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HM Senior Coroner
West London Coroner Service
25 Bagleys Lane
Fulham
London
SW6 2QA

National Medical Director
NHS England
Wellington House
133-155 Waterloo Road
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SE1 8UG

17 January 2025

Dear Coroner,

Re: Regulation 28 Report to Prevent Future Deaths – Frank Steve Rios Ospina who died on 26 March 2023

Thank you for your Report to Prevent Future Deaths (hereafter “Report”) dated 25 October 2024 concerning the death of Frank Steve Rios Ospina on 26 March 2023. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Frank’s family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Frank’s care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report and I apologise for any anguish this delay may have caused Frank’s family or friends. I realise that responses to Coroner Reports can form part of the important process of family and friends coming to terms with what has happened to their loved ones, and I appreciate this will have been a difficult time for them.

NHS England is the responsible organisation for the commissioning of healthcare in Immigration Removal Centres, which is devolved to regional teams. Commissioning healthcare is undertaken on the principle of equivalence, which has been defined by the Royal College of General Practitioners (RCGP), and broadly states that the aim is to ensure people detained in England are offered provision of and access to appropriate services and treatment, considered to be at least consistent in range and quality, with that available in the wider community.

I have considered the concerns raised in your Report regarding the use of Detention Services Order 09/2016, Rule 35. Please see my response below, which my colleagues from NHS England’s Health & Justice Specialised Commissioning Team have input into.

NHS England accepts that there is learning with regards to the appropriate use and adherence to the [Home Office Adults at Risk policy](#) and Rule 35 assessment process, which require the balanced consideration of vulnerability to ensure the appropriateness of decisions around suitability of detention. In this case these

safeguarding processes fell short, resulting in key information about Frank's attempts to take his life and current vulnerabilities being overlooked.

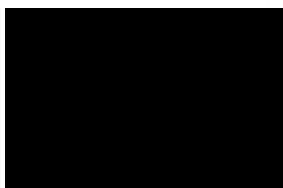
NHS England is working with the Home Office policy team to amend the Adults at Risk policy and Rule 35 assessment process. The aim of this work is to move the assessments towards a multidisciplinary approach, ensuring that completion of the assessment can be undertaken by a registered healthcare professional at the Immigration Removal Centre (IRC). Introducing this approach will ensure the management of safeguarding and vulnerability are not solely the responsibility of general practitioners. NHS England and the Home Office will, prior to full implementation during 2025, jointly develop a stakeholder engagement session to share the revised requirements with IRC providers and operators.

The [NHS England Health and Justice Clinical Reference Group](#) developed Detention Centre Rule 35 and Short-Term Holding Facility Rule 32 [clinical guidance](#), which advocates this multidisciplinary approach. This guidance was disseminated to all IRC healthcare providers via an online event chaired by the NHS England Health & Justice National Clinical Lead in April 2024. The IRC Partnership Group provides the governance and oversight of the attainment of the NHS England and Home Office Detention joint priorities and assures the national system of the quality and consistency of healthcare provisions and reduction of health inequalities.

I would also like to provide further assurances on the national NHS England work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors, and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Frank, are shared across the NHS at both a national and regional level and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director