

INQUEST BRIEFING

**The restraint related death of David
'Rocky' Bennett**
Briefing Date Thursday 5th February

INQUEST

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Rocky Bennett Briefing

Introduction

David “Rocky” Bennett had mental health problems throughout a lot of his life and eventually was detained as a patient at the Norvic Clinic, an NHS medium secure unit, Norwich. After an incident, involving racist abuse on 30 October 1998, nurses at the clinic restrained Rocky. He was certified dead at 1.20am 31st October 1998. INQUEST has been working with the family and their lawyers since November 1998.

Rocky is one of many black men who have died following the use of control and restraint in custody. INQUEST has documented the fact that black men are disproportionately represented amongst those who die in police custody and prison following the use of force. As there is no central, publicly accessible register of deaths in psychiatric hospitals it is not clear whether this is the case within mental health detention.

Case Summary

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. On October 31st 1998, at 9.45am his sister, Dr Joanna Bennett received a phone call from another sister to say the police had come round to tell her that Rocky was dead. They had left no contact information for the A & E department where Rocky had been taken.

Both sisters phoned the Norvic Clinic in which he had been detained, but both got through to different departments. Subsequently one was told that he had developed breathing problems during the night and been taken to A&E the other was told only that the Norvic Clinic was carrying out an inquiry and so no more information could be given. Dr Joanna Bennett requested a meeting with the doctor to get further information and was told this would not be possible, until Monday, 2nd November.

On getting through to the A&E department they were told that the incident had been violent and that the police would provide any additional information. It was only after asking to view her brother’s body that she was informed he had been taken 50 miles away for a post-mortem that was due to start at that time. So in hindsight we can see that when the police came to inform the family on Saturday morning of Rocky’s death, his body was being transferred for a post-mortem. It is worth noting that in some cultures, though not in Rocky’s it is against the religious law to undergo a post-mortem. It was in discussions with a nurse at the A&E department and the police that the family was told that Rocky had been restrained by a number of nurses and that it was thought that he had died at the Norvic Clinic.

The family had a meeting with staff on the Monday but could get no more information from the Norvic Clinic and were forced to seek out their own sources of advice and support. It was by a chance meeting with a journalist that his sister was told to contact INQUEST and it was only then that a solicitor was arranged. The solicitor and INQUEST then arranged for an independent expert to carry out a second post-mortem.

The Inquest

The inquest into Rocky Bennett’s death opened on 3 May 2001, nearly two and a half years after he died. The jury at the inquest heard 8 days of evidence about the death of Rocky. They

concluded that Rocky had in fact died at the Norvic clinic and the date of his death was changed to 30th October, the cause of death was due to prolonged restraint and long-term anti-

psychotic drug therapy and returned a verdict of Accidental Death aggravated by Neglect on 17 May 2001. All the experts who gave evidence agree that the single most important cause of death was the prolonged period of restraint. Rocky died as a direct result of force used during his restraint by five nurses.

The jury heard evidence that nurses lay across Mr Bennett and the bruising to his body was consistent with considerable and excessive force being applied. The damage to his body would not have been there if approved restraint techniques had been applied. One of the nurses involved in the restraint knew that prolonged restraint carried with it the risk of positional asphyxia and yet she said and did nothing to alert the others during at least 20 -30 minutes of prone restraint.

They heard that on the night of his death there was no doctor available at the clinic to deal with any kind of medical emergency. The doctor called on the night of the incident arrived one and a half hours later, after Rocky was in fact dead. It transpired that Rocky was held face down for over 20 minutes by nurses, some of whom employed, what their own trainer in restraint described as unacceptable and unapproved techniques of restraint.

The jury heard expert evidence that the restraint caused the death and that if it had been applied in the approved manner the death would not have occurred. HM Coroner for Norfolk, sitting at the County Court, King's Lynn, made six searching recommendations following the verdict. INQUEST particularly welcomed his 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.

Following the inquest the family, their lawyers and INQUEST called on the Government to consider holding a public inquiry into Rocky's death. Instead the Minister agreed to an extended form of the usual inquiry that follows a death in psychiatric detention. The inquiry started in the autumn of 2002 with public sessions opening in March 2003. The public sessions examined the national lessons that needed to be learnt.

INQUEST and the family hope that the Inquiry report will address:

- ◆ 'institutional racism' within the NHS;
- ◆ the lack of central collection of information on deaths of detained patients and monitoring of the issues arising from inquests;
- ◆ over diagnosis of severe mental illness in Black people with mental health problems;
- ◆ over use of seclusion and detention and over medication of Black patients;
- ◆ the over representation of Black people as psychiatric patients and their under representation as staff;
- ◆ the apparent failure of the psychiatric services to implement appropriate strategies to manage frustration and anger;
- ◆ the apparent failure of mental health services to provide appropriate support and care at an early stage;
- ◆ the poor treatment of bereaved families following a death;
- ◆ the failure of the NHS to learn from previous deaths following the use of control and restraint and failure of Government to ensure cross communication across different custodial settings.

Treatment and Responsibility

Rocky's sister, Dr Joanna Bennett, is herself a mental health professional and describes Rocky's treatment as having no focus [on his recovery] instead just treating him as though he was dangerous and violent. She goes further to say that there is little or no evidence of any

therapeutic intervention to help Rocky's progress in his will to manage his illness. She states this with some authority after spending many hours on the phone to his primary nurse in an effort to establish what kind of care and treatment package her brother was being given. She was told nothing apart from the fact that he was still symptomatic. This has implications in Rocky's case because the only indication he had ever been given of his discharge was when he became symptom free. Rocky had been in the psychiatric system since 1980. He was very frustrated.

The family feels that the patients and those in psychiatric care take a very much subordinate position to the protection the institutions give themselves and their staff. Rather than the institution taking responsibility for Rocky's death, his sister believes that those individual nurses responsible for caring for Rocky should be held accountable. After that accountability is defined then the professional bodies must be questioned about their training and policies that have led to the death of one too many patients.

Nurses involved in an incident such as that preceding the death of Rocky Bennett should not be able to continue to practise whilst an investigation is in progress. The NHS cannot continue to talk about good practice if as an institution it continues to defend nurses whose actions in such circumstance result in a death.

Families' motivation following a death is to find out the truth, including a full explanation from official sources to prevent it happening again, to obtain an apology and an acknowledgement of wrong doing or blameworthiness if found and for those responsible to be brought to account for their actions.

Restraint of Black People – The Issues

Since the early 1990s INQUEST has monitored a disturbing pattern of deaths in custody following the excessive use of force by police officers. There have also been a number of deaths following medical neglect. The disproportionate number of individuals, particularly Africans and African-Caribbeans, dying in the aftermath of the use of force has reinforced the idea that many of these deaths are a reflection of racism within institutions and that black people are amongst those singled out for potentially lethal restraint. We call upon the governing bodies to create and enforce policies that will ensure the protection of those patients who are in psychiatric care to prove once and for all that racially motivated abuse such as this is not tacitly condoned at every level.

Many of these cases have presented disturbing images of violence and racism – ascribing to black people stereotypical characteristics of extraordinary strength and dangerousness, attempting to blame the victim for their own death either by their pathological condition or their personal choice.

Another group over represented are the mentally ill where 'negative imagery' once again informs their treatment - the stereotype of the mentally ill as 'mad', 'bad' and 'dangerous'. It would only serve to encourage public confidence if custodial institutions were seen to invite and welcome public scrutiny of their actions in order that lessons are learnt and further tragedies prevented.

For two decades we have documented our concerns about deaths where the use of restraint by state agents has either caused or played a significant contributory factor in the death of the deceased. Casework in police, prison and psychiatric custody has revealed concerns about the excessive use of force generally, including the use of CS spray, US style batons, firearms, strip cells and medication as well as the use of dangerous 'control and restraint' methods such as body belts, 'neck holds, and other restraint techniques resulting in the inhibition of the respiratory system, asphyxia and death.

Cases have revealed a use of violence by state agents on some occasions that is greatly disproportionate to the risks posed involving black people and the mentally ill. This raises questions about the attitudes and assumptions of some state officials and pre-conceived ideas about the propensity to violence of particular groups of people.

Mental Health Services for Black People – The Issues

Academic research has shown that people from black and minority ethnic groups have greater health problems and are less easily able to access health care than the dominant white population.¹

Although these concerns have been widely documented and researched for several decades very little has been done. This has contributed to fear and distrust by people from minority ethnic groups towards NHS mental health services. The key issues of over diagnosis; over use of seclusion and detention; over use of medication and perhaps the most illustrative, the lack of understanding of other cultures and the subsequent misunderstandings of patients are well known.

Dr Joanna Bennett is concerned that direct and institutional racism is addressed within the mental health system and that there is a commitment from government to ensure someone is accountable for ensuring clear targets are set and action is taken.

The Lack of Figures on Psychiatric Deaths

One of the most disturbing problems revealed by Rocky's death is the lack of mandatory and central monitoring of the numbers of people who die in psychiatric custody and the circumstances of their deaths. This contributes to a culture of secrecy and silence and the possibility for cover up and inadequate public scrutiny of such deaths. INQUEST has campaigned hard to get these figures from other custodial settings and as a result, we receive notice of nearly all deaths that occur in prison and police custody. We are the only organisation in England and Wales who record these figures and keep track of the trends that occur in various institutions. However there is no central database of figures of deaths in psychiatric care and therefore no figures of the deaths of people from minority ethnic groups in psychiatric care. Why can't the health service achieve what the prison service and police now achieve with relative ease?

Comment

As the inquiry report on Rocky Bennett is released we note that there has been virtually no change in practice within the NHS. There must be proper guidelines in place to ensure that safe restraint methods are used and that aggressive force is non-existent. Standard centrally accredited training must be given to all those who could potentially use restraint within any custodial setting to ensure minimal damage to human lives. We call for complete transparency

¹ Inside Outside – Improving Mental Health Service for black and Minority Ethnic Communities in England 2003

within the mental health system in terms of its restraint policies, all deaths in psychiatric care and in particular those deaths that have been caused partially or fully by the use of restraint. The investigation systems that follow such deaths must also be changed to ensure those responsible are held to account at an individual and corporate level. We want the NHS to eliminate racism within its institution and to severely condemn any staff member who is found to be discriminatory. Only then do we feel that the caring profession will be able to achieve what it sets out to do. Care and protect.

The family in Rocky Bennett's case were treated shoddily and with no respect. At no point could they confidently state what had happened to Rocky from the information given to them by the authorities. At no time were they consulted on where Rocky's body should be taken or about the post-mortem. At no time were their decisions perceived as being more important than those of the institutions even though Rocky Bennett did not belong to an institution, he was part of the Bennett family.

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