UNITED CAMPAIGNS FOR JUSTICE

Death in Prison Custody

Report on the death of Kenneth Severin

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Association of London Government

THE DEATH OF KENNETH SEVERIN

The ill treatment and subsequent death of remand prisoner Kenneth Severin whilst being restrained by prison officers in Belmarsh prison raises serious human rights issues.

His death revealed concerns in the following areas:

- the use of prison for those with mental health problems;
- the standard of treatment and care of those with severe mental health problems in prison;
- the standard of health care provided by the Prison Medical Service;
- the poor communication between Mental Health services and the courts;
- the stereotyping of black men with mental health problems within the criminal justice system;
- the use of punishment as opposed to care for the disturbed within Belmarsh prison;
- the adequacy of the inquest for investigating such deaths;
- the failure of the Prison Ombudsman to investigate deaths in prison
- the failure of the Prison Service to make public the internal prison inquiry
- the failure of the Prison Service to learn from previous deaths following the use of control and restraint

Introduction

Kenneth Severin was a 25 year old African Caribbean man with serious mental health problems who was remanded to Belmarsh prison by the magistrates court - a decision which cost him his life. He had never been in prison before and was remanded for an offence of attempted burglary after he had tried to gain entry to a house in which he had once lived. At the time of his arrest in the early hours of 31.10.95 he was homeless - his council flat having been burnt out and vandalised. Past diagnoses had suggested he was suffering from paranoid schizophrenia and he was suffering mental health difficulties at the time of the offence. Despite being known to the local Mental Health Team and having a Community Psychiatric Nurse he did not receive the help and support he needed in order to enable him to live safely in the community.

Police and court experience

On his arrest by police he was taken to Greenwich police station for interview. Police accepted that he was mentally ill and they therefore arranged for an appropriate adult to attend the police station for his interview. Contact was also made with his community psychiatric nurse who did not tell the police that Kenneth was suffering from schizophrenia but *assumed* the police realised he was mentally ill. He was charged and refused bail on the basis that he had no address to go to and '...*for his own protection as he does not always appear to know what he is doing'* (Custody record) He appeared at Greenwich magistrates court on 1st November 1995 and was described in court as a paranoid schizophrenic. No bail application was made on his behalf on the basis that there was little known about him and there was nowhere for him to go. Kenneth was therefore subsequently remanded to HMP Belmarsh. He next appeared at the magistrates court on 8th November. The duty psychiatrist was unable to see him as he had to leave early. A bail application was made but refused by the Magistrate on the basis that because of his mental condition there was a likelihood of him not appearing at Court. The matter was adjourned for seven days for him to see the duty psychiatrist. On 15th November Kenneth again appeared at Greenwich Magistrates Court where he saw the Duty psychiatrist who declared him fit to plead and stand trial. A full bail application was again made but refused.

Prison experience

Kenneth was first remanded to Belmarsh prison from Greenwich magistrates court on 11th October 1995 and following a reception screening interview with a prison doctor he was located in the health care centre because of this mental health difficulties. Despite Kenneth's mental health history one of the main issues to emerge about the health care centre was that bizarre or disruptive behaviour was seen by prison staff as a discipline and control problem rather than a medical issue. Prior to his death in prison on 25th November he was charged with two spectacularly trivial offences and subject to two adjudication's :Firstly for refusing to move his cup etc. from the observation hatch when ordered to do so and secondly by allegedly being abusive to a prison officer by saying "Stop switching off my light you arsehole". Despite being identified as a paranoid schizophrenic a Medical officer assessed him as being fit for adjudication and cellular confinement.

On the night of his death prison officers were called to the Health Care Centre after being informed that a prisoner had been swinging a 'line' from his cell window to Kenneth Severin's cell. Use of a 'line' was a relatively common occurrence in prison whereby torn strips of sheeting or other material is swung between cells to pass articles such as magazines, tobacco, matches etc. and also contraband including drugs. Kenneth was never asked about the 'line' and it was simply removed from the other inmate's cell.

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At night in the Health Care Centre there were two medically qualified staff on duty as well as discipline staff. A doctor was available on call. Nurse Ward had some contact with Kenneth shortly before midnight when he asked for some cakes and some sugar, which she gave to him. She did not know he was a schizophrenic. She had never had any contact with him before but said that there was nothing about his behaviour that gave her any cause for concern. About one and a half hours later she was asked by the senior health worker to go and see Kenneth. She was not told why nor was she given any information about his medical history and the fact that he was mentally ill as he did not see this as relevant. She did not look at any medical records. She noticed a marked difference in him from her previous contact and said that he was hostile and shouting. She managed to calm him down by the time she left him and had no concerns about him being at any risk of harming himself.

Principal officer Benson was the most senior officer in the prison that night and effectively in charge. He was contacted by officers on duty in the hospital wing at about 00:55 saying that Kenneth was causing a disturbance by shouting and banging on his door. He and three officers including a dog handler went to the health centre where they were informed that Kenneth had been agitated since 22:00 that evening. He went to his cell to talk to him and said that he was shouting 'I shouldn't be here.' 'See the judge', 'Let me go home' and also other incoherent things. PO Benson accepted that Kenneth's behaviour was bizarre but he knew nothing about him nor did he seek to find out any information from medical staff. He did not consider it appropriate to have any medical input in the decision to relocate Kenneth into strip conditions despite the official guidelines stressing that this should be the case. According to his records Kenneth had been agitated for at least the previous three hours but nursing staff were not aware of this. All prison officers insisted that the strip cells were never used as punishment and justified their decision to locate Kenneth in strips by virtue of his being of potential harm to himself. At no time had any medical or discipline staff considered him to be a suicide risk.

It is unclear whether anyone explained to Kenneth that he was being moved to a strip cell but a struggle started when he was told he could not take his personal stereo with him. Such was the struggle that it took five officers to restrain him using techniques called 'Control and Restraint'. He was placed in ratchet cuffs behind his back and taken according to officers still struggling via a lift to a strip cell on the upper floor of the health care centre. In the strip cell seven officers were involved with the restraint of Kenneth where he was placed face down still handcuffed onto a mattress. He was then totally stripped of his lower body clothing and his handcuffs were removed as were his upper body clothes contrary to the prison regulations which state " A prisoner may be deprived of normal clothes only if, in the light of the individual case this is considered essential to prevent self injury or injury to others". (1)

Prison officers said it was standard practice to strip any prisoner going to a strip cell and could not justify this practice in the prison rules or guidelines. (2) His pulse was checked once and then again because of concern at his stillness. It was apparently fine. The prison officers then left the cell . Because he was so still the senior nurse was called who found him naked, lying on his stomach, his hands in the same position as they would have been when the handcuffs were removed. An ambulance was called but all attempts to resuscitate him failed.

All officers involved in the control and restraint denied the use of excessive force, the use of a neck hold or the application of any pressure on the back. They were all unable to explain the deep bruising over the back found at the two post mortems. None of the prison officers who gave evidence had received any training in the potential dangers of control and restraint in particular placing someone face down with their hands handcuffed behind their back. Even more disturbing was the fact that the officer responsible for Control and Restraint training had never heard of positional asphyxia until his attendance on the day of the inquest and was not sure why there was a potential danger in placing a prisoner in such a position. A circular instruction issued in 1993 although it formed part of the Control and Restraint manual had not filtered down to officers who regularly used such techniques or even to the trainer. The circular had been issued as a result of concerns expressed about control and restraint at the inquest into the death of Omasase Lumumba who died in 1991 in Pentonville prison after being restrained. A new circular instruction was issued on the 16th December 1996 less than two weeks before the inquest which none of the officers including the trainer had seen or been made aware of.

All prison officers involved in the restraint of Kenneth Severin referred to the *'superhuman'* and *'incredible strength'* of Kenneth. They all denied that they had used unnecessary force and contended that they had followed the guidelines on control and restraint to the book.

The only non prison personnel accounts of the incident were two prisoners Peter and (no relation) Paul Jones. Peter Jones was on the lower floor of the health care centre in the cell next to Kenneth he heard shouting and banging from the cell . He went to sleep and later heard the sound of other voices who he assumed were prison officers. He heard different noises which he inferred was Kenneth being beaten up and heard him shouting 'Call the police, call the police.' He said that his cell hatch was open and that he saw Kenneth not struggling and being dragged away by prison officers.

Paul Jones was on the upper floor of the health care centre and recalled Kenneth shouting up for matches, tobacco and cigarette papers. Later he heard a door being opened downstairs and Kenneth shouting, 'Leave me alone I haven't done anything and 'No more please'. He later saw Kenneth being walked on the upper floor past his window.

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Dr Jerreat, a pathologist who performed a first post mortem on behalf of the coroner concluded that no drugs or alcohol had contributed to death. He noted deep bruising over the back which he concluded were most likely due to pressure on the back rather than from blows or kicks. There was also some bruising to the neck. He was satisfied that the cause of death was due to asphyxia as a result of the position that Kenneth was restrained in combined with pressure being exerted on the back. A second post mortem carried out on behalf of the family by Dr Hunt agreed with Dr Jerreat's conclusion as to the cause of death. The prison service instructed a third pathologist to review the other two reports and comment about possible causes of death. He accepted that although other more unusual causes could not be excluded the most likely cause was positional asphyxia. He though disagreed with the other two pathologists regarding the deep bruising to the back which he considered was most likely due to muscle tearing during a struggle.

Verdict

The Coroner left three possible verdicts for the jury to bring back, accident, and open which would be returned on the balance of probabilities and unlawful killing. (The verdict of unlawful killing has to be beyond reasonable doubt a very difficult verdict for a jury to bring when the death has occurred within a closed institution and witnesses to the death are prison staff.) The jury went out on Friday 10th January 1997 and on Monday 13th January reached a majority decision of 9:2 that the cause of death was positional asphyxia following struggle and restraint during relocation and returned an open verdict. The coroner made seven very strong recommendations and described the "*appalling state of affairs" surrounding* this case.

The verdict highlights the fact that the jury in rejecting the authorised version of events of all prison officers showed they had grave reservations about the officers' account and Kenneth's treatment in prison and that they were not satisfied that the death was 'accidental'.

The inquest system

As in the case of every death in custody in England and Wales, a Coroner's inquest was convened in front of a jury. There had been a police investigation into the death and the file was passed to the Crown Prosecution Service who decided that there was insufficient evidence to bring charges. There was also an internal prison investigation the contents of which are never made public.

An inquest is the only opportunity that a bereaved family has to inquire into the circumstances of a relative's death.(3) Inquests into deaths in controversial circumstances are complex legal processes that require specialised legal preparation and representation. The system of legal aid does not extend to representation at inquests so that ordinary people, in this case the bereaved have to finance their own representation while unlimited public funds allow a team of lawyers to represent the prison service whilst the prison officers and nursing staff are represented from union or professional association funding. (4) There is also no disclosure of documentation to the family of the deceased before the inquest despite the recommendation of the previous Chief Inspector Of Prisons Judge Stephen Tumim that all parties should enter the inquest with the same information. The inequality in access to representation and documentation at inquests is unacceptable and severely inhibits the fairness of the inquest process.

The inquest has a very narrow remit and it is manifestly not a public inquiry. It is concerned primarily with the medical cause of death and consequently the range of issues of concern to the family could not be properly explored at the inquest. Following the inquest, consideration was given to any possible legal action but it was decided by lawyers that all legal remedies had been exhausted.

INQUEST wrote to the Prisons Ombudsman as the independent body that can investigate complaints against the Prison Service to request that they investigate this case because there were a lot of issues that needed to be explored. The Ombudsman replied, indicating that while he was very sympathetic to our request he could not investigate the complaint because firstly, part of the case concerns the clinical judgement of doctors, which is specifically excluded from his remit, and a second and potentially more important obstacle was that he had no remit to investigate complaints about a prisoners' treatment from third parties which rules out the family of the deceased.

The Parliamentary Ombudsman

INQUEST has been working with Kenneth Severin's MP John Austin about the many issues of concern in this case. We have asked the Home Secretary Jack Straw to consider extending the remit of the Prisons Ombudsman so that he can accept complaints from third parties i.e. the next of kin of those who die in custody.

In the absence of any other mechanism to raise our concerns INQUEST complained to the Parliamentary Ombudsman which looks into misfeasance and maladministration in public office. In a damming report (6) the Ombudsman expresses particular concerns about prison health care and the treatment of a mentally ill man.

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> *"..Mr Severin received no more care than would have been accorded to a prisoner in the main prison despite the fact that he was mentally ill and had accordingly been located in the health care centre. I conclude that a combination of inadequate health care staffing and inadequate communication between non-health care and health care staff denied Mr Severin medical consideration at the time when he most needed it, and allowed less well judged approaches to the situation to prevail. That merits my strongest criticism. ")*

The report also criticised failings at a local and national level within the Prison Service to ensure that prison officers were properly trained in the dangers of control and restraint.

> *" … the [Prison Service] were slow to alert prison Governors fully to the danger of positional asphyxia; they failed to translate such warnings as they gave into adequate instructions for their training staff; and the training arrangements at Belmarsh failed to keep officers up to date regarding such limited modifications as were made. The result was that in 1995 Mr Severin was dealt with in the same way as he would have been in 1990, despite the deaths which had occurred in the meantime. That was a deeply unsatisfactory state of affairs."*

The report is also highly critical of the continuing failure by the prison service to disclose to the family a copy of the internal investigation report. The Ombudsman found Ms Coles' complaints about the treatment of Kenneth Severin in Belmarsh prison and the failure of the Prison Service to disclose the internal inquiry report "fully justified".

Comment

The treatment and care of Kenneth is an indictment of the way the criminal justice system deals with the mentally disordered offender. From his first contact with police Home Office guidelines make it quite clear that he should have been diverted from custody from the outset. (7)

It demonstrates the total inadequacy and inappropriateness of prison for the mentally ill and shows what dangerous places prisons are for such a vulnerable group of people. The use of control and restraint on someone who is mentally ill can only exacerbate someone's distress. To be forcibly restrained and stripped naked by seven prison officers can only be described as brutal and terrifying, inhuman and degrading treatment.

The inquest revealed a total lack of communication between medical and discipline staff where the medical welfare of prisoners in Belmarsh Health Care Centre was given low priority. The deaths of Germain Alexander (1989, Brixton prison) and Omasase Lumumba (1991 Pentonville prison) following the use of restraint resulted in inquest verdicts of neglect and unlawful killing where the use of control and restraint was a central issue. The inquest into the death of Kenneth Severin failed to establish why the dangers of positional asphyxia had not been communicated to every prison officer. It demonstrates the failure of the Prison service to respond to previous deaths and issue clear guidelines and training in acceptable methods of restraint.

The damming criticism by the Parliamentary Ombudsman is a vindication of what INQUEST has been saying for years about the secrecy that surrounds the investigative process following a prison death and the failure of the Prison service to learn the lessons. It is the first public acknowledgement by a public body that responsibility for the death rests with the prison service. The failure to disclose the internal inquiry highlights the complacency and contempt that the Prison service demonstrates following prison deaths and gives us no confidence that it is committed to openness, transparency and accountability.

Kenneth Severin was one of three young black men to die while being restrained in prison between October and December 1995. Dennis Stevens died in HMP Dartmoor on 18th October 1995 (inquest held December 1997) and Alton Manning died in HMP Blakenhurst on 8th December 1995 (inquest held from 12th January to 25th March 1998) INQUEST made a detailed submission to the United Nations CERD Committee (5) on our concerns about the number of black people dying in custody and our concerns at the disproportionate number of young black men who die in suspicious circumstances. These concerns have also been expressed by Human Rights Watch and the Rapporteur on Torture. No criminal or disciplinary charges have been brought against any officer involved in these cases.

Notes

1. Prison standing Order 3E paragraph 24(3) December 1990

2. Prison Authority standing Order 3E, Section B 3(1) states that the unfurnished cells may be used for the temporary confinement of a violent or refractory prisoner only if "the use of such accommodation is necessary to prevent the prisoner causing self injury, injuring another prisoner or staff, or damaging property or creating a serious disturbance.." .....no prisoner shall be confined in [such a cell] as punishment".

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3. The family of Kenneth Severin were referred to INQUEST by the Greenwich Action Committee Against Racial Attacks. INQUEST arranged for solicitor Mark Scott to take on the case and arranged for eminent barrister Edward Fitzgerald QC to represent the family for free at the inquest. The inquest was convened at Southwark Coroner's Court on January 2nd and lasted ten days

4. The prison service were represented by a QC and Junior counsel and had the treasury solicitor in attendance. Both the Prison Officers Association and the RCN instructed Counsel to represent them.

5. INQUEST report to the United Nations 'Racial Discrimination And Deaths In Custody' 1996

6. The Parliamentary Ombudsman's Report March 1999

7. Government policy states that "...those suffering from mental disorder who require specialist medical treatment or social support should receive it from health or social services. Detention in prison is likely to be damaging to the mental health of a mentally ill person and the Prison service is not equipped to provide treatment."

INQUEST works directly with the families of those who die in custody. It monitors deaths in custody - in police custody, prisons, immigration detention centres, as well as the inquiries held into them. INQUEST aims to raise public awareness about controversial deaths, and campaigns for the necessary changes to improve the investigatory process, increase accountability of state officials and avert further deaths.

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