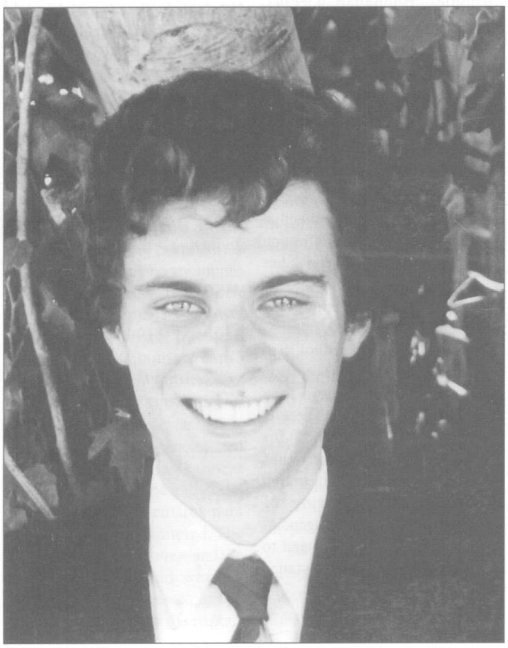
Ensuring a right to life - even in prison

Paul and **Audrey Edwards** describe their fight to learn the truth about their son Christopher's death.

Our son, Christopher, had an honours ,degree in Economics with Japanese; spoke four other languages; was a competition chess player; had cycled extensively in England, Australia, New Zealand, North America and North Africa; and was a charming, polite, sensitive young man. He also suffered from mental illness, which became apparent in his mid twenties. Like many people suffering mental illness he had no insight into his condition and did not recognize his illness. With parental encouragement he saw two psychiatrists who agreed he was on the verge of a severe mental illness and prescribed the anti-psychotic drug Stelazine. Christopher took the drug irregularly, and only to please us, his parents.



Christopher Edwards

After the initial visits he was not prepared to visit the psychiatrists again on the grounds that he was not ill and did not need to do so. For their part the psychiatric professionals would not seek to intervene, although they had recognized the severity of his mental illness. He was an adult entitled to make his own decisions and in their view they had no right to intervene to rescue him from his illness. Our attempts to secure treatment were to no avail; the psychiatrist principally involved rejected our request to see him on the basis of it not being appropriate and visits to the GP and the local secure mental hospital were equally fruitless.

Similar stories to the above could be repeated many times over. The people involved will certainly be leading a life of inner misery; few will be employed; many will be homeless and rootless; many will self-harm, with a significant proportion committing suicide; and thousands are held in prison. Christopher's case differed in that while he suffered the misery and was unemployed, he escaped homelessness and self-harm; but he did not escape prison.

Admission to prison

One day he caused a breach of the peace for which he was arrested. The police dealing with him thought he was mentally ill. We told them and the psychiatric social worker, who was called in, of Christopher's history of mental illness. Even so he was found fit to go into court. All in the court recognized his mental illness but the magistrates did not consider they had power to send him to hospital so he was remanded to prison for three days. We were told that in that time we, with the assistance of the probation service, had to find him a hospital bed. Christopher behaved bizarrely at the prison and was put in a cell on his own 'for his own protection' according to the prison officer who put him there.

Another young man - Richard - was remanded by another court to the same prison on the same day. He had a long history of severe mental illness associated with violence and had been in the same prison previously, where his behaviour was so bizarre he had to be transferred to high security psychiatric facilities. Five weeks prior to this latest remand he had been the subject of a case conference at which the risk he could murder someone was specifically minuted. The medical professionals were not prepared to section him. They said staff were frightened of him and a police inspector at the meeting said he was put under pressure to find a way of putting Richard in prison.

When Richard was taken to prison the police delivering him believed prison officers remembered him from his previous stay - hardly surprising given his previous behaviour. He too was put in a cell on his own; he was not fit to go in with other inmates according to the prison officer concerned, the same officer who had put Christopher in a cell on his own for his own protection. Yet a short time later this officer transferred Richard into the same cell as Christopher. Within a few hours Christopher had been kicked and beaten to death. His left ear could not be found and he had to be identified by his dental records.

The cell alarm had been pressed but was ineffective. A subsequent external inquiry found the alarm was capable of being sabotaged by the insertion of a matchstick and the inquiry could not rule out it had been tampered with deliberately. The prison officer on night duty at the relevant time refused to appear before the external inquiry. When the assault was discovered six prison officers gathered outside the cell. They did not enter, but went off to don protective gear thus wasting valuable minutes during which Christopher's life might have been saved.

It is impossible to convey the impact of such a tragedy on the family. Among our reactions was one we have observed in other families after major disasters, namely an intense wish to know

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what happened and why. We also had a burning desire that Christopher's story should be known so that no-one else would suffer as Christopher had done. We made the assumption that the agencies involved, all publicly financed and acting in the name of the community, would share our commitment to the identification and publication of the truth. This assumption was very soon undermined as it became clear that the prime objective of all the agencies was not the truth, but institutional self-protection.

Attempting to discover the truth

None of the facts given above were told to us by the authorities at the time. Indeed the Prison Service (to quote the Parliamentary Ombudsman four years later) maintained a false impression concerning the possible extent of Prison Service culpability well beyond the point at which the existence of that impression could legitimately be ascribed to an incomplete understanding of events. The Essex Police told us the same untruths as the Prison Service, although it was contradicted by the evidence they had in the witness statements in their possession but which they refused to disclose to us.

Our first assumption was we would learn the truth from the Inquest but because there was a trial there was no Inquest. The trial did not reveal the full facts because Richard pleaded guilty to homicide through diminished responsibility. A plea and directions hearing was turned into the trial which lasted about 40 minutes. There was no jury and there was only one witness, a psychiatrist confirming the extent of Richard's mental disorder and the availability of a secure bed at Rampton. The judge endorsed the view of the defence that the circumstances in which the two were placed in the same cell were a scandal, but made it clear that was not a matter for his court.

We had always been convinced there had been major failings by the public agencies involved and from the outset had pressed the police to investigate the possibility of corporate negligence but they refused to do so. It was not acceptable to us for the judge to acknowledge there had been a scandal but for nothing to be done about it. Our inquiries revealed that we were not able to initiate any action against the agencies. We learned that the UK legal system does not place any value on human life itself and only recognizes the impact on a very limited group of people affected by the loss of life. We were unable to act because we were not financially dependent on Christopher and nor were we present at the time of his death.

At the time there was much discussion in the media about the right to blood money of the relatives of a British nurse, the victim of murder in Saudi Arabia. The Islamic legal system we thought had much to commend it because it at least recognized the injury to a family unit when a member is killed.

The Inquiry

In the absence of any other option we campaigned for an independent public inquiry to find out and publish the truth about Christopher's death. Eventually this was agreed and we were allowed to propose terms of reference and were told that what we had proposed was in line with what was intended. Indeed the first words of the official terms of reference were 'To investigate the death of Mr. Edwards in Chelmsford Prison'. The pretence that it was such an investigation was maintained for the first two years, illustrated by the fact that all correspondence from the Inquiry Secretariat bore a heading indicating it was an Inquiry into the death of our son. This heading was dropped and by the time it was published it had changed into an *Inquiry into the Care and Treatment of Richard Linford and Christopher Edwards.* The report when published (after three years and a £1 million cost) was fundamentally unsatisfactory. While it produced a catalogue of failures, it failed itself to examine all aspects of the death so that, for example, the police who conducted the investigation were not even interviewed. It was characterised by a bland acceptance of the inevitability of failure and it refused to make a judicial allocation of responsibility for the tragedy.

Our commitment to ensure that the truth is revealed, responsibility allocated and that future policy is based on truth and accountability survived the failure of the external inquiry. At first the only option appeared to be the formal complaint processes applicable to each agency. Very limited action had been taken by the agencies acting on their own initiative. Only two people involved in this tragedy were disciplined by their employers. The prison doctor was dismissed but as his faults - failing to pass on information and failing to return to the prison after the death was identified - were far less material than other prison service employees involved we are forced to believe the Prison Service had other reasons for seeking his dismissal. The other person dismissed was a social worker who had pushed the case that Richard was homicidal and should be sectioned, advice which was rejected by the psychiatrist, who remains in post.

Ineffective remedies for change

The complaint processes are not very effective remedies for ensuring change. We had discovered very early on that the Chief Inspector of Prisons has no power to investigate individual cases and the Prison Service Ombudsman has no power to investigate matters on behalf of dead prisoners or their families. Much later the Parliamentary Ombudsman did uphold our complaint about the performance of the Prison Service after the tragedy and required the Prison Service to apologise for maintaining to us a false impression of their culpability or, in our words, for a 'cover-up'.

The NHS Trust to whom we complained about the performance of two psychiatrists declined to take disciplinary action against them. The General Medical Council, to whom we also made representations, found it appropriate to counsel the two about their practices but they did not advise the NHS Trust about this, so limiting the impact of their decision as a force for change.

Perhaps the most astonishing response came from the local magistrates' complaint process. The external Inquiry stated that magistrates had expressed their concern about Christopher's personal safety in prison and asked that this be conveyed to the prison. We subsequently obtained a copy of evidence by a magistrate supporting this statement. Our complaint that the fact this message had not been passed on revealed a failure in the justice system was turned down on the grounds that, notwithstanding the external Inquiry report, the magistrates had *not* expressed any concern about Christopher's safety and, therefore, there was no message to convey to the prison! This initial finding is now being reviewed in the light of our expressed incredulity. The outcome of representations to the Police Complaints Authority and the Health and Safety Executive are still awaited.

In view of our inability to find any satisfactory legal or non-legal remedy for what happened to Christopher we were greatly encouraged by the suggestion we discuss our case with the civil rights organization Liberty. After careful consideration Liberty agreed to take Christopher's case to the European Court of Human Rights which unlike current UK law, recognises a positive right to life not associated with any financial dependency. Our understanding is that if our case is upheld the UK will be obliged to change the present system and law to protect the lives of mentally disordered offenders in prison (40% of prisoners suffer some form of mental illness) and provide a remedy in the UK courts should another such tragedy occur.

While nothing can compensate for the loss of our son, a positive decision from the European Court would offer some comfort in the knowledge that his life and brutal death were not in vain but were a key to the better treatment and protection of others like him in future years. If there is not a positive decision we can only encourage campaigners to press for changes in UK law and insist on the accountability of public agencies to ensure such a tragedy does not recur.

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