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# NICE GUIDANCE – A PROFOUNDLY INADEQUATE RESPONSE TO THE DEATH OF DAVID 'ROCKY' BENNETT

The National Institute for Clinical Excellence (NICE) guidelines for the short-term management of disturbed/violent behaviour were issued today.

Helen Shaw – co-director of INQUEST said;
`The section on physical intervention in the quick reference guide is a profoundly inadequate response to the appalling death of David 'Rocky' Bennett, ignores the recommendations of the Bennett Inquiry and is dismissive of the panel and its expert witnesses. It is particularly shocking that there is no reference that alerts practitioners to the deaths that have occurred following physical restraint and the special dangers posed by prone restraint.'

Dr Joanna Bennett, sister of Rocky Bennett, said: "I am extremely disappointed with the NICE guidelines as they fail to address key issues raised by the David Bennett Inquiry around control and restraint. Mental health services continue to be in denial about critical incidents and deaths associated with control and restraint.

The guidance adds nothing new and fails to set a time limit for prone restraint despite the JCHR report's recommendation that a case had been made for such a time limit. It also makes no mention of sudden deaths positional asphyxia or procedures following a critical incident, thereby missing the opportunity to provide practitioners with a framework for improving current practice."

Expert evidence at the Inquiry and at inquests into deaths following restraint has repeatedly demonstrated the particular danger of restraining people face down. Most recently in December 2004 the parliamentary Joint Committee on Human Rights added their concern in the report of their Inquiry into Deaths in Custody saying; `*In our view use of the prone position, and in particular prolonged use, needs to be very closely justified against the circumstances of the case, and this should be reflected in guidance. There is a case for guidance prescribing time-limits for prone restraint, departure from which would have to be justified by individual circumstances.'*

Throughout the Bennett Inquiry the panel and the family were repeatedly assured that the NICE guidance would deal definitively with the issues arising from the restraint that contributed to Rocky's death. This has clearly not happened. Neither INQUEST nor the Bennett family were contacted by NICE during their work to compile this guidance.

| NICE Guidance | http://www.nice.org.uk/pdf/cg025niceguideline.pdf |
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INQUEST is the only non-governmental organisation in England and Wales that works directly with the families of those who die in custody. It provides an independent free legal and advice service to bereaved people on inquest procedures and their rights in the coroner's courts.

Background

Rocky Bennett was a 38-year-old black man who died in the Norvic Clinic, Norwich in October 1998 having been a detained patient there for three years. His death followed an incident involving the use of prone restraint. The jury at the inquest in May 2001 returned a verdict of accidental death aggravated by neglect and said that the cause of death was due to prolonged restraint and long-term anti-psychotic drug therapy.

The inquiry was set up following calls from the family, their lawyers and INQUEST for a public inquiry into the death. The then Health Minister, Jaqui Smith instead ordered 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.

The report of the Inquiry launched in February 2004 made 22 recommendations including a three minute time limit on the use of prone restraint. Since Rocky Bennett died in 1998 there have been other deaths in alarmingly similar circumstances and after one similar death in 2000 the local UNISON branch reported that nursing staff had complained to the union that they had not received proper training in restraint techniques. On 28th May 2004 24-year-old Azrar Ayub, a patient at the secure Edenfield Unit at Prestwich hospital near Manchester was found dead after being sedated and restrained by staff at the hospital.

A full briefing on the case is available from INQUEST – www.inquest.org.uk