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In Memoriam: Kenneth Severin, Jimmy Mubenga and Sean Rigg

Crimes without Punishment and Punishment without Crime

Postscript to *Experiences of a Medical Whistleblower in Great Britain*

This postscript to protracted and abortive searches for truths from 1994 through to 2012 is dedicated to the memory of several of the many men who have died in custody under "restraint"; some in the presence of witnesses who heard them plead that they were being killed by officials responsible for their care.

Kenneth Severin: stripped naked, handcuffed and restrained

In Mr Severin's case, with which I was directly involved, vital evidence has been withheld & probably destroyed. He died in November 1995 and his case was the subject of a TV documentary film and an in depth report.

The twists and turns in the Severin saga are documented from a psychiatrist's perspective in several publications, most comprehensively the on-line paper about **Abuse of Power - a Medical Whistleblower in Great Britain**(http://www.scp08.co.uk/)

I had been concerned about these issues since Severin's Mental Health Review Tribunal hearing in 1994.

Although well known to have been suffering from schizophrenia, as too had his father, Kenneth Severin was thought by a social worker 'care manager' representing Social Services at the Tribunal hearing to be not mentally ill but simulating it.

Two completely unforeseeable consequences were:

A. the preventable death of that mentally ill patient,

B. the writer's suspension and eventual dismissal from the medical panel of the Mental Heath Review Tribunal !

I have continued to pursue my enquiries into Mr Severin's case ever since 1994 when, as a consultant psychiatrist, I had urged his need for continued compulsory treatment.

Outrage at my suspension was expressed widely, most cogently perhaps by the hospital doctor present throughout the hearing : "25 July 1994. I recently attended a Mental Health Tribunal regarding Kenneth Severin, as the nominated deputy of Consultant Psychiatrist *Dr Blackwell*. ***Given the complex nature of the case I found Dr Woolf's questioning of Care manager T.A, the patient K. S. and myself wholly appropriate. Dr Woolf's firm, fair and probing questions were necessary to elucidate the finer aspects of this case.*** *R. M.*"

Soon after leaving hospital Mr Severin was in trouble and was remanded to prison, where he suffered severe restraint by prison officers, leading to his death.

The hospital notes are silent as to exactly when he had left hospital, whether he had been formally discharged, allowed leave, or simply absented himself whilst still "under Section"?

There was no consultant's Discharge Report to be found, not even a note by the RMO Dr Blackwell or his deputy to explain what had happened. There is no copy in the medical notes of the tribunal's findings, just a cryptic entry signifying the social worker's surprise at the outcome of our deliberations.

How and why he was allowed to leave hospital with no explanation is central to the tragic consequences.

As a known sufferer from mental illness, Kenneth Severin ought not to have been remanded in prison at all, and certainly not without the prison staff being made aware of his mental condition.

It appears possible that his aggressive paranoia had scared neighbours, who got rid of him by setting fire to his flat, and might have caused the prison officers to take even more extreme measures to control him; in Court the officers' defence was that he was remarkably strong and his aggression scared them into taking extreme action.

At Kenneth Severin's Inquest the Coroner criticised comprehensively poor communications between the different agencies, with many aspects of the management of his case contributing to his death in custody.

After my active membership of the Tribunal was restored (excepting within the borough in which I lived and in which the Severin Tribunal had taken place) I took an opportunity to show a press notice of that fatal outcome to the attention of the regional chairman, with the paradoxical consequence of it annoying him, by showing up his earlier action in 1994.

So he found a trivial, spurious basis to suspend me again, compounding it by contriving to have me dismissed permanently from membership of the the tribunal's medical panel by the Lord Chancellor, with (as it inexplicably turned out) no right of Appeal.

That then Chairman had previously sought - secretly ! - to prevent "his" doctors from continuing to act as Expert Witnesses to assist lawyers by providing independent tribunal reports; a normal professional activity.

Those two actions combined finished my career as a forensic psychiatrist, forcing me in later life into an unpaid non-medical occupation [http://www.musicalpointers.co.uk/index.htm], as strongly advised for suspended doctors by the Society of Clinical Psychiatrists [http://www.scpnet.com/advice.htm]

The Severin case became notorious, as exemplified by Inquest's *Report on the death of Kenneth Severin 1995* and a Channel 4 documentary film *Citizen's Arrest - Death in Custody,* made with the co-operation of the director of *Inquest*, which had represented Mr Severin's family.

I have offered widely to share my copy of the film; an offer not taken up...

In it, one sees the prison's gate staff declining to accept personal delivery of a letter about the case, insisting that it be posted by Royal Mail (I had a similar demand from the Oxleas Director of Social Services !).

Kenneth Severin's sisters and mother had authorised me to explore the case in depth through my hospital connections, but before I could proceed they were required by our local Hospital Trust's Information Governance Supervisor to authenticate their permissions formally, twice over ! The family have appreciated my efforts to "*keep the flame alive - your mission is a good one and we will support you in all the assistance we can give*".

All my efforts have however been dogged by resistance and evasion. As a local retired psychiatrist, I have been required to authenticate myself with formal documents, and to pay fees for abortive correspondence searches.

I had myself instigated a first ever complaints system for Mental Health Review Tribunal members, an apparent omission when the Tribunal was set up. One such was duly endorsed and put in place, but with a "non-retrospective" clause which excluded review of my own complaint and the unique dismissal of an MHRT doctor.

Years afterwards, I still have not seen the crucial correspondence with the then Lord Chancellor which terminated my career as a forensic psychiatrist; at their last try the new Justice Ministry failed to find the key letter in the former Lord Chancellor's archive, by looking in the wrong place...

The then Director of Social Services had been reluctant to meet me about Kenneth

Severin in 2010 (and declined to accept an e/mail request to do so - it was therefore re-delivered in person !). In an eventual short, defensive meeting he gave us to believe that all the patient's records would have been destroyed during implementation of digitisation programmes.

He declined to help facilitate a meeting with the key social worker &/or her senior (to whom I had written in 1994 with no answers) - they had sparked my suspension and ultimate removal from the tribunal but both were believed to have left the service.

Neither was his help forthcoming to put me in touch with Mr Severin's relatives, one of whose addresses was eventually discovered by a Whistleblowing organisation which, in turn, was baulked in their efforts to contact the elusive former regional chairman and failed to interest an investigative journalist in the topics.

Kenneth Severin's sisters appreciated my involvement, but numerous attempts to achieve meetings and open discussion with representatives of relevant organisations had been resisted and evaded through the years, including ***Inquest*** and its laywer; the **Royal College of Psychiatrists**; two successors to Judge Palmer as **MHRT Regional Chair**; the **Council on Tribunals**; the **General Medical Council**; the local **Hospitals Trust,** and government ministries **Department of Health** and the **Justice Ministry**...

It has proved hard also to persuade people to spare half an hour to watch the Channel 4 TV documentary *Citizen's Arrest* about Severin's case, which I had been eager to share.

Access to revisit Mr Kenneth Severin's clinical and social records was delayed by complex new legal requirements; copies of the hospital notes were eventually provided but proved crucially incomplete, without any indication of when and on what terms he was discharged, allowed to leave or, possibly, just absented himself from hospital.

There was a minimal note indicating surprise that he'd not been discharged by the tribunal, but none to tell the team that I had had assessed him as very vulnerable and had brought that out in the hearing.

There is minimal handwritten input from the social side and we gradually ascertained complete separation between health and social record keeping and that, in any case, any social service notes had been destroyed**.**

I looked in vain for a customary Discharge Report in the bundle of photo-copied papers, having had to search on my own because a doctor who had been detailed to invigilate my inspection of the actual hospital notes could not spare time to do so.

Furthermore, Mr Severin's social records proved impossible to find and eventually the Council's Information Governance Officer opined that "*they might have existed*", telling me that Greenwich has no system in place to ensure the retention of sensitive material in contentious cases.

What became importantly clear was the complete separation of our local Health Authority Trust from the Council, the latter responsible for social records. I have urged a local psychiatrist representing a RCPsych project on discharge reports to try to ensure that in the national protocol they are developing, social and clinical reports should be combined.

I have been concerned about these issues ever since the 1994 Mental Health Tribunal Hearing about Mr Severin, a schizophrenia sufferer, thought by a social worker not to be mentally ill.

That had two repercussions; the preventable death of that mentally ill patient, who was killed under prison staff "restraint", and my own suspension and subsequent dismissal from membership of the Mental Heath Review Tribunal arising indirectly from that social worker's resentment of essential questioning.A full account of these interrelated consequences are dealt with in my extended reports, widely published nationally and internationally; notably in my comprehensive paper on line (http://www.scp08.co.uk/).

4. This postscript has summarised the obstacles encountered in exploring these closely interrelated matters, notably the evasiveness of medical and government departments and the widespread avoidance of face to face discussions.

A key factor in my own experience had been the appointment of a retired Crown Court Judge as the Tribunal's Regional Chairman, following the tragic premature death of his predecessor solicitor James Cooke, a wise colleague and friend to his Members.

Cooke's short-lasting successor for South Thames Region, Judge Henry Palmer, effectively brought my lengthy medico-legal psychiatric career to abrupt termination. He avoided disclosing essential correspondence, and even failed to to respond to my representations when asked to do so, first by the Lord Chancellor himself and latterly from a leading Whistleblower organisation...

Even my own frustrated MP, whose several representations on my behalf have never been properly addressed, has closed the case to further correspondence.

The charity ***INQUEST*** (http://www.inquest.org.uk/) uses the term "deaths in custody" to refer to all deaths in state detention. *INQUEST*'s casework and monitoring service has recorded over 3,600 deaths in prison and in police custody (http://inquest.gn.apc.org/issues/home) in England & Wales since 1990!

They have highlighted a reluctance to approach deaths in custody as potential homicides even where there have been systemic failings and gross negligence.

A disproportionate number of mentally ill people and those from minority ethnic communities have died as a result of excessive force, restraint or serious medical neglect. None of *Inquest*'s cases has led to the prosecution of their attackers.

Having represented numerous families of detainees, many of them mentally ill, *Inquest* had to report that not a single one of the alleged perpetrators has been convicted of a criminal offence.

Jimmy Mubenga, an illegal immigrant, died at Heathrow Airport on 12 October 2010 during his forcible removal from England while being deported back to Angola by staff of G4S Security (the commercial organisation notorious for a security arrangements fiasco at the Olympics). Another passenger heard him screaming repeatedly: "*They're going to kill me*."

No one was held responsible for his death.

Sean Rigg's death in inappropriate police custody was found by an inquest jury to have followed the use of unnecessary force by the police on August 2008 and has also been the subject of a searching TV documentary film. Police are not expert in recognising even serious acute mental symptoms.

His family has pressed for criminal charges to be brought against those responsible and for a public inquiry into the number of deaths in custody.

There has not been a single successful homicide prosecution for a death in custody.

This suggests a need to review my understanding that key witnesses (such as fellow prisoners - Severin - or fellow passengers - Mubenga - who hear victims of fatal assault calling out, are not normally called for the defence? And a contributory role of the Data Protection Act leaving people supervising those in custody ignorant of their medical backgrounds.

It surprises us that the questions raised in the Channel 4 film, and in my papers about Severin's case, have not otherwise evinced more media interest.

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