Prisons & Probation Ombudsman
Independent Investigations

Independent investigation into the death of Mr Frank Ospina, a detainee at Colnbrook Immigration Removal Centre, on 26 March 2023

A report by the Prisons and Probation Ombudsman

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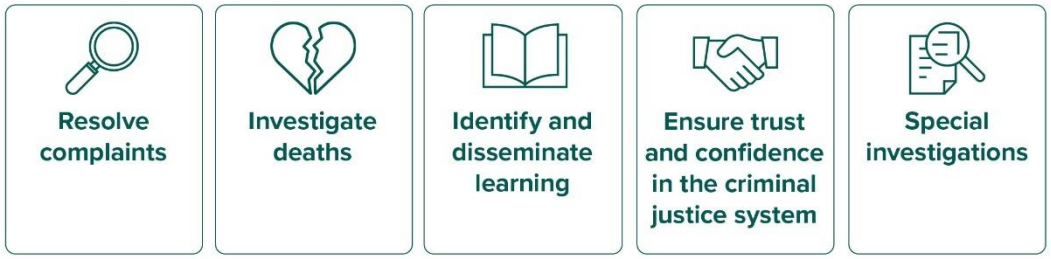
OUR VISION

To deliver high quality and timely independent investigations and work closely with partners to achieve tangible benefits for the safety and confidence of those in custody and under community supervision.

WHAT WE DO



WHAT WE VALUE

The Prisons and Probation Ombudsman aims to make a significant contribution to safer, fairer custody and community supervision. One of the most important ways in which we work towards that aim is by carrying out independent investigations into deaths, due to any cause, of prisoners, young people in detention, residents of approved premises and detainees in immigration centres.

If my office is to best assist in ensuring the standard of care received by those within service remit is appropriate, our recommendations should be focused, evidenced and viable. This is especially the case if there is evidence of systemic failure.

Mr Frank Ospina was found dead in the care suite at Colnbrook Immigration Removal Centre on 26 March 2023. He had used his own scarf to strangle himself. He was 39 years old. I offer my condolences to Mr Ospina's family and friends.

At the time of his death, Mr Ospina was being monitored using suicide and self-harm prevention procedures and should have been checked twice an hour. However, he had not been checked for over an hour when he was found dead. A detention custody officer had recorded that he had undertaken a check half an hour before when he had not done so. Mr Ospina appeared to have been dead for at least two hours when he was found, which casts doubt on whether previous checks were carried out correctly.

Mr Ospina's mental health deteriorated from 22 March onwards when he self-harmed and repeatedly said that he wanted to die. IRC staff should have alerted the Home Office so that they could have reviewed whether Mr Ospina's continued detention was appropriate, in line with Home Office policy. This did not happen.

Following its last inspection of Colnbrook in 2022, HM Inspectorate of Prisons found that there were insufficient safeguards against the detention of detainees with suicidal thoughts and that reports to notify the Home Office of suicidal detainees were seldom prepared when necessary. This process needs to improve if the Home Office is to prevent future deaths by suicide at Colnbrook.

This version of my report, published on my website, has been amended to remove the names of staff and detained persons involved in my investigation.

Adrian Usher
Prisons and Probation Ombudsman **May 2024**

Contents

Summary

Events

1. On 4 March 2023, Mr Frank Ospina was detained at Colnbrook Immigration Removal Centre (IRC) pending his removal to Colombia.

2. When he arrived at the IRC, Mr Ospina said he would be at risk from gangs if he returned to Colombia. Staff subsequently noted that he had declined the offer of voluntary departure and had raised a possible asylum claim.

3. On 16 March, Mr Ospina told staff that he wanted to return to Colombia voluntarily. He said his mother would bring his passport to the IRC, which she subsequently did.

4. On 19 and 21 March, Mr Ospina saw healthcare staff and said he was stressed about his immigration situation. They gave him advice on how to improve his mood and advised him to contact the welfare team for an update on his case.

5. On 22 March, Mr Ospina jumped from the second floor internal balcony onto the safety netting. Staff started suicide and self-harm prevention procedures (known as ACDT). Mr Ospina said that he had been talking to underage girls online. He said he wanted to confess and go to prison. He said he was a bad person and he wanted to die. Staff placed Mr Ospina under constant supervision in the care suite. A doctor prescribed antidepressant medication.

6. On 23 March, staff held an ACDT review. Mr Ospina said he felt better for talking to staff the previous day and that he had no thoughts of suicide or self-harm. Staff reduced his observations to one an hour and moved him from the care suite back onto the main unit.

7. On 24 March, Mr Ospina self-harmed by whipping himself with the wire from a television aerial and banging his head against the wall. Staff held a further ACDT review and increased his observations to two an hour.

8. On 25 March, staff held another ACDT review and moved Mr Ospina back to the care suite as his mental health continued to deteriorate. Later that day, police interviewed Mr Ospina about his online contact with underage girls and he became distressed. He was taken back to the care suite and remained on two observations an hour.

9. CCTV shows that on 26 March, a detention custody officer (DCO) checked on Mr Ospina at 7.22am, 7.42am and 7.52am. The DCO said that he saw Mr Ospina in bed on each occasion. At around 8.00am, another DCO took over. He recorded that he checked on Mr Ospina at 8.30am but CCTV shows that he did not. He told the investigator that he had written it down as a reminder to do the check but had got side-tracked with other tasks and not done it.

10. Shortly after 9.00am, the DCO went to Mr Ospina's room to check on him. He opened the door and looked in. Mr Ospina was not in his bed and did not respond when the DCO called out to him. The DCO closed the door and called for colleagues to attend as he thought he should not go into the room alone. After 13

minutes, staff attended and went into the room where they found Mr Ospina lying on the floor of the toilet area with a scarf tied around his neck. A manager instructed staff to start CPR even though there were signs that Mr Ospina had been dead for some time. When healthcare staff arrived, they also continued with CPR until paramedics arrived and confirmed that Mr Ospina was dead.

Findings

11. A DCO falsely recorded that he had checked on Mr Ospina at 8.30am when he had not done so. Mr Ospina should have been checked twice an hour but was not checked for over an hour, between 7.52am and 9.03am. He had rigor mortis when found, which suggests that he had been dead for at least two hours. This casts doubt on the other DCO's account that he saw him in bed at 7.22am, 7.42am and 7.52am.

12. The DCO who found Mr Ospina had not worked in the care suite before. He was unaware that Mr Ospina should have been unlocked at 8.30am. He was also unaware that additional staff were not needed to enter detainees' rooms.

13. The purpose of Rule 35 procedures, as set out in published Home Office detention policies, is to ensure that particularly vulnerable individuals, including those with suicidal intentions, are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention. No Rule 35 report was raised in relation to Mr Ospina after he self-harmed and expressed suicidal thoughts, meaning that no one reviewed his continued detention as we would have expected.

14. During its last inspection of Colnbrook in February and March 2022, HM Inspectorate of Prisons found that there were insufficient safeguards against the detention of detainees with suicidal thoughts. They found that Rule 35 reports were seldom prepared when necessary. The most recent annual inspection of Adults at Risk in Immigration Detention by the Independent Chief Inspector of Borders and Immigration also found that the Rule 35 process was not working effectively.

15. The clinical reviewer found that the care Mr Ospina received for his mental health was of a good standard and was equivalent to that which he could have expected to receive in the community.

Recommendations

- The Centre Manager should ensure that staff understand their responsibilities when carrying out ACDT observations, including that they:
  - obtain a clear visual sighting of the detainee using a torch if necessary; and
  - accurately record the time of the check once they have completed it.
- The Centre Manager should ensure that ACDT reviews are multidisciplinary with input from healthcare and any other relevant staff, including DET.

- The Home Office should amend DSO 09/2016 so that it:
  - it is clear what suicidal intentions means; and
  - requires nurses and other healthcare professionals to report to a doctor any detainee who is showing suicidal intentions.
- The Home Office should review the training provided to IRC staff on Rule 35 reports, particularly for those at risk of suicide.

The Investigation Process

16. The Home Office notified us of Mr Ospina's death on 26 March 2023.

17. The investigator issued notices to staff and prisoners at Colnbrook IRC informing them of the investigation and asking anyone with relevant information to contact her. One detainee responded but did not provide sufficient information to facilitate an interview.

18. The investigator obtained copies of relevant extracts from Mr Ospina's detention and medical records.

19. NHS England commissioned an independent clinical reviewer to review Mr Ospina's clinical care at the IRC.

20. The investigator interviewed four members of staff at the IRC in August 2023.

21. We informed HM Coroner for West London of the investigation. The Coroner sent us the results of the post-mortem examination. We have sent the Coroner a copy of this report.

22. The Ombudsman's family liaison officer contacted Mr Ospina's mother, with assistance from the Colombian Embassy, to explain the investigation and to ask if she had any matters she wanted us to consider. Mr Ospina's mother wanted to know:

    - Why her son was not removed to Colombia immediately.
    - Why her son had a scarf with him that he could use as a ligature when he had previously tried to take his life.
    - Why staff had not carried out proper checks on her son on the morning of 26 March.

    We have addressed these issues in the report.

23. We shared our initial report with Mr Ospina's mother, via the Colombian Embassy. She did not raise any factual inaccuracies.

24. We shared our initial report with the Home Office. The Home Office requested revised wording to one paragraph which has been amended within our report. The action plan has been annexed to this report.

Background Information

Colnbrook Immigration Removal Centre (IRC)

25. Colnbrook is an immigration removal centre situated next to Heathrow Airport in West London. It holds up to 330 detainees. Mitie Care and Custody run the centre under contract from the Home Office. Practice Plus Group provides physical and mental health services. There is a six-bed care suite for detainees considered to be in crisis and requiring time out from the normal regime. The care suite is upstairs from the healthcare facility but is run by Mitie staff.

Rule 35 - Adults at risk in immigration detention

26. The purpose of Rule 35 of the Detention Centre Rules 2001 is "to ensure that particularly vulnerable detainees are brought to the attention of those with direct responsibility for authorising, maintaining and reviewing detention". Detention Services Order 09/2016 provides guidance to Home Office and IRC staff on the operation of Rule 35.

27. Sub-paragraphs (1) to (3) of Rule 35 say that a medical practitioner must report detainees to the Home Office where:

- the detainee's health is likely to be injuriously affected by continued detention.
- the detainee is suspected of having suicidal intentions.
- the detainee may have been a victim of torture.

28. The Home Office weighs the health assessment against immigration and public protection considerations to decide whether detention remains appropriate. DSO 09/2016 says that applications should be dealt with by the Home Office caseworker within two working days.

HM Inspectorate of Prisons

29. The last inspection of Colnbrook took place between 28 February and 18 March 2022. Inspectors described the Centre as reasonably safe and decently run. Most detainees spent around a month at the Centre, reported positive relationships with staff, and said they felt safe there. Inspectors found that the suicide and self-harm monitoring process (known as ACDT) generally worked well to support detainees in crisis.

30. Health services were generally of a good standard and there was good support for those who were most distressed, but it was disappointing that there was less provision for those with lower-level mental health issues who needed support before things reached crisis point.

31. Inspectors found that there were insufficient safeguards against the detention of detainees with suicidal thoughts. Rule 35 reports were seldom prepared when

necessary. Some distressed detainees who should have been released earlier due to physical and mental health problems were not served well by inadequate assessments in Rule 35 reports. Inspectors reported that in the previous six months, a third of detainees had been released following a Rule 35 report, more than at the previous inspection in 2018. However, very few reports related to health concerns or suicide risk and those in the inspectors' sample contained little detail. The recommendation made in the 2018 inspection that Rule 35 reports should be monitored to ensure they were submitted when necessary, had not been achieved.

32. Inspectors reported that uncertainty about their future was the most common cause of frustration for detainees, so it was disappointing that the Home Office's Detention Engagement Team (DET), that was supposed to answer questions and provide support, was functioning so poorly. Low staffing levels and a lack of ambition from leaders meant that there was almost no face-to-face interaction, while the team's telephones often rung unanswered.

Independent Monitoring Board

33. Each immigration removal centre has an Independent Monitoring Board (IMB) of unpaid volunteers from the local community who help to ensure that detainees are treated fairly and decently. In its latest annual report for the year to 31 December 2022, the Board was concerned that while detainees received a reasonable standard of healthcare provision, ongoing healthcare staff shortages could impact on the services provided to detainees, particularly in relation to mental health provision. The Board noted a significant increase in incidents of self-harm and the number of detainees subject to suicide and self-harm monitoring. Detainees reported their distress was usually due to frustration about their immigration status or not being released when they expected to be.

Independent Chief Inspector of Borders and Immigration

34. The Independent Chief Inspector of Borders and Immigration carried out its third annual inspection of 'Adults at risk in immigration detention' from June to September 2022. It found that Rule 35, which is an important safeguard for particularly vulnerable individuals being held in immigration detention, was not working consistently or effectively.

35. Inspectors reported that there were disproportionately high volumes of Rule 35 reports concerned with torture in comparison with exceptionally low volumes of Rule 35 reports relating to health and suicidal intentions. They noted that while DSO 09/2016 said that "nurses and other healthcare professionals are aware that they must report to an IRC doctor any detainee who claims to be a victim of torture or gives an indication that this might have been the case", there is no requirement for nurses and other healthcare professionals to report equivalent concerns to the IRC doctor where a detainee's health is likely to be injuriously affected by continued detention or where there are concerns of suicidal intentions.

Previous deaths at Colnbrook IRC

36. Mr Ospina was the first prisoner to die at Colnbrook since 2016. In 2016, there was one homicide and one self-inflicted death. In the previous self-inflicted death, we

made recommendations to Colnbrook about healthcare staff attending ACDT reviews.

Key Events

37. Mr Frank Ospina, a Colombian national, arrived in the UK on a visit visa on 9 February 2023. He was not permitted to work during his stay. On Friday 3 March, Home Office Immigration Enforcement officers found him working at a restaurant. They served him papers telling him that he was to be removed from the UK and would be detained pending his removal to Colombia. On 4 March, Mr Ospina was taken to Colnbrook Immigration Removal Centre (IRC).

38. When Mr Ospina arrived at the IRC, staff used a Spanish interpreting service and noted no physical or mental health problems. During his induction, Mr Ospina said he would be at risk from gangs if he returned to Colombia. Although Mr Ospina's first language was Spanish, staff did not always use interpreting services as they said his level of English was sufficient to hold a conversation with him.

39. On 8 March, Home Office staff carried out the seven-day detention review. They assessed that Mr Ospina was at high risk of absconding if released on bail and recommended that he should continue to be held in detention until his removal to Colombia. Staff recorded that Mr Ospina had declined the offer of voluntary departure. Staff noted that Mr Ospina had raised a possible asylum claim when he said at his induction that he was at risk from gangs if returned to Colombia. A Home Office manager recorded that this should be explored further by staff in the Detention Engagement Team (DET) at the IRC. The manager authorised continued detention on 9 March.

40. On 15 March, Home Office staff carried out the 14-day detention review. The actions from the previous review were still outstanding and staff were no clearer if Mr Ospina intended to raise an asylum claim. Staff noted that the likely timescale for Mr Ospina's removal would be a further four to five weeks unless he raised an asylum claim. On 16 March, a Home Office manager authorised Mr Ospina's continued detention while waiting for DET staff to establish whether Mr Ospina was making an asylum claim. The next detention review date was scheduled for 31 March (28 days).

41. On 16 March, Mr Ospina told DET staff that he wanted to accept the offer to return voluntarily to Colombia. Staff noted that he did not have his passport but he said his mother could bring it to the centre.

42. On 19 March, Mr Ospina said he wanted to speak to healthcare staff as he was feeling stressed. A triage nurse assessed him and advised him to eat healthily, do some exercise and keep busy. The nurse also advised him to contact the IRC welfare team for advice regarding his immigration situation.

43. On 21 March, Mr Ospina attended a walk-in clinic and told the nurse that he was stressed and he had no solicitor. The nurse spoke to staff on the unit who advised that he should contact the welfare team for advice.

44. On 22 March, at around 9.00am, Mr Ospina jumped from the second floor internal balcony onto the safety netting. A Detention Custody Manager (DCM) completed a Concern Form and Immediate Action Plan as part of the suicide and self-harm prevention process (known as ACDT procedures). The DCM noted that Mr Ospina

told staff that he wanted to die and that he was not a nice person. He said he was feeling stressed and was not sleeping as he was afraid of going back to Colombia. Mr Ospina told staff that he had been using a web cam to talk to underage girls. He said he wanted to confess and to go to prison. The DCM placed Mr Ospina under constant supervision and moved him to the care suite while waiting for his first ACDT review. She referred Mr Ospina to the mental health team and noted that he should have supervised shaves but did not remove any other items from him.

45. At 10.30am, staff held the initial ACDT assessment interview in the care suite. Mr Ospina, and two DCMs attended. Staff used an interpreter. Staff noted that Mr Ospina said he felt better now that he had told them about his online contact with underage girls. He said he had self-harmed three days previously but had not told anyone. Staff noted that the care suite was the only suitable location for him due to his risk of jumping over the balcony. He remained in the care suite under constant supervision.

46. At 10.30am on 22 March, Home Office staff updated Mr Ospina's Home Office record to say that he had told DET staff that he wanted to return to Colombia.

47. Mr Ospina's mother visited the centre at around 2.00pm to drop off her son's passport but she did not see him.

48. At around 3.00pm, a doctor saw Mr Ospina and prescribed sertraline (an antidepressant). Mr Ospina told the doctor he had previously been treated for anxiety and depression in Colombia. Due to his risk of suicide and self-harm, the medication was not given to him in his possession so he received it each day in the presence of healthcare staff. The doctor wrote that he planned to review Mr Ospina again in two to three weeks.

49. At around 4.00pm on 23 March, a DCM chaired Mr Ospina's first ACDT review. Staff used an interpreter. No one attended from healthcare (the Head of Healthcare told us that healthcare staff were available to attend ACDT reviews only between 10.00am and 12.00pm). Nor did DET, but they provided input by email. The DCM noted that Mr Ospina had spoken to his solicitor (who had been appointed after Mr Ospina's conversation with the welfare team) and was still waiting to see DET and the mental health team. He said that he did not want to return to Colombia and wanted an opportunity to remain in the UK. Mr Ospina said that his medication was helping him and he had no thoughts of suicide or self-harm. Staff stopped constant supervision and set observations at one an hour. They moved him from the care suite back onto the main unit.

50. At around 1.45pm on 24 March, a DCM chaired a further ACDT review after Mr Ospina self-harmed. He used the wire from a TV aerial to whip himself and was also banging his head against the wall. Staff did not use an interpreter as they noted that Mr Ospina spoke English. No one from healthcare or DET attended the ACDT review, although a mental health nurse provided information in advance by telephone. Mr Ospina said he had seen DET staff and they had said he would be prosecuted if he did not sign immigration paperwork. He was also concerned that staff had told the police that he had been engaging with underage girls online. Staff told him that they had not informed the police. Staff noted that Mr Ospina was compliant with his medication but still waiting to see the mental health team. He

said he was not going to harm himself. Staff increased his observations to two an hour.

51. Later that day, a mental health nurse carried out a triage assessment with Mr Ospina. The nurse noted that Mr Ospina was having thoughts of suicide and self-harm but did not have an active plan to end his life. He noted that Mr Ospina was complying with his medication and being supported by the ACDT process.

Events of 25 March

52. At 11.25am on 25 March, a DCM chaired an ACDT review. A mental health nurse attended and DET provided input by telephone. Staff did not use an interpreter as they noted that Mr Ospina spoke English. Mr Ospina told staff that he wanted to die as the Home Office was investigating what he had done, and he did not want to go to prison for 30 years. The DCM noted that Mr Ospina's demeanour had changed since the day before. She noted that DET staff had seen him that morning and asked him to sign biodata forms, which had possibly been a trigger. She noted that the Home Office had asked Mr Ospina to decide whether he wanted to return to Colombia or remain in the UK as he had been changing his mind. The mental health nurse said she would refer him to the psychologist. She noted that there was no enduring mental illness and that Mr Ospina appeared to be struggling with guilt about his alleged offences and the potential repercussions. Staff decided to move Mr Ospina to the care suite. The DCM noted that he should have supervised shaves and limited items in his room, but no further details were given.

53. Detention Custody Officer (DCO) A was on duty in the care suite when Mr Ospina arrived. DCO A told the investigator that, at that time, he had only worked at the centre for seven months and this was the first time he had worked in the care suite. DCO A said Mr Ospina had his belongings in two large bags. He said he was not made aware of any items Mr Ospina could not take into the room, so he allowed him to take the bags in and he did not check them. He was tasked with calming Mr Ospina and checking on him twice an hour. He was the only member of staff but there were no other residents in the care suite at the time so he said he spent most of the time with Mr Ospina.

54. Around 3.00pm, staff informed the police that Mr Ospina told them he had been talking to underage girls online.

55. DCO A said that Mr Ospina wanted to know what was going on with his immigration status and he contacted his colleagues in the welfare team to see if they could help. They advised him to bring Mr Ospina to them. DCO A said that the visit caused Mr Ospina some distress, but he did not know the nature of what he was told. Home Office records show that DET staff spoke to Mr Ospina and they noted he seemed unsure if he wanted to return to Colombia or stay in the UK. He eventually said he wanted to stay in the UK.

56. DCO A said that, shortly after arriving back at the care suite after seeing DET staff, he was asked to bring Mr Ospina to legal visits. DCO A said he was unaware what the visit was about but, on arrival, he realised that it was a visit from the police. The police spoke to Mr Ospina in relation to his disclosure that he had been talking to underage girls online. Mr Ospina had previously been told by staff that they had not reported this information to the police so this led to him becoming more distressed.

57. DCO A told the investigator that Mr Ospina was very unsettled when he returned him to the care suite and he spent time talking to him and calming him down. He wrote in Mr Ospina's ACDT paperwork that he was distressed after the police visit. He said he also verbally informed the duty manager and other colleagues at the time. A DCM said that she was not made aware that Mr Ospina had been seen by the police and that his demeanour had changed. Had she known, as ACDT case manager, she said she would have considered a further review.

58. At around 9.00pm, DCO A handed over to his colleague, DCO B. DCO A told the investigator that Mr Ospina had calmed down and was talkative with him but he became distressed again when he realised that DCO A was handing over to someone else.

59. DCO B told the investigator that Mr Ospina was agitated, pacing the room and saying that he wanted to call the police. Staff allowed him to do so but they did not know what Mr Ospina said to the police. The police told the investigator that Mr Ospina had said he had been grooming children in the UK and he wanted them to take him out of the Centre so he could show them the evidence. They told him they were unable to do anything immediately and he said he would be deported if they left it too late.

60. DCO B said that Mr Ospina did eventually settle down and he took him a hot drink at around 11.00pm. DCO B continued to check on Mr Ospina at least twice an hour. He told the investigator that he was concerned about the amount of personal possessions Mr Ospina had in his room, but he did not feel it was his place to remove any of them.

Events of 26 March

61. CCTV shows that DCO B carried out checks on Mr Ospina at 7.22am, 7.42am and 7.52am. CCTV shows that at 7.22am, DCO B looked into the room and cupped his hands around his face as though he was trying to get a better view. He did not do this for the subsequent checks, which consisted of a quick glance into the room. There was no light in the room and the main lights on the unit were off. DCO B said that he did not use a torch for any of the checks as he said he did not want to disturb Mr Ospina. DCO B was confident that he saw Mr Ospina lying in his bed during all the checks he conducted during the night and early morning of 26 March and he had no concerns about him.

62. DCO B handed over to DCO A at around 8.00am. DCO A told the investigator that he briefly looked into Mr Ospina's room as he was on his way to the handover and he noticed his bed was empty. He said he asked DCO B how Mr Ospina had been and he told him that he was fine during the night and he had last checked on him just before 8.00am. DCO A noted that he would have to do another check at 8.30am and he said he wrote this in the ACDT paperwork as a reminder to do it. However, he said he was side-tracked doing other work and then went to prepare Mr Ospina's breakfast, so he missed the 8.30am check.

63. CCTV shows the main lights on the unit came on at 8.31am. DCO A went to Mr Ospina's room at 9.03am and opened the door but he did not go inside. DCO A told the investigator he was concerned as Mr Ospina was not in his room and he noticed that his bed was the same as when he had looked in earlier. He called out to him

but he did not respond so he closed the door and went to call colleagues to help. DCO A said that he thought it was unsafe to go further into the room without the support of a colleague as this is what he had been trained to do when working in the Care and Separation Unit (CSU) which is used for more volatile residents.

64. CCTV timings show that it was a further 13 minutes before DCO A's colleague, DCO C, arrived. At 9.16am, they both went into Mr Ospina's room and found Mr Ospina lying on the floor of the bathroom with a scarf tied around his neck. DCO A said he was certain that Mr Ospina had been dead for some time as he appeared stiff and cold with signs of rigor mortis. No one called a medical emergency code but DCO A said he and DCO C called other members of staff to attend and phoned the control room.

65. A Duty Shift Manager attended at 9.18am. She removed the ligature from Mr Ospina's neck and told staff to start CPR. Another member of staff went to call a nurse from a nearby clinic who attended with the emergency bag at 9.22am and continued CPR even though there were clear signs that Mr Ospina had been dead for some time. Paramedics arrived and declared, at 9.47am, that Mr Ospina was dead. Body worn camera footage records paramedics confirming that Mr Ospina had signs of rigor mortis and staining on his body suggesting he had been dead for some time.

Contact with Mr Ospina's family

66. Mr Ospina did not provide a named next of kin when he arrived at Colnbrook and this resulted in a delay in informing his family that he had died. The investigator was told that although Mr Ospina's mother had dropped his passport at the centre, she had not visited her son and so her details were not recorded in his file. With assistance from the Colombian Consulate, the Home Office's family liaison officer spoke to Mr Ospina's mother on the telephone on 29 March, although Consulate staff had already made her aware of her son's death by that time. Mr Ospina's mother asked that staff at the Colombian Consulate act on her behalf.

67. The Home Office assisted in the arrangements and financial cost of repatriating Mr Ospina to Colombia for his funeral.

Support for detainees and staff

68. An IRC manager debriefed the staff involved in the emergency response to ensure they had the opportunity to discuss any issues arising, and to offer support. The staff care team also offered support. However, DCO A said he did not feel sufficiently supported. He said he was not offered the opportunity to go off duty and was asked to attend an interview in the care suite while Mr Ospina's body was being removed.

69. The IRC posted notices informing other detainees of Mr Ospina's death and offered support. Staff reviewed all detainees assessed as at risk of suicide or self-harm in case they had been adversely affected by Mr Ospina's death.

70. In the days following Mr Ospina's death, detainees staged a protest regarding their perceived treatment at the IRC.

Post-mortem report

71. The post-mortem and toxicology reports showed that Mr Ospina died due to strangulation. The toxicology results showed a high level of his prescribed antidepressant medication, sertraline, although the toxicologist was unable to conclude if he had taken an excessive amount immediately before his death.

72. Although evidence indicates that Mr Ospina had been dead for some time by the time he was found, the exact time of death has not been established. However, the pathologist's view is that body changes reported by paramedics, such as rigor mortis and staining, would be unlikely to occur until at least two hours had passed since the time of death.

Findings

Management of Mr Ospina's risk of suicide and self-harm

73. Detention Services Order (DSO) 01/2022 provides instruction and guidance for identifying and supporting individuals in detention who may be at risk of suicide or self-harm. Any individual identified as at risk of suicide or self-harm must be managed using the Assessment Care in Detention and Teamwork (ACDT) procedures.

74. Mr Ospina was supported using ACDT procedures from 22 March, when he jumped from the balcony, until his death on 26 March.

ACDT observations

75. On the day he was found dead, Mr Ospina should have been checked twice an hour. The ACDT paperwork records that a check was made on Mr Ospina at 8.30am but CCTV shows that it did not happen. Mr Ospina had not been checked for over an hour, between 7.52am and 9.03am, when he was found dead. DCO A said he had recorded the 8.30am check to remind him to do it but had then got side-tracked and not done it. This practice is unacceptable. In fact, Mr Ospina should have been unlocked at 8.30am, but DCO A was unaware of this as he usually worked in the CSU, where prisoners remained locked in their rooms. He said he was unaware of the regime in the care suite.

76. Mr Ospina had rigor mortis when he was found, which suggests that he had been dead for at least two hours. This casts serious doubt on DCO B's account that he had seen Mr Ospina lying in his bed when he checked on him at 7.22am, 7.42am and 7.52am. The unit was dark, there was no light on in Mr Ospina's room and DCO B did not use a torch so we doubt that he could have seen Mr Ospina clearly.

77. We recommend:

The Centre Manager should ensure that staff understand their responsibilities when carrying out ACDT observations, including that they:

- **obtain a clear visual sighting of the detainee using a torch if necessary; and**
- **accurately record the time of the check once they have completed it.**

ACDT management

78. DSO 01/2022 says that healthcare staff should be invited to all case reviews and that DET staff should be invited if considered relevant. Written contributions should be provided if staff are unable to attend.

79. We found that healthcare staff attended only one review and provided verbal input to another. They provided no input at all to the first case review, at which staff decided to stop constant supervision and set observations at one an hour. DSO 01/2022 says that healthcare staff must attend the case review held after a detainee

is placed under constant supervision. The Head of Healthcare told us that healthcare staff were only available to attend ACDT reviews between 10.00am and 12.00pm. We note that the case review was held at 4.00pm. Nine other residents were subject to ACDT procedures at the same time as Mr Ospina.

80. We consider that DET staff were relevant to Mr Ospina's case and should have been invited to all case reviews. They attended none and provided written input to only one. The value of multidisciplinary reviews in the effective management of suicide and self-harm risk is self-evident. Given the relatively low numbers of residents managed under ACDT procedures at the time of Mr Ospina's death and yet the apparent difficulties in arranging reviews when relevant staff can attend, we make the following recommendation:

The Centre Manager should ensure that ACDT reviews are multidisciplinary with input from healthcare and any other relevant staff, including DET.

81. DSO 01/22 says, "Consider the location of any possessions which might be used to self-harm and may need to be removed from the individual. Removal of items should never be automatic and should be kept to a minimum as it can have a negative impact on wellbeing. Decisions relating to the removal of items must be fully defensible and must be recorded in the ACDT plan at the point the decision is taken…"

82. Staff noted that Mr Ospina should have supervised shaves but there is no record that they removed any other items from him. While we note that Mr Ospina used his own scarf to strangle himself, it does not appear that there would have been justification to remove this item, and similar items, from him. Up to being found dead, he had not used any clothing as ligatures.

Rule 35 – review of detention for adults at risk

83. Despite Mr Ospina jumping from a balcony on 22 March and telling staff that he wanted to die, a Rule 35 report was never completed for him. On 24 March, Mr Ospina again told staff that he was having thoughts of suicide but again, no Rule 35 report was submitted. This meant that Mr Ospina's detention was not reviewed by Home Office staff to assess whether his continued detention was appropriate.

84. When the investigator asked the Head of Healthcare why a Rule 35 report had not been submitted for Mr Ospina, he said that Mr Ospina had always denied suicidal intent and they had no reason to doubt him. He also said that there were delays in getting an appointment with a doctor and a backlog of Rule 35 reports awaiting a decision from the Home Office.

85. The failure to complete Rule 35 reports is an issue that has been highlighted by HM Inspectorate of Prisons following its inspections of Colnbrook in both 2018 and in 2022. During its 2018 inspection, inspectors found that Rule 35 reports were rarely submitted for detainees who were suicidal. They recommended that Rule 35 reports should be monitored to ensure that they were submitted when necessary. However, the 2022 inspection found that this had not been achieved. Inspectors found that there were insufficient safeguards against the detention of detainees with suicidal thoughts and Rule 35 reports were seldom prepared when necessary. The Home Office's Service Improvement Plan issued in response to the recommendations said

that a training pack had been developed for medical practitioners across the immigration detention estate and delivery was expected to start in summer 2022. It also said that the healthcare provider was aware of the concerns in this area and was actively working with the Home Office to address them.

86. We note that following its latest annual review of Rule 35, the Independent Chief Inspector of Borders and Immigration found that this important safeguard was not working consistently or effectively. Inspectors reported that there were disproportionately high volumes of Rule 35 reports concerned with torture in comparison with exceptionally low volumes of Rule 35 reports relating to suicidal intentions. While there is a requirement for nurses and healthcare professionals to report to an IRC doctor any detainee who claims to be a victim of torture, there is no requirement for them to do so for detainees with suicidal intentions.

87. Mr Ospina self-harmed while at Colnbrook and told staff he wanted to die. We consider that staff should not have taken Mr Ospina's subsequent denial that he had suicidal intent at face value and instead considered whether he was at risk of suicide based on his actions and known risk factors. We consider that Mr Ospina's behaviour indicated that he was particularly vulnerable, and his detention should have been reviewed. We consider that there needs to be more clarity in policy guidance about what suicidal intentions means and also that nurses and healthcare professionals should be required to report detainees with suicidal intentions to an IRC doctor.

88. We recommend:

The Home Office should amend DSO 09/2016 so that it:

- **is clear about what suicidal intentions means;**
- **requires nurses and other healthcare professionals to report to a doctor any detainee who is showing suicidal intentions.**

The Home Office should review the training provided to IRC staff on Rule 35 reports, particularly for those at risk of suicide.

Clinical care

89. The clinical reviewer concluded that Mr Ospina's physical and mental health care was at least equivalent to that which he could have expected to receive in the community. She considered that the mental health care provided was of a good standard and provided within an appropriate time frame.

Centre Manager to note

Emergency response

90. DCO A was confused about the guidance on entering a detainee's room as he had only worked in the CSU where staff are told not to go into a room alone. He therefore tried to contact colleagues to assist him as he was alone in the care suite and had no experience working there. As a result, there was a delay of 13 minutes

between DCO A becoming concerned about Mr Ospina and staff entering his room. It made no difference in this case as Mr Ospina had been dead for some time, but a delay could be crucial in a future medical emergency. We make the Centre Manager aware of this issue.

91. When staff found Mr Ospina, there were clear signs that he had been dead for some time as he was stiff and cold. The Duty Shift Manager told staff to start CPR and, when healthcare staff arrived, they continued CPR. While we recognise the challenging circumstances in which decisions such as this are made, there is clear guidance from the Royal College of Nursing (RCN) that CPR should not be carried out when it would be futile.

Staff training

92. The Centre Manager may wish to review the training and guidance provided to staff working in the care suite to ensure that they are fully aware of the regime, carry out their duties with confidence, and appropriately observe vulnerable detainees.

Support for staff

93. DCO A said he did not feel sufficiently supported. He said he was not offered the opportunity to go off duty and was asked to attend an interview in the care suite while Mr Ospina's body was being removed. The Centre Manager will wish to consider how staff are supported following a death.

Inquest

94. At the inquest, held from 30 September to 11 October 2024, the jury concluded that Mr Ospina died by suicide. The jury found multiple failings that contributed to his death and considered there were missed opportunities to provide more appropriate and responsive care given the severity of his mental health crisis. These included:

- Failure to submit a Rule 35 report which deprived Mr Ospina of a review of his detention.
- Mr Ospina being allowed only a closed visit which contributed to the deterioration in his mental health.
- Mitie's security staff did not communicate with staff directly responsible for Mr Ospina's care that they had reported his disclosure to police, which meant that staff could not mitigate the impact of the police interview on Mr Ospina's mental health.
- Unacceptably inadequate observations on 25 and 26 March that failed to recognise that Mr Ospina was not in his bed.
- Lack of risk assessment and review of items in his possession when Mr Ospina was sent to the care suite.
- Insufficient urgent mental health care when Mr Ospina reported suicidal thoughts.

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