Bhatt Murphy Solicitors

PRESS RELEASE

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FAMILY OF LEONARD FARRUKU RELEASE STATEMENT FOLLOWING INQUEST INTO HIS DEATH

Before HM Senior Coroner Rachael Griffin for Dorset

Dorset Coroner's Court

15 September 2025 to 2 October 2025

Leonard Farruku died aged 27 on 12 December 2023 in the bathroom of his shared room aboard the Bibby Stockholm barge, having been accommodated there by the Home Office on a no choice basis.

Leonard was born in Tirana, Albania, the youngest son to his parents Petrit and Shkendije and younger brother to sisters Marsida and Jola. From a young age, Leonard had a clear talent for music and loved to play the accordion at weddings. He was a happy and cheeky child, but began to struggle with his mental health after the death of both his parents whilst he was a teenager.

Over 3 weeks, the inquest heard how Leonard sought asylum in the UK in August 2022, and in March 2023 was accommodated by the Home Office in the Esplanade Hotel[1] in Paignton, before being moved to the Bibby Stockholm barge on 3 November 2023.

The inquest heard that Leonard was "*calm and polite*" on arrival at the Esplanade, but that in July 2023 his behaviour suddenly and "*drastically*" changed. He caused extensive damage to his bedroom but would not allow hotel staff entry to fix the damage or assess risks to his safety. Staff described his speech changing and aggressive and erratic behaviour. Leonard appeared confused and was observed frequently talking to himself, making '*delusional*' statements and asking irrelevant questions. Staff became unable to follow a conversation with him and he later stopped communicating with staff altogether. The clear impression of staff was that Leonard was severely mentally unwell.

The Inquest heard from a Consultant Forensic Psychiatrist, Dr Dinesh Maganty. Based on the contemporaneous evidence of Leonard's presentations, Dr Maganty considered that Leonard was likely suffering from a psychotic mental illness with an affective mood component, and that he required prompt assessment and treatment. That treatment would likely have involved a combination of psychotropic medication, psychological therapy, nursing care and occupational therapy.

Mental health crisis team assessment

On 11 August 2023, Leonard told hotel staff he could see *"invisible things*" and asked for his deceased father to be brought to his room. Hotel staff rang the local mental health crisis team - the Assessment and First Response Service ("AFRS") run by Devon Partnership NHS Trust - and reported his mental health presentation. The AFRS inquest

[1] The housing provider was Clearsprings Ready Homes (CRH) who contracted out the day-to-day running of the hotel to Stay Belvedere Hotels Ltd (SBHL).

witness agreed that at this time, Leonard was showing symptoms characteristic of psychosis.

AFRS decided that Leonard needed to be assessed by mental health professionals within 72 hours and arranged to visit him jointly with the Home Treatment Team the next day. When they attended the hotel, Leonard was not present. Staff relayed further details about Leonard's concerning presentation. The AFRS nevertheless downgraded Leonard to the lowest risk rating and closed his case to the service without having assessed him.

AFRS accepted at the inquest that they should have made further attempts to assess Leonard. The Coroner identified this as a significant missed opportunity but considered that it was not possible to say what the outcome of the assessment would have been because Leonard did not undergo a mental state examination.

Leonard's sisters said: *"We are glad that the Coroner recognised that Leonard needed medical assessment and support on 11 August 2023. We do not agree however that it is impossible to say what would probably have happened. The hotel staff who saw Leonard every day knew that something was seriously wrong with his mental state. The psychiatric expert (Dr Maganty) concluded that there was sufficient evidence that Leonard was likely suffering with a combination of a psychotic mental illness with an affective mood component. It seems that everyone who had repeated contact with Leonard at that time knew that he was really unwell. We just can't understand why mental health services only tried to see him once and then did nothing despite everything they had been told."*

Hotel staff told the inquest that after AFRS's failed attempt to assess Leonard in August 2023, Leonard continued to present as severely mentally unwell.

Home Office failure to consider information about Leonard's mental health in placing him on the barge

Home Office policy recognised that certain persons were unsuitable for placement on the barge on the basis of risks associated with their mental or physical health. Between July and November 2023, SBHL staff submitted 11 incident reports to CRH reporting concerns about Leonard's disturbed behaviour, at least 3 clearly stating that staff believed Leonard to have mental health problems. CRH sent 10 of these reports to the Home Office.

However, none of this information was considered by the Home Office caseworker who considered whether Leonard was suitable to be accommodated on the Bibby Stockholm barge due to a system defect in how the Home Office stored and considered such information at the time.

On the day Leonard was transferred to the barge, the local authority (Torbay Council) raised an urgent concern about Leonard's transfer to the barge on the basis of what they had been told about his mental health, which was relayed to the Home Office. The Home Office took no action in response. The Coroner identified this as a further missed opportunity and expressed surprise that the Home Office witness had been equivocal about the need for action.

Leonard's sisters said: *"We are shocked that when deciding whether it was safe to move Leonard to the barge, the Home Office did not look at their own safeguarding database, even after an email raising concerns about Leonard's suitability from the local authority. It*

seems obvious to us that a man presenting the way Leonard was should never have been placed on the barge."

Inaccurate Home Office assurances

Witnesses from both Dorset Council (which held statutory safeguarding responsibilities for those on the barge) and NHS Dorset (which commissioned the healthcare provision on the barge) told the inquest that, based on Home Office assurances, it was their shared understanding that no one with secondary health care needs would be placed on the barge. The inquest heard how this understanding was at odds with the suitability threshold outlined in Home Office policy (which remains in place in similar form for the assessment of suitability for accommodation at other largescale asylum accommodation sites). Julia Ingram, Director of Adult Social Care at Dorset Council and a qualified social worker of 27 years, told the Coroner that in her view, the fact that Leonard had been identified as needing a mental health assessment in August 2023 meant that he was not suitable for the barge based on the relevant Home Office assurances.

Home Office failure to share information about Leonard's mental health with barge staff

The inquest also heard that the Home Office failed to share any information about Leonard's mental ill health with staff on the barge, despite proactive duties to do so. Barge Manager Dean Link (of Landry & Kling) told the Coroner that had he received the information in the 3 November 2023 email raising concerns about Leonard's mental health, Leonard would have been placed on the welfare register for regular monitoring and automatically booked in for a review by the barge GP. Mr Link stated that he did not recall ever receiving information about any resident's mental health from the Home Office over the entire period that the barge was operational.

Leonard's sisters said: "*The Home Office failed to tell barge staff that there were serious concerns about Leonard's mental health. If he had seen the barge GP as he should have done, the GP would have arranged the mental health assessment we believe he so desperately required and he would also have been recognised as unsuitable to be on the barge. The Home Office did nothing and Leonard remained on the barge without any support or treatment until his death."*

Coroner's conclusions

On 2 October 2025, the Coroner concluded that Leonard died by suicide and gave the following narrative:

"Before he was offered accommodation on the Bibby Stockholm, Leonard had been accommodated in a hotel in Devon where he had displayed symptoms suggestive of mental ill health. He had been referred to a local mental health service in Devon for an assessment of his mental state, which was attempted on the 12th August but did not take place. A pre-transfer suitability assessment conducted by the Home Office did not explore mental health concerns that had been reported to the Home Office. No assessment of Leonard's mental state was conducted before Leonard was moved to the Bibby Stockholm on the 3rd November 2023 or prior to his death.

Whilst it is possible that Leonard was suffering from a low mood and/or a mental disorder which contributed to his decision to take his own life, there is insufficient evidence to indicate that this was probably the case."

Leonard's sisters said: *"We are glad that the Coroner recognised that there were serious missed opportunities to help and support Leonard by both mental health services and the Home Office. After listening to all the inquest evidence, and especially that of the hotel staff and Dr Maganty, we firmly believe that Leonard was severely mentally unwell between July and December 2023 and in need of urgent assessment and treatment. Instead of being helped by the English authorities, he was placed in the hostile and completely unsuitable environment of the barge. We believe that if Leonard had received proper assessment and treatment in August 2023, he would still be alive today. We miss him every day."*

Christina Bodénès, solicitor for the family, said: *"Leonard's case is a tragic example of the dangers of the Home Office's policy of placing vulnerable asylum seekers in unsuitable accommodation without having a proper system in place to assess their vulnerability and risk. The Home Office had a wealth of information indicating that Leonard was seriously unwell at the time they made the decision to place him on the barge, but took none of this into account. Given the current government's commitment to expanding the use of large scale sites to accommodate asylum seekers, it is extremely concerning that the Home Office still refused to accept at Leonard's inquest that they should have been concerned about Leonard's mental health when he was transferred to the barge, or that they should have taken swift action when Torbay local authority raised urgent concerns about his suitability to live there."*

Deborah Coles, Director at INQUEST, said: *"We can all agree that everyone, especially those seeking safety, should be treated with dignity and humanity. Yet this inquest has laid bare the fatal consequences of placing people like Leonard Farruku on barges in de facto imprisonment where safeguards exist only on paper. These harmful policies isolate people from community, support and healthcare, and deny them dignity. Amid racist rhetoric around immigration, we must remember the real human cost. We won't forget Leonard, and we won't stop demanding justice for all those failed by inhuman and racist immigration policies."*

NOTES TO EDITORS

For further information or request for comment please contact **Christina Bodénès** at Bhatt Murphy on 020 7729 1115 or c.bodenes@bhattmurphy.co.uk

Leonard's sisters are represented by **Christina Bodénès** and **Mark Scott** of Bhatt Murphy instructing **Raj Desai** of Matrix.