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# FINAL PUBLIC SESSION OF INDEPENDENT INQUIRY INTO THE DEATH OF DAVID `ROCKY' BENNETT 28th July 2003

The final public session of the David 'Rocky' Bennett enquiry will be held on 09.30 am Thursday 31 July 2003 at the Weatherhead Room at Central Hall Storey's Gate, Westminster, London, SW1H 9NH.

This session will include the closing remarks from Sadiq Khan and will sum up a highly controversial inquiry. Please see below for case details.

David 'Rocky' Bennett, a 38-year-old Black man, was certified dead in the early hours of Saturday 31 October 1998. He had been a detained patient in the Norvic Clinic, an NHS medium secure unit, in Norwich for three years. His death followed an incident involving the use of restraint. The inquest opened on 3 May 2001 and returned a verdict "Accidental Death aggravated by Neglect" on 17 May 2001. Following the inquest HM Coroner for Norfolk made six searching recommendations with an emphasis on the need for national standards on restraint in psychiatric hospitals, and for staff to be pro-active in dealing with incidents of racist behaviour by and against patients.

The family of Mr. Bennett, their lawyers and INQUEST called on the Government to consider holding a public inquiry into Mr. Bennett's death. Instead the Minister agreed to an extended form of the usual inquiry that follows a death in psychiatric detention with a public element looking at the national lessons to be learnt. We are now at the closing point of this enquiry which has highlighted several contentious issues.

INQUEST has drawn national and international attention to the disproportionate number of deaths of black people in custody following the use of force or gross medical neglect. There have been detailed coroners recommendations on the use of restraint and the dangers of positional asphyxia following deaths in police and prison custody. Yet despite urging from ourselves and the MPs concerned in Mr Bennett's case, no formal mechanism has been established to ensure the dangers of prone restraint are being learnt in all relevant forums and government departments. There is complex and controversial scientific debate about deaths following prone restraint and yet it continues to be routinely used in many settings (psychiatric, social services and educational) without due regard to the potential dangers.

One of the ways in which bereaved families can find comfort and move on from such a tragedy is if they believe, despite the horrific nature of the particular circumstances of the death, that some positive changes will be made for the future. The death of David Bennett could provide an opportunity to precipitate root and branch change in the treatment of all people with mental health problems and in particular address the specific needs of Black patients.

Note for Editors
The official contact for media inquiries in relation to the Inquiry is Peter Davies, head of communications, Norfolk, Suffolk and Cambridgeshire Strategic Health Authority. Tel: 01223 597552 or 07970 458823.



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As well as taking evidence from professional experts, the Inquiry panel have stated that they welcome views and representations from organisations who believe they can assist the panel. People wishing to contribute or see the terms of reference can contact Geraldine Howard, Secretary to the David Bennett Inquiry 01603 307244 or email comments to comments@davidbennettinquiry.co.uk