EXTERNAL
AI INDEX NUMBER: EUR 45/19/96

20 December 1996

UNITED KINGDOM: PRISON DEATHS

Amnesty International is concerned about a number of issues surrounding the deaths in prison in disputed circumstances of three black detainees in 1995: Alton Manning, Kenneth Severin and Dennis Stevens. In each case there have been allegations that fatality may have occurred as a result of ill-treatment, the use of unlawful force and/or unauthorized restraint methods. Such allegations are consistent with the injuries detected on Alton Manning's, Kenneth Severin's and Dennis Stevens' bodies.

Alton Manning's prison death

Alton Manning, a 33-year-old man from Sparkbrook, Birmingham, died in the privatized Blakenhurst Prison on 8 December 1995. According to the prison authorities in Redditch, West Midlands, Alton Manning turned violent whilst undergoing a random routine search of his cell and person and, therefore, had to be restrained. Once restrained, between four and six officers were escorting him on a two-minute walk to the segregation unit when they discovered that Alton Manning had stopped breathing. Efforts to revive him proved hopeless.

At 1.15 am the prison rang the family to say that Alton Manning was dead and that a post-mortem had already been carried out, but its results had proved inconclusive. In this connection, Amnesty International is concerned that Alton Manning's family had not been informed of their right to have an independent pathologist present at the post-mortem.

The family arrived at Redditch's Alexandra Hospital at 4 am where they waited until 9.10 am before being allowed to see Alton Manning's body. The family described the body as "battered". His sister took photographs; they reportedly show nine fresh cuts on his face, his cheekbones pushed upwards, forehead dented and face swollen and disfigured.

An excerpt from the official pathology report carried out by Dr Helen Whitwell, a Home Office pathologist, states Alton Manning's death "falls into the category of death resulting from respiratory impairment and restriction during restraint, leading to asphyxia. ... In this case, there is evidence that airway occlusion [blockage] arose due to pressure to the neck (as evidenced by external findings). In addition, restriction of chest movement while on the ground with pressure applied to the back of the chest would occur". Allegedly, the report also made reference to bruising on Alton Manning's back which is consistent with eye-witnesses' accounts indicating that Alton Manning was beaten and knelt on by several prison officers.

The family's pathologist, Dr Ian R. Hill, stated: "In my opinion the [asphyxia] was due to the way in which he was handled". Given that both pathologists who have examined Alton Manning's body concurred that he died from asphyxia, and given that this is consistent with allegations that after a struggle with prison officers Alton Manning was restrained using a neck hold, serious questions arise with respect to why this technique was deemed necessary in restraining Alton Manning.

Guidelines were issued by the Association of Chief Police Officers (ACPO) in 1994 warning of the dangers of neck holds. The Police Complaints Authority (PCA) in 1993 stated: "[a] neck hold which exerts any pressure on the carotid artery or which compresses the airway involves, except in extreme circumstances, an unacceptably high element of risk".

There have also been reports that Alton Manning had been beaten by a number of prison officers and subjected to racism and harassment. These reports are substantiated by a number of letters that Alton Manning had written complaining of harassment from police and prison officers for four years before his death. In this connection, the parliamentarian Bernie Grant had written prior to Alton Manning's death to the acting Director General of the Prison Service about Alton Manning's complaints of mistreatment. The reply, which was received after Alton Manning's death, stated that an inquiry into claims of mistreatment had been completed and that there was no evidence to support his allegations. Bernie Grant claims that "[t]he fact that Mr Manning had complained repeatedly over several months about his treatment in prison only adds to the concern which his family has expressed about the circumstances of his death".

An investigation was launched and the Home Office said that the Operational Director for the North of England had appointed a senior prison governor to inquire into Alton Manning's death. Police from Redditch also carried out an investigation into the circumstances of the death. Pending the outcome of the investigation, no officers were suspended; Acting Deputy Director of Blakenhurst, Peter Siddons, said "[t]here have been no suspensions following the incident and there is no expectation whatsoever that there will be any".

In May 1996, the results of the police inquiry were submitted to the Crown Prosecution Service (CPS) to decide whether to institute criminal proceedings against the prison officers involved. In September 1996, however, the CPS declined to bring criminal charges. To date, no inquest has been held into the disputed circumstances of Alton Manning's death.

Blakenhurst Prison was opened in 1993 and is privatised, run by UK Detention Services. The prison is part American-owned. John Hooker, assistant director of operations, said that they would not accept racial abuse and had never had to discipline any officers for this. However, he admitted that complaints of a racial nature had been made, which are investigated by a "representative of the Home Office who works here as an over-seer".

Kenneth Severin

Kenneth Severin, a 25-year old Afro-Caribbean man, died on 26 November 1995 during a transfer from the hospital wing of Belmarsh Prison to a strip cell.

Kenneth Severin had allegedly been subjected to racist harassment at his Greenwich home in south London. While awaiting rehousing by the council he was arrested, apparently trying to get back into his boarded-up home, charged with trespass and detained on remand in Belmarsh Prison, South East London.

Kenneth Severin had a history of sporadic mental illness. Such illness, however, had been kept successfully under control with medication. Despite this, Kenneth Severin was refused bail on the grounds that his mental condition might have prevented him from attending court. He had never been in custody before and had no previous convictions for violence.

He was in the hospital wing of the prison. Notably, the regime and conditions of the hospital wing have been condemned by a psychiatrist and the local Member of Parliament. On 26 November 1995 Kenneth Severin apparently became agitated when a drugs search was initiated. The decision was made to move him to a strip cell using control and restraint methods. He was handcuffed and his clothes removed. At some point it was noticed that he was not breathing and attempts to resuscitate him failed. It is unknown at what point he collapsed and died. The post-mortem report found that no drugs or alcohol caused or contributed to his death. However, there were findings of postural asphyxiation.

Given that Kenneth Severin had a history of mental illness, in conformity with the UN Standard Minimum Rules for the Treatment of Prisoners, he should have been detained in a specialized institution. In this connection, Rule 22(2) states: "Sick prisoners who require specialist treatment should be transferred to specialized institutions...". Furthermore, Rule 24 states that "[t]he medical officer shall see and examine every prisoner as soon as possible after his admission and thereafter as necessary, with a view particularly to the discovery of physical or mental illness and the taking of all the necessary measures....". In addition, Rule 82(1) and (2) also states that "[p]ersons who are found to be insane shall not be detained in prisons and arrangements shall be made to remove them to mental institutions as soon as possible" and that "[p]risoners who suffer from other mental diseases or abnormalities shall be observed and treated in specialized institutions under medical management".

An inquest into Kenneth Severin's death, which was supposed to reopen on 17 October 1996, has been postponed to 2 January 1997.

Dennis Stevens' prison death

Dennis Stevens, a 29-year old man of Jamaican origin, was found dead in a cell at Dartmoor Prison on 18 October 1995. He had spent his last 24 hours held in a body-belt with his hands manacled to his waist in a security cell in the segregation unit at Dartmoor Prison.

Amnesty International has received information that Dennis Stevens may have died as a result of the ill-treatment to which he was subjected prior to, as well as while, being placed in a body-belt. The reported injuries to his head and face seem to be consistent with these allegations of ill-treatment. In this context and given Dennis Stevens' previous record as a model inmate, the organization considers that serious questions arise both from the disputed circumstances of Dennis Stevens' death and the events leading up to the prison authorities' decision to have him restrained in a body-belt despite having already transferred him to the segregation unit of Dartmoor Prison.

In this connection, it would appear that the Prison Service has not given proper consideration to the 1991 report of the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment (CPT) on its visit to the United Kingdom carried out from 29 July to 10 August 1990. In that report the CPT concluded that "the body belt is a potentially dangerous form of restraint; it could often exacerbate rather than improve a prisoner's psychological

state and might also entail physical risks for the prisoner. Use of the belt will rarely - if ever - be justified".

Dennis Stevens, a father of two children, had been held in prison since 1988, serving a 12-year sentence for armed robbery. Prior to his move to Dartmoor Prison, he had been a model prisoner and had been granted special privileges because of his good behaviour. In mid-September 1995, however, he was transferred from HMP Erlestoke to Dartmoor Prison, allegedly in connection with a series of incidents involving another prisoner who had racially abused Dennis Stevens and scalded him with hot water. Given the seriousness of such allegations, the rationale for transferring Dennis Stevens to Dartmoor, a prison where only five per cent of the inmates are black, appears to be somehow questionable.

Four days prior to his death, Dennis Stevens told his girlfriend, Sharon Palmer, that he had had an argument with a prison officer who was denying him access to toilet paper. The same day Dennis Stevens was transferred to Dartmoor's segregation unit. In this connection, there have been reports from other prisoners that Dennis Stevens had been beaten by prison officers prior to his death. These allegations seem to be consistent with the description, given by his girlfriend, of violent injuries visible on Dennis Stevens' face and head. She stated that "he had these terrible scratches, deep grazes, all down one side of his face. It looked as if he had been dragged along the floor. There was a deep discoloured dent in the side of his head, just above his left eye. It was big, quite deep. The police told my brother he [Dennis Stevens] sustained this injury when the officers tried to restrain him".

According to a Prison Office spokeswoman, Dennis Stevens had been placed in a body-belt after committing serious assaults on staff. With regard to this, however, the authorities acknowledge that Dennis Stevens' behaviour was in marked contrast to that he had previously exhibited.

Richard Tilt, the Director General of the Prisons Service, to whom Amnesty International had written to inquire about Dennis Stevens' death, replied to the organization stating that "the governor [of Dartmoor Prison] exceptionally authorised his restraint [Dennis Stevens'] in a body belt. During the time he was in a body belt, Mr Stevens was seen by a doctor and health care staff. During the night before Mr Stevens' body was found, checks were made at 15 minute intervals by him being observed through the glass in the cell door". However, the organization believes that serious doubts arise with respect to the effectiveness of the above-mentioned checks in establishing the physical and mental health of a person held in a body-belt.

With respect to the use of body-belts, the Prison Service Standing Order 3E states that "[a] first application should never....be made for a period in excess of 24 hours". Serious questions arise about the fact that it was deemed necessary to continue to keep Dennis Stevens in a body-belt for up to the maximum length of time permissible before having to have the order reviewed.

An investigation into the circumstances of Dennis Stevens' death was launched by Devon and Cornwall police. A secret internal investigation into the events before the discovery of Dennis Stevens' body has been carried out by the Prison Service. In May this year, the findings of the police inquiry were submitted to the CPS. To date, however, no inquest has been held into Dennis Stevens' controversial death. At least three post-mortems were carried out. According to reports, the latest post-mortem's findings show that "pressure and restriction of the blood supply during restraint caused or contributed to muscle damage which resulted in [his] death". This is consistent with allegations that unlawful force was used in restraining Dennis Stevens in the body-belt. According to reports, the

pressure resulting from the application of the body-belt on Dennis Stevens was the cause of muscular necrosis which resulted in his death. Following these results, the family has called for an independent public inquiry into his death.

Several questions arise with respect to the nature of the medical care that Dennis Stevens received during the 24 hours he was strapped up in a body-belt. Another question arising is why it was deemed necessary to place Dennis Stevens in a body-belt given that he was already being held in a special cell in Dartmoor's segregation block.

According to Prison Service statistics for England and Wales, body-belts had been used in 96 incidents during the financial year of 1994-95.

A report by the Howard League for Penal Reform, entitled Use of Mechanical Restraints by Prisons and published in 1995, questioned whether body-belts were only used as a measure of "last resort" and accused the prison authorities of using them on a routine basis. Stephen Shaw, the director of the Prison Reform Trust, said that body-belts were medieval relics which should be outlawed.