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# GOVERNMENT PUBLISH RESPONSE TO INDPENDENT INQUIRY INTO THE RESTRAINT RELATED DEATH OF BLACK MAN ROCKY BENNETT IN PSYCHIATRIC DETENTION

Today the government has finally published its response to the report of the Independent Inquiry into the death of David Rocky Bennett that was launched in February 2004. The family have waited six years and three months to hear what action will be taken to prevent others dying in similar circumstances.

Helen Shaw, co-director of INQUEST, who has worked alongside Dr Bennett since shortly after Rocky died in October 1998 said:

"The government now has the chance to radically reform the delivery of mental health services to people from black and minority ethnic communities. It also has the chance to stop the practice of using physical force as the first response to violence and to confront the currently inadequate response to staff and patient racism within mental health settings. But it should not take violent death to precipitate such change and it remains to be seen what will really happen at the point of service delivery – these issues are not new and no fundamental change has taken place in the six years since Rocky Bennett died.

It has been nearly a year since the publication of the Inquiry report and there is still no standard policy on the use of restraint across all mental health and other custodial settings. The opportunity has been missed to ensure the use of dangerous prone restraint techniques that have contributed to many of the deaths in custody that have caused most public concern is properly regulated."

INQUEST also shares the concerns of the parliamentary Joint Committee on Human Rights who reported in December 2004 following their inquiry into deaths in custody that there is no independent body to investigate deaths in psychiatric detention or central monitoring and publicly available statistics of the numbers and types of deaths that occur. We will continue to campaign for such changes to be put in place to ensure that public servants who are entrusted with the care of seriously vulnerable and sick people are held to account for their actions when someone in their custody dies.

Notes to editors
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.

Read the Government response
http://www.dh.gov.uk/PublicationsAndStatistics/Publications/PublicationsPolicyAndGuidance/PublicationsPolicyAndGuidanceArticle/fs/en?CONTENT_ID=4100773&chk=grJd1N


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Background

Rocky Bennett was a 38-year-old black man who died in the Norvic Clinic, Norwich 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.

Speaking before the launch of the report his sister Dr Joanna Bennett said: "Like many Black men, my brother feared that he would die in mental health services. Tragically in 1998 those fears became a reality for my family. My hope is that the outcome of this inquiry will go someway to preventing similar deaths occurring in the future and will prove to be a watershed in the treatment and care of black people using mental health services in the UK."

The report was hard hitting in its condemnation of the racism prevalent within NHS mental health services and the contribution the panel believed it made to Rocky Bennett's death. The panel who conducted the inquiry included Professor Sashidaran, a psychiatrist with unrivalled expertise in mental health and the black community and Dr Richard Stone, who was a member of the Lawrence Inquiry team. On launching the report the Chair, Sir John Blofeld was clear about the strength of the evidence the panel had heard: `It is time to take action. Limited action has been taken in the past but it is a sorry tale of too little too late. Black and minority ethnic citizens should not have to claim their rights, they should be given them as a matter of course. They are not demanding more than they are entitled to, nor are they claiming preferential treatment, they are simply asking for justice, which has been denied to them for too long.'

On the morning of the launch of the report the Secretary of State, Dr John Reid MP made a commitment to set out an action plan by May 2004. 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.

The Orville Blackwood report published ten years ago made many similar recommendations that were not implemented and this report and its recommendations must not be allowed to suffer the same fate. Speaking at the launch of the report Dr Joanna Bennett said: `Rocky died a brutal death, pinned face down on the ground by those people who were trusted to care for him. It breaks my heart ever time I think about it and that image will live with me forever. What makes me so angry is that my brother was not the first to die in this way. There have been many similar deaths in the past, not only in mental health services, but also in police custody and in prisons. It's a total disgrace that the lessons have still not been learnt.'

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