Home Office

[redacted]
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Mrs Lydia Brown
HM Senior Coroner for West London
Coroners' Court
25 Bagleys Lane
London
SW6 2QA

By Email: [redacted]

Your case reference: [redacted]

16 December 2024

MR FRANK OSPINA
REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

Dear Mrs Brown,

Thank you for your Regulation 28 report, dated 25 October 2024, following the inquest into the death of Mr Frank Ospina. I am very grateful to you for sharing your findings and for the opportunity to reflect on the processes that were in place around the time of Mr Frank Ospina's detention last year. I am replying as Minister for Border Security and Asylum.

I can assure you that the Home Office takes the health and welfare of people in detention very seriously. Your report identified three matters of concern which have the potential to lead to future deaths, if left unaddressed, which have been carefully considered by officials. This response summarises the action being taken to address the three concerns as well as wider work being undertaken by the Home Office to prevent future deaths in immigration detention.

I am aware that officials from NHS England will write to you separately with regards to your concerns about the operation of Detention Centre Rule 35. I understand that Mitie Care and Custody will also be writing to you, and their response may touch on some of the issues which I address below.

Concern 1 – Rule 35 Detention Centre Rules 2001

With regards to your first concern relating to Rule 35 of the Detention Centre Rules 2001, you have raised two issues which together resulted in a Rule 35 (2) report not being raised in the case of Mr Ospina.

The first issue relates to a mismatch in the healthcare provider and Home Office expectations and practical application of the Rule 35 provisions. This is being addressed through the development of an interim update to the published guidance Detention Services Order (DSO) 09/2016. The interim guidance will make clear that healthcare staff must inform the doctor of a detained person if staff have concerns of suicidal intention.

This will strengthen the existing Assessment Care in Detention and Teamwork (ACDT) guidance which requires non-clinical staff working in an immigration removal centre (IRC) to report the opening of an ACDT plan to both healthcare teams and the local Safer Detention Co-ordinator. The interim version of DSO 09/2016 will also include guidance as to indicators of "suicidal intentions" for clinical and non-clinical staff, to ensure concerns are being raised appropriately. The draft updated interim DSO is currently with key partners, including NHS England for review and is expected to be published in March 2025.

In terms of the limitations on the production of a Rule 35 report, where only a General Practitioner can produce a Rule 35 report, the Home Office is currently conducting a review of the statutory Adults at Risk (AaR) policy and Rules 34 and 35 of the Detention Centre Rules 2001. The option to remove this restriction and extend the production of Rule 35 reports to other relevant healthcare professionals is being considered and will form part of an external engagement process. The review is expected to be completed in Spring 2025. Any changes would require new statutory instruments to be laid before Parliament.

Concern 2 – Closed Visits

I am aware that a closed visit was imposed for Mr Ospina and his mother, which the inquest found to be inappropriate and unnecessary. Work has been undertaken in relation to your concern that under current practices, closed visits could potentially take place without the knowledge or consent of the Duty Manager, or without the necessary documentation being completed.

In line with published Home Office guidance DSO 04/2012 'Visitors and visiting procedures for detained individuals', 'closed visits' (those which take place behind glass, with no physical contact between the detained individual and the visitor) should only take place in certain circumstances, such as suspicion of drug smuggling, or risk to visitors or children. Any decision to impose a closed visit should be taken on a case-by-case basis, following a documented risk assessment by the IRC supplier. In response to this concern, officials have undertaken a review of closed visits across the estate covering the past 4 months and have issued communications to staff to ensure understanding of when a closed visit can be used and responsibilities around doing so.

Officials have also considered longer term assurance and revised the draft DSO on visits to introduce annual self-audits and quarterly assurance reviews of both closed and banned visits. Learning from the recent review of closed visits is currently being considered and will be incorporated into the DSO. The updated DSO is expected to be published before March 2025.

Concern 3 – Accessibility for visitors

In relation to your concern regarding the accessibility of the visit procedures for family and friends visiting loved ones in an IRC, I am aware that you had particular concern with regards to language barriers, which caused difficulty for Mr Ospina's mother in arranging a visit.

My officials have taken action to explore options to translate the visitor information for IRCs and Residential Short-Term Holding Facilities on Gov.uk and the development of web pages to enable translation is underway. Officials have commissioned the translation of the current visitor information into the top 20 languages of those in detention. Allowing time to translate the relevant information and the development of relevant web pages, we expect this work to be complete by the end of January 2025.

Learning from this undertaking will be shared with our suppliers, and we will be endorsing the translation of visitor information pages on their respective websites.

Continuous learning and improvement

There is wider improvement work, both complete and ongoing, to ensure we continue to learn from the death of Mr Ospina. The Home Office has already strengthened the vulnerability identification and reporting mechanism (IS91 RA) through communications, training and the development of guidance, enabling material changes in health, risk and vulnerability to be consistently communicated to Home Office teams responsible for making decisions on ongoing detention. Work is also underway to review the documentation used for the risk assessment process, (IS91 RA forms A – C) with the intention to develop guidance on the process and use of the forms in the published Detention General Instructions.

An internal thematic review into the operation of ACDT was completed in April 2024 and progress against recommendations was reviewed in November 2024. The published ACDT guidance, which is currently under review, will be revised to embed learning from the thematic assurance review and the inquest. The revised DSO will include guidance on the responsibilities, quality, and recording of observations, as well as further clarification on the management of personal items for those who are at risk of self-harm or suicide. Guidance on both issues has already been shared with staff by way of safeguarding bulletin. The revised ACDT guidance is expected to be published in late Spring 2025 after internal and external review.

I am aware that during the process of the inquest, a potential issue was raised with the functionality of call bells in the care suite at Colnbrook IRC. Immediate action was taken to implement an additional, alternative means of communication between a detained individual and officers, in the form of wearable wrist call bells and these were in place from 7 October 2024 and will remain in place until repairs are completed on the call bells in the care suite. We have confirmed with the contracted service providers the timeframe for the repairs would be approximately two days, though as yet, we do not have a confirmed date on when the work will begin. In November 2024, officials undertook an assurance review into the accommodation certification process and record keeping across the detention estate and further learning has been identified. The published guidance on accommodation standards (DSO 06/2018) will be updated to reflect this learning, with expected publication in June 2025 following both internal and external engagement.

The Home Office is committed to continuous improvement in relation to the safeguarding and wellbeing of detained individuals and committed to embedding changes from the identification of learning from internal audits, ‘near-miss’ incidents and deaths in detention. I would like to assure you that in addition to first and second-line assurance carried out by Home Office officials, we welcome the scrutiny and independent oversight from a number of inspection and monitoring bodies, advisory panels and committees.

Independent scrutiny is a vital part of assurance that our detention facilities are safe, secure, and humane. IRCs are subject to robust statutory oversight by Independent Monitoring Boards (IMB) and inspection (including by His Majesty’s Chief Inspector of Prisons, the Independent Chief Inspector of Borders and Immigration and others), ensuring that detained individuals are treated with proper standards of care and decency. We carefully consider the resulting findings and recommendations and involve all relevant parties in those considerations.

Preventing deaths in the immigration removal estate in particular remains a high priority. The Home Office is a co-sponsor to the Ministerial Board to Deaths in Custody, which originates from the recommendations of Robert Fulton's Review of the Forum for

Preventing Deaths in Custody (2008). Following a Home Office commissioned review into immigration detention by the Independent Advisory Panel on Deaths in Custody (IAPDC), a 'Prevention of future deaths in immigration detention strategy' is underway. This work includes research into the impact of cultural differences and trauma on suicide prevention strategies, learning from near miss incidents in detention and work with the Samaritans. Progress against recommendations made by the IAPDC are reported through the governance structures of the MBDC.

I hope that the information provided addresses your concerns satisfactorily.

Yours sincerely,

Minister for Border Security & Asylum