# Inquest exposes systemic failings over asylum seeker's death aboard Bibby Stockholm



An inquest into the death of Leonard Farruku, a 27-year-old Albanian asylum seeker, has raised serious concerns about the Home Office’s handling of his mental health prior to his transfer to the Bibby Stockholm accommodation barge in Dorset. Despite the Government’s ongoing commitment to expanding large-scale sites for asylum seekers, the Home Office reportedly failed to properly assess Leonard's mental health before moving him onto the barge. Leonard tragically took his own life after being found unresponsive in his room on 12 December 2023.

Leonard's sisters, Marsida Keci and Jola Dushku, have voiced strong criticism of the Home Office, arguing that a thorough mental health assessment and subsequent treatment could potentially have prevented his death. They expressed frustration that urgent concerns raised by Torbay local authority about Leonard’s suitability to live on the barge were not adequately addressed by the Home Office. The inquest laid bare a series of missed opportunities to support Leonard during a vulnerable period, with his mental health struggles reportedly dating back to the death of their parents.

The conditions aboard the Bibby Stockholm have also come under scrutiny. Reports from former residents and refugee support groups describe the barge as imposing "prison-like" conditions, with extensive security measures and restrictions on visitors that contribute to poor mental health among its inhabitants. Residents felt trapped and unable to access support from the outside, adding to the sense of isolation and distress. These findings are supported by a report from Care4Calais and local refugee groups, which called for the immediate closure of the barge due to the harmful impact such accommodation has on vulnerable asylum seekers.

The Home Office’s refusal to acknowledge its responsibility in recognising and acting on Leonard's mental health needs is particularly troubling in light of these broader criticisms of the barge’s environment. The inquest into Leonard’s death not only examines the particular failings in his case but also highlights systemic issues in how vulnerable individuals are supported within the current asylum accommodation framework. Leonard’s family has raised serious concerns about the adequacy of the accommodation and the safeguard systems designed to protect residents like him.

This case shines a harsh light on the consequences of the Home Office’s approach to asylum accommodation and mental health care. It underscores the critical importance of thorough assessments and prompt responses to mental health concerns, especially in settings that can exacerbate isolation and distress. The evidence presented at the inquest suggests an urgent need for reform in how asylum seekers’ mental health is managed and how their living conditions are monitored to prevent such tragedies.

### 📌 Reference Map:

* Paragraph 1 – [[1]](https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html), [[4]](https://www.inquest.org.uk/leonard-farruku-inquest-opens), [[7]](https://www.irishnews.com/news/uk/home-office-did-not-respond-to-concerns-about-man-who-died-on-bibby-stockholm-EJZJFSEMTVPL5CIWHZD2FD4G4E/)
* Paragraph 2 – [[1]](https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html), [[2]](https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html), [[3]](https://www.independent.co.uk/news/uk/home-news/home-office-dorset-clearsprings-ready-homes-bournemouth-devon-b2838237.html), [[7]](https://www.irishnews.com/news/uk/home-office-did-not-respond-to-concerns-about-man-who-died-on-bibby-stockholm-EJZJFSEMTVPL5CIWHZD2FD4G4E/)
* Paragraph 3 – [[5]](https://www.thelondoneconomic.com/politics/bibby-stockholm-residents-report-poor-mental-health-and-airport-style-security-373212/), [[6]](https://www.the-independent.com/news/uk/politics/bibby-stockholm-report-small-boats-b2533434.html)
* Paragraph 4 – [[1]](https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html), [[4]](https://www.inquest.org.uk/leonard-farruku-inquest-opens)
* Paragraph 5 – [[1]](https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html), [[2]](https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html), [[3]](https://www.independent.co.uk/news/uk/home-news/home-office-dorset-clearsprings-ready-homes-bournemouth-devon-b2838237.html), [[7]](https://www.irishnews.com/news/uk/home-office-did-not-respond-to-concerns-about-man-who-died-on-bibby-stockholm-EJZJFSEMTVPL5CIWHZD2FD4G4E/)

Source: [Noah Wire Services](https://www.noahwire.com)

## Bibliography

1. <https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html> - Please view link - unable to able to access data
2. <https://www.standard.co.uk/news/crime/home-office-dorset-devon-paignton-english-b1252886.html> - An inquest revealed that the Home Office failed to assess the mental health of Leonard Farruku, a 27-year-old Albanian asylum seeker, before transferring him to the Bibby Stockholm barge in Dorset. Leonard's sisters, Marsida Keci and Jola Dushku, believe that proper mental health assessment and treatment could have prevented his death. They criticised the Home Office for not addressing concerns raised by Torbay local authority regarding Leonard's suitability for barge accommodation. The inquest highlighted missed opportunities to support Leonard during his vulnerable state.
3. <https://www.independent.co.uk/news/uk/home-news/home-office-dorset-clearsprings-ready-homes-bournemouth-devon-b2838237.html> - An inquest found that the Home Office missed opportunities to assess the mental health of Leonard Farruku before moving him to the Bibby Stockholm barge, where he later took his own life. Leonard's sisters questioned how their brother, who had struggled with mental health issues since the death of their parents, was allowed to be moved to the barge. The inquest revealed that concerns about Leonard's mental health were not properly recorded or acted upon by the Home Office.
4. <https://www.inquest.org.uk/leonard-farruku-inquest-opens> - The inquest into Leonard Farruku's death aboard the Bibby Stockholm barge opened on 15 September 2025. Leonard, a 27-year-old Albanian asylum seeker, was found unresponsive in his room on 12 December 2023. The inquest will examine Leonard's mental health before and during his time on the barge, the decision to transfer him, and the systems in place to safeguard vulnerable individuals. Leonard's family has expressed concerns about the adequacy of the accommodation and support provided.
5. <https://www.thelondoneconomic.com/politics/bibby-stockholm-residents-report-poor-mental-health-and-airport-style-security-373212/> - Former residents of the Bibby Stockholm barge have reported poor mental health and 'airport-style security' on board. Multiple individuals described conditions akin to being 'in prison' and feeling like 'zoo animals'. The report, produced by Care4Calais, Stand Up To Racism, and the Portland Global Friendship Group, called for the immediate closure of the barge and highlighted the harmful impact of such accommodation on vulnerable individuals seeking asylum.
6. <https://www.the-independent.com/news/uk/politics/bibby-stockholm-report-small-boats-b2533434.html> - Asylum seekers on the Bibby Stockholm barge have described 'prison-like conditions', including extensive searches and restrictions on visitors. A report by local refugee support groups and charity Care4Calais found that residents felt trapped and unable to seek support from friends outside. The report also highlighted concerns about the adequacy of the accommodation and support provided to vulnerable individuals seeking asylum.
7. <https://www.irishnews.com/news/uk/home-office-did-not-respond-to-concerns-about-man-who-died-on-bibby-stockholm-EJZJFSEMTVPL5CIWHZD2FD4G4E/> - An inquest revealed that the Home Office did not respond to concerns raised about the mental health of Leonard Farruku before he was transferred to the Bibby Stockholm barge, where he later took his own life. Leonard's sisters questioned how their brother, who had struggled with mental health issues since the death of their parents, was allowed to be moved to the barge. The inquest highlighted missed opportunities to assess and support Leonard's mental health.