COUR EUROPÉENNE DES DROITS DE L'HOMME
EUROPEAN COURT OF HUMAN RIGHTS

THIRD SECTION

CASE OF KEENAN v. THE UNITED KINGDOM

(Application no. 27229/95)

JUDGMENT

STRASBOURG

3 April 2001

In the case of Keenan v. the United Kingdom,

The European Court of Human Rights (Third Section), sitting as a Chamber composed of:

Mr J.-P. COSTA, *President*,
Mr W. FUHRMANN,
Mr P. KŪRIS,
Mrs F. TULKENS,
Mrs H.S. GREVE,
Mr M. UGREKHELIDZE, *judges*,
Sir Stephen SEDLEY, ad hoc *judge*,
and Mrs S. DOLLÉ, *Section Registrar*,

Having deliberated in private on 4 July 2000 and 13 March 2001,

Delivers the following judgment, which was adopted on the last-mentioned date:

PROCEDURE

1. The case was referred to the Court, in accordance with the provisions applicable prior to the entry into force of Protocol No. 11 to the Convention for the Protection of Human Rights and Fundamental Freedoms ("the Convention") by the European Commission of Human Rights ("the Commission") on 25 October 1999 (Article 5 § 4 of Protocol No. 11 and former Articles 47 and 48 of the Convention). It originated in an application (no. 27229/95) against the United Kingdom of Great Britain and Northern Ireland lodged with the Commission under former Article 25 of the Convention by a United Kingdom national, Mrs Susan Keenan ("the applicant"), on 28 February 1995.

2. The applicant alleged that her son, Mark Keenan, had died from suicide in prison due to a failure by the prison authorities to protect his life, that he had suffered inhuman and degrading treatment due to the conditions of detention imposed on him and that she had no effective remedy in respect of her complaints. She relied on Articles 2, 3 and 13 of the Convention.

3. The Commission declared the application admissible on 22 May 1998. In its report of 6 September 1999 (former Article 31 of the Convention) [*Note by the Registry*. The report is obtainable from the Registry], it expressed the opinion, by fifteen votes to five, that there had been no violation of Article 2, by eleven votes to nine, that there had been no violation of Article 3 and, unanimously, that there had been a violation of Article 13.

4. The applicant was represented by Messrs Toller Beattie, solicitors practising in Braunton, and by Mr T. Owen, a lawyer practising in London.

The United Kingdom Government ("the Government") were represented by their Agent, Mr P. Berman, of the Foreign and Commonwealth Office.

5. On 13 December 1999 a panel of the Grand Chamber determined that the case should be examined by a Chamber constituted within one of the Sections of the Court (Rule 100 § 1 of the Rules of Court). Subsequently the application was allocated to the Third Section (Rule 52 § 1). Within that Section, the Chamber that would consider the case (Article 27 § 1 of the Convention) was constituted as provided in Rule 26 § 1. Sir Nicolas Bratza, the judge elected in respect of the United Kingdom, withdrew from sitting in the case (Rule 28). The Government accordingly appointed Lord Justice Sedley to sit as an *ad hoc* judge (Article 27 § 2 of the Convention and Rule 29 § 1).

6. The applicant and the Government each filed observations on the merits (Rule 59 § 1).

7. On 4 July 2000 the Chamber decided, after consulting the parties, that no hearing on the merits was required (Rule 59 § 2 *in fine*).

THE FACTS

I. THE CIRCUMSTANCES OF THE CASE

8. The applicant is the mother of Mark Keenan who, on 15 May 1993, at the age of 28, died from asphyxia caused by self-suspension whilst serving a sentence of four months' imprisonment at HM Prison Exeter.

9. The immediate circumstances surrounding Mark Keenan's death are inevitably obscure, since he took his life while alone. For the rest, the parties have in the main accepted the facts as established by the Commission and these are reproduced below in Section A. The medical reports concerning Mark Keenan's state of health prior to his death are summarised in Section B.

A. The facts of the case

10. From the age of 21, Mark Keenan received intermittent treatment in the form of anti-psychotic medication for a condition which it appears was first diagnosed whilst he was serving a four-year prison sentence for assault. It appears to have been reported by Mark Keenan that he was diagnosed as suffering from paranoid schizophrenia. Following his release from prison in 1988, Mark Keenan's general practitioner continued the prescription of anti-psychotic medication.

11. His medical history included symptoms of paranoia, aggression, violence and deliberate self-harm, and his behaviour was sometimes

unpredictable. In November/December 1992, shortly before he was admitted to prison, he had received treatment at North Devon District Hospital following two incidents in which he had injected himself with overdoses of insulin. Following the first incident, on 9 November 1992, it was noted that he was complaining of paranoia. Diagnoses of borderline personality disorder and paranoid schizophrenia were made and it was noted that he had a history of frequent episodes of deliberate self-harm. He was discharged after ten days on a prescription of anti-psychotic medication. The second incident, on 16 December 1992, was associated with the breakdown in his relationship with his girlfriend. The admission notes recorded as diagnoses "Personality disorder. Paranoid psychosis. Suicide threats". He discharged himself on 18 December 1992.

12. On the same day he was admitted to HM Prison Exeter, having been remanded in custody following an assault on his girlfriend. On admission, he was received by the prison's health care centre for observation and assessment, having mentioned a history of suffering from paranoid schizophrenia.

13. On 21 December 1992, when the medical notes recorded that there had been no evidence of schizophrenia that day, an attempt was made to transfer him from the health care centre to ordinary location. Later the same day he was re-admitted to the health care centre because he had been kicking at his cell door and appeared paranoid to prison staff. The explanation provided by Mark Keenan was that he had taken some cannabis which had "tripped him out" and made him paranoid, shaky and tense. Subsequently, on 23 December, he was discharged to ordinary location having been assessed as fine, with no psychiatric symptoms, cheerful and coping. By the evening, he was complaining that he was "cracking up". He was advised to "calm down and think positively about going to court tomorrow". In the event, on 24 December 1992, he was released on bail.

14. Mark Keenan was re-admitted to HM Prison Exeter on 1 April 1993, having been convicted of the assault on his girlfriend and sentenced to four months' imprisonment. He was again received by the prison's health care centre for observation and assessment. On 5 April 1993 Dr Keith, the prison's senior medical officer, consulted Dr Roberts, the consultant psychiatrist who had been treating Mark Keenan before his admission to prison. Dr Roberts advised that Mark Keenan had a personality disorder with anti-social traits and that under stress he disclosed some fleeting paranoid symptoms. Dr Roberts concurred with the medication which Dr Keith had prescribed (thioridazine) and suggested a clopixol injection with chlorpromazine. He also advised that Mark Keenan should be treated symptomatically.

15. On 14 April 1993 Mark Keenan barricaded himself inside the ward room of the health care centre in protest against his proposed transfer to ordinary location. On 15 April 1993, following an adjudication concerning

the incident, the governor imposed a suspended punishment of fourteen days' extra imprisonment. On 16 April 1993 he was discharged to ordinary location but re-admitted to the health care centre the following evening after his cell-mate reported that he was uptight and had fashioned a noose from a bed sheet which he was keeping under his bed. On his return to the health care centre, he was placed in an unfurnished cell and put on a fifteen-minute watch. The entry in his medical notes for 17 April 1993 records:

> "Brought to Health Care Unit at 21.30 hours ... states he will hang himself. A noose has been made out of strips of sheets. In conversation with Keenan, [says] he is under pressure from kitchen workers who have stated they will contaminate his food etc. The look of relief on his face was great when I told him he will have to stay here."

16. A subsequent entry, on 18 April 1993, records "owes on wing hence can't cope [with ordinary location]".

17. On 23 April 1993 it was decided that Mark Keenan should be assessed by the prison's visiting psychiatrist, Dr Rowe. On 26 April 1993, before he had been assessed, a further attempt was made to transfer him to ordinary location. He was re-admitted to the health care centre the following day. The entry in his medical notes for 27 April 1993 records:

> "Brought to treatment room shaking and hyperventilating. Declined any further medication. Unable to cope. Admitted to health care centre for observation and assessment. Seen at 17.45 hours. He says he felt panicky and paranoid in main prison. He felt he was going to be attacked. He felt he might have to defend himself. Located in single cell on lower landing."

18. On 29 April 1993 Mark Keenan was assessed by Dr Rowe, who did not consider that it was currently necessary to transfer him to a hospital for psychiatric treatment, but prescribed a change in his medication, and recorded in his medical notes:

> "He is an old patient of mine who suffers from a mild, chronic psychosis. He is not usually violent, although he is easily stressed and then can be unpredictable."

He also recommended that Mark Keenan should have no association until the panic/paranoia subsided.

19. On 30 April 1993 the question of moving Mark Keenan to ordinary location was again raised with him. The entry in his medical notes for 30 April 1993 records:

> "He does not feel fit for [ordinary location] as he is afraid he might be injured, further mention of paranoia by him. To remain in a single cell."

20. In the course of the day his mental state was noted to deteriorate, with evidence of aggression and paranoia. Dr Seale, who had no psychiatric training, considered that the change in medication might be responsible and therefore prescribed a return to his previous medication. At 6 p.m. Mark Keenan assaulted two hospital officers, one seriously. Following the assault, he was placed in an unfurnished cell within the health care centre and put on

a fifteen-minute watch. It is not known how long the watch was kept in place.

21. On 1 May 1993 Dr Bickerton, who had six months' training in psychiatry as a senior house officer, certified Mark Keenan fit for adjudication in respect of the assault and fit for placement in the segregation unit within the prison's punishment block. He recorded in Mark Keenan's medical notes for 1 May 1993:

> "Calm and rational. No sign of mental illness. Slept well, feels relaxed. Claims he was frustrated yesterday and this is why he attacked the officer. Fit for normal cellular confinement in punishment block."

22. The same day, Mr McCombe, the prison's deputy governor, ordered Mark Keenan to be placed in segregation in the punishment block under Prison Rule 43. Mr McCombe considered segregation appropriate, as Mark Keenan's behaviour was unpredictable and he posed a threat to staff. No date appears to have been given for his release from segregation.

23. Whilst in segregation, Mark Keenan would have been locked up about twenty-three hours each day. Although the segregation unit was visited each day by a doctor, the prison chaplain and the prison governor, Mark Keenan would, in contrast to location within the health care centre or the main prison, have had minimal contact with staff, and none with fellow prisoners.

24. On 1 May 1993, following his transfer to the segregation unit, Mark Keenan requested a "listener" (a prisoner trained by the Samaritans in the counselling of inmates who may be suicidal). At 6.05 p.m. Mr Gill, one of the prison's hospital officers, was contacted after Mark Keenan had indicated to prison officers on the segregation unit that he was feeling suicidal. The medical notes record:

> "Went to see [Keenan]. 1997 raised [(a form completed for the referral of an inmate, perceived to be a suicide risk, to the medical officer)]. Listener in cell with inmate. Reassurances given that he is not suicidal but tense, agitated [and] needs to talk it over. Will get [medical officer] to see when he attends later."

25. At 6.45 p.m., however, Mark Keenan was threatening to harm himself and was therefore transferred to an unfurnished cell in the hospital wing and put on a fifteen-minute watch. It remains unclear how long this watch was maintained.

26. At 7.45 p.m. Dr Bickerton attempted to speak to Mark Keenan through his cell door. Whilst noting that he appeared very agitated and distressed, and claimed to be hearing voices and thinking he was Jesus Christ, Dr Bickerton doubted that he was suffering from any psychotic illness. Mark Keenan's medical notes record that he spent the greater part of the night banging on and kicking his cell door, shouting obscenities and making threats to prison staff. On 2 May 1993 Dr Simkins recorded in Mark Keenan's medical notes:

"This morning denying he is suicidal. Verbally abusive to staff. Some bruises from hitting door. This man is a considerable hazard to staff and has become obnoxious to other hospital inmates due to his behaviour. He is unpredictable and has made threats to his life. He has been placed on Rule 43. I have explained to him that his remaining in the [unfurnished] cell is in order to assess his attitude in the next 24 hours. I will increase chlorpromazine to 400mg qds and resume Kemadrin and chloral nocte. He says he will not take medication."

27. The medical notes for 3 May 1993 record:

"a.m. – very much better in attitude. Slept well. Requests to return to [the segregation unit in the punishment] block. Agreed."

28. Mark Keenan was duly returned to the segregation unit. A note in the segregation unit's occurrence book for 3 May 1993 records:

"Keenan [was] brought in from the hospital. Seems slightly more lucid than before, however still needs watching. At tea time Keenan asked to [talk to a listener] as he stated he felt he was 'going into one', which I took to mean kicking off ... staff beware."

29. The medical notes record at 9 p.m.:

"Troublesome in block. Given extra chlorpromazine. Seemed to calm down after a chat. If he is talking suicidally overnight then unfurnish his block cell and review 'mane' [query, in the morning]."

30. Save for a short note on 4 May 1993 that at "11.00 hours clopixol 500 mg given", no further entry was made in Mark Keenan's medical notes from the 3 May 1993 until his suicide on 15 May 1993. Dr Bradley, who had no psychiatric training, saw Mark Keenan in the course of routine morning visits to the segregation unit on 4 to 7 and 10 to 14 May 1993. She recalled:

" ... We had the cell door open on the majority of occasions. I recall there may have been one time when I spoke through his glass window ... but that was because they were short of staff. He had the opportunity to talk to me.

We discussed his medication. He never mentioned any feelings of depression to me or not coping. On the whole Keenan appeared calm and with it with me. He appeared clear and not disturbed. I also checked with the staff as to his behaviour through the day, and they replied that there was nothing that concerned them."

31. The occurrence book of the segregation unit records, however, on 4 May 1993:

"Keenan abusive, aggressive and offering violence to staff. Relocated to [cell] A1-4 for a quietening down period. Keenan phone call to solicitor at 10.00 hours re assault on H/O Dent. On return [from phone call] to A1 [landing] states he will behave himself. Relocated to [cell] A1-5."

32. The entry for 6 May 1993 records:

"Keenan refused cup of tea. Said there was something out in it. When told that there was nothing out in it he decided to drink it. He is starting to act very strange. Staff to be aware."

33. The entry for 7 May 1993 records:

> "Keenan seen by doctor. Refused medication. Staff to still offer medication. To be logged if taken or refused."

34. Following the entry on 7 May 1993 there is reference to the fact that on 8, 9 and 10 May 1993 he accepted his medication. Thereafter there is no reference to Mark Keenan in the occurrence book until his suicide on 15 May 1993.

35. In a letter to his mother, dated 13 May 1993, he complained that his state of mind was not very good.

36. On 14 May 1993 Dr Bradley assessed Mark Keenan to be fit for adjudication in respect of his assault on the two prison officers on 30 April 1993. The record of the adjudication contains the certification by the doctor that he was fit for adjudication and for cellular confinement. The doctor added the following observations:

> "At the time of the alleged offence Mr Keenan was receiving medication for a chronic psychiatric problem and he had had a recent change in medication."

37. The adjudication took place on 14 May 1993, some two weeks after the events concerned. Mark Keenan was found guilty of assault. In mitigation, he told the deputy governor, Mr McCombe:

> "I suffer from a split personality disorder. I have been in and out of institutions all my life. I now have a chance to make good. My mum has booked a holiday in Cornwall. I have behaved myself."

The deputy governor said that he noted what the applicant said but that he was facing extremely serious charges. He awarded twenty-eight additional days in prison together with seven days' loss of association and exclusion from work in segregation in the punishment block. At that point, Mark Keenan had only nine days to go before his expected release. The sentence had the effect of delaying his release from 23 May until 20 June 1993 – pursuant to the applicable provisions, he had been entitled to release after half of his four-month sentence, with account also being taken of time spent in detention on remand.

38. Shortly after the adjudication, Mark Keenan was seen by the chaplain, who recalled in his evidence at the inquest that Mark Keenan had been unhappy about the decision and had said: "I was thinking of kicking off, but I don't think I will." The chaplain stated that at no stage did Mark Keenan indicate that he might take his own life.

39. At 9.45 the following morning, on 15 May 1993, Mark Keenan was seen by Dr Bickerton who recalled that he seemed calm, polite and relaxed. He was then seen by the deputy governor, Mr McCombe, who later described him as having been in a highly agitated state, but relaxing when he was informed that his right to buy tobacco had not been suspended.

40. In the afternoon Mark Keenan was visited by a friend, M.T., whom he had known for about five years. M.T., who saw Mark Keenan for some

twenty minutes, found him to be disappointed that he had an additional twenty-eight days to serve in prison, but otherwise in good spirits and, when M.T. left, as looking forward to his next visit the following Saturday. Prison officer Haley, who returned Mark Keenan to his cell following the visit, recalled that Mark Keenan was very talkative and appeared to be in high spirits.

41. Prison officer Milne, who saw Mark Keenan at or about 5.15 p.m., recalled that he seemed all right and asked if he could use the telephone at 6 p.m. Mr Milne agreed, but in the event it does not appear that Mark Keenan was allowed out of his cell to make the call. According to the evidence given later at the inquest, Mr Milne, who was on duty on landing A1 – the segregation block –, was absent in the toilet for ten minutes from about 6.25-6.30 p.m. On his way from the toilet to assist on landing A3, he noticed that the cell call indicator for landing A1 was depressed. The call buttons in each cell lit up indicators on each landing to ensure that if an officer was not present on one landing, the light could be seen by officers on other landings. There was no noise issuing from the indicator as it seemed that someone, a prisoner or prison officer, had de-activated the buzzer, access being possible to the system from each landing. Mr Milne called to another officer to accompany him and immediately went to Mark Keenan's cell and proceeded to open it. He estimated that a minute went by between seeing that the light was on and opening the cell door.

42. At 6.35 p.m. on 15 May 1993, Mark Keenan was discovered by the two prison officers hanging from the bars of his cell by a ligature fashioned out of a bed sheet. At 7.05 p.m. he was pronounced dead.

43. At some point before he committed suicide, Mark Keenan had depressed the call button in his cell. It would not have been possible for him to depress the call button whilst suspended. It was Mr Milne's evidence at the inquest that Mark Keenan must have depressed the call button during the ten minutes when he was using the staff toilets since the light on the landing, which would have indicated that the call button had been depressed, was not on when he left.

44. In an undated letter, received by Dr Roberts after 15 May 1993, Mark Keenan wrote:

> "As you will well know I am in prison for assault on [G.S.], which I received 4 months. I cannot take much more. I have seen Dr Rowe in here he wrote me up for some new tablets fenzodine white tablets like white smarties. I just went mad on them, and ended up on assault on two staff. I am asking you if you can give me treatment when I get out and get me better. I was using drugs in Bmth as well, I feel very unstable but the doctor will not help me at all. I need help please could you send the Governor a report on me, I can't take much more."

45. On 25 August 1993, at the inquest before a coroner, the jury recorded a verdict of death by misadventure and that the cause of death was asphyxiation by hanging. Evidence was submitted in public proceedings by

fourteen witnesses, six of whom gave oral testimony. The witnesses included the applicant, the prison officers on duty who had discovered Mark Keenan's body, the police inspector who had investigated the death, the deputy governor of the prison, a number of prison hospital officers and the senior prison doctor, the prison chaplain and M.T., who had visited Mark Keenan on the day he died. Statements were submitted by these persons, as well as by Dr Bickerton and Dr Bradley.

46. On 17 November 1993 the applicant was granted legal aid limited to obtaining further evidence and counsel's opinion on the merits and quantum of damages in a potential action against the Home Office in respect of the treatment of her son and the conditions of his detention.

47. In a report dated 17 August 1994, Dr Maden, the consultant forensic psychiatrist instructed by the applicant's solicitors, expressed his opinion that Mark Keenan, as a prisoner suffering from paranoid schizophrenia, was unfit to be placed in segregation in the punishment block and that the failure of the prison authorities to accommodate him in the hospital wing was an important contributory factor to his death (see paragraph 50 below).

48. In an opinion dated 14 October 1994, counsel advised in the light of the psychiatrist's report that, notwithstanding the grave breach of duty by the Prison Service in keeping Mark Keenan, a mentally ill prisoner, in a punishment cell without any proper medical monitoring, an action in negligence under the Law Reform (Miscellaneous Provisions) Act 1934 would not succeed since there was no evidence that Mark Keenan had suffered any injury of a kind in respect of which a cause of action could be maintained. He was already mentally ill and there was no indication that he suffered any worsening in his condition, or developed any new condition as a result of his confinement. Mere distress was insufficient, and the fact of his death was not such as to constitute in English law an injury in respect of which a cause of action lay. In respect of proceedings under the Fatal Accidents Act 1976, counsel advised that, since Mark Keenan was over 18 when he died, the applicant did not qualify for bereavement damages and there were no dependants who might be able to pursue a claim. To the extent that the applicant might have incurred any funeral expenses, these were not sufficient to justify the support of legal aid. The effect of this advice was to prevent the applicant from pursuing any contemplated litigation since, in the light of the advice, legal aid would be withdrawn.

49. By a letter of 12 December 1994, the applicant was informed by the Legal Aid Board that they were considering whether to discharge her legal aid certificate given counsel's opinion that she had no reasonable prospect of success. By a decision of 8 March 1995, the Legal Aid Board discharged her legal aid certificate since it was unreasonable in the circumstances that she continue to receive assistance.

B. Medical reports concerning Mark Keenan's state of health

1. Dr Maden's report of 17 August 1994

50. Dr Maden, MD, MRCPsych, a consultant forensic psychiatrist at the Bethlem Royal Hospital, prepared a report at the request of the applicant's solicitors, on the basis of materials from the inquest, Mark Keenan's prison medical record, his medical notes from North Devon District Hospital and his general practice medical record. He had had no contact with Mark Keenan before his death. His report included the following:

"*Family and personal history*

There is a family history of psychiatric disorder, in that his maternal grandmother is said to have died in a mental hospital, his mother suffered a severe depressive illness after the cot death of Mark's younger brother and his father is described as an alcoholic who was occasionally violent.

Mark Keenan['s] childhood was disturbed and unhappy. His parents separated when he was about a year old. His mother suffered from severe, intermittent depression throughout his childhood. His behaviour at school was disruptive, including fighting and truancy. He is said to have been in care at various times from the age of 12 years, and spent time in foster homes, detention centres and approved schools. His work record was poor, consisting of occasional short-term manual work. A report by Dr Adam (dated 23.3.93) states that he tended to stop jobs because of paranoid thoughts.

His disturbed behaviour continued after leaving school. He is said to have spent times in London at the age of 15 years as a rent boy and convictions included breach of the peace (age 15 y.), car theft and breaking into a jewellers (age 16 y.), convictions relating to fighting at the ages of 17 and 20 years and a conviction for G.B.H. at the age of 21 years after stabbing his sister's boyfriend.

Psychiatric history

He is said to have been diagnosed as suffering from paranoid schizophrenia when he was aged 21 years (in 1985), whilst he was serving a prison sentence for the offence of G.B.H. He had paranoid thoughts and was started on treatment with cloxipol (anti-psychotic medication).

Whilst serving his prison sentence, he is said to have spent a brief spell in Grendon Underwood prison, where he was told that his paranoid schizophrenia was too severe for him to get involved in group therapy.

In 1988, he was discharged from prison and continued clopixol until it was changed to depixol (a similar, injectable, anti-psychotic medicine) by his G.P. ...

His first admission to a psychiatric hospital was to St Annes, Poole, ... in December 1988.

From 9.11.92 until 19.11.92, he was admitted to North Devon District Hospital. He had taken an overdose, injecting himself with insulin. He was also complaining of 'paranoia'. The admission summary lists the diagnoses as 'borderline personality disorder' and 'paranoid schizophrenia'. It also notes his history of 'frequent episodes of DSB (deliberate self-harm)'. The discharge summary also noted that he was 'unable to cope living on his own'... and that he was disruptive on the ward ... It was noted that 'there did not seem to be too much evidence for his paranoia', but he was discharged

on three different types of anti-psychotic medication (including a fortnightly injection) and an anti-depressant. ...

From 16.12.92 until 18.12.92, he was admitted to North Devon District Hospital, after taking an overdose following the breakdown of his relationship with his girlfriend. The summary of this admission lists the diagnoses as 'Personality disorder. Paranoid psychosis. Suicidal threats.' Shortly after taking his own discharge, he was arrested for the assault on his former girlfriend which led to his prison sentence. ...

Opinion

1. Mark Keenan suffered from paranoid schizophrenia. He appears to have developed this illness in 1985 ... After his discharge from prison in 1988, he maintained fairly regular contact with psychiatric services and his G.P. and for most of this time, was being given an injectable anti-psychotic medication. Among the psychiatrists who saw him, there appears to be general agreement about the diagnosis of schizophrenia.

2. I note that he was also given diagnoses of personality disorder and substance abuse at various times. There is evidence to support the diagnosis of personality disorder. However, none of the psychiatrists who saw him appear to have doubted the additional diagnosis of schizophrenia and all continued his treatment with anti-psychotic medication. The significance of the diagnosis of personality disorder is that he would have been a more difficult patient to look after, than the average patient with schizophrenia.

3. Schizophrenia is a serious and long lasting mental illness that may be controlled to a greater or lesser extent by medication but is not cured by that medication. Self-harm, suicide and violence are recognised complications of schizophrenia. Many of the symptoms which Mr Keenan showed in the time leading up to his death are recognised symptoms of schizophrenia, including paranoia, hearing voices, disturbed sleep, aggression, ambivalence and thoughts of self-harm. These symptoms can have other causes but, in the case of a patient known to suffer from schizophrenia, it would be usual to assume that the symptoms were due to the schizophrenic illness. It is impossible to make any reliable distinction between symptoms which are due to schizophrenia and those which are due to an individual's personality.

4. The diagnosis of schizophrenia has important implications. The management of the condition is primarily the responsibility of doctors, as the normal prison rules cannot be expected to cope with persons whose mental state is grossly abnormal, without guidance from doctors. The following comments are therefore made with reference to what would constitute an acceptable standard of care for a person with schizophrenia.

5. From the evidence I have seen, the standard of medical record keeping was inadequate on at least two occasions. Between 19.4.93 and 26.4.93, the management plans changed from continuous observation in the prison Health Care Centre, and a decision to seek the opinion of a visiting psychiatrist (Dr Rowe), to a decision to transfer Mr Keenan to ordinary location. There is no information in the medical notes to explain this decision. On 17.4.93, Mr Keenan was stating to staff that he intended to hang himself and a noose had been found in his cell. Given this evidence of serious suicidal intent, it would be good practice to record in the medical notes the reason for discontinuing the higher level of observation and returning to normal location.

There is no entry in the medical notes for the eleven days leading up to Mr Keenan's death. Given that the entries up to this point record disturbed and unpredictable behaviour and threats to his life and threats of violence to others, there were good

reasons for monitoring his mental state regularly and there is no record to show that this was done.

6. Following the visit and assessment by Dr Rowe on 29.4.93 the evidence I have seen suggests that the standard of care received by Mr Keenan fell below that which he was entitled to expect. Dr Rowe confirmed that Mr Keenan suffered from 'mild chronic psychosis' and recommended adding a new form of anti-psychotic medication to his existing regime of anti-psychotic medication. A recommendation was also made on the same day that Mr Keenan not be allowed association until his panic/paranoia had subsided. Dr Rowe (who had previous knowledge of the patient) also noted that the patient was not usually violent.

On the next day (30.4.93), his mental state was noted to deteriorate with evidence of paranoia and aggression. The change in medication recommended by Dr Rowe was then reversed. On 1.5.93, Dr Bickerton concluded that there was no sign of mental illness and pronounced Mr Keenan fit for normal cell location in the punishment block.

With the benefit of hindsight, it is apparent that Mr Keenan was not fit to be located in the punishment block. Two things run throughout his medical notes. One is his fear of being located anywhere other than the hospital, the second is his tendency towards suicidal behaviour. I believe that the failure to accommodate him in the hospital wing was an important contributory factor to his death.

In my opinion, it is not possible to justify the reversal of the change in medication recommended by Dr Rowe, without further reference to Dr Rowe (or another psychiatrist). Dr Rowe's clear opinion was that the patient was suffering from a psychosis and that the correct treatment was a change in anti-psychotic medication. Dr Rowe's advice was not followed consistently. For example, Dr Bickerton concluded on 1.5.93 that there was no sign of mental illness, despite Dr Rowe's opinion of 29.4.93 and the evidence in the medical notes of paranoia and aggression on 30.4.93. It is most unlikely that the type of mental illness documented by Dr Rowe (described as chronic) would have disappeared completely within two days.

On the evidence I have seen, I believe that Dr Bickerton was incorrect in his judgment (that there was no mental illness present on 1.5.93) and that, as a doctor without psychiatric qualification, he should not have taken a different course of action from that recommended by the psychiatrist."

2. Dr Reveley's report of 15 February 1995

51. Dr Reveley, a second consultant psychiatrist instructed by the applicant's solicitors, expressed her opinion on the basis of the inquest proceedings and medical records, including the notes from prison and the North Devon District Hospital. She had never met or treated Mark Keenan. Her report included the following:

"*Opinion*

37. I am of the view that Mark Keenan suffered from paranoid schizophrenia, paranoid type as defined by the ICD-10 classification of Mental and Behavioural Disorders 1992. One of the essential features of this disorder is presence of delusions in the context of a relative preservation of cognitive functioning and affect. The individual suffering from this disorder is therefore generally able to describe the typical examples of hallucinations. Examples of the most common paranoid symptoms included delusions of persecution, grandiose delusions, hallucinatory voices that

threaten the patient, hallucinations of taste and smell. There is ample evidence that Mark Keenan suffered from such symptoms during his final prison sentence. Violence and self-harm are often associated with this condition, as indeed they were in the case of Mark Keenan. The Diagnostic and Statistical Manual of Mental Disorders, 4th edition 1994 draws attention to this finding: 'The persecutory themes may predispose the individual to suicidal behaviour, and the combination of persecutory and grandiose delusions with anger may predispose the individual to violence.'

38. Mark Keenan was also variously diagnosed as suffering from substance abuse and personality disorder. Neither of these diagnoses is inconsistent with paranoid schizophrenia and they often coexist with that condition. It is also clear Mark Keenan was consistently treated with anti-psychotic medication, and that the prison medical staff impliedly accepted a diagnosis of psychosis by continuing to treat with anti-psychotic medication. Indeed he specifically received a diagnosis of 'mild chronic psychosis' while in prison. Any diagnosis of psychosis is always of the utmost significance. There are three main psychiatric conditions that lead to psychosis: schizophrenia, manic depressive disorder and substance abuse (e.g. ecstasy, LSD, amphetamines, alcohol, and sometimes cannabis). It may be impossible to distinguish between the individual psychotic disorders when someone is first seen by a psychiatrist, and uncertainty about a patient's diagnosis may remain for years. But having said this, there is almost never any disagreement among psychiatrists about whether a patient is psychotic. Indeed psychotic symptoms can be successfully treated with anti-psychotic drugs even where there is some diagnostic confusion about the classification of the psychotic state. The evidence is that the prison medical staff while accepting that there was no formal diagnosis of his mental disorder, continued to treat his psychotic symptoms with anti-psychotic medication. ...

41. Mark Keenan was treated with anti-psychotic medication while in prison. On account of the medication his condition is, apparently, maintained by this medication with the exception of the isolated flare-ups. These isolated incidents are regarded by the prison doctors as discrete episodes of bad behaviour. When there is no observable episode, Mark Keenan appears to have been regarded as mentally well, or at least sufficiently well to be punished by segregation. This is in my view to adopt a dangerously over-simplified view of mental disorder. The analogy would be with someone with a fever who is given fever reducing drugs, and thereafter put outside on a cold winter's day on the principle that he is showing no signs of a temperature. In such circumstance no-one would be surprised if there were a recrudescence of the fever. In Mark Keenan's case there was a failure by the prison authorities to recognise a fundamental psychiatric truth when they found him fit for the punishment block. They were assessing the mental state of a heavily medicated individual whose underlying problems were being maintained and masked by that medication. (Despite the finding that he was sufficiently normal for the punishment block I note that there was no indication in the notes that his medication should be discontinued).

42. Because Mark is adjudged to be well, he received no nursing care on the punishment block. Nursing care is not just about the administering of medication. It is vital to the successful management of mental illness, not least because the nurse is a trained observer and can react quickly and effectively where there are indications that an individual's mental state is a cause for concern. Nursing is primarily the process of looking after physical or emotional needs of patients with the aim or restoring, improving, maintaining, or promoting well-being. The notion of punishment is incompatible with the goals of nursing – and indeed with all medical care.

43. An acceptable level of care in the management of Mark Keenan's condition during this period would have included a close monitoring of the medication as

regards dose and side effects; a close monitoring of his mental state as regards symptomatology, and as regards any increased risk of self-harm or suicide. There is no evidence that adequate monitoring of this type was performed during the last thirteen days of his life.

44. This is particularly surprising in the context of his earlier problems which included self-harm and violent outbursts and given that there had been a number of changes in the medication prescribed during the time he spent in Exeter Prison.

45. The nature of schizophrenia is such that there are remissions or periods of less florid symptomatology where the positive symptoms, i.e. those associated with a distortion of normal functioning, are not exhibited. During such periods the so-called negative symptoms may continue to be in evidence. Negative symptoms are symptoms that reflect a diminution or loss of normal functioning. They include affective flattening (immobility of feature, unresponsiveness, poor eye contact and reduced body language), alogia (poverty of speech which is often manifested by brief, laconic, empty replies, often accompanied by a diminution in the number of thoughts which is reflected in decreased fluency and productivity of speech), avolition (an inability to initiate and persist in goal-directed activities) and anhedonia (loss of interest and loss of pleasure in life). These negative symptoms account for a substantial degree of morbidity associated with the disorder. They are particularly common in the prodromal (before episode) and residual (after episode) phases of the disorder, and can often be very severe in their own right. ...

47. It is my view that Mark Keenan was recognisably at a very high risk of deliberate self-harm or suicide. This risk would have been evident even if he had not been placed on the punishment block during the last days of his life. It has been shown that, compared with the general population, people who deliberately harm themselves experience four times as many stressful life problems in the six months before the act. The events are various but a recent quarrel with a spouse, girlfriend, or boyfriend is particularly common and other events include separation from or rejection by a sexual partner, and a Court appearance. About a third to a half of all people who harm themselves are suffering from a Personality disorder. Several studies agree that there are a number of factors that seem to distinguish patients who go on to repeat deliberate self-harm. These include previous psychosis, personality disorder of the anti-social type, criminal record, alcohol or drug abuse, lower social class, and a history of unemployment. It is also significant that among patients who have been involved in an earlier episode of deliberate self-harm, the suicide rate in the subsequent 12 months is about 100 times greater than in the general population.

48. As regards the risk of completed suicide, studies show that prisoners have a higher suicide risk than the general population, and that one in ten of all those suffering from schizophrenia end their own lives, and that four fifths of all those who take their own lives are being treated with psychotropic drugs. (The above statistics are taken from the *Oxford Textbook of Psychiatry*, OUP, 1983, and are widely accepted.)

49. It is not possible to quantify precisely what the degree of risk as regards self-harm or suicide was for Mark Keenan, It is my opinion that he was recognisably in one of the very highest risk groups and that following his removal to the punishment block it was more likely than not that there would be some episode of self-harm during the period of his seclusion. This being the case, I am of the view that the failure to recognise this risk meant that his treatment during the last eleven days of his life fell substantially below acceptable standards of care. ...

51. Individuals with paranoid delusions can often be helped by psychological support, encouragement and assurance. During treatment best results are achieved if doctor/nurse maintains a good relationship with the individual, and is dependable and avoids letting the patient down. He should show compassionate interest in the individual's delusions, but without colluding in them, or condemning them, and most importantly without ignoring them. The treatment Mark Keenan received in the punishment block fell far short of this model.

52. In my view the way in which Mark Keenan, an individual suffering from paranoid schizophrenia, was treated, was likely to arouse in him feelings of hopelessness, fear, anguish, and inferiority. The circumstances of his imprisonment on the punishment block were humiliating, debasing and degrading, and had the effect of undermining his will to cope with, and battle against, his psychotic illness. His will to resist the illness was cumulatively undermined and resulted in the taking of his own life. The prison regime to which he was subjected disregarded his basic right as an ill person to be medically treated and properly cared for and thereby broke his will to endure imprisonment. The International Code of Medical Ethics declares that 'Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest'. The acts performed and the advice given by medical staff in respect of Mark Keenan's treatment were manifestly not in his interest. What he suffered during the last days of his life was likely to have been terrifying, and I use that word advisedly, in its original sense of instilling terror. I have treated many paranoid schizophrenics and I have never doubted their capacity to believe absolutely in the apparent threats created by their delusions. A punishment that requires a psychotic individual to face those threats alone and without proper medical support is wholly unacceptable, and in my view constitutes an inhuman and degrading punishment."

3. Dr Keith's report of 2 August 1996

52. In a report dated 2 August 1996, Dr Keith, the prison's senior medical officer, in response to the psychiatric reports obtained on behalf of the applicant, stated as follows:

"These reports were compiled upon the documentary evidence available to the doctors and to my knowledge neither of them had the opportunity to see or examine Mr Keenan. The medical weight of their reports must therefore be significantly diminished. These reports were prepared over a year (Dr Maden) and nearly two years (Dr Reveley) after the death of Mr Keenan.

The historical data given in both reports was compiled from other documents and originally probably would have come from Mr Keenan himself or his mother – the basis of most medical histories comes directly from the patient without ascertaining their veracity. On reception Mr Keenan gave a history of schizophrenia – no specific symptoms of schizophrenia were observed from his reception onwards during his time in custody on remand or when convicted.

From comments by Drs Maden and Reveley upon entries in the Inmate Medical Record (IMR) – I prescribed Clopixol because Mr Keenan was so adamant that he wanted it and was helped by it, and because Dr Roberts had suggested it be tried, 'if he doesn't do so well'. It was prescribed not as an anti-psychotic but as a tranquilliser on the basis of the above. My conversation with Dr Roberts and my prescribing Clopixol are in fact separate entries in the IMR and it is important to refer to the original IMR entries rather than my witness statement. I recall I was reluctant to

prescribe Clopixol because of the paucity of symptoms and signs of psychosis. As far as I can recall, Keenan gave no reason why he did not want to continue his Thioridazine except that he received no benefit from it and he was adamant that he felt better on Clopixol and Chlorpromazine. It is important to note that I do not recall that he had experienced any side effects due to Thioridazine which might have limited my prescribing Chlorpromazine. Both Drs Maden and Reveley put great weight upon his medication indicating a diagnosis – this was not the case. The dosage of Clopixol commented upon in Dr Reveley's report was indicated to me by Dr Roberts.

The symptoms noted on 3.4.93 were quite reasonably thought possibly to be due to the change in medication and Dr. Simkins indicated that he return to his previous medication. Dr Rowe attended the prison for two half-day sessions weekly at that time and was our only visiting psychiatric resource. Dr Reveley implied that because Mr Keenan was unwilling to go to the main prison on 14.4.93 he should have been kept in the hospital. Were unwillingness to leave an indication of continuing location in the hospital we would have a totally static population.

In the IMR for 17.4.93 the entry was made by a Hospital Officer not a Doctor. The Hospital Officer, SEN Gill, has no formal psychiatric training. We did not have, at that time, any psychiatrically qualified nurses. Please see my entry for 18.4.93, 'owes on the wing hence can't cope'. The reports do not refer to this. If he owed on the wing it is highly likely that he would be threatened with food contamination, this would represent reality rather than paranoia, and there is always the possibility that the noose was made so that he could return to the sanctuary of the hospital. A prepared noose is enough indication in itself for hospitalisation and 15 minute watch irrespective of mental state rather than implying a disturbed mental state in itself as described by Dr Reveley.

The entry for 23.4.93 in the IMR, "to assess next week", was cancelled by my hand probably fairly soon after it was written (most likely on 26.4.93 – same pen). The interpretation of this was that there was no indication that he needed to see Dr Rowe and that he was well and symptom-free. He was noted fit for work and gym. No contemporaneous record was made because there was nothing of import to note.

It is appropriate here to observe that while there is an agreed paucity of notes at some (and only some) stages of the IMR ... nil entries may be taken as indication that no abnormality or overt disorder was present.

On the segregation wing all prisoners are medically screened before adjudication and the range of punishments known to the doctor. The duty doctor does the round in the segregation unit before the Governor attends there so that any new inmates located there can be medically checked prior to the Governor's adjudications. *All* inmates in the segregation unit are seen *every* day by the duty doctor. If an inmate in the segregation unit becomes ill so that hospital care is indicated he is promptly transferred to the hospital. A diagnosis of a mild chronic psychosis is not a contra-indication *per se* for transferring to the segregation unit – indeed the daily visits by the Governor, Doctor and Chaplain provide a greater degree of observation and care than possible on the main wings. I do not think that Mr Keenan would have been continuously an in-patient in a psychiatric hospital were he in the community. I must agree that the segregation unit generally is not conducive to mental well-being but all prison medical staff are trained in and are highly aware of the effects of imprisonment and segregation and review each inmate on the segregation unit each day with this in mind. The duty doctor's daily visits to the segregation unit to assess Mr Keenan's medical state included judging whether his medication level was appropriate and whether he was a suicidal risk. Dr Reverley's implication that medical staff connive

with the 'authorities' to punish is totally untrue. We provide medical care and our ethical stance is concerned with this and this alone. We hold doctors' meetings regularly at which our ethical stance is clearly outlined. This is something I know we all care about passionately and is the cornerstone of the medicine all of us practise here.

I am not of the opinion that Mark Keenan suffered from paranoid schizophrenia. This is based on my own observations and Dr Roberts' doubt about his diagnosis (and he was the Psychiatrist who had observed him as an in-patient the most recently prior to his reception). We did not have a patient, 'known to suffer from schizophrenia', (Dr Maden). He was known to us via Dr Roberts' information as a patient suffering from, 'personality disorder, anti-social, under stress, some fleeting paranoid symptoms'. Keenan appeared quite normal most of the time during his periods of custody and observation.

Self-harm, suicide and violence are recognised complications of personality disorder. Only the self reported paranoia and hearing voices are symptoms of schizophrenia. There is ample evidence that Keenan's episodes of paranoia were intermittent and transitory. (Dr Roberts described, 'episodic paranoia', and Dr Reverley, 'isolated flare-ups'), linked to the taking of illicit substances. From the IMR, "says he has had cannabis which tripped him out and made him paranoid'. ...

Mr Keenan was afraid of being on ordinary location but not of being in the segregation unit. This supports a theory that he had real and not imaginary fears for his safety on the wing, especially in the light of him telling me 'he owed'. Nevertheless Mr Keenan was always admitted to the hospital when he had a 'flare-up'. Dr Reverley's analogy of mental illness and a fever is neither appropriate nor convincing.

There is no clear description of delusions, in fact their description is vague except, 'thinking he is Jesus'. I did not find any continuity of a strongly held delusional system.

It is clear from the IMR that Mr Keenan had long periods when he did not display any symptoms or signs of mental illness and he was therefore at these times mentally well. Being well there were no contra-indications to being located in the main prison or segregation unit.

It was notable that Mr Keenan did not display the signs that Dr Reveley describes for us, i.e. immobility of features, unresponsiveness, poor eye contact, reduced body language, alogia. This was further evidence to us that he did not suffer from a florid psychosis.

Overall, from the two reports prepared, I find the evidence for a florid psychosis to be slim. Dr Reveley is not a forensic psychiatrist and appears unfamiliar with prison medical care. Her comments are emotive rather than objective.

Mark Keenan was known to us as an impulsive, self-harming and aggressive man who periodically had episodes when he described paranoid feelings and vague delusional symptoms. There is no evidence to support the diagnosis of schizophrenia with which he strongly self-labelled himself. His disturbed episodes and death may well have been the sequel to drug taking in the main wing, consequent upon which were threats of reprisal."

4. Dr Faulk's report of 17 March 1996

53. Dr Faulk, instructed on behalf of the Government, stated, *inter alia*, as follows:

"*Opinion*

36. It has been asserted that by the complainant and the 2 psychiatrists (Drs Maden and Reveley) that have reviewed the case that Keenan was wrongly diagnosed, his symptoms overlooked and that he was placed in situations which would inflame his condition. Both doctors concluded that Keenan suffered from schizophrenia and that much of his behaviour could be explained by this. Having made this diagnosis they say his fears and anxieties must have been due to an underlying delusional state. This is an assumption based on the belief that Keenan was schizophrenic. On the basis of their assumption that Keenan was seriously mentally ill it is also asserted that the prison should have anticipated his suicidal tendencies and taken better precautions and not subjected him to the privation of the punishment block.

37. The prison was not staffed by consultant psychiatrists. The doctors there would very properly rely on the opinion of the NHS specialists who had been caring for their inmates before imprisonment. The diagnosis given to them by Keenan's latest psychiatric specialist (Dr Roberts) was of 'personality disorder, antisocial in type', and that Keenan was liable to 'fleeting paranoid symptoms' when under stress.

38. It is true that Dr Rowe had also treated Keenan in the past and had described him as suffering from 'a mild chronic psychosis'. This is not a specific diagnosis but a general description. In any case Dr Rowe did not consider Keenan so ill as to require treatment in psychiatric hospital. He indicated, like Dr Roberts, that Keenan would have short lived periods of psychosis (and panics) at which time he would need special care and treatment. He recommended that Keenan not be given association until recovered from his 'panic and paranoia'. This recommendation seems to have been met.

39. The staff in Exeter proceeded along the lines outlined by Dr Roberts giving the medication he recommended in the hope of reducing Keenan's symptoms e.g. his volatility, his poor response to stress and his tendency to transient psychotic periods. They also admitted Keenan to the HCC when his condition appeared to deteriorate.

40. Much of Keenan's behaviour can be understood as manipulative to escape the pressures of the ordinary wings into the relative peace of the HCC. There is no evidence that the fears he expressed about being attacked on the wings were not understandable or even reasonable ones. There is no reason, given Dr Roberts' diagnosis, not to accept Keenan's account at face value. Where there were episodes which might have been psychotic ones (e.g. when he claimed to be Jesus and hearing voices) he was taken into the HCC and appeared to recover quickly as Dr Roberts indicated he would.

41. In the end Keenan seemed to accept the regime of the punishment wing and settle down. The observations we have all support that this was so. Keenan obviously was initially angered by the punishment given out on 14.5.93 though he seemed to have overcome his anger. There was no evidence that he had become psychotic. His worries (15.5.93) about his access to the shop being stopped by the governor were perfectly understandable. It is not necessary to postulate mental illness to explain them. I conclude that the medical management of Keenan during his stay in Exeter prison was perfectly reasonable particularly given the opinion of Dr Roberts. We do not know what Keenan intended on the night of 15.5.93. The pattern was very similar

to previous life threatening attempts with a warning to others so he might be saved. Perhaps he had decided that he could not or would not face a further period on the punishment block and that he would demonstrate this by the attempt during which he would be saved and returned to the HCC. I do not think anyone could have anticipated what he did or when he did it. My only criticism would be that at the very end scissors to cut the ligature were not available on the punishment wing."

II. RELEVANT DOMESTIC LAW AND PRACTICE

A. Prison regulations

1. Health and welfare

54. Section 7 of the Prison Act 1952 required each prison to have a medical officer who, according to Rule 17 of the Prison Rules 1964 promulgated by the Secretary of State, was responsible for "the care of the health, mental and physical, of the prisoners in that prison".

55. Rule 18 provided:

"(1) The medical officer shall report to the governor on the case of any prisoner whose health is likely to be injuriously affected by continued imprisonment or any conditions of imprisonment. ...

(2) The medical officer shall pay special attention to any prisoner whose mental condition appears to require it, and make any special arrangements which appear necessary for his supervision and care.

(3) The medical officer shall inform the governor if he suspects any prisoner of having suicidal intentions, and the prisoner shall be placed under special observation."

56. Health care within prisons was also governed by Standing Order 13, which defined the responsibilities and duties of the members of a prison health care team. Paragraph 31 provided:

"The initial medical assessment of all prisoners to the health care centre on or shortly after reception into prison, or as a result of concern about their mental state, should include consideration of special arrangements needed for their supervision to prevent attempts to harm themselves or commit suicide. Where it is considered that special supervision is medically indicated the medical officer will order supervision in one of the following forms:

(a) continuous supervision, in which the prisoner is observed by a designated officer who remains constantly in his or her presence; or

(b) intermittent supervision in which the prisoner is observed by a designated officer at intervals of not more than 15 minutes."

57. The Prison Service also issued its own guidelines. At the relevant time, these were in the form of Circular Instruction 20/89 providing guidance, *inter alia*, relating to staff responsibilities, action on reception, referral and assessment during custody and preventative measures in respect of prison suicides. Circular Instruction 20/89 defined the task of the Prison Service as being

> "to take all reasonable steps to identify prisoners who are developing suicidal feelings; to treat and manage them in ways that are humane and most likely to prevent suicide; and to promote recovery from suicidal crisis".

The central element of this system was the suicide referral form (F1997). Wing managers (senior prison officers) transmitted referrals to the prison medical officer who decided whether any suicide prevention measures should be taken. Following criticism by the Chief Inspector of Prisons in his report "Suicide and Self-Harm in Prison Service Establishments in England and Wales", new guidelines were issued in 1994 – Instruction to Governors 1/1994. This required, *inter alia*, a specific Self-Harm/At Risk form (F2052SH) to be used where a prisoner was identified by any member of staff as needing special care due to the risk of suicide or self-harm. This enabled the observations of all personnel in contact with the prisoner to be recorded and was intended to provide a comprehensive and ongoing record of the prisoner's state of mind. A case review by the key personnel involved in the prisoner's care (for example, the senior medical officer, a governor grade and the senior wing officer) was to take place before the prisoner was taken off the Self-Harm/At Risk form.

58. Under sections 47 and 48 of the Mental Health Act 1983, any prisoner suffering from a serious mental illness might be transferred to a hospital for detention and treatment.

59. Rule 43 of the Prison Rules 1964, pursuant to which Mark Keenan was placed in segregation, required the prison governor to remove a prisoner from segregation in the event that a medical officer so advised on medical grounds. Rule 53(2) provided that no punishment in cellular confinement was to be imposed unless a medical officer had certified that the prisoner was in a sufficiently fit state of health.

60. There was no requirement under statute or the Rules for a prison to be staffed by a medical officer with psychiatric qualifications. The medical officer did have discretion to request a psychiatric opinion when considered appropriate (Rule 17).

61. In an article published in the *British Medical Journal* (April 2000, vol. 320, "Inpatient care of mentally ill people in prison: results of a year's programme of semistructured inspections"), the medical and nursing inspectors of Her Majesty's Inspectorate of Prisons stated, *inter alia*:

> "The quality of services for mentally ill prisoners [fall] far below the standards in the National Health Service. Patients' lives [are] unacceptably restricted and therapy limited. The present policy dividing inpatient care of mentally disordered persons between the prison service and the NHS needs reconsideration."

2. Discipline and confinement

62. Under the Prison Rules 1964, a prisoner could be confined in a prison's segregation unit or punishment block under two provisions.

63. Under Rule 43, a governor had the power to segregate a prisoner where this appeared desirable for the maintenance of good order or discipline or in his own interests. This was limited to three days, after which any extension had to be authorised by a member of the Board of Visitors or the Secretary of State.

64. Under Rule 50(1)e, the governor had the power to punish a prisoner convicted of a disciplinary offence by ordering up to fourteen days' cellular confinement in the punishment block.

65. The conditions of prisoners segregated in a prison's punishment block have been considered by the Chief Inspector of Prisons and Lord Justice Woolf, who carried out an inquiry into the prison system.

In his 1985 report "A Review of the Segregation of Prisoners under Rule 43", the Chief Inspector of Prisons commented:

> " 'Good order' inmates were held in very restricted conditions ... They were usually located in the area of the prison called the segregation unit or punishment block, alongside inmates who were there under punishment ...They were generally subjected to much the same sort of regime as the prisoners under punishment, except that they were allowed a few extra privileges. They were locked up on their own in a cell for nearly the whole day; only coming out to have an hour's exercise walking round a yard, to collect their meals, to empty their chamber pots and to have an occasional shower. These excursions perhaps helped to break the monotony but usually did not provide them with much social contact. Opportunities to talk with fellow inmates were very limited and their relationships with staff were often antagonistic or distant ... [paragraph 2.29]
>
> ... removal from association can involve the loss of various opportunities and advantages in addition to the obvious deprivation of human contact. The decision to segregate should therefore always be taken with care but especially so when the inmate concerned has not directly requested segregation. Accordingly, decisions to impose segregation on unwilling prisoners should be subject to particularly strong and effective safeguards." (paragraph 3.4)

He added that segregation "can entail living under an impoverished and monotonous regime which may even be psychologically harmful".

66. Lord Woolf, in his report "Prison Disturbances", April 1990, Cm 1456, stated:

> "While segregation under Rule 43 is not intended to be a punishment, the use of the Rule will almost invariably adversely affect the inmate who is made subject to it. In most establishments anyone segregated under Rule 43 will be subjected to regime restrictions very similar to those undergoing punishment." (paragraph 12.267)

67. Although there is no obligation on the governor or Board of Visitors to consult a doctor before initiating segregation, the governor is obliged to discontinue it if so advised by a medical officer on medical grounds (Rules 17 and 18 of the 1964 Rules).

3. Remedies available to prisoners

(a) Requests and complaints procedure

68. If a prisoner has a complaint in relation to the conditions of his imprisonment or an adjudication, he may use the "remedies and complaints" system.

69. If the complaint relates to conditions of detention and cannot be resolved informally, the prisoner may make a formal application which will be recorded and a senior member of staff will discuss the matter with the prisoner usually within two days. If the prisoner remains dissatisfied, he then completes a request/complaint form to be considered by the governor, who usually replies within seven days. The prisoner may then appeal to the Area Manager of the Prison Service.

70. A complaint about an adjudication is submitted immediately to the Area Manager.

71. In either case, if the prisoner is dissatisfied with the decision of the Area Manager he may make an application for judicial review or make a complaint to the Prison Ombudsman.

(b) Prison Ombudsman

72. Since 1994, prisoners who have exhausted the internal complaints system appeal to the Prison Ombudsman, who may make recommendations to the Prison Service if he upholds a complaint. He cannot quash or overrule a Prison Service decision.

In his annual report for 1996, the Prison Ombudsman stated, in respect of the complaints system:

> "3.6. ... the Ombudsman's service – and indeed the Prison Service's internal requests/complaints system – is working well with regard to complaints about relatively formal and non-urgent topics. Prisoners generally know the well-established procedures for dealing with grievances about disciplinary adjudications and property loss and are willing to wait while the somewhat lengthy complaint processes are worked through.
>
> 3.7. The situation is very different for most other categories of complaint. Assaults, refusal of temporary release, the imposition of closed visits ... all these are matters which prisoners want resolved immediately. They are also issues for which the request/complaints procedures may superficially appear to be inappropriate or issues which prisoners are afraid to raise with staff within the prison. Certainly, the relatively lengthy and formalised process of complaint to the governor (taking a week plus), an appeal to Headquarters (taking at least six months) and an Ombudsman's investigation (taking up to three months and sometimes more) will not commend itself to a disaffected prisoner wanting immediate redress."

(c) Judicial review

73. Case-law establishes that the High Court enjoys jurisdiction to grant judicial review of a decision either to segregate a prisoner pursuant to

Rule 43 of the Prison Rules 1964 or to punish him pursuant to Rule 50 (*R. v. Deputy Governor of Parkhurst Prison, ex parte Hague* [1992] 1 Appeal Cases 58). The court would review the matter in accordance with the well-established principles of administrative law, namely, whether the decision was perverse or irrational, whether the decision was made by reference to irrelevant factors or without regard to relevant factors, or made for an improper purpose, in a procedurally unfair manner or in a manner which breached any governing legislation or statutory instrument. However, the court of review cannot substitute its own decision on the merits of the case for that of the decision-making authority.

(d) Action for negligence, assault and misfeasance in public office

74. A prisoner able to prove that his conditions of confinement have caused him injury, physical or psychiatric, resulting from the negligence of the prison authorities may claim an award of damages. If a prisoner is assaulted, he may maintain an action for assault, even in the absence of proof of physical injury. Damages may be awarded for any indignity or humiliation suffered, while exemplary damages may be awarded where the court concludes that there has been "oppressive, arbitrary or unconstitutional action by the servants of the government" (*Rookes v. Barnard* [1964] Appeal Cases 1226).

75. An action for the tort of misfeasance in public office may also be maintained if there has been a deliberate or dishonest abuse by a public officer through the purported exercise of a power otherwise than in an honest attempt to perform the relevant function. It includes performance of an act which the official has no power to perform with the object of injuring the claimant or where he knew he had no authority to perform it and actually foresaw that it could cause harm to the claimant or an identifiable class to whom the claimant belonged. "Harm" is not limited to physical or psychiatric damage.

B. Inquest proceedings

76. Following the death of a prisoner and regardless of the cause, an inquest must be held pursuant to section 8(1)c of the Coroners Act 1988. Such inquests must be held with a jury (section 8(3)a). The coroner is the independent judicial officer charged with inquiring into deaths of various categories. His duties have been judicially defined:

> "It is the duty of the coroner as the public official responsible for the conduct of inquests, whether he is sitting with a jury or without, to ensure that the relevant facts are fully, fairly and fearlessly investigated. He is bound to recognise the acute public concern rightly aroused where deaths occur in custody. He must ensure that the relevant facts are exposed to public scrutiny, particularly if there is evidence of foul

play, abuse or inhumanity." (*R. v. North Humberside Coroner, ex parte Jamieson* [1995] Queen's Bench 1 (Court of Appeal) 26C)

77. Rule 20 of the Coroner's Rules allows the parent of a deceased person to examine witnesses at an inquest either in person or through counsel or a solicitor. There is, however, no legal aid for representation at inquests. Nor at the time of the inquest in this case was there any right to disclosure of documents.

78. Under section 11(5)b of the Coroner's Act 1988 and Rule 36 of the Coroner's Rules, proceedings and evidence at an inquest must be directed solely to ascertaining

– who the deceased was;
– where the deceased came by his death;
– when the deceased came by his death;
– how the deceased came by his death.

No verdict may, however, be framed in such a way as to appear to determine any question of the criminal liability of a named person or civil liability.

79. The scope of an inquest has been described judicially as follows:

"... It is noteworthy that the task is not to ascertain how the deceased died, which might raise general and far-reaching issues, but 'how ... the deceased came by his death', a far more limited question directed to the means by which the deceased came by his death.

... I further consider that [previous judgments] make it clear that when the Broderick Committee stated that one of the purposes of an inquest is 'to allay rumours or suspicions' this purpose should be confined to allaying rumours and suspicions of how the deceased came by his death and not to allaying rumours or suspicions about the broad circumstances in which the deceased came by his death." (Sir Thomas Bingham, MR, Court of Appeal, *R. v. the Coroner for North Humberside and Scunthorpe, ex parte Roy Jamieson*, April 1994, unreported)

"The cases establish that although the word 'how' is to be widely interpreted, it means 'by what means' rather than in what broad circumstances ... In short, the inquiry must focus on matters directly causative of death and must, indeed, be confined to those matters alone ..." (Simon Brown LJ, Court of Appeal, *R. v. Coroner for Western District of East Sussex, ex parte Homberg and Others* (1994) 158 Justice of the Peace 357)

"... it should not be forgotten that an inquest is a fact finding exercise and not a method of apportioning guilt. The procedure and rules of evidence which are suitable for one are unsuitable for the other. In an inquest it should never be forgotten that there are no parties, no indictment, there is no prosecution, there is no defence, there is no trial, simply an attempt to establish the facts. It is an inquisitorial process, a process of investigation quite unlike a trial ...

It is well recognised that a purpose of an inquest is that rumour may be allayed; But that does not mean it is the duty of the Coroner to investigate at an inquest every rumour or allegation that may be brought to his attention. It is ... his duty to discharge his statutory role – the scope of his enquiry must not be allowed to drift into the uncharted seas of rumour and allegation. He will proceed safely and properly if he investigates the *facts* which it appears are relevant to the statutory issues before him."

(Lord Lane, Court of Appeal, *R. v. South London Coroner, ex parte Thompson* (1982) 126 Solicitors' Journal 625)

C. Proceedings for injury and death caused by negligence

80. A person who suffers injury, physical or psychiatric, in consequence of the negligence of another may bring an action for damages for that injury. An exacerbation of an existing condition constitutes such injury. Upset and injury to feelings resulting from negligence in the absence of physical or psychiatric damage or exacerbation do not entitle a plaintiff to damages. Any personal-injury action maintainable by a living person survives for the benefit of his estate and may be pursued after his death.

81. Claims arising from the death of an individual caused by negligence are brought under the Fatal Accidents Act 1976 or the Law Reform (Miscellaneous Provisions) Act 1934. The former enables those who were financially dependent on the deceased to recover damages for the loss of support; the scheme is compensatory and, save for the sum of 7,500 pounds sterling for bereavement awarded to the spouse of a deceased or parent of a deceased child under 18 at the time of death, damages are awarded to reflect the loss of support. The latter enables damages to be recovered on behalf of the deceased's estate and may include any right of action vested in the deceased at the time of his death together with funeral expenses.

82. According to the case-law, the common law imposes a duty of care on prison authorities in respect of those in their custody. The prison authorities have a duty to exercise reasonable care in the prevention of injury and harm and a duty to provide medical care. This duty extends to the protection of a mentally ill prisoner against committing suicide. In *Kirkham v. the Chief Constable of Greater Manchester* [1989] 3 All England Law Reports 882, the custodial authority was held liable for failing to prevent a suicide.

In *Commissioner for the Police for the Metropolis v. Reeves* [1999] 3 Weekly Law Reports 283, concerning the claims of the deceased's spouse under the Fatal Accidents Act, the House of Lords confirmed that even in the case of a prisoner of apparently sound mind the authorities remain liable for a negligent failure to prevent his suicide, although in such a case the liability is shared with the deceased because of his voluntary act. Respect for personal autonomy did not preclude that steps be taken to "control a prisoner's environment in non-invasive ways calculated to make suicide more difficult" (p. 369A-B).

As regards the standard of care, in *Knight v. Home Office* [1990] 3 All England Law Reports 243, which concerned, *inter alia*, whether a continuous as opposed to a fifteen-minute watch should have been in place on a mentally ill prisoner at the relevant time, Pill J held that the duty to take reasonable care of such a prisoner

> "should not and does not expect the same standard across the entire spectrum of situations, including the possibility of suicide, as it would in a psychiatric hospital outside prison. The duty is tailored to the act and functions performed."

However, more recently, in *Brooks v. Home Office* (*The Times*, 18 February 1999), the High Court held in relation to the provision of ante-natal care to a pregnant woman:

> "We are concerned with a remand prisoner, a high risk pregnancy. I cannot regard *Knight* as authority for the proposition that the plaintiff should not, while detained in Holloway, be entitled to expect the same level of ante-natal care, both for herself and her unborn infants, as if she was at liberty, subject of course to the constraints of having to be escorted and, to some extent, movement being retarded by those requirements."

THE LAW

I. ALLEGED VIOLATION OF ARTICLE 2 OF THE CONVENTION

83. The applicant complained that the prison authorities, through their treatment of her son prior to his suicide, failed to protect his right to life contrary to Article 2 of the Convention. This Article provides in its first paragraph:

> "Everyone's right to life shall be protected by law. No one shall be deprived of his life intentionally save in the execution of a sentence of a court following his conviction of a crime for which this penalty is provided by law."

84. The Government rejected this assertion, while the Commission found, by fifteen votes to five, that there had been no violation of this provision.

A. The parties' submissions

85. The applicant submitted that Article 2 of the Convention required a Contracting State to take steps to safeguard the lives of those within its jurisdiction. Such protection to persons in custody should be practical and effective, involving the appropriate training and instructions to State agents who are faced with situations where the deprivation of life – including deliberate acts of self-destruction by a prisoner – may take place under their auspices and control. These authorities were under a specific duty to take reasonable care to protect prisoners from self-destructive acts and there was a heightened standard of vigilance where vulnerable persons, such as children or mentally disturbed individuals, were concerned.

86. Applying a strict scrutiny to the facts of this case, the applicant submitted that the prison authorities placed her son in a segregated

environment in circumstances that involved a significant deprivation of therapeutic care, while they knew he was subject to a real and immediate risk of self-harm. This segregation was not ordered for medical or therapeutic reasons, the prison's view of her son as a "discipline problem" prevailing over his need for appropriate care. The prison authorities were on notice that the applicant's son was mentally ill and that he had a history of self-harm and a suicidal disposition. They ought to have realised that in imposing a disciplinary punishment on him and segregating him without specialist care, observation or treatment there was at all times a real and immediate risk that he might kill himself intentionally or unintentionally. The omission to seek the available expertise of Dr Rowe before determining her son's fitness for adjudication put him at risk unreasonably and there was wholly insufficient psychiatric observation and therapeutic care after 4 May 1993.

87. The Government submitted that although Article 2 could in certain circumstances impose a positive obligation to protect a person's life from third parties, wholly different considerations apply when the risk to the person is from the individual himself. To require the State to protect a person against himself would be an approach inconsistent with the principles of individual dignity and autonomy underlying the Convention. To the extent that the prison authorities were under a domestic-law duty to take reasonable care to prevent suicide by prisoners suffering from mental illness, they stated that the obligation had been fully discharged in Mark Keenan's case.

88. The Government argued that the evidence available to the prison authorities when viewed objectively showed that there was no real and immediate risk to his life of which they knew or ought to have known. The authorities had been particularly vigilant in monitoring his condition for indications of risk and had placed him in the health care centre, or on special watch, when necessary. The doctors, experienced in dealing with disturbed inmates, saw no indication however in the final days of his life that he posed any risk at that time. Furthermore, there was no step which the prison authorities could reasonably have taken on the information available to them at the time which would have saved Mark Keenan's life. Nothing short of a continuous watch, the need for which was not apparent, would have made any difference in the circumstances.

B. The Court's assessment

89. The Court recalls that the first sentence of Article 2 § 1 enjoins the State not only to refrain from the intentional and unlawful taking of life, but also to take appropriate steps to safeguard the lives of those within its jurisdiction (see *L.C.B. v. the United Kingdom*, judgment of 9 June 1998, *Reports of judgments and decisions* 1998-III, p. 1403, § 36). This involves a

primary duty on the State to secure the right to life by putting in place effective criminal-law provisions to deter the commission of offences against the person backed up by law-enforcement machinery for the prevention, suppression and punishment of breaches of such provisions. It also extends in appropriate circumstances to a positive obligation on the authorities to take preventive operational measures to protect an individual whose life is at risk from the criminal acts of another individual (see *Osman v. the United Kingdom*, judgment of 28 October 1998, *Reports* 1998-VIII, p. 3159, § 115).

90. Bearing in mind the difficulties in policing modern societies, the unpredictability of human conduct and the operational choices which must be made in terms of priorities and resources, the scope of the positive obligation must be interpreted in a way which does not impose an impossible or disproportionate burden on the authorities. Accordingly, not every claimed risk to life can entail for the authorities a Convention requirement to take operational measures to prevent that risk from materialising. For a positive obligation to arise, it must be established that the authorities knew or ought to have known at the time of the existence of a real and immediate risk to the life of an identified individual from the criminal acts of a third party and that they failed to take measures within the scope of their powers which, judged reasonably, might have been expected to avoid that risk (see *Osman*, cited above, pp. 3159-60, § 116). In this case, the Court has to consider to what extent this applies where the risk to a person derives from self-harm.

91. In the context of prisoners, the Court has already emphasised in previous cases that persons in custody are in a vulnerable position and that the authorities are under a duty to protect them. It is incumbent on the State to account for any injuries suffered in custody, which obligation is particularly stringent where that individual dies (see, for example, *Salman v. Turkey* [GC], no. 21986/93, § 99, ECHR 2000-VII). It may be noted that this need for scrutiny is acknowledged in the domestic law of England and Wales, where inquests are automatically held concerning the deaths of persons in prison and where the domestic courts have imposed a duty of care on the prison authorities in respect of those in their custody.

92. The Government have argued that special considerations arise where a person takes his own life, due to the principles of dignity and autonomy which should prohibit any oppressive removal of a person's freedom of choice and action. The Court has recognised that restraints will inevitably be placed on the preventive measures taken by the authorities, for example in the context of police action, by the guarantees of Articles 5 and 8 of the Convention (see *Osman*, cited above, pp. 3159-60, § 116, and pp. 3162-63, § 121). The prison authorities, similarly, must discharge their duties in a manner compatible with the rights and freedoms of the individual concerned. There are general measures and precautions which will be

available to diminish the opportunities for self-harm, without infringing on personal autonomy. Whether any more stringent measures are necessary in respect of a prisoner and whether it is reasonable to apply them will depend on the circumstances of the case.

93. In the light of the above, the Court has examined whether the authorities knew or ought to have known that Mark Keenan posed a real and immediate risk of suicide and, if so, whether they did all that could reasonably have been expected of them to prevent that risk.

94. It is common ground that Mark Keenan was mentally ill. The Government, relying on the reports of Dr Keith and Dr Faulk, disputed that he was schizophrenic. The applicant, referring to the reports of Dr Maden and Dr Reveley, submitted that his history and the treatment which he was receiving plainly show that he was schizophrenic. The relevance of this difference of opinion appears to be that, as a diagnosed schizophrenic, Mark Keenan would have suffered from a condition in which the risk of committing suicide was well known and high. The Court observes that, in the material before it, there is no formal diagnosis of schizophrenia provided by a psychiatric doctor who treated Mark Keenan. The description given to the prison authorities by Dr Roberts, who had been Mark Keenan's psychiatrist in the period before his death, was that Mark Keenan suffered from a personality disorder with anti-social traits and that under stress he exhibited fleeting paranoid symptoms. Dr Rowe, who had previously treated Mark Keenan, told the prison authorities that he suffered from a mild, chronic psychosis.

95. The Court finds that the prison authorities were aware, however, that Mark Keenan's problem was chronic and involved psychosis, with intermittently recurring flare-ups. His behaviour after admittance at Exeter Prison put the authorities expressly on notice that he exhibited suicidal tendencies. This is shown by the remarks he made on 17 April and 1 May 1993 and is a significant, although not the only possible interpretation of his conduct in making the noose which was found in his cell on 16 April 1993. The Court is satisfied, therefore, that the prison authorities knew that Mark Keenan's mental state was such that he posed a potential risk to his own life.

96. Dr Keith expressed some doubt as to how genuine Mark Keenan's threats were, his opinion being that he was manipulative and possibly trying to secure his return to the hospital wing for personal reasons, namely, to avoid normal location, as he "owed" other prisoners. The Court, however, sees force in the applicant's submission that the risk posed by Mark Keenan was not only that of intentionally killing himself, but of unintentionally killing himself in an attempt to manipulate the prison authorities. The Court considers that his mental state was such that his threats had to be taken seriously and were therefore to that extent real. The immediacy of the risk varied, however. Mark Keenan's behaviour showed periods of apparent

normalcy or at least of ability to cope with the stresses facing him. It cannot be concluded that he was at immediate risk throughout the period of detention. However, the variations in his condition required that he be monitored carefully in case of sudden deterioration.

97. The question accordingly arises as to whether the prison authorities did all that could reasonably be expected of them, having regard to the nature of the risk posed by Mark Keenan.

98. The Court recalls that on 1 April 1993, on arrival at Exeter Prison, Mark Keenan was admitted to the health care centre for observation and assessment. The senior prison medical officer consulted Mark Keenan's psychiatrist about the medication to be given to treat his mental disorder. No incidents occurred until it was proposed to transfer him to normal location, when a noose was found in his cell. After one night on normal location, Mark Keenan was returned to the health care centre and was put under a fifteen-minute watch as a precaution. On 26 April 1993, after a brief attempt to place him on normal location again, he was brought back to the health care centre. Shortly afterwards, on 29 April, it was arranged for Dr Rowe to examine Mark Keenan. His medication was changed. When shortly afterwards his behaviour became aggressive, a prison doctor prescribed a return to his previous medication. When he then assaulted two prison officers on 30 April 1993, he was placed in segregation. After he made threats of suicide, he was taken back to the health care centre and put under a fifteen-minute watch. On 3 May, following an improvement in his conduct and at his own request, he returned to segregation. It is to be noted that a doctor visited him daily while he was in segregation. Between 3 and 7 May, Mark Keenan showed some disturbed conduct, refusing medication and having an episode of aggressiveness. Between that time and 15 May when he killed himself, no further incidents were recorded. After the adjudication on 14 May 1993, when he received a punishment of seven days' segregation, he showed some anxiety about access to the prison shop, but otherwise appeared to be coping. A friend who visited and a prison officer on duty that day even considered that he seemed to be in good spirits shortly before he died.

99. The Court finds that, on the whole, the authorities responded in a reasonable way to Mark Keenan's conduct, placing him in hospital care and under watch when he evinced suicidal tendencies. He was under daily medical supervision by the prison doctors, who on two occasions consulted external psychiatrists with knowledge of Mark Keenan. The prison doctors, who could have required his removal from segregation at any time, found him fit for segregation. There was no reason to alert the authorities on 15 May 1993 that he was in a disturbed state of mind rendering an attempt at suicide likely. In these circumstances, it is not apparent that the authorities omitted any step which should reasonably have been taken, such as, for example, a fifteen-minute watch. There was the unfortunate

circumstance that the alarm buzzer had been de-activated. It is regrettable that it was possible for a prisoner or prison officer to interfere with this warning mechanism. However, the visual alarm was functioning and was spotted by staff, although not immediately. It has not been suggested by the applicant that this played any material role in Mark Keenan's death.

100. The applicant argued, however, that the background events must be regarded as increasing the likelihood of her son committing suicide and that the authorities failed in their responsibilities by not properly assessing his unfitness for segregation and by imposing punishment on him. The applicant has criticised in particular the prison doctors' abilities, pointing out that none were psychiatrists and, in particular, that Dr Seale, who changed the medication ordered by Dr Rowe, had no psychiatric training at all. She also emphasised that the infliction of disciplinary punishment on Mark Keenan should have been foreseen as likely to increase the stresses on his fragile mental state and informed psychiatric opinion should have been sought.

101. The Court considers that these arguments are to some extent speculative. It is not known what made Mark Keenan commit suicide. The issues raised regarding the standard of care with which Mark Keenan was treated in the days before his death fall rather to be examined under Article 3 of the Convention.

102. The Court concludes that there has been no violation of Article 2 of the Convention in this case.

II. ALLEGED VIOLATION OF ARTICLE 3 OF THE CONVENTION

103. The applicant complained that her son was subjected to inhuman and/or degrading treatment by the prison authorities in May 1993, contrary to Article 3 of the Convention, which provides as follows:

> "No one shall be subjected to torture or to inhuman or degrading treatment or punishment."

104. The Government contested this complaint and, in its report, the Commission held, by eleven votes to nine, that there had been no violation of Article 3 of the Convention.

A. The parties' submissions

105. The applicant submitted that, while segregation of persons in detention did not in itself breach Article 3 of the Convention, the State had to examine carefully whether the personality of a prisoner and his mental vulnerability might cause otherwise justifiable treatment to bring about suffering and a breakdown of physical and mental resistance. She referred to the Court's case-law which emphasised the position of inferiority and

powerlessness of mental patients (see, for example, *Herczegfalvy v. Austria*, judgment of 24 September 1992, Series A no. 244, pp. 25-26, § 82). While some coercive measures may be justified on grounds of medical necessity, the punishment inflicted on Mark Keenan was not based on any medical decision as to the therapeutic methods necessary to preserve his physical or mental health; there were insufficient medical notes to justify it and the measure itself brought about the suicidal/self-harming behaviour. In this case, Mark Keenan was known to be responding to his unsatisfactory environment by, for example, experiencing suicidal thoughts and refusing his medication.

106. Bearing in mind the acute concern caused by the high rate of suicide in the European prison population, the applicant submitted that the provision of medical evaluations of Mark Keenan by prison doctors untrained in psychiatry did not amount to a practical and effective protection of his rights under Article 3. Furthermore, there had been wholly insufficient psychiatric observation and therapeutic care after 4 May 1993. He had been punished for behaviour occasioned by, or closely connected with, a change in medication, and the inquest did not deal sufficiently with the circumstances in which he died or the justification for his treatment by the prison authorities in the period preceding his death.

107. The Government pointed out that the applicant's claims concerning the alleged effect on Mark Keenan of the segregation was based on Dr Reveley's report. Her conclusions, however, were not supported by the evidence and were based on hindsight and a degree of speculation. While Mark Keenan was in the segregation unit, he received his medication, daily medical visits and other visits, and his condition did not deteriorate. The medical officer could have terminated segregation at any time if it had been necessary. He was declared fit by doctors for segregation on 1 and 3 May and, on 14 May, for adjudication and punishment. Even if he did suffer some feelings of hopelessness, fear, etc., it did not reach the level of severity required by Article 3; nor did it involve anything other than the usual element of humiliation inherent in any punishment. The application proceeded before the Commission on the basis that the detention caused him no injury even in the sense of exacerbating his pre-existing condition.

108. The Government emphasised that there was no contemporaneous evidence that Mark Keenan was suffering from a significant level of anguish or distress prior to his death attributable to his conditions of detention, it being impossible to distinguish the suffering resulting from his mental illness from any additional strain which might have been imposed on him due to the segregation. He was reported as being cheerful on the day of his death, there only being a moment of brief agitation which had subsided after reassurance about his right to buy tobacco. While the Government accepted that there was an obligation to provide adequate medical treatment to persons in detention, they argued that he was in receipt of such treatment

throughout his period of detention. In conclusion, Mark Keenan was not subjected to inhuman or degrading treatment contrary to Article 3 of the Convention.

B. The Court's assessment

109. The Court recalls that ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is relative: it depends on all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim (see, among other authorities, *Tekin v. Turkey*, judgment of 9 June 1998, *Reports* 1998-IV, p. 1517, § 52).

110. In considering whether a punishment or treatment is "degrading" within the meaning of Article 3, the Court will also have regard to whether its object is to humiliate and debase the person concerned and whether, as far as the consequences are concerned, it adversely affected his or her personality in a manner incompatible with Article 3 (see, for example, *Raninen v. Finland*, judgment of 16 December 1997, *Reports* 1997-VIII, pp. 2821-22, § 55). This has also been described as involving treatment such as to arouse feelings of fear, anguish and inferiority capable of humiliating or debasing the victim and possibly breaking their physical or moral resistance (see *Ireland v. the United Kingdom*, judgment of 18 January 1978, Series A no. 25, p. 66, § 167), or as driving the victim to act against his will or conscience (see, for example, the Commission's opinion in the Greek Case, Chapter IV, Yearbook 12, p. 186).

111. It is relevant in the context of the present application to recall also that the authorities are under an obligation to protect the health of persons deprived of liberty (see *Hurtado v. Switzerland*, judgment of 28 January 1994, Series A no. 280-A, opinion of the Commission, pp. 15-16, § 79). The lack of appropriate medical care may amount to treatment contrary to Article 3 (see *İlhan v. Turkey* [GC], no. 22277/93, § 87, ECHR 2000-VII). In particular, the assessment of whether the treatment or punishment concerned is incompatible with the standards of Article 3 has, in the case of mentally ill persons, to take into consideration their vulnerability and their inability, in some cases, to complain coherently or at all about how they are being affected by any particular treatment (see, for example, *Herczegfalvy*, cited above, pp. 25-26, § 82, and *Aerts v. Belgium*, judgment of 30 July 1998, *Reports* 1998-V, p. 1966, § 66).

112. The Court recalls that Mark Keenan was suffering from a chronic mental disorder, which involved psychotic episodes and feelings of paranoia. He was also diagnosed as suffering from a personality disorder. The history of his detention in Exeter Prison from 14 April 1993 disclosed episodes of disturbed behaviour when he was removed from the hospital

wing to normal location. This involved the demonstration of suicidal tendencies, possible paranoid-type fears and aggressive and violent outbursts. That he was suffering from anguish and distress during this period and up until his death cannot be disputed. His letter to his doctor, received after his death, shows a high level of desperation (see paragraph 44 above). However, as the Commission stated in its majority opinion, it is not possible to distinguish with any certainty to what extent his symptoms during this time, or indeed his death, resulted from the conditions of his detention imposed by the authorities.

113. The Court considers, however, that this difficulty is not determinative of the issue as to whether the authorities fulfilled their obligation under Article 3 to protect Mark Keenan from treatment or punishment contrary to this provision. While it is true that the severity of suffering, physical or mental, attributable to a particular measure has been a significant consideration in many of the cases decided by the Court under Article 3, there are circumstances where proof of the actual effect on the person may not be a major factor. For example, in respect of a person deprived of his liberty, recourse to physical force which has not been made strictly necessary by his own conduct diminishes human dignity and is in principle an infringement of the right set forth in Article 3 (see *Ribitsch v. Austria*, judgment of 4 December 1995, Series A no. 336, p. 26, § 38, and *Tekin*, cited above, pp. 1517-18, § 53). Similarly, treatment of a mentally ill person may be incompatible with the standards imposed by Article 3 in the protection of fundamental human dignity, even though that person may not be able, or capable of, pointing to any specific ill-effects.

114. In this case, the Court is struck by the lack of medical notes concerning Mark Keenan, who was an identifiable suicide risk and undergoing the additional stresses that could be foreseen from segregation and, later, disciplinary punishment. From 5 May to 15 May 1993, when he died, there were no entries in his medical notes. Given that there were a number of prison doctors who were involved in caring for Mark Keenan, this shows an inadequate concern to maintain full and detailed records of his mental state and undermines the effectiveness of any monitoring or supervision process. The Court does not find the explanation of Dr Keith – that an absence of notes indicates that there was nothing to record – a satisfactory answer in the light of the occurrence book entries for the same period.

115. Further, while the prison senior medical officer consulted Mark Keenan's doctor on admission and the visiting psychiatrist, who also knew Mark Keenan, had been called to see him on 29 April 1993, the Court notes that there was no subsequent reference to a psychiatrist. Even though Dr Rowe had warned on 29 April 1993 that Mark Keenan should be kept from association until his paranoid feelings had died down, the question of returning to normal location was raised with him the next day. When his

condition proceeded to deteriorate, a prison doctor, unqualified in psychiatry, reverted to Mark Keenan's previous medication without reference to the psychiatrist who had originally recommended a change. The assault on the two prison officers followed. Although Mark Keenan asked the prison doctor to point out to the governor at the adjudication that the assault occurred after a change in medication, there was no reference to a psychiatrist for advice either as to his future treatment or his fitness for adjudication and punishment.

116. The lack of effective monitoring of Mark Keenan's condition and the lack of informed psychiatric input into his assessment and treatment disclose significant defects in the medical care provided to a mentally ill person known to be a suicide risk. The belated imposition on him in those circumstances of a serious disciplinary punishment – seven days' segregation in the punishment block and an additional twenty-eight days to his sentence imposed two weeks after the event and only nine days before his expected date of release – which may well have threatened his physical and moral resistance, is not compatible with the standard of treatment required in respect of a mentally ill person. It must be regarded as constituting inhuman and degrading treatment and punishment within the meaning of Article 3 of the Convention.

Accordingly, the Court finds a violation of this provision.

III. ALLEGED VIOLATION OF ARTICLE 13 OF THE CONVENTION

117. The applicant claimed that there had been no effective remedies in respect of her complaints. She relied on Article 13 of the Convention, which reads:

> "Everyone whose rights and freedoms as set forth in [the] Convention are violated shall have an effective remedy before a national authority notwithstanding that the violation has been committed by persons acting in an official capacity."

The Government rejected the claim, while the Commission, unanimously, found a violation of this provision on the ground that the applicant had no remedy at his disposal by which to have examined the liability of the authorities in respect of her son's death and be afforded the possibility of compensation.

A. The parties' submissions

118. The applicant submitted that Article 13 required that there be a remedy which determined whether the prison authorities' positive obligation to protect her son's right to life had been complied with. There was no remedy available, however, which was effective in practice as well as law. An action by the estate of her son against the prison authorities for

negligence required proof that the deceased had suffered an injury (other than the fact of his death) or that some financial loss to the estate was caused (such as funeral expenses) or that, while he was alive, he was victim of a deliberate or malicious abuse of power. Even if it had been in theory possible for the applicant to bring an action to reclaim the funeral expenses, it was inconceivable that legal aid would be granted for that purpose.

119. She pointed out that an action in negligence for the death could only be brought by a spouse, the parent of a deceased minor (under 18) or a dependant who had suffered loss as a result of the death. No actions, therefore, could ever be brought when an unmarried person, over 18, unemployed or otherwise impecunious with no financial dependants, died in custody as a result of a breach of the State's duty of care to prisoners.

120. As regarded remedies available to Mark Keenan prior to his death, she submitted that judicial review would not have been effective as it only provided a review of issues of lawfulness, not issues of disputed fact or medical opinion. It was also inconceivable that any application would be heard within the short time frame necessary. The internal complaints procedure was also inadequate, complaint lying in the first place to the governor (53% of complaints being dealt with within seven days) and then to the Prison Headquarters, which had a time-limit of six weeks for replying. It was unreasonable and unrealistic, therefore, to suggest that Mark Keenan could have availed himself of the available procedures prior to his death, due to the ineffectiveness of the procedural safeguards concerned and his own mental state.

121. The Government contended that during his detention Mark Keenan had available to him the remedies of judicial review and the right of redress through the prison complaints procedure. Judicial review had been found by the Court previously to furnish an effective remedy, cases alleging the infringement of human rights being approached by the domestic courts with "anxious scrutiny". The Court had also found that the right to petition the Home Secretary was an effective remedy in *Silver and Others v. the United Kingdom* (judgment of 25 March 1983, Series A no. 61, p. 43, § 116). The request/complaints procedure was a more sophisticated mode of redress, which was also effective for the purposes of Article 13, which covered procedures other than judicial ones. Mark Keenan also had available to him the possibility of an action in tort for damages for negligence where prison conditions caused him to suffer physical or psychiatric injury, or the exacerbation of an existing condition (which cause of action vested in his estate after his death), and an action for assault or misfeasance in the exercise of a public office.

122. As regarded the remedies available to the applicant, the Government agreed that the inquest, which did not permit the determination of issues of liability, did not furnish the applicant with the possibility of establishing the responsibility of the prison authorities or obtaining

damages. However, the estate could commence actions relating to any injury or aggravation of Mark Keenan's mental illness suffered by him prior to his death. They disputed the Commission's conclusion that the applicant did not have a remedy which would have effectively examined the failure to prevent her son committing suicide. If the prison authorities had culpably failed to prevent his death or if his conditions of detention had caused his death, an action would have lain in negligence. With regard to the Commission's conclusion that there was no remedy to examine liability for causing her son suffering before his death, they disputed that there was any suffering caused by the conditions of his detention. Mark Keenan was in good spirits prior to his suicide. They acknowledged that the law of negligence did not award damages for distress which did not result from a physical injury or did not amount to psychiatric damage.

B. The Court's assessment

123. The Court reiterates that Article 13 of the Convention guarantees the availability at the national level of a remedy to enforce the substance of the Convention rights and freedoms in whatever form they might happen to be secured in the domestic legal order. The effect of Article 13 is thus to require the provision of a domestic remedy to deal with the substance of an "arguable complaint" under the Convention and to grant appropriate relief, although Contracting States are afforded some discretion as to the manner in which they conform to their Convention obligations under this provision. The scope of the obligation under Article 13 varies depending on the nature of the applicant's complaint under the Convention. Nevertheless, the remedy required by Article 13 must be "effective" in practice as well as in law. In particular, its exercise must not be unjustifiably hindered by the acts or omissions of the authorities of the respondent State (see *Aksoy v. Turkey*, judgment of 18 December 1996, *Reports* 1996-VI, p. 2286, § 95; *Aydın v. Turkey*, judgment of 25 September 1997, *Reports* 1997-VI, pp. 1895-96, § 103; and *Kaya v. Turkey*, judgment of 19 February 1998, *Reports* 1998-I, pp. 329-30, § 106).

Given the fundamental importance of the right to the protection of life, Article 13 requires, in addition to the payment of compensation where appropriate, a thorough and effective investigation capable of leading to the identification and punishment of those responsible for the deprivation of life, including effective access for the complainant to the investigation procedure (see *Kaya*, cited above, pp. 330-31, § 107).

124. On the basis of the evidence adduced in the present case, the Court has found that the respondent State is responsible under Article 3 of the Convention for inflicting inhuman and degrading treatment and punishment on Mark Keenan, who was mentally ill, prior to his death in custody. The applicant's complaints in this regard are therefore "arguable" for the

purposes of Article 13 in connection with both Articles 2 and 3 of the Convention (see *Boyle and Rice v. the United Kingdom*, judgment of 27 April 1988, Series A no. 131, p. 23, § 52; *Kaya*, cited above, pp. 330-31, § 107; and *Yaşa v. Turkey*, judgment of 2 September 1998, *Reports* 1998-VI, p. 2442, § 113).

125. The Court observes that two issues arise under Article 13 of the Convention: whether Mark Keenan himself had available to him a remedy in respect of the punishment inflicted on him and whether, after his suicide, the applicant, either on her own behalf or as the representative of her son's estate, had a remedy available to her.

126. Concerning Mark Keenan himself, the Court observes that the punishment of further imprisonment and segregation was imposed on him on 14 May 1993 and that he committed suicide on the evening of 15 May 1993. The Commission found that the respondent State could not be liable for failing to provide a remedy which would have been available to him within a period of twenty-four hours. It is, however, the case that no remedy at all was available to Mark Keenan which would have offered him the prospect of challenging the punishment imposed within the seven-day segregation period or even within the period of twenty-eight days' additional imprisonment. Even assuming judicial review would have provided a means of challenging the governor's adjudication, it would not have been possible for Mark Keenan to obtain legal aid, legal representation and lodge an application within such a short time. Similarly, the internal avenue of complaint against adjudication to the Prison Headquarters took an estimated six weeks. The Court notes the Prison Ombudsman's finding that there was no expeditious avenue of complaint for prisoners who required speedy redress (see paragraph 72 above).

127. If it was the case, as has been suggested, that Mark Keenan was not in a fit mental state to make use of any available remedy, this would point not to the absence of any need for recourse but, on the contrary, to the need for the automatic review of an adjudication such as the present one. The Court, moreover, is not persuaded that effective recourse against the adjudication would not have influenced the course of events. Mark Keenan had been punished in circumstances disclosing a breach of Article 3 of the Convention and he had the right, under Article 13 of the Convention, to a remedy which would have quashed that punishment before it had either been executed or come to an end. There has therefore been a breach of Article 13 in this respect.

128. Turning to the remedies available after Mark Keenan's death, it is common ground that the inquest, however useful a forum for establishing the facts surrounding Mark Keenan's death, did not provide a remedy for determining the liability of the authorities for any alleged ill-treatment or for providing compensation.

129. The Government have submitted that the applicant could have pursued an action in negligence, either on behalf of her son's estate, claiming that he had suffered injury before his death or (if he had left dependants) in respect of his death under the Fatal Accidents Act provisions. These would, they stated, have provided a determination of liability and damages. The Court is not persuaded, however, that a finding of negligence by the courts by itself would be capable of furnishing effective redress for the applicant's complaints. To the extent that Mark Keenan inflicted harm on himself before the moment of his death, he can be said to have suffered physical damage. Although the Court accepts the Government's submission to this effect, it does not accept (and the Government do not assert) that adequate damages would have been recoverable or that legal aid would have been available to pursue them. Nor is it established that Mark Keenan suffered any psychiatric injury from his treatment before his death. The medical reports referred to anguish, fear and hopelessness, even terror. There is no evidence that this would be regarded as "injury" in the sense recognised by domestic law and the Government accepted that anguish and fear are not covered. Furthermore, the applicant, as the mother of an adult child and a non-dependant, is unable to claim damages under the Fatal Accidents Act on her own behalf.

130. The question arises whether Article 13 in this context requires that compensation be made available. The Court itself will in appropriate cases award just satisfaction, recognising pain, stress, anxiety and frustration as rendering appropriate compensation for non-pecuniary damage. The Court considers that, in the case of a breach of Articles 2 and 3 of the Convention, which rank as the most fundamental provisions of the Convention, compensation for the non-pecuniary damage flowing from the breach should in principle be available as part of the range of possible remedies.

131. In this case, the Court concludes that the applicant should have been able to apply for compensation for her non-pecuniary damage and that suffered by her son before his death.

132. Moreover, despite the aggregate of remedies referred to by the Government, no effective remedy was available to the applicant in the circumstances of the present case which would have established where responsibility lay for the death of Mark Keenan. In the Court's view, this is an essential element of a remedy under Article 13 for a bereaved parent.

133. Accordingly, there has been a breach of Article 13 of the Convention.

IV. APPLICATION OF ARTICLE 41 OF THE CONVENTION

134. Article 41 of the Convention provides:

> "If the Court finds that there has been a violation of the Convention or the Protocols thereto, and if the internal law of the High Contracting Party concerned allows only

partial reparation to be made, the Court shall, if necessary, afford just satisfaction to the injured party."

A. Damage

135. The applicant claimed compensation for non-pecuniary damage in respect of her son's inhuman and degrading treatment in prison, relying on Dr Reveley's opinion (see paragraph 51 above). She also claimed an appropriate award for her own grief, emotional loss, distress and bereavement, referring to the shattering effect of losing her only son.

136. The Government submitted that a finding of a violation would in itself constitute just satisfaction for a breach of all or any of the Articles under which complaint is made. However, if the Court was minded to award compensation, they considered that a sum of around 10,000 pounds sterling (GBP) would be appropriate.

137. The Court recalls that it has found above that the infliction of punishment on Mark Keenan in the circumstances of the case was inhuman and degrading, contrary to Article 3. It found that the prison authorities' conduct did not infringe Article 2 of the Convention, that is to say, that the respondent State could not be held responsible for Mark Keenan's death. It also found a violation of Article 13 in respect of the lack of remedies available to Mark Keenan to challenge the adjudication or to the applicant in respect of proceedings after his death.

138. The Court finds that Mark Keenan must be regarded as having suffered significant stress, anxiety and feelings of insecurity resulting from the disciplinary punishment prior to his death. The applicant, his mother, must also be regarded as having suffered anguish and distress from the circumstances of his detention and her inability to pursue an effective avenue of redress. Making an assessment on an equitable basis and bearing in mind that this was a case of suicide and not deliberate torture, the Court awards for non-pecuniary damage the sum of GBP 7,000 in respect of Mark Keenan to be held by the applicant for his estate, and GBP 3,000 to the applicant in her personal capacity.

B. Costs and expenses

139. The applicant claimed costs of GBP 4,929.59 for the proceedings in the domestic courts and GBP 32,566.84 for the proceedings before the Convention organs, both sums inclusive of value-added tax (VAT).

140. The Government submitted that the sums claimed were excessive, in particular the disbursements of GBP 19,000 in respect of counsel's fees. Whatever award made should also be apportioned to reflect any findings of non-violation. They proposed that the sum of GBP 15,000, inclusive of VAT, would be a reasonable figure.

141. The Court observes that the applicant has been successful in establishing a breach of Articles 3 and 13 of the Convention. It finds force in the Government's criticisms of the amounts claimed by way of counsel's fees, which included a sum of GBP 8,250 for the submission of the memorial to the Court. Making an assessment on an equitable basis and having regard to awards made in other cases, the Court awards the sum of GBP 21,000, inclusive of VAT.

C. Default interest

142. According to the information available to the Court, the statutory rate of interest applicable in the United Kingdom at the date of adoption of the present judgment is 7.5% per annum.

FOR THESE REASONS, THE COURT

1. *Holds* unanimously that there has been no violation of Article 2 of the Convention;

2. *Holds* by five votes to two that there has been a violation of Article 3 of the Convention;

3. *Holds* unanimously that there has been a violation of Article 13 of the Convention;

4. *Holds* unanimously
   (a) that the respondent State is to pay the applicant, within three months, the following amounts:
      (i) in respect of non-pecuniary damage, GBP 10,000 (ten thousand pounds sterling);
      (ii) for costs and expenses, GBP 21,000 (twenty-one thousand pounds sterling), inclusive of VAT;
   (b) that simple interest at an annual rate of 7.5% shall be payable from the expiry of the above-mentioned three months until settlement;

5. *Dismisses* unanimously the remainder of the applicant's claims for just satisfaction.

Done in English, and notified in writing on 3 April 2001, pursuant to Rule 77 §§ 2 and 3 of the Rules of Court.

S. DOLLÉ
Registrar

J.-P. COSTA
President

In accordance with Article 45 § 2 of the Convention and Rule 74 § 2 of the Rules of Court, the following separate opinions are annexed to this judgment:

(a) concurring opinion of Mr Costa;
(b) concurring opinion of Sir Stephen Sedley;
(c) joint partly dissenting opinion of Mr Fuhrmann and Mr Kūris.

J.-P.C.
S.D.

CONCURRING OPINION OF JUDGE COSTA

(Translation)

I voted with the majority of the Court in favour of finding that the respondent State had not violated Article 2 of the Convention, but had violated Article 3.

I would like to clarify how, in my mind and in the present case, these two Articles fit together and why I do not perceive any contradiction between the two findings.

One seemingly paradoxical, but – to my mind – simple and logical, way of arriving at the conclusions of the judgment would be to reverse the order of the points in the operative provisions and the paragraphs of the judgment which provide the supporting reasons.

Admittedly, it may seem natural to begin, as does the judgment, with the right to life and to continue with the inhuman and degrading punishment and treatment. In the circumstances of the present case, however, I find it more appropriate to do the opposite. I have scarcely any doubt as far as Article 3 is concerned. Five days before being imprisoned, Mark Keenan, who had been treated in hospital, had been diagnosed as presenting a personality disorder, paranoid psychosis and suicide threats. After being released on bail, then re-imprisoned some four months later to serve a four-month prison sentence, the young man, whose state of health was known to the prison's senior medical officer (who had consulted the psychiatrist who had been treating him), manifested very serious disorders. Fifteen days after he had been imprisoned, he threatened to hang himself and a noose fashioned from a bed sheet was found in his cell. Two weeks later he attacked two hospital officers. A prison doctor, who had had only six months' training in psychiatry, certified him fit for adjudication in respect of the assault and, in the meantime, fit for placement in the segregation unit within the prison's punishment block, a measure which was taken the same day by the prison's deputy governor. Mark Keenan then threatened to commit suicide, claimed to be hearing voices and to think he was Jesus Christ. He nonetheless remained in the segregation unit from 3 to 15 May. On 14 May the deputy governor ordered him to serve twenty-eight additional days in prison for having attacked the hospital officers (it should be noted that, on that date, he had only nine days left before his expected release date). It was on the following day that he hanged himself with a ligature fashioned from a bed sheet.

In my opinion, and however delicate the assessment which the prison authorities had to make, the confinement of the applicant and the sentence to a further four weeks in prison when he had only days left before the expected date of his release constituted treatment and punishment contrary

to Article 3, having regard to Keenan's personality. In that connection, I find a comparison with *Kudła v. Poland* ([GC], no. 30210/96, ECHR 2000-XI), in which the Court did not find a violation of Article 3, very illuminating.

However, I would, personally, have reached the same conclusion if the young man had attempted to kill himself without success or if he had manifested his desperation in other ways, such as injuring himself, as – alas – sometimes happens. In other words, it is not, in my view, Keenan's death which revealed the inhuman nature of what he had endured. The two things are distinct.

It is precisely for that reason that I have no difficulty, even though a death occurred, in concluding that there has not been a violation of Article 2. The positive obligation on the States to take appropriate steps to protect life, particularly in respect of someone placed under the supervision of the prison authorities, does not appear to me to have been violated in the present case. Mark Keenan was regularly monitored and was given medical treatment in prison. He was also put on "fifteen-minute watches" (16 April, 30 April, 1 May). The risk that he might commit suicide was known and was taken seriously. His severely deranged and fragile personality made him a suicide risk, but also meant that he was unpredictable, and it was impossible to keep him under observation twenty-four hours a day. In short, I do not think that his right to life was violated by the respondent State, even negligently.

In sum, I do not therefore disagree with the operative provisions of the judgment, but I do think that the reasoning which was followed has the disadvantage of suggesting that Article 3 is in some way a substitute for Article 2 and that it is because the Court did not find that there had been a violation of that Article that it fell back on Article 3. I think, on the contrary, that the two Articles are autonomous and that, in other scenarios, the opposite finding could be arrived at, that is, a violation of Article 2 but not of Article 3. There is thus no logical hierarchy between them. Admittedly, the practice is to follow the order of the Convention itself and to examine first the complaint based on Article 2. That approach is not obligatory, however, and the present case seems to me to illustrate that.

CONCURRING OPINION OF JUDGE Sir Stephen SEDLEY

Article 2

1. With some hesitation I have joined with the other members of the Court in finding no breach of Article 2. The essential basis of the majority's finding of a breach of Article 3 and of the unanimous finding of a breach of Article 13 is, after all, that a disturbed prisoner, known to be a suicide risk but now approaching the end of his short sentence, was administratively sentenced for a violent breach of discipline to a further substantial spell of imprisonment, the first part in punitive isolation, without the possibility of appeal or review. It is understandable that these facts were regarded by the dissenting members of the Commission as indicative of a breach of Article 2. Mr Rozakis, for example, wrote:

> "... the authorities, while they knew about the suicidal tendencies of Mark Keenan, and [while] they had in their hands reasonable means to avert the fatal incident, opted for a policy which contributed to rather than avoided his taking of his life."

2. Article 2 contains not a general assertion of the right to life but a specific obligation of Signatory States to protect that right by law. This is why the facts which have led the Court to find a breach of Article 3 might no less aptly have been regarded as demonstrating a breach of Article 2. Nevertheless, in the light of the view of the other members of the Court that a causal link is not sufficiently made out, I have not dissented.

Article 3

3. For the same reasons, I have had doubts about the finding of a violation of Article 3. At the date of the present judgment the Court is still considering in other proceedings the compatibility with Articles 5 and 6 of a system which allows a State official to impose an unappealable penalty of loss of liberty upon a prisoner. Taking the disciplinary system, therefore, to be proper, I can see force in the view that so long as disturbed offenders remain in the general prison population they cannot be exempted from its provisions, provided the prison doctor certifies them fit for punishment.

4. Moreover, unlike most breaches of Article 2, a breach of Article 3 requires no fatality. Yet, if Mark Keenan had not killed himself, it is not easy to see what his case would have been under Article 3. As the Court has more than once said, all punishment is to an extent degrading. Moreover, as is confirmed by the pattern of voting in the present case, violation of Article 13 does not require an established, but only an arguable, breach of a substantive Convention right. In the end, however, I have cast my vote in favour of a finding of a breach of Article 3 because it is evident from the

fatal outcome that the stress of the punishment on this disturbed offender was greater than it ought to have been made to bear. In the light of the inadequate monitoring of his condition, the combination of the infliction and the timing of this punishment can properly be characterised as inhuman.

5. This conclusion, it should be noted, is not dependent on a consequential death. That the same or not very different findings might have answered the question of causation under Article 2 and have been characterised as a failure of the law to protect Mark Keenan's right to life needs perhaps to be borne in mind by those with responsibility in this area of public administration.

Article 13

6. Although money is sometimes the only form in which redress for an injustice can be given, it does not follow that the requirement of Article 13 for an effective remedy will necessarily be satisfied by a payment of damages. The present case, in my opinion, demonstrates in at least two important respects that an effective remedy may lie elsewhere.

Mark Keenan

7. It is because of the want of recourse for a mentally disturbed prisoner against a punitive award of extra days that there was a breach of Article 13 in relation to the deceased. He had no effective remedy against a punishment which arguably violated his rights under Articles 2 and 3 (we do not yet know whether Articles 5 or 6 were also violated). It is plain from the report of the senior prison medical officer at HMP Exeter, Dr Keith, (on which most of my own conclusions in this case are based) that Mark Keenan's condition and behaviour are by no means exceptional. Other cases will differ in degree but not necessarily in kind. It will be for the United Kingdom government to decide to what extent the logic of the Court's decision calls either for automatic review or for a right of immediate appeal in relation to awards of additional days to prisoners of particular kinds or prisoners generally.

Susan Keenan

8. As to the question of a remedy – the word is hardly appropriate – for Mark Keenan's death, I do not believe that a claim in domestic law by his mother for a sum of money could be regarded without more as an effective remedy, and I do not suppose that she so regards it. What is necessary in such a case as this, as the Court has several times stressed, is a proper and effective inquiry into responsibility for the death. This can, it is true, take the form of an action for damages if the allocation of liability is a

prerequisite of an award. Here, however, the Court has concluded (and the amount of the Government's own contingent offer of just satisfaction confirms) that the paucity of the damages available to a non-dependent parent such as the applicant in her capacity as administratrix of her son's estate makes her cause of action an ineffective remedy – not in the sense that more money would make it an effective remedy but in the sense that it is too little to be worth pursuing. Indeed the decisions of the Court of Appeal and the House of Lords in *Hicks v. Chief Constable of South Yorkshire* [1992] 1 All England Law Reports 690, 2 All England Law Reports 65, that crush injuries leading to death within moments do not sound in damages, makes it extremely unlikely that any damages at all would be awarded for a brief period of suffering before a violent death; and if any damages were awarded, they would be at most a few hundred pounds.

9. What could, however, afford an effective remedy for death of the present kind is an inquest with procedures which assure the rights and interests of persons such as the applicant and with power to determine responsibility where this is possible. It is common ground that the English inquest in its modern form does not afford these things. This is not because the Coroners' Act 1988 forbids it: on the contrary, by section 11(5)(b)(ii) it requires a finding to be made as to how the deceased came by his death, a provision plainly capable of including an allocation of responsibility in a proper case. It is because Rule 42 of the Coroners' Rules 1984, made in the exercise of delegated powers by the Lord Chancellor, forbids the framing of the verdict in such a way as to appear to determine civil liability or a named person's criminal responsibility.

10. It is not for this Court to determine how the United Kingdom is to secure compliance with Article 13 following a prison suicide. But it may be observed that the patriation of the Convention by the Human Rights Act 1998 has not brought the issue, as it brings other issues, within the processes now available to the national courts for securing compliance with the Convention, because Article 13 has not been included in the Convention rights scheduled to the Act. As a result, the requirement of section 3 of the Act that all legislation is so far as possible to be read and given effect in a way which is compatible with the scheduled Convention rights does not give the courts any mandate to interpret the word "how" in section 11 of the Coroners' Act 1988 in a way compatible with Article 13. It must therefore be for the Government rather than the courts in this instance to decide how to make good the applicant's lack of an effective remedy for the suicide in custody of her son.

JOINT PARTLY DISSENTING OPINION OF JUDGES FUHRMANN AND KŪRIS

The majority of the Chamber has concluded that there has been a violation of Article 3 of the Convention as regards the allegations of the applicant that her son was subjected to inhuman and/or degrading treatment by the prison authorities in May 1993. We regret that we are unable to share this opinion.

1. It is considered by the majority of the Chamber that the imposition of a serious disciplinary punishment on Mark Keenan by the prison authorities was not compatible with the standard of treatment required in respect of a mentally ill person and must therefore be regarded as constituting inhuman and degrading treatment and punishment within the meaning of Article 3 of the Convention. In the opinion of the majority, there had been a defective monitoring of his condition and a lack of informed psychiatric input into his assessment and treatment which disclosed significant defects in the medical care provided to a mentally ill person known to be a suicide risk.

2. As correctly recalled in paragraph 109 of the judgment, ill-treatment must attain a minimum level of severity if it is to fall within the scope of Article 3. The assessment of this minimum is relative: it depends on all the circumstances of the case, such as the duration of the treatment, its physical and/or mental effects and, in some cases, the sex, age and state of health of the victim.

The State must ensure that a person is detained in conditions which are compatible with respect for his human dignity, that the manner and method of the execution of the measure do not subject him to distress or hardship of an intensity exceeding the unavoidable level of suffering inherent in detention and that, given the practical demands of imprisonment, his health and well-being are adequately secured by, among other things, providing him with the requisite medical assistance (see *Kudła v. Poland* [GC], no. 30210/96, §§ 94 et seq., ECHR 2000-XI).

The decisive point is whether there were physical or mental indications which rendered or should have rendered the prison authorities aware that there was a risk of any acute or severe suffering as a result of the measure (see *Bollan v. the United Kingdom* (dec.), no. 42117/98, ECHR 2000-V).

3. We share the opinion of the majority of the Commission that there is no contemporaneous evidence that prior to his death Mark Keenan was suffering from a significant level of anguish or distress attributable to his conditions of detention.

It has to be noted that on the same day on which he committed suicide, at about 6.25 p.m., he was visited in the morning by Dr Bickerton, who found him calm, polite and relaxed, then by the deputy governor, Mr McCombe, with whom he only had a discussion about the right to buy tobacco and who

left him relaxed. Last but not least, in the afternoon of the same day he was visited by an old friend who saw him for some twenty minutes and found him in good spirits, save for a disappointment concerning the fact that he had an additional twenty-eight days to serve in prison. This visitor left him looking forward to his next visit the following Saturday and, in the recollection of the prison officer who returned Mark Keenan to his cell after the visit, Mark Keenan appeared to be in high spirits and was very talkative.

Under these circumstances, we cannot but conclude that the prison authorities had no realistic prospect of perceiving that Mark Keenan was at risk of committing suicide and that the prison authorities did all that could reasonably be expected of them. This finding led by the way to the reasoning, also used by the Chamber in its unanimous conclusion, that there had been no violation of Article 2 of the Convention in this case.

The same arguments militate in our opinion also in favour of finding that there has been no violation of Article 3 and, like the majority of the Commission, we cannot find a sufficient basis for drawing conclusions, to the requisite standard of proof beyond reasonable doubt, that the segregation of Mark Keenan constituted treatment of the severity prohibited by Article 3 of the Convention.