West London Coroner Service
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Date: 25 October 2024
Case: [redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

Home Office, [redacted] Home Secretary

NHS England

MITIE

CORONER

1 I am **Mrs. Lydia Brown Senior Coroner** for **West London**

CORONER'S LEGAL POWERS

2 I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 30 March 2023 I commenced an investigation into the death of Frank Steve Rios OSPINA. The investigation concluded at the end of the inquest . The conclusion of the inquest was

Frank Ospina died by suicide

3 Cause of death was recorded as

1a Ligature compression of the neck

1b

1c

II Coronary Heart Disease

CIRCUMSTANCES OF THE DEATH

4 Please see attached jury findings

CORONER'S CONCERNS

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1) During the inquest evidence was heard about the use of Detention services order 09/2016 Detention centre rule 35 (2)

The purpose of rule 35 of the Detention Centre Rules 2001, as set out in Detention - general guidance (chapter 55), is 'to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention.

Rule 35 (2) states

2. 'The medical practitioner shall report to the manager on the case of any detained person he suspects of having suicidal intentions, and the detained person shall be placed under special observation for so long as those suspicions remain, and a record of his treatment and condition shall be kept throughout that time in a manner to be determined by the Secretary of State.

5 'The manager shall send a copy of any report under paragraphs (1), (2) or (3) to the Secretary of State without delay.

Despite Frank Ospina being witnessed as having made an attempt to take his life, and self-reporting a further attempt during his detention, no R35 report was made.

The GP evidence was that there was a long waiting list of 4 weeks of over 100 individuals who were dealt with in separate dedicated surgeries, that he had only made "a small number" of R35 (2) reports and that he would usually await and rely on additional evidence such as that from a Consultant Psychiatrist before submitting a R35 (2) report. In contrast, the Home Office evidence was that they were "surprised" that a R35 report had not been submitted. If it had been it would have been considered by a responsible officer within 2 working days.

There was a clear mismatch between the healthcare and Home Office expectations and practical application of the R35 provisions. HMC was advised that this is under review currently by the Home Office and NHS England and so this report is written to inform and assist that review process by raising the concerns from this inquiry. HMC would also question the restriction of the report having to be generated by a general practitioner, although detainees were seen by a multi-disciplinary team of healthcare professionals, many of whom could potentially carry out this task.

(2) Visits. The inquest was advised that Frank Ospina's mother visited him in the Heathrow Immigration Removal Centre on one occasion, and that was conducted as a "closed" visit.

Her son was accompanied by 2 Officers and their meeting held behind a glass screen where no physical contact was possible. The Officers were overhearing the family conversation and making notes.

MITIE who are responsible for the day to day running of the IRC were unaware that a "closed" visit had occurred and apologised for this, confirming it was inappropriate and Frank Ospina and his mother should have been allowed to meet in the usual communal area where they could have embraced and had a private conversation. This was the last time Frank Ospina was seen alive by his mother and the visit greatly distressed her.

HMC is concerned that any "closed" visits could take place seemingly without the knowledge and consent of the Duty Manager, that no documentation had to be presented and the "closed visit" room was accessible even though rarely required (the inquest was advised it had not been used at all during the past few months).

(3) Frank's mother does not speak English and found it very difficult to arrange a visit. In fact rather than successfully navigate the system, she just turned up and was permitted to see her son as set out above. Telephone calls were not facilitated with an interpreter. The web site where visits should be booked is entirely and only in English. This is a facility that by definition detains foreign nationals and predictably some of the family members do not speak English. A quick check of the local authority website (Hammersmith and Fulham) revealed a full immediate translation facility into over 100 languages, and so this is readily available technology. The Home Office and MITIE should consider the communications currently available to relatives trying to visit their loved ones and whether these can be improved by reasonable adjustments.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report, but given the Christmas period I will extend this to 3 January 2025.

Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons

Family members and their representatives

[redacted], Liberty Human Rights

8 I have also sent it to [redacted], Liberty Human Rights who may find it useful or of interest.

I am also under a duty to send the Chief Coroner a copy of your response.

The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response,

about the release or the publication of your response by the Chief Coroner.
25 October 2024

9 Signature 

Lydia Brown Senior Coroner for