

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	<p>REGULATION 28 REPORT TO PREVENT FUTURE DEATHS</p> <p>THIS REPORT IS BEING SENT TO:</p> <p>1. The Minister of State for the Home Office Caroline Nokes MP</p>
1	<p>CORONER</p> <p>I am Stephen Nicholls, assistant coroner, for the coroner area of Dorset.</p>
2	<p>CORONER'S LEGAL POWERS</p> <p>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.</p>
3	<p>INVESTIGATION and INQUEST</p> <p>On 13/04/17 I commenced an investigation into the death of Branko Zdravkovic aged 43. The investigation concluded at the end of the inquest on 27/11/18. The conclusion of the inquest was Suicide, medical cause of death ligature suspension.</p>
4	<p>CIRCUMSTANCES OF THE DEATH</p> <p>Branko Zdravkovic was born in Slovenia. He lived in the UK since at least 2008. The Immigration Authorities had cause to detain him and seek his removal from the UK. He was taken to the Immigration Removal Centre, The Verne in Dorset arriving there on 21/03/17. Whilst at The Verne he was placed in the Segregation Unit on two separate occasions as a result of his behaviour under the influence of Spice. He was placed on an Assessment Care in Detention Treatment (ACDT) on two occasions. He self-harmed and was threatening suicide, and as he was later reassessed his risk had reduced and he returned to his unit. He was under regular observations by the staff. He was found suspended by a ligature in a toilet cubicle despite CPR and the attendance of both Healthcare and an ambulance he was pronounced dead at 00.09 on the 09/04/17.</p>
5	<p><u>CORONER'S CONCERNS</u></p> <p>During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.</p> <p>The MATTERS OF CONCERN are as follows. –</p> <p>The Inquest heard evidence from a Doctor and Psychiatrist and Healthcare staff working at the IRC that they had received training and were told not to make a report under Rule 35(2) of the Detention Centre Rules (SI 2001/238) but instead to use the ACDT procedures to monitor suicidal tendencies. There was also evidence from several witnesses that there was no formal procedure for informing the Home Office when a detainee was placed on ACDT. In the case of a suicidal detainee, the ACDT procedure is necessary and desirable, but it cannot replace the statutory duty to make a report under Rule 35. Rule 35 imposes a requirement to speedily review whether someone should be released because of concerns recorded by the medical practitioner. Without</p>

	that information being provided the state cannot carry out its obligations under Article 2 ECHR.
6	<p>ACTION SHOULD BE TAKEN</p> <p>In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.</p>
7	<p>YOUR RESPONSE</p> <p>You are under a duty to respond to this report within 56 days of the date of this report, namely by 12th April 2019. I, the coroner, may extend the period.</p> <p>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.</p>
8	<p>COPIES and PUBLICATION</p> <p>2. I have sent a copy of my report to the Chief Coroner and to the following Interested Persons The Interested persons as follows: .1. Representatives of [REDACTED]</p> <p>2 Ministry of Justice 3 Home Office 4 Dorset University Foundation Healthcare Trust 5 Care UK 6. Exeter Drugs Project</p> <p>I am also under a duty to send the Chief Coroner a copy of your response.</p> <p>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.</p>
9	<p>Dated: 13 February 2019 <i>SONicholls</i> Assistant Coroner Stephen Nicholls</p>