West London Coroner's court

Re: Inquest Touching the Death of Brian Christopher Dalrymple

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** 1. **The Home Office** (concerns 1,2,3,4 and 5 apply) 2. **GEO Group, UK Ltd** (concerns 1,2,3,4,and 5 apply) 3. **Serco** (concerns 4 and 5 apply) 4. **Nestor Primecare** (concerns 3 and 4 apply) 5. **The Practice Plc** (concerns 3 and 4 apply)
1	**CORONER** I am Jeremy Chipperfield, assistant coroner, for the coroner area of West London
2	**CORONER'S LEGAL POWERS** 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.
3	**INVESTIGATION and INQUEST** The investigation into the death of Brian Christopher Dalrymple concluded at the end of the inquest on 27-Jun-14. The jury's conclusion of the inquest was "natural causes contributed to by neglect"; the medical cause was a ruptured dissection of the thoracic aorta and hypertension. The jury produced a narrative conclusion, a copy of which is attached herewith.
4	**CIRCUMSTANCES OF THE DEATH** Having entered the UK from the USA on 14-Jun-11, Mr Dalrymple was refused entry by the UKBA and detained at Harmondsworth Immigration Removal Centre pending removal. On 27-Jul-11, he was removed to Colnbrook Immigration Removal Centre where he died on 31-Jul-11. The fatal rupture was caused by extreme hypertension- a condition for which he declined treatment and monitoring for most of the period of his detention. He expressed unusual views about his ability to control hypertension (by spiritual means) as well as about other matters and exhibited unusual behaviour during his detention. After his death it was discovered that Mr Dalrymple was schizophrenic and had been prescribed medication for this condition in the USA. The inquest considered issues related to his deteriorating psychiatric condition and capacity in detention, amongst others.

5	**CORONER'S CONCERNS**

During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The **MATTERS OF CONCERN** are as follows. –

(1)
There is a lack of awareness amongst detention staff at Harmondsworth of: (i) behaviours (and reported experiences) which may indicate the existence of mental health issues affecting particular detainees- particularly in relation to schizophrenia; and (ii) the need to ensure that such potential indicators are brought to the attention of those responsible for the particular detainee's healthcare.

Despite the training which had been received by such staff prior to Mr Dalrymple's detention, indicators of his mental ill-health were not recognised as such. Witness [redacted] identified events and circumstances from the point of Mr Dalryple's presentation at port and throughout his period of detention that he said "should have been picked up" and triggered a psychiatric assessment (for which there was an "overwhelming need"). In Mr Dalrymple's case such concerns were not properly acknowledged at Harmondsworth.

The DCOs had not received sufficient training in the recognition of relevant indicators. The evidence was that officers were and remain unclear whether particular behaviours, unusual in local society at large, should be regarded as significant amongst the population at Harmondsworth.

It was clear from the evidence given by the Deputy Immigration Manager, and that of a clinical Contract Manager / Interim Healthcare Manager that significant reliance is placed on the detention officers to raise concerns over a detainee's mental heath.

(2)
Relevant and significant observations recorded by detention centre staff and others are not actively brought to the attention of relevant healthcare staff.

In the present case, custody officers' entries in wing history records were sufficient (alone or in combination) to alert a reader to the possibility of mental health issues affecting Mr Dalrymple whilst detained at Harmondsworth IRC; these indicators were missed. In the terms of Witness [redacted] - the overall picture of developing (relapsing) mental disorder was not available to any one set of people.

(3)
Medical practitioners may be employed at Harmondsworth IRC without knowledge necessary to that role.

The locum GP who gave evidence at the inquest was unaware of Detention Centre Rules 2001 or of the duties imposed on him by them- rule 35, for example. He was also unaware that healthcare staff had access to wing history documents.

(4)
Routine medical visits to segregated detainees are inadequate properly to assess detainees' healthcare needs.

The evidence was that each detainee would be asked through the wicket "Any medical problems?", and if the answer was negative, there would be no further interaction-

	witness [redacted] described the practice as "not fit for purpose"; and (5) The absence of a comprehensive and accessible (computerised) clinical record relating to each detainee at IRCs Harmondsworth and Colnbrook.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 13-Nov-14. I, the coroner, may extend the period. 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.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:- [redacted] (mother of the deceased and representing the family of the deceased) [redacted] I have also sent a copy of this report to:- HM Inspector of Prisons National Offender Management Service and Independent Advisory Panel on Deaths in Custody MITIE I am also under a duty to send the Chief Coroner a copy of your response. 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.
9	**18-Sep-14** **Jeremy Chipperfield** JK Chipperfield