

Branko Zdravkovic – inquest reveals systemic breach of statutory duty to report detainee’s risk of suicide to Home Office

By Jane Ryan and Catherine Shannon of Bhatt Murphy Solicitors

Name of deceased:

Mr Branko Zdravkovic

Place of death:

The Verne, Immigration Removal Centre (IRC)

Date of death:

9 April 2017

Date of inquest:

19 – 27 November 2018

Coroner:

HM Assistant Coroner for Dorset Stephen Nicholls

Solicitor:

Jane Ryan and Catherine Shannon, Bhatt Murphy Solicitors

Counsel:

Leonie Hirst, Hirst Chambers

Other interested

persons represented:

Home Office, Ministry of Justice, Care UK, Dorset University NHS Foundation Trust and EDP Drug and Alcohol Service

Conclusion:

Suicide with narrative

The inquest into the death of Mr Branko Zdravkovic considered the adequacy of the support and treatment provided to people at high risk of suicide and self-harm while in immigration detention, together with the efficacy of the mechanism for reviewing a detainee’s continued detention when such risks are identified.

Background

Mr Zdravkovic was born in Slovenia. He had been living in the UK for almost a decade and was based in London with his long-term partner immediately prior to his immigration detention. While in the UK Mr Zdravkovic regularly worked as a waiter.

On 5 January 2017 Mr Zdravkovic was served with a notice of liability to administrative removal. On 20 March 2017, Mr Zdravkovic was arrested from the address he shared with his partner and taken to Belgravia police station. He was detained under immigration powers and transferred to the Verne IRC, on the Isle of Portland, Dorset, the following day.

Three days after Mr Zdravkovic’s arrival at the Verne an IRC officer found him crying, in low mood and expressing suicidal thoughts. Mr Zdravkovic stated he did not have specific intentions to self-harm at that stage. The officer did not open a document on the Assessment, Care in Detention and Teamwork (ACDT) system.

The following day Mr Zdravkovic took an unknown substance, believed to be the New Psychoactive Substance known as Spice (NPS). During this episode Mr Zdravkovic said he wanted to kill himself and fell to the floor. He was segregated for almost 24 hours in the Verne’s care and separation unit (CSU). ACDT monitoring was commenced the same day; but the ACDT was closed three days later.

Just over a week later on 4 and 5 April 2017, Mr Zdravkovic showed unusual and unpredictable behaviour which was believed to be linked to NPS use. He was again segregated in the CSU for almost two days, despite appearing highly distressed and at risk of self-harm. Another ACDT was opened.

Following a review Mr Zdravkovic was returned to the residential wing on 7 April 2017 and the frequency of his observations were reduced. On 8 April 2017 Mr Zdravkovic was found suspended from a ligature in a communal bathroom. He was pronounced dead in the early hours the next day, 19 days after entering the Verne IRC.

The inquest

The inquest was heard over seven days commencing on 19 November 2018. At the pre-inquest review hearing stage the Home Office resisted being designated as an Interested Person (IP), contending that it was not sufficiently closely connected to the circumstances of Mr Zdravkovic’s death to warrant such involvement. Submissions from the family argued that in view of the Home Office’s role in authorising and maintaining Mr Zdravkovic’s detention as well as its role in ACDT reviews and use of force and segregation decisions it should be an IP. The coroner agreed and the Home Office was deemed an IP. In addition a senior executive officer for the National Returns Command, part of the Home Office, gave evidence. Other witnesses included IRC officers and healthcare staff.

No Rule 35(2) report was made in Mr Zdravkovic’s case following any of the incidents outlined above. When the role of Rule 35 reports was explored in evidence the IRC GP and other healthcare staff stated they had received training which expressly instructed that

the Rule 35(2) process should not be used where a detainee was considered at risk of suicide, but rather that the risk should be managed through the ACDT process. It is understood that the training referred to was delivered by the Home Office. In any event, the evidence revealed a clear risk that detainees at risk of suicide would not be brought to the attention of the Home Office (whose involvement in the ACDT process is not mandatory), and that a prompt review of detention following receipt of a Rule 35 report as is required by Detention Service Order 09/2016 would not be triggered.

The inquest heard that Mr Zdravkovic may have been detoxing from alcohol while detained. Mr Zdravkovic's partner gave evidence that he had suffered distressing psychological and physiological symptoms when he had previously sought to detox. Mr Zdravkovic's history of alcohol dependency had not been elicited from him during his reception to the Verne which took place at approximately 4am on the morning of his arrival, nor had his community GP records been sought. The evidence was that the Verne's medical team would try not to accept detainees undergoing detox as it has no inpatient facility to meet their needs.

Witnesses further confirmed that the CSU, which is not a healthcare facility, was routinely used to segregate detainees experiencing acute mental health crises – as in Mr Zdravkovic's case – because there was no alternative area where they could be effectively monitored. After hearing submissions the coroner decided that no conclusions in respect of probably or possibly causative matters should be left to the jury. The jury returned a verdict of suicide on the balance of probabilities.

Prevention of Future Deaths Report

At the hearing conclusion the coroner requested additional evidence from the Home Office; the coroner subsequently issued a PFD report requiring that action be taken to ensure compliance with Rule 35(2) to the then Minister of State for the Home Office. The PFD report also raised concern that there was no formal procedure for informing the Home Office where ACDT monitoring was commenced in respect of a detainee.

The Home Office PFD response stated that its training did not advocate the substitution of Rule 35(2) reporting for ACDT monitoring procedures; rather the response attributed the evidence heard at the inquest to "some local misunderstanding on this point at the Verne IRC during the period under examination". However, the response at the same time revealed that only six Rule 35(2) reports were prepared across the IRC estate between 1 November 2017 to 1 November 2018.

The coroner's PFD report and Home Office response are available here: <https://www.judiciary.uk/publications/branko-zdravkovic/>

Comment

Mr Zdravkovic's death raises issues of grave concern regarding the mechanisms and practices in place to protect immigration detainees at risk of suicide. The formal Rule 35(2) process has two important aspects. First, it ensures that the Home Office, as the detaining authority, is formally made aware of the circumstances of a suicidal detainee. Second, on receipt of a Rule 35 report, the Home Office is required to consider the information in the Rule 35(2) report, to review detention, and to make

a formal response to the report giving reasons for continued detention. The detainee and legal representatives are supposed to be informed. It is a critical procedure to curtail administrative detention. The Home Office's confirmation that only six Rule 35(2) reports were raised in the year prior to 1 November 2018 is staggering and exposes the gross underuse of a safeguard designed to circumscribe the detention of the most vulnerable detainees. It is regrettable the Home Office resisted being an IP given its fundamental responsibility for and oversight of Mr Zdravkovic's detention.