currently stands – would not be available to the young person unless they were first detained and then released on bail or temporarily admitted. We know of a number of local authorities who are already bearing the full cost of supporting such 'appeal rights exhausted' young people and receive no assistance from DfES or any other source. The Immigration Service appears to be unable to remove them and in many hundreds if not thousands of cases no attempt has been made to do so. We conclude that it is likely that the measures introduced –if they work as planned - may substantially *increase* the costs to local authorities.

However, we believe that in large part these measures will not work because children will start to go missing from care before they reach 18

years old. The Children's Commissioner regards this as a very serious child protection issue. We are aware of the introduction in the *UK Borders Bill* of the power to require a person with leave to live in a certain place and report to an immigration officer or the Secretary of State. We understand that this will be used primarily against two groups including unaccompanied children approaching the end of their period of limited leave. Once children start having such conditions imposed it is very likely that they will start to disappear from the care system.

We think the Borders and Immigration Agency has seriously underestimated the likelihood of this happening with large numbers of unaccompanied asylum seeking children who are approaching 18. We explained to the young people we consulted with the consequences of the current and planned changes to the leave system and BIA's commitment to ensuring that those subject to the new regime would be rendered unlawfully in the UK by the time they were 18. These are their responses:

"I personally will go and work illegally."

"Crime rate would increase."

"Some people might think if you have children you will still get support."

"I would have a baby with English girl."

"I would have to get money somehow."

Some young people also thought that this would be a huge waste of the country's resources since they felt they are able to contribute so much given the chance:

"An increase in criminal cases. There is going to be a big impact even on home children since many of them learn a lot from these young kids who come into the country."

"Doctors, teachers and social worker numbers will decrease because a number of skills will be kicked out of school. Anti-social behaviour will increase. Many kids will take French leave from care."

"Let us stay in the country for longer if we need to finish courses, diplomas etc."

"Other people are allowed to come here and work – why no

Afghanis and Iraqis?”

We do not think the young people who spoke to us are exaggerating the kinds of reactions that future unaccompanied asylum seeking children might have in the face of the options they will have open to them. Young people being resourceful and tenacious are unlikely to be persuaded that a return to dangerous situations is the best course for them. They are likely to make every effort to remain and survive outside of the official economy. This will be a tragic waste of their youth and their potential and a loss to this country of a huge reserve of talent.

6 The specialist authority (criteria)

Our response to paragraphs 58-62 in Planning Better Outcomes and Support for Unaccompanied Asylum Seeking Children

The criteria themselves appear broadly correct. The reality of ensuring that these criteria are met in any authority *in practice* will be a far more complex matter. Lessons can be drawn from the 'dispersal' regime under National Asylum Support Service (NASS) but care must also be taken in too strict a comparison as children's needs and requirements are different.

It is significant that in relation to the Borders and Immigration Agency's (BIA) view of these children as a group that no *specific* mention has been made about child and adolescent mental health services. If there is an acceptance that many of these children will have been traumatised and are likely to suffer mental health problems, then a suitable infrastructure to meet these needs within reach of the specialist authority is crucial.

A high standard of care and proven adherence to childcare legislation and guidance by the local authority should be part of the criteria. Any local authority chosen must be able to demonstrate that they have structures and systems in place that meet best childcare practice.

We want to know more about what is meant by 'suitable educational services'. There must be access to good schools with language support available for those of statutory school age. A school place should be available on arrival in the specialist authority. Likewise, an appropriate English for Speakers of Other Languages (ESOL) infrastructure with adequate places available must be present in local FE colleges for those over 16. There should also be appropriate educational opportunities beyond ESOL for this group.

The availability of legal advice is not a matter that is under the control of a local authority. Legal representation on such a vital matter as a child's asylum claim cannot be left to chance. It is therefore imperative that the Legal Service Commission works closely with BIA and the specialist authorities to ensure that every child is represented. It will normally be the role of the social worker to ensure that a child has legal representation. BIA must be flexible in relation to the New Asylum Model (NAM) timetable where legal representation can not be secured to assist with the Statement of Evidence Form (SEF) and attendance at the asylum interview. No child should have to complete a SEF without legal assistance and no child should attend an asylum interview without being legally represented. The guarantee of legal representation should form part of the 'joint working arrangements' between BIA case owners and the child's allocated social worker. It must be recognised that local conditions in respect of legal representation may imply delays to NAM and this should be explicitly part of the 'flexibility criteria' operated by case owners.

Interpretation is a key issue for children. Many have a deep distrust of interpreters and we would like to see some standards/professional code for all interpreters working with children. Interpreters with access to children should all be subject to the enhanced Criminal Records Bureau check and a pool of such interpreters should be available prior to the specialist authority taking on children.

The consultation document does not explain how the initial authority, the receiving authority, and the NAM fit together. We understand from NAM that a strict timetable is aimed for within the children's segment which starts once the child has been 'routed' following the screening interview. The assumption must be that the NAM process therefore starts within the 'initial authority' rather than in the specialist authority. We cannot see how this will work for children, for legal providers, for local authorities or for BIA itself. As stated earlier, we believe there is a strong argument to delay the start of NAM for those children destined to be transferred to a specialist authority until they reach it.

50 – 60 authorities with around 100 children each is likely to be an underestimate of need and works on an assumption of each child staying with the authority for two years only and on a figure of approximately 3,000 new arrivals each year. This of course fails to take into account that a significant proportion of children arrive prior to their 16th birthday and that many – possibly 50% or more of 'age disputed' cases will be found to be children following a social services assessment. Age disputed cases later found to be children are not covered in the Home Office statistics on numbers of unaccompanied minors and therefore the actual figure for arrivals may be significantly higher than around 3,000 per year.

If this view is correct then either more than a hundred would need to be accommodated by each specialist authority or large numbers will need to remain in the authorities in which they are currently placed. The arrival of 100 children in an authority will have a significant impact on local resources –including social work, health and educational resources. There should be a phased introduction to allow local infrastructure to be built. Authorities should not be given 'specialist' status unless they can demonstrate an appropriate standard of child care and must not be given status simply in order to alleviate pressures experienced by over-stretched authorities in London and the South East.

Procurement and commissioning of services – Paragraphs 63-64

Care Matters makes recommendations in respect of improving the quality of placements through commissioning. Base line standards should be set by DfES. We do not see a role for the Borders and Immigration Agency (BIA) in partnership arrangements with local authorities in procuring services for children. This is outside of BIA's expertise or remit.

We leave the last word to one of the children we consulted:

“Please do not waste our lives please – we R children.” 

7 Summary of 11 MILLION's recommendations

11 MILLION led by the Children's Commissioner recommends:

1. adequate levels of funding are provided for both the under 18's and the over 18's for whom local authorities have continuing leaving care duties to allow them to meet their legal obligations under the *Children Act 1989* and related legislation.

2. the proposals in this consultation are underpinned by the appointment of a legal guardian for every unaccompanied child as recommended by the United Nations Committee on the Rights of the Child.

3. funding guidance to local authorities should reflect the stricter definition of an 'unaccompanied asylum seeking child' adopted in the consultation document allowing local authorities to obtain the grant for some children whom they are currently unable to claim for.

4. all unaccompanied asylum seeking children remain 'looked after' (in the formal care system) until they are 18 years old unless informed consent has been obtained to another support route such as under the leaving care provisions of the Children Act.

5. the current non-statutory guidance, Local Authority Circular (2003) 13, should be re-issued as statutory guidance or withdrawn and replaced with statutory guidance. Statutory guidance should also be issued for Scotland, Wales and Northern Ireland.

6. local authorities who indicate in their grant claim that they are supporting children under section 17 should have their grant for each section 17 supported child withheld until they can demonstrate that *informed consent* has been given by the young person to this route of assistance including a full understanding of the implications for 'leaving care' provision.

7. the Borders and Immigration Agency re-examine their commitment to the 'co-location' of social workers at ports of entry and screening unit if it is intended to conduct age assessments at these venues and at this juncture.

8. the proposal for greater use of medical techniques for age assessment is dropped. If it is intended to make greater use of these techniques, the research referred to in the consultation must be open to professional scrutiny.

9. where an age assessment is necessary, this should take place in a regional assessment centre and be conducted by social workers and other professional who would not have ongoing responsibility for the young person's care.

10. where it is known that a child is to be transferred to a 'specialist authority', the Borders and Immigration Agency should put asylum processing under the New Asylum Model 'on hold' until after transfer.

11. where a decision is made by the 'initial' authority that a placement in semi-supported accommodation is 'suitable' following transfer, that arrangements are in place to ensure that this assessment is still valid in the context in which the child or young person finds him or herself following transfer.

12. decisions on where a child is placed must be made by local authority child care professionals in line with their Children Act duties. There is no role for Borders and Immigration Agency in the management of placement decisions.

13. an end to the pressure on children at 16 to move from foster care where they are not ready to do so. Any new funding arrangements should meet the full costs of keeping children in foster care after age 16 if that is the child's wish and if it is the social workers view that this is in the child's best interests.

14. an independent evaluation of the New Asylum Model children's segment as soon as possible. The terms of reference for such an evaluation must consider the effects of interviewing children as young as twelve as well as the 'outcome' of the application.

15. the *Refugee or Person in need of International Protection (Qualification) Regulations 2006* be amended to include *'acts of a gender-specific or child specific nature'* in line with the EU 'Qualification Directive' they were required to implement.

16. the Government to devise a strategy to improve the knowledge and skills base of *all* specialists involved in handling children's asylum claims including New Asylum Model 'case-owners', legal representatives, immigration judges and higher judiciary. We would welcome the endorsement and active use of *"Working with children and young people subject to immigration control: Guidelines for best practice"* published by the Immigration Law Practitioners' Association.

17. the Government spells out the impact of any proposed changes to the current Discretionary Leave policy (such as 'no leave' for the 16-18 age group) on the employment, training and education opportunities of young people and to consult again before any further changes are implemented.

18. the Government restores the right of appeal to those granted limited leave of one year or less. It has an opportunity to do so by supporting the amendment to section 83 of the *Nationality, Immigration and Asylum Act 2002* which will be introduced in the House of Lords during the *UK Borders Bill.*

19. ‘Immigration considerations’ should be aligned in a more flexible way with care planning arrangements. For example, those who are enrolled on courses to equip them with skills – wherever their future may lie - should be allowed to complete those courses without the threat of removal prior to finishing.

20. better information, in accessible form, should be provided to children about the possible outcomes of their asylum application.

21. any planned returns of children under the age of 18 should only be considered where there has been a legal guardian appointed and only if this is in the child’s best interests. The Borders and Immigration Agency should reconsider the Immigration and Nationality Directorate’s previous plans to conduct an inter agency assessment process where such a removal is contemplated.

22. the Borders and Immigration Agency (BIA) acknowledge the child protection concerns implied by the new arrangements and in particular the prospect of children going missing from care close to their 18th birthday. The National Register of Unaccompanied Children should be used to analyse and report on the numbers of children who go missing from care under the proposed arrangements. The arrangements should be reconsidered if the data shows that children are going missing from care to a greater degree than at present.

23. every child should be *guaranteed* a legal representative to help them complete the Statement of Evidence Form and accompany them to the asylum interview. Processing of asylum claims under the children’s segment of New Asylum Model must remain flexible to allow every child to be legally represented.

24. set standards and a professional code to be introduced for all interpreters working with children. Interpreters with access to children should also all be subject to the enhanced Criminal Record Bureau check.

25. a pool of interpreters who have undergone the required Criminal Record Bureau checks and who are accredited to work with children should be available prior to the specialist authority taking on children.

26. there should be a phased introduction of children to the specialist authorities to allow local infrastructure to be built. Authorities should not be given ‘specialist’ status unless they can demonstrate an appropriate standard of child care.

27. base line standards in respect of improving the quality of placements through commissioning should be set by DfES rather than the Borders and Immigration Agency.

8 Words used in this document

We aim to make our reports easy to read for people without specialist knowledge of policy areas. Listed below are words and abbreviations used in this document that might need further explanation:

Asylum seeker

A person who has applied to the government of a country other than their own for protection or refuge ('asylum') because they are unable or unwilling to seek the protection of their own government.

Unaccompanied asylum seeking child (UASC)

The definition adopted by the Home Office for this consultation is: *"(i) an individual who is under 18 and applying for asylum in his/her own right; and is (ii) separated from both parents and not being cared for by an adult who by law or custom has responsibility to do so."*

What are we responding to?

When the Government wants to introduce important changes they often have a public consultation. This document is 11 MILLION's response to a Home Office public consultation document *"Planning better Outcomes and Support for Unaccompanied Asylum seeking Children".* The Government issued the consultation document on March 1st and anyone wishing to comment must have replied by 31st May.

United Nations Convention on the Rights of the Child (UNCRC)

Every child and young person under the age of 18 has rights, no matter who they are, where they live or what they believe in. These rights are protected by an agreement between almost all of the countries in the world. This is called the United Nations Convention on the Rights of the Child.

Joint Committee on Human Rights (JCHR)

A group or committee of people drawn from the House of Commons and the House of Lords that has a power to look at anything the Government does that might affect 'human rights'. 'Human rights' are part of this countries law under the *Human Rights Act.*

Borders and Immigration Agency (BIA).

Until earlier this year the BIA was known as the Immigration and Nationality Directorate (IND). They are the part of the Home Office that deals with all matters to do with asylum and immigration.

Trafficking

The full definition is complicated but more or less 'trafficking' means getting and keeping control over another person by threatening, forcing, kidnapping or tricking them and then moving them somewhere else and forcing them to do something that makes money or provides another benefit to the 'trafficker'.

Leave

'Leave' means 'permission'. When people talk about 'limited leave' they mean that the permission to stay or come into the country is only for a certain amount of time. 'Discretionary Leave' is one type of 'limited leave' and is often given until a young person is 18 years old. 'Indefinite Leave' means there is no time limit on how long you can stay in the country for.

Specialist authority

Under the current proposals in this consultation, the Government wants unaccompanied asylum seeking children to be 'placed' (go and live) in a certain number of 'specialist authorities'. These will be local authorities (who employ social workers) who agree to take on a certain number of unaccompanied children and who promise to deliver a certain standard of care to those children whom they accept. At the moment unaccompanied children usually live in, or are cared for by, the local authority in which they first find themselves.

Appendix 1 – 'Estimation of Chronological Age in Children' by Neil Cameron , Bed, MSc, PhD. First published in *Science and Public Policy* in February 1982 and reproduced here with the permission of the author.

Age Estimation

Estimation of chronological age in children

N Cameron

"It cannot be right to base decisions on a child's future on inaccurate techniques of age assessment".

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Lecturer in Human Growth, Institute of Child Health, London, since 1978. Clinical Auxologist, Growth Disorder Clinic, Hospital for Sick Children, Great Ormond Street, London, since 1973. Visiting Lecturer in Human Growth, Department of Anthropology, Cambridge University; and also in Department of Human Biology, Chelsea College, London University. Has also been a visiting lecturer at a Belgian and several US and Canadian universities.

The author demonstrates the invalidity of current procedures, including X-raying, used to determine the chronological age of immigrants from the Indian sub-continent.

Keywords: Ageing tests; maturity assessment; immigration

In January 1979 the British Home Secretary announced that an inquiry, under the Chairmanship of Sir Henry Yellowlees, would be undertaken into the role of port medical officers and the use of medical techniques in relation to immigration control. The setting up of this inquiry was the result of public criticism of the use of virginity tests and X-ray examinations. Virginity testing, and X-raying of adults and pregnant women was terminated as a result of this public pressure, but X-rays of children to determine their chronological age, and hence their identity, continue[1]. Accurate knowledge of chronological age is required when it is of prime importance in establishing identity to guarantee the right of entry to the U.K.

Dates of birth of children from some socio-cultural groups of the Indian subcontinent are not as important as they are in the Western world. Thus an accurate record of date of birth is not always available but may be related chronologically, in the child's historical data, with a particular cultural event, eg. birth near to a particular religious festival. Various anthropological techniques have been developed to determine birth dates from such historical cross-examination but for the purposes of immigration control, presumably in cases in which the stated birth date is suspect, the British Government appear to rely almost exclusively on the opinion of medical advisers who provide an estimate of chronological age based on the data collected during a physical examination of the subject.

The medical adviser completes a printed form that is prepared by the British High Commission. This form requires him to provide some objective data on, for example, height, weight, number of teeth and the appearance of ossification centres in certain bones, and subjective assessments on the normality of, for example, "Building and Posture, Gait, Musculature, Skin Elasticity and Tone, Hair Greying and Loss". The appearance of external genitalia and the presence or absence of facial, pubic and axillary hair are also commented on. From these sources of information the medical adviser arrives at an estimate of chronological age.

To the Human Biologist who specializes in Human Growth and Development there are some particularly disturbing features of this age "assessment". The most important being that all the data collected relate to the *maturity* of the individual and *not* to chronological age. Even if the medical adviser is totally rigorous in his data collection and uses the most appropriate techniques to arrive at his assessment he is still only able to assess *maturity*. The medical adviser therefore relates maturity directly to chronological age for the purposes of immigration control. He is saying that if a child has the maturity of a ten-year-old then his age is ten years. This statement cannot be made without reference to the expected variation of chronological age about a given maturity and is thus in some cases misleading and in others untrue.

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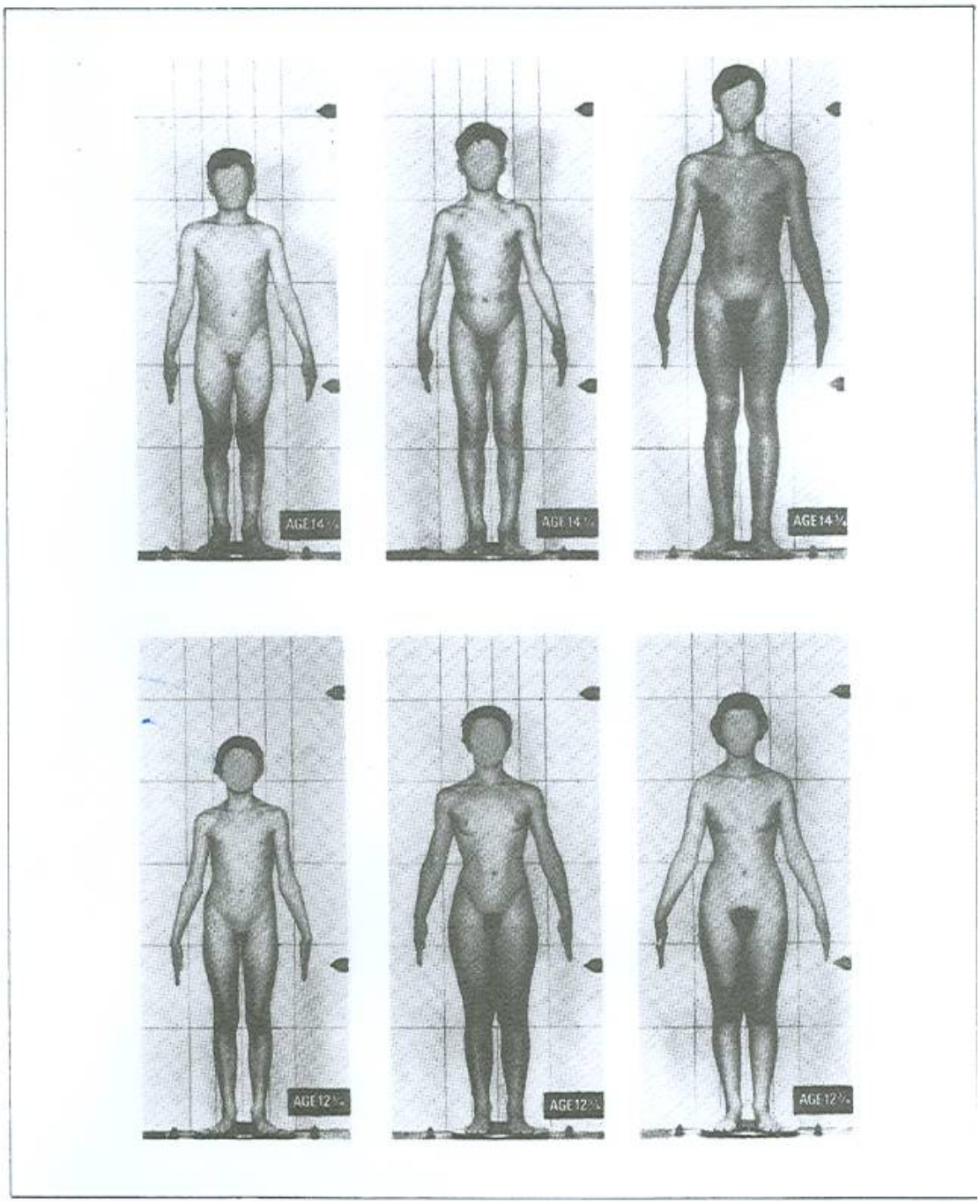
asylum seeking children. June 2007

Maturity indicators

Figure 1 illustrates three British boys all aged 14¾ years and three British girls aged 12¾ years.[2] It is obvious that they exhibit varying degrees of maturity – those on the right *look* physically older than those on the left – yet they are all of the same chronological age. The point is that there *is* a variation of maturity about any chronological age. In order to quantify this variation and create standards of normal variation various "maturity indicators" have been identified that have a known distribution at each chronological age. Maturity indicators are observable characteristics of the body that pass

Figure 1. Three boys, aged 14¾, different stages of puberty; three gir aged 12¾, at different stages of puber (From J M Tanner, 1978: Foetus In Man; London: Open Books.)



through a sequential series of changes from immaturity to maturity. It is of paramount importance that the sequence of changes is the same in all individuals.

To use breast development as an example; all pre-pubertal girls have infantile breasts and all normal adult females have adult breasts. The sequence of changes that the breasts pass through between these two extremes is, to all intents and purposes, invariate. Thus any mid-pubertal girl can be said to belong to a particular maturity group as classified by breast development. The example of breast development highlights one of the problems of this form of maturity indicator. The development of the breasts can only be analysed whilst the female is passing through the changes of puberty; before or after this time there are no changes to observe and thus this maturity indicator is useless except to classify her as pre-pubertal or post-pubertal. A better maturity indicator is one that is not fixed in time but covers the *complete* age range that coincides with normal growth.

The maturity indicators most commonly used are: (1) skeletal development, (2) dental development and (3) the development of secondary sexual characteristics. These indicators will be discussed in some detail because they are internationally accepted as being reliable in the estimation of maturity. If chronological age *has* to be assessed from maturity then these techniques would be the most appropriate. The use of other methods, particularly those used by Government medical advisers will also be discussed.

Skeletal maturity

The maturation of the skeleton provides an easily identifiable set of maturity indicators providing that the radiographs of the pertinent areas of the body are obtained in the correct way, ie. with correct positioning of the body, the correct X-ray tube-film distance and correct exposure.

To assess the maturation of the skeleton one observes the changes occurring in both the shape of the individual bones and their inter-relationships with other adjacent bones. Obviously any departure from the accepted radiographic techniques or posing of the subject will result in non-standard views of the bones which thus makes their assessment difficult or, at times, invalid.[3,4] The process of skeletal maturation will be briefly reviewed so that the reader is acquainted with the terminology used when discussing the various techniques of bone age assessment.

At birth the bones of the skeleton are represented by cartilaginous models. Some of these models will have started to ossify and appear as opaque shapes on the radiographic plate. Most commonly these are the shafts of the long bones. From birth to maturity the maturation of the long bones eg. the radius, is characterised by the appearance of endochondral centres of ossification, called "epiphyses", adjacent to the ends of the ossified shaft. At first the epiphysis is spherical and appears circular on radiographs but later changes shape to approximate that of the cartilaginous end of the bone. This epiphysis finally "fuses" with the shaft of the bone by the replacement of the cartilaginous disc, separating it from the shaft, with bone. Both the appearance of the epiphyseal ossification centres and their final fusion to the shaft may be clearly observed by the trained observer when viewing a radiograph. They thus form important maturity indicators.

Cartilaginous models of round bones eg. the carpals are also laid down in the prenatal period. Ossification usually starts after birth with the appearance of an "ossification centre" in the middle of the cartilaginous model. At first this centre expands rapidly in all directions but later growth is more rapid in some directions than others. The ossified area gradually develops to match the shape of the adult bone.[5]

Techniques for the assessment of skeletal maturity may be simply divided into three types; the number of centres method, the Atlas method and the bone-specific scoring method.[5] Briefly the first relies on counting the number of ossification centres visible in various parts of the skeleton. Roche (1978) says of these methods that they have "considerable appeal", radiographic positioning does not have to be rigidly controlled, assessors need only minimal training and observer errors are infrequent. They are, however, only useful at certain ages when ossification centres are appearing. Once they have all appeared no further assessment of maturity is possible with this technique. Thus after the first few years of life these techniques are useless, and have been superseded by Atlas and bone-specific scoring techniques.

Atlas and bone-specific scoring techniques rely on the fact that the epiphyses of long bones and ossification centres of round bones pass through a series of visible changes in shape as they mature. These changes in shape form the maturity indicators. The grading of these indicators present in particular bones allows one to calculate a "skeletal age" or "bone age".

Atlas techniques were developed in America during the 1930's. Whilst many areas of the body may form possible sites to grade maturity indicators, criteria of safety, availability, ease of positioning and the number of visable ossification centres meant that Atlases were produced to cover the hand-wrist, foot-ankle and knee.[6,7,8] These Atlases contain a series of radiographic "standards" representing different maturational ages of boys and girls during their growth and development (a standard is simply a photograph of a radiograph). Each standard was chosen from a group of *white* children of very high socio-economic status, living in Cleveland, OH and born between 1917 and 1942.

The Atlas method is applied by comparing the radiograph to be assessed with the standards until one is found that is at the same maturity level as the radiograph ie. shows the same maturity indicators. However, all bones in any area are not of exactly the same maturity thus interpolation between standards is usually necessary. In this case a bone-specific skeletal age is determined for each bone and the median of these ages is the skeletal age of the child. For this purpose the Atlases contain written descriptions and sketches of the maturity indicators which relate to a particular standard.

It is now common practice to use only hand-wrist radiographs to determine skeletal age unless injury to the hand or wrist prevents this. Such practices have become common because of fears over radiation exposure both to the areas for assessment and to the gonads of the subject. It is far easier to "isolate" the hand-wrist from the rest of the body and so protect the body by the use of lead-sheeting.

Bone-specific scoring techniques were developed in England and reached practical acceptance with publication of the Tanner-Whitehouse I technique (TWI) in 1962. This was later updated and is known as TWII[4]. The practical basis of this technique is to assign

numerical scores to the bones of the hand and wrist depending on their maturity levels. To avoid statistical bias the scores of the seven carpal bones, radius and ulna are added to those of only 11 of the 19 bones of the metacarpals and phalanges. This "total" bone maturity score corresponds to a particular "bone age". TWII also incorporates two shortened versions of the method just described. In the first system only the Radius, Ulna and Short Bones (metacarpals and phalanges) are used to arrive at the RUS bone age and in the second only the Carpal bones to arrive at CARPAL bone age.

Dental maturity

The number of teeth present in the mouth at any chronological age has been used for some time to give a child a "dental age" in the same way as the number of visible ossification centres have been used to estimate skeletal age. There are inherent limitations to this method: (1) while this application may be useful for population groups it must be recognised that there is a high probability of inaccuracies for any individual child; (2) little information is available during periods when no variation in the number of teeth occurs. Demirjian (1978)[9] states that "if predictions (of chronological age) are to be made for individuals, low birth weight, local pathological conditions, supernumery teeth, the early or late loss of deciduous teeth, and some general pathological conditions should be taken into consideration". Teeth however, are less prone to the environmental changes than skeletal maturity but attempts to use them as predictors of chronological age, for instance in children from New Guinea,[10] have been criticized by several authors.[11,12,13]

Gleiser and Hunt (1955)[14] first suggested that the calcification of a tooth may be a more meaningful indication of somatic maturation than its clinical emergence. Since that time the concept of assessing dental maturation in a similar way to skeletal maturation (by studying the development of teeth on radiographs) has gained popularity for the reasons stated by Demirjian (1978)[9]: (1) tooth emergence is a fleeting event and therefore difficult to determine. In addition the literature contains different definitions of the word "eruption" when applied to the teeth, ranging from the moment the alveolar bone is broken to the attainment of the occlusal level. Calcification, on the other hand, is a continuous process which can be assessed from X-rays. (2) Exogenous factors eg. infection and premature extraction, may disturb tooth emergence (3) Each tooth must be assessed individually for a tooth eruption system to work. Thus the estimation of maturity becomes a crude process because the overall picture of the definition cannot be viewed. The equivalent process in skeletal maturity would be to use only the radius rather than the whole hand and wrist. (4) Clinical emergence can only be used at certain ages. Deciduous teeth emerge between 6 and 30 months, then there are no changes until the permanent teeth begin to emerge between 6 and 12 years. Only the third molar emerges after 14 years. Thus it would be impossible to assess the dental maturity of a child using time of emergence between the ages of 2.5 and 6 years and after 12 years.

The assessment of maturity from radiographs of the teeth is subject to the same general criteria as that of skeletal maturity. Radiographs must be taken in specified positions and certain maturity indicators are viewed and rated by the trained observer and compared to tooth-specific standards.

Correlations between dental age and skeletal age are poor; their maturation is essentially independent as the two have different embryological origins, and perhaps differences in genetic control.[9]

Secondary sexual characteristics

It is obvious from Figure 1 that one of the most visible indicators of maturity is the advancement of the secondary sexual characteristics from their pre-pubertal to their adult configurations. In boys this involves classifying the development of the genitalia, pubic hair, axillary hair and in some cases testicular size or volume and in girls the breasts, pubic hair, axillary hair and the age at which they experience menarche. Classifications of these phenomena are on scales of 1 to 5; 1 being pre-pubertal and 5 being adult. Reynolds and Wines (1951)[15] and Nicolson and Hanley (1953)[16] developed rating schemes which allowed Tanner (1962)[2] finally to define the classifications. These classifications, sometimes referred to as the "Tanner Scale" are universally used when referring to sexual maturity.

The fact that genitalia or breasts and pubic hair are rated separately is in recognition of their different hormonal control and different timings during adolescence. The appearance of the breast bud is as a rule the first sign of puberty in the female but the first signs of pubic hair may be before or after this time. Marshall and Tanner (1969, 1970)[17,18] published the definitive work on the variations in the pattern of pubertal changes in British boys and girls. Of special interest to this article is the relationship between pubertal stage and skeletal maturation.

In the British population, and indeed those populations reported on in Western Europe, girls are in advance of boys in general somatic growth. In terms of height for instance, they enter their adolescent growth spurt, *some two years* earlier, exhibit their maximum velocity and finish growing some two years in advance of boys. This 2 year difference however is not apparent in sexual development. Here the difference is only about 6 months – by the age of 11½ years about 50 per cent of girls have started breast development and by 12 years about 50 per cent of boys have started the development of the genitalia. Growth in height and skeletal maturity, therefore, are largely independent of secondary sexual development and should not be grouped together without good cause.

These three systems of assessing maturity are those currently employed by the vast majority of experts in this field of the human sciences. It is evident that the systems have all acquired measurement scales either of a discrete or continuous type to facilitate numeration and to assess variation in the appearance of maturity indicators. They cannot be combined to provide an overall estimate of maturity and indeed because they are under different forms of biological control this would be a difficult thing. They must all be viewed as independent assessments of maturity with general but not specific association. A child need not conform to the same maturational age when assessed by the three different systems. Even within the same system variations in maturity may be apparent. Thus their interpretation is not a simple thing and should not be undertaken by those without a thorough background in maturity assessment.

Chronology, maturity, variation

Central to the problem of estimating chronological age from a given maturity is the relationship of maturity to chronological age. It must not be forgotten that systems for estimating maturity were developed so that the maturity of a child of known chronological age could be investigated. None of the systems was developed primarily to determine chronological age in a situation in which date of birth was unknown or reported age suspect. The reason for this is that maturity bears only a general relationship to chronological age. It is highly unlikely, for instance that a girl of chronological age 5 years would have developed breasts beyond stage 1 of the Tanner scale ie. pre-pubertal. Similarly one would not expect a 5-year-old to have a skeletal maturity or "bone age" of say 10 "years" and a dental age of 1 "year". It would be expected that all the maturity criteria used on a normal 5-year-old would return estimates near to 5 years but not necessarily exactly 5 years.

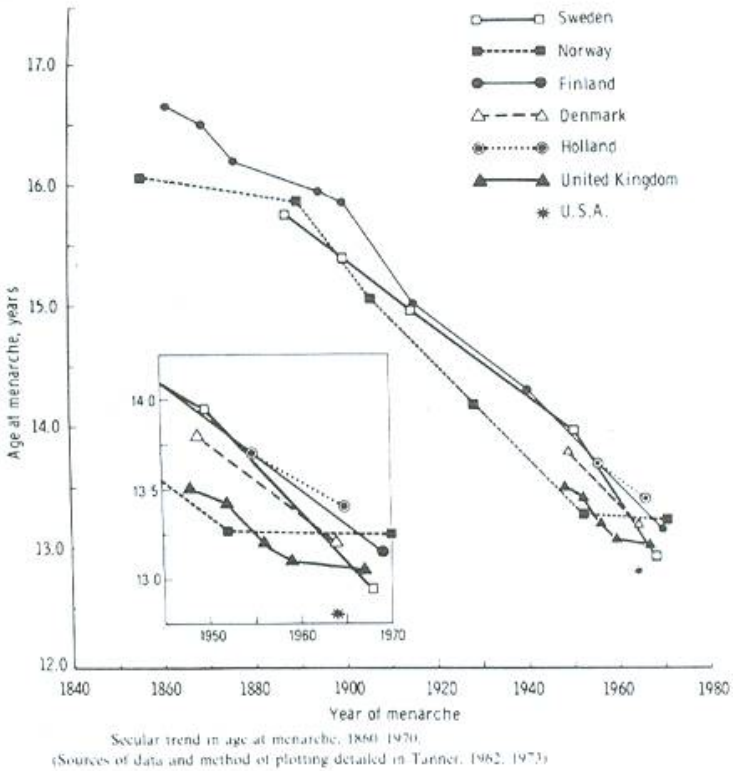
The variation in the so-called "tempo" of growth has been well documented.[2] In any group of children one will find some that have the maturity expected of their chronological age, others will be advanced and show a greater maturity and yet others delayed showing less maturity.

Skeletal maturity generally varies by some 2 "years" either side of chronological age.[4] Thus a skeletal age of 14.4 "years" may be found in boys aged 12.4 to 16.4 years of age. Similar variations are apparent in girls. Greater variation will be expected if the subject being investigated is of a different source group from that used to determine the standards for assessment. We may illustrate this by looking at the source group used for the American Atlas techniques.[6, 7, 8] If a group of *average* 14-year-old boys is used the expected average bone "age" will be 14 "years". This depends, of course, on the fact that the 14-year-olds used to create the standards accurately reflect the average 14-year-olds of the Country.

In the American system the source sample was composed of extremely privileged children. Thus instead of having the average maturity of 14-year-olds they exhibited the maturity of older children of the general American population. So advanced were they that the maturity of English children calculated from these standards still appears as delayed and only a few samples of American children have been shown to compare to the original sample.[19] Therefore if the American Atlas technique was used to estimate the maturity of an underprivileged Indian boy his maturity might well represent that of a much younger American child.

The British system of Tanner et al (1975)[4] is rather better in this context. Their source sample were middle and lower-middle class children X-rayed between 1950 and 1970 during the course of longitudinal growth studies, but still they do not conform to other ethnic groups. Changes in general living conditions, nutrition, ethnic origin and disease patterns will all combine to advance or delay the individual in relation to the standards of assessment. A major problem is that it is not known by how much such factors affect maturation, simply that they do.

Individual differences in sexual maturation can be quite striking because of the visual nature of the assessment system. The girls in Figure 1 are obviously different in terms of sexual maturation yet are of the same chronological age. Even within the same subject differences in the timing of, for instance, breast and pubic hair development may be seen. In British girls described by Marshall and Tanner (1971)[18] some girls were adult in their breast development whilst still in the midst of pubic hair development and conversely there were others who had completed their pubic hair development but not their breast development. As a general rule the girls passed through their breast development between 9 and 19 years, but one might find all stages represented in a sample of girls between the age of 12 and 16 years. Similarly pubic hair development occurred between 9 and 17 years but all stages would be apparent between the ages of 12 and 16 years. In boys, the development of the genitalia took place between 9.5 and 17 years and



Secular trend in age at menarche, 1860–1970.
(Sources of data and method of plotting detailed in Tanner, 1962, 1973)

Figure 2. Secular trend in age at menarche 1860–1970. (From J M Tanner, 1962.)

the development of pubic hair between 11 and 17 years yet between the age of 13 and 16 years all the stages might be observed in any particular sample of boys.

Secondary sexual characteristics are therefore only useful between certain ages. They are of no help prior to puberty or after adult characteristics have been acquired. Even when they may be observed at an interim stage of development they can only determine chronological age to within ± 2 years in 95 percent of British children, assuming that the stages have been correctly rated – *secondary sexual development is generally regarded as a difficult assessment to make.*

The age at which girls experience menarche, the first menstrual period, is often used as an indicator of maturity. In most cases it is a very definite occurence that requires no specialized techniques or instrumentation to assess, simply the asking of the correctly phrased question. Once again, however, the variation in chronological age of its occurrence is about ± 2 years. If the mean and standard deviation of the menarcheal age of a population is known then at least the presence of regular menstruation will allow the assessor to establish that the subject is most probably older than a certain chronological age. The average menarcheal age of London girls is, for instance, 13 years (Tanner 1973) with a standard deviation (SD) of about 1 year either side of this. Thus a girl who has experienced menarche is likely to be older than 11 years, ie. mean less 2 SD, but in some cases may be younger.

Dental maturity also has a variation of about 2 years in its chronological occurrence (Demirjian, 1978) with girls being slightly in advance of boys from about 5 years onwards.

Secular trend

Finally there is a further factor that confounds the interpretation of maturity. Maturity indicators are known to be subject to a phenomena known as the secular trend. This is a trend for maturity indicators to occur at progressively younger ages with each succeeding generation. Figure 2 shows clearly the situation for menarcheal age in various western countries. It seems most probable that in the middle of the 19th century girls experienced menarche at 16 to 17 years of age and yet now they experience it between 13 and 14 years of age.

This trend has, to all intents and purposes ceased in London and some European Countries during the last 20 years but it continues elsewhere.[20] Whilst it is the result of improved living and social conditions there is a strong genetic effect which causes menarche to occur at younger ages in some less well controlled environments than exist in the western world. In rural girls around Naples, for instance, mean menarcheal age was 12.5 years in 1970 compared to 13 years in London, Montreal and upper class girls in Santiago. At the other end of the scale girls of the Bundi tribe from New Guinea experience menarche at a mean age of 18 years.[19] It is not proven that a secular trend in dentition exists although there are published reports both proposing and opposing a secular trend.[9]

The combination of skeletal maturation and sexual development to derive some better estimate of chronological age depends on the association between these two phenomena being an intimate one, and they, in turn, being intimately linked with chronological age. We have already seen that at best chronological age varies by some 2 years either side of a particular bone age or stage of sexual maturity. Marshall (1974)[21] demonstrated that skeletal age was just as variable as chronological age at the beginning of genital development in boys or breast development in girls. The hormones controlling sexual development, however, also affect skeletal maturation so that at some periods during puberty there is a closer association than at other times eg. menarche. Indeed, in the British girls studied by Marshall (1974)[21] most of the girls experienced menarche between skeletal ages of 13 and 14 years whilst their chronological ages varied from 11 to 15 years. But this situation was an isolated one and only matched by a reduction in the variability of skeletal age for a particular percentage of adult height reached. Combinations therefore would apparently not be a valid way of reinforcing the information to be gained from a measure of skeletal age. The information so far available does *not* allow one to say that if a girl has just experienced menarche, is in breast stage 4, pubic hair stage 4 and her skeletal age is 13.5 "years" then it is likely that she is between 13 and 14 chronological years of age. Secondary sexual development does *not* reinforce the knowledge already gained from skeletal development.

Indian techniques

We have looked so far at the major techniques to estimate maturity, the inherent variation of chronological age about any maturational age, and at the problems involved in attempting to amalgamate the knowledge from any combination of the techniques. It is a fact that even using the best techniques ie. the most appropriate techniques on a British child, we could estimate chronological age to no better than a 4 year range in 95 percent (± 2SD) of the cases. In 5 per cent we would be outside this age range. It is also a fact that these techniques are, for the most part, based in children of European ancestry and thus bear even less relationship to those children who are the subject of scrutiny by a British High Commission.

What then is the position in India? What techniques are being used to determine chronological age and do they have any positive advantages over those just described?

It is apparent from the forms completed by the Government medical advisers in India that *they do not use any of the most valid techniques*. For skeletal maturity they use the times of appearance and fusion of ossification centres; for dental maturity the number of erupted teeth and for secondary sexual development no objective techniques bar a simple "present" or "absent" observation.

In response to a Parliamentary Question by Lord Avebury (7 April 1981) Lord Trefgarne, for the Government, stated that:–

The Medical adviser concerned (who is Professor of Special Radiology and Vice-President of Dacca Medical College) used tables drawn up by Dr. Basu and Dr. Gallstone. These are based on research in Calcutta and are included in *Modi's Medical Jurisprudence*, published in India.[1]

In fact Lord Trefgarne was referring to tables of dates of appearance and fusion of various ossification centres in the skeleton from the published work of Galstaun (1937) (not Gallstone)[22] and Basu and Basu (1938).[23]

My comments on these tables were published in a Report by White (1981)[1] from the office of Lord Avebury. The comments in brief were (1) the extreme age of the data – being published in 1937 and 1938 they were collected between 1928 and 1937; thus inferences based on ages calculated from these data would have to be qualified with regard to the secular trend apparent in the last 50 years. (2) dates of appearance and fusion are, as we have seen, unsatisfactory techniques to estimate maturity. They are useful only during small age ranges and leave large periods of adolescence without maturity criteria. (3) The original samples were extremely small, drastically reducing the statistical confidence which could be placed on any statements emanating from them. (4) Possible growth differences between the subjects because of different socio-cultural backgrounds were ignored. The conclusion was that "these criticisms make the use of these data an extremely dubious process".

Dental maturity calculated from the number of erupted teeth suffers from the criticism stated earlier in this paper. The grading of secondary sexual development by a simple present or absent observation ignores totally the sequential nature of sexual development and its association to a particular level of maturity.

As far as the other observations on "gait", "skin elasticity" etc are concerned this author knows of *no* techniques which use such signs as indicative of maturity. Indeed the response from the medical advisers to these classifications is, from those I have observed, "normal". Thus one must assume the converse to this observation is "abnormal" and therefore the maturity indicator is the normality of, for example, gait or skin tone. At their best these techniques must be viewed as unsatisfactory and invalid in distinguishing chronological age differences in children.

The situation exists therefore in which multiple X-rays of immigrants are taken and they are subjected to a visual physical examination *without apparently any valid techniques* to assess maturity, let alone chronological age, being applied to the data so collected.

Conclusion

It is apparent that there are techniques available to assess maturity that have been tried and tested over a number of years in a variety of situations and found to be appropriate for particular populations, (strictly, those that are from the same source as the original sample). These techniques do *not* estimate chronological age. In addition, statements on maturity should be qualified by reference to the socio-cultural background of the individual and their ethnic group. The medical advisers relied on by the British Government use wholly inappropriate techniques to arrive at chronological age assessments. The fact that the Government accepts these estimations means that they are unaware of the problems involved in chronological age assessment.

White (1981)[1] concludes, from his exhaustive study into the theory and practice of X-raying immigrants, with the following question and statement:

'Is it right to make a major decision about a child's future on the basis of evidence which is as inaccurate as an estimation of his age from radiological examinations? The Yellowlees Report contains no limitations or safeguard recommendations which show either an understanding of any of the issues involved or a concern for the people the report affects. The current practices have not come under close scrutiny by the British Government and the Yellowlees report has skimmed blindly over the issues'.

The answer to White's question must be "No". It cannot be right to base decisions on a child's future on such inaccurate techniques. Whilst the end point of the Government's actions may be laudable this end must be reached by the best means available.

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Appendix 2 - Letter from Professor Peter Hindmarsh of University College London Institute of Child Health to Professor Sir Albert Aynsley-Green , Children's Commissioner for England, 29th May 2007

UCL INSTITUTE OF CHILD HEALTH
DEVELOPMENTAL ENDOCRINOLOGY RESEARCH GROUP
CLINICAL AND MOLECULAR GENETICS UNIT

Professor Sir Albert Aynsley Green
The Children's Commissioner for England
1 London Bridge
London SE1 9BG

29 May 2007

Dear Al

Bone "Age" Examination

Thank you for asking me to comment on the proposal by the Home Office to issue new policies for asylum seeking children with particular respect to medical assessment of chronological age.

This issue was raised braced several years ago and addressed by a joint working group led by Dr Anna Sharma between the Royal College of Paediatrics and Child Health and the Home Office. The conclusion of the group was that it was not possible to estimate the chronological age of a child by X-ray examination of the teeth or the skeleton.

The fundamental problem resides in the mistaken concept that skeletal maturation can be expressed in terms of time when in fact it represents the amount of growth completed compared to and adult with fused growth plates (usually expressed as a percentage). This is an unfortunate misunderstanding and one which Jim Tanner tried to resolve in his publications by constantly referring to skeletal maturation in terms of a bone "age." Despite this, the idea that skeletal maturation relates in some way to chronological age has crept into the scientific literature although the basis for this is non-existent. Bone "age" is simply a shorthand method for describing the percentage of growth that has taken place. Just how spurious the concept of skeletal maturation is in measuring chronological age comes from the observation that all adults have at the same Bone "Age" despite clearly having different chronological ages. Dental or skeletal X-rays were never designed, therefore, to estimate chronological age and the units of the measurement are not time but percentage of growth.

Applying the Bone "Age" assessment methodology to British children is problematic and if they were to it to be applied to children of different nationalities a number of problems would arise. First, we would need a set of Bone "Age" standards for each of the populations under study. Current standards are based on North American and British children and it is highly unlikely that these could be applied with any degree of scientific rigour to children from different ethnic backgrounds. Second, given that children from these diverse backgrounds are likely to have experienced different degrees of well-being and health compared to British children it is likely that the tempo of puberty would be influenced in a number of ways. An accelerated puberty would lead to premature maturation of the skeleton and give the false impression that an individual had an older chronological age than they actually had. The converse is more likely in that chronic diseases in the developing world would lead to a slowing of the tempo of puberty such that Bone "Age" would be younger than the chronological age. Whatever way the situation is looked at, and leaving aside the fact that Bone "Age" is not a measure of time, it is likely that all that will be generated from the dental and skeletal X-ray examination are data which are ard to interpret. Finally, there is also the precision and accuracy of Bone "Age" estimation with errors of 3-6 "months" within an individual assessor and of 6-12 "months" between assessors.

These scientific observation need to be placed in the context of two further questions. First, what is the benefit of exposing an individual to X-rays when they can be of no appreciable advantage to the individual and the study is not undertaken from a medical diagnostic standpoint. The number of Bone "Age" examinations undertaken by the Endocrine Team at Great Ormond Street Hospital for Children had dropped by 50% over the last 5 years as we recognise the limitations of such an examination even for medical diagnostics. Second, given the age of the child is in question any examination would require a process of informed consent to be followed and this would require detailed explanation of the

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investigation proposed along with an acknowledgement that the examination was of no benefit to the individual concerned. It is doubtful given the environment in which these examinations are proposed to be undertaken that informed consent could be obtained in a manner which we would recognise as part of Good Clinical Practice.

Finally, I would draw your attention to previous views of the Home Office that further estimation of the age of the individual could be obtained by pubertal examination. This clearly would raise major issues from the ethical and scientific standpoints and I raise it only to warn you that this was on the agenda last time.

I hope that you find these notes of value.

With best wishes

Yours faithfully

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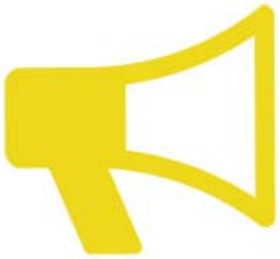

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