DEATH ROW PHENOMENON, DEATH ROW SYNDROME AND THEIR AFFECT ON CAPITAL CASES IN THE US

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ABSTRACT

In relation to the use of solitary confinement with death row inmates, death row phenomenon and death row syndrome are two concepts which are slowly gaining ground in international circles. Death row phenomenon is used to describe the harmful effects of death row conditions, including exposure to extended periods of solitary confinement and the mental anxiety that prisoners experience whilst waiting for their death, whilst death row syndrome is used to describe the consequential psychological illness that can occur as a result of death row phenomenon. This article looks at the meaning of these two concepts, the ways in which they have begun to enter into judicial opinion and questions the potential effect they may have on the legality of capital sentences. The article also briefly considers the legitimacy of these concepts as medical conditions and assesses whether they are instead another example of the medicalization of morals.

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Introduction

The death penalty, the sentence of death for a person convicted of a capital offence, is currently used in 58 countries around the world, with the United States of America (US) being one of these nations (http://www.amnesty.org/en/death-penalty/abolitionist-and-retentionist-countries, last accessed 27 October 2010). Due to its federal system of governance, it is left to each US state to decide whether or not to use capital punishment and currently, 37 states, the Federal Government, and the US Military reserve the right to sentence offenders to death. The death penalty was first used in the US in 1608, when Captain George Kendall was hanged in the Jamestown colony of Virginia, and since that time thousands of people have been hanged, electrocuted, shot, gassed and lethally injected (Espy and Smykla, 2004). Texas is renowned for being the most active death penalty state, having executed 439 people since the punishment was re-introduced in 1976. In 2009, California had the largest number of death row inmates awaiting execution (690) (http://www.deathpenaltyinfo.org/death-row-inmates-state-and-size-death-row-year, last accessed 27 October 2010).

Arguments for and against the death penalty are as old as the sentence itself and will not be rehearsed here. Instead, this article looks at the concepts of death row phenomenon and death row syndrome. Whilst these are only beginning to emerge, this article looks at their meaning, the ways in which they have begun to enter into judicial opinion and begins to question the potential effect they may have on the legality of capital sentences. Whilst a death row inmate held in the US is used as a case study to aid with this endeavour, there is no reason why the argument, to the extent that it can be proven, cannot be applied to all countries that currently house death row prisoners.

Defining Death Row Phenomenon and Death Row Syndrome

Defining the concepts of death row phenomenon and death row syndrome is difficult, especially because there is some contention as to whether the conditions they refer to actually exist. On the basis that they are legitimate, death row syndrome is currently being used in the US to describe the consequential psychological illness that can occur as a result of death row phenomenon; with death row phenomenon being the harmful effects of the conditions experienced on death row, including solitary confinement and the mental anxiety that prisoners experience whilst waiting for their death sentence to be imposed. Although the two terms sound similar, and indeed are often used interchangeably, death row phenomenon refers specifically to conditions such as solitary confinement, whilst waiting for death, whereas death row syndrome describes the:

> resulting psychological harms of that experience, or the set of psychological effects for inmates that can result from extended periods of time spent on death row, in harsh conditions, coupled with the unique stresses of living under [a] sentence of death (Smith, 2008:242).

Whilst some psychiatrists and academics in the fields of sociology and psychology (for e.g. Bluestone and McGahee, 1962; West, 1975; Johnson, 1979) note the existence of death row syndrome, it is not currently recognised as being a mental health disorder by the American Psychiatric Association (APA) in its Diagnostic and Statistical Manual of Mental Disorders. Whilst this does not aid with establishing the existence of the concepts, perhaps this is to be

expected, especially as in the past many medical terms, for example psychopathy (see Johnstone, 1996), have been initially contested and then have later gained at least partial acceptance in medical arenas. Such denial by the APA however leaves death row phenomenon and death row syndrome with an ambiguous status: with neither being clinical terms and as will be discussed below only just emerging as legal terms; although this claim is arguably contentious as well.

Defining death row phenomenon and death row syndrome is, therefore, far from easy, although the case of *Soering v. UK* ((1989) 11 E.H.R.R. 439, detailed below) does aid in establishing a general definition, with it being argued that it is this case where the two concepts originate from (http://www.deathpenaltyinfo.org/time-death-row, last accessed 5 February 2010). A basic understanding of death row phenomenon, therefore, is that it is the combination of circumstances to which a prisoner would be exposed to if held in solitary confinement on death row. These circumstances can be separated into three further categories: the harsh, dehumanizing conditions of imprisonment itself; the sheer length of time spent living under such conditions; and the psychological repercussions associated with a death sentence. Smith (2008) refers to these essential components as the 'temporal component', the 'physical component' and the 'experiential component' (240). It is worth noting that the temporal and the physical, taken individually are generally deemed insufficient to give rise to death row phenomenon, as such conditions are arguably also experienced by non-capital prisoners. Indeed solitary confinement is commonly used in 'supermax' (super-maximum-security) prisons for non-capital offenders throughout the US and additionally can be used for extended periods of time (King, 1999). It is thus the experiential component that makes a death sentence unique. The important elements of death row phenomenon would therefore appear to be the experience of solitary confinement in conjunction with other experienced conditions particularly specific to death row inmates. These two aspects will therefore be looked at in more detail in an attempt to enhance our understanding of what death row phenomenon and death row syndrome are.

2.1 The Effects of Solitary Confinement

The Istanbul Statement on the use and effects of solitary confinement (available at http://solitaryconfinement.org/istanbul, last accessed 4 February 2010) defines solitary confinement as 'the physical isolation of individuals who are confined to their cells for twenty-two to twenty-four hours a day' and it is this meaning which will be adopted for the purposes of this article. The use of solitary confinement with offenders in the US is not new, with it being used in the early 1820s in Auburn Prison, New York and from 1829 in Eastern State Penitentiary, Philadelphia, with it being known for some time that containment in solitary conditions can lead to grave psychological harm. Indeed, the findings of one US Supreme Court Justice, exemplify the extremity of living under such conditions:

> A considerable number of the prisoners fell, after even a short confinement, into a semi-fatuous condition, from which it was next to impossible to arouse them, and others became violently insane; others still, committed suicide; while those who stood the ordeal better were not generally reformed, and in most cases did not recover sufficient mental activity to be of any subsequent service to the community (*Re Medley* 134 U.S. 160 (1890)).

Certainly, the negative effects of solitary confinement have been so prominent that it has been used as a method of torture and/or brain washing in the USSR, China and North Korea (Haney, 2009). Indeed in the context of using solitary confinement for coercive interrogations, Shalev (2008) describes it as 'psychological torture' (9). It has also led to a number of countries including the US to prohibit the use of solitary conditions with mentally ill offenders (*Jones 'El v. Berge*, 164 F. Supp. 1096 (W.D. Wis. 2001); and *Ruiz v. Johnson*, 37 F.Supp. 2d 855 (S.D. Texas, 1999)). This suggests that if a prisoner is found to be mentally unstable then there is a strong possibility that this mental deterioration has been caused by the solitary incarceration rather than by any pre-existing conditions; although it is of course accepted that such filtering procedures are not perfect. Even bearing this qualification in mind, it is disturbing that approximately one third of inmates in solitary or supermax conditions are suffering from a 'serious mental disorder' (Haney, 2009:14). Lovell (2008) goes further and predicts that some 45 per cent of those prisoners living within supermax units are suffering from 'psychosocial impairments' (22). Haney (2009) likewise estimates that two-thirds or more of those prisoners living in solitary conditions are suffering from 'a variety of symptoms of psychological and emotional trauma, as well as some of the psychopathological effects of isolation' (15). Even if it is accepted that some of these prisoners would have had pre-existing conditions, which may have been further exacerbated, this still does not explain the occurrence of them all; leading to the proposition that it is the conditions of solitary containment which have caused such complaints.

Over the years there have been a number of studies which have looked at the effects of solitary confinement on prisoners, some of which are reviewed below, although it should be noted that these do differ in their scope and methodology[1]. Despite this caveat, conditions often associated with solitary confinement include paranoia, visual and auditory hallucinations, self mutilation, suicidal thoughts (Haney, 2003), debilitating depression (Abramson *et al*., 1978), anger, bitterness, boredom, stress, loss of a sense of reality, impaired concentration (Scharff Smith, 2006) and fantasy of revenge (Haney, 2009). Indeed Scott and Gendreau (1969) talk about 'confinement psychosis', a condition distinguished by a 'psychotic reaction characterised frequently by hallucinations and delusions, produced by prolonged physical isolation and inactivity in completely segregated areas' (338). Such complaints are argued to be caused by the sensory and social deprivation which prisoners in solitary confinement face. Such deprivation can additionally cause loss of dignity and self worth and in some cases prisoners may simply give up; not being able to motivate themselves to complete the simplest of tasks. Gareth Lindeman, a prisoner held at the supermax facility in Florence, Colorado agrees, stating that 'the brutality of isolation . . . breaks down the human spirit, it breaks down the human psyche, it breaks your mind' (CBS, 2009). Haney (2009) additionally describes how some prisoners actually become uncomfortable with small periods of liberty; being too accustomed to an environment where everything is organised for them. In other cases prisoners act out in order to feel alive, filling their idleness with plans of attack against prison officers and officials. In these circumstances the solitary conditions are likely to make an offender even more dangerous than if he were in the normal prison estate.

Research in Denmark further supports that described above, claiming that solitary confinement is a 'significant risk factor for the development of non-psychotic psychiatric morbidity in comparison with imprisonment in non-SC' (solitary confinement) conditions (Andersen *et al.,* 2000: 23). Even academics who have been known to deny the negative effects of solitary confinement, such as Suedfeld *et al.* (1982), still acknowledge that extended periods can cause a prisoner to become 'inhibited, anxious, cautious, dissatisfied,

dull, submissive to authority, and lacking in self insight' (328). Furthermore, they acknowledge that the longer prisoners are in solitary conditions the higher their scores for depression and hostility will be; with long-term containment associated with 'suspicion, distrust, forceful and self-seeking behaviour' (329)[2].

2.2 Other Debilitating Effects of Death Row Phenomenon

As mentioned above, death row phenomenon and its consequent claimed psychological illness, death row syndrome is more than just the experience of solitary conditions. What is also required is the experience of other debilitating effects specific to death row inmates. One issue which separates death row prisoners from other long-term and life without parole inmates is living under an ever present sentence of death, with much of this time spent not knowing when the actual execution will take place. Furthermore is the inordinate time which inmates are finding they have to wait before their execution actually takes place. Death row inmates in the US will usually spend at least 10 years awaiting execution, with some waiting over 20 years (http://www.deathpenaltyinfo.org/time-death-row, last accessed 5 February 2010). Whilst this can be argued to be of their own making, in that much of the delay is caused by their own exhaustive appeal attempts; the Supreme Court of California has held that:

> The cruelty of capital punishment lies not only in the execution itself and the pain incident thereto, but also in the dehumanizing effects of the lengthy imprisonment prior to execution during which the judicial and administrative procedures essential to due process of law are carried out. Penologists and medical experts agree that the process of carrying out a verdict of death is often so degrading and brutalizing to the human spirit as to constitute psychological torture. The Respondent concedes the fact of lengthy delays between the pronouncement of the judgment of death and the actual execution, but suggests that these delays are acceptable because they often occur at the instance of the condemned prisoner. We reject this suggestion. An appellant's insistence on receiving the benefits of appellate review of the judgment condemning him to death does not render the lengthy period of impending execution any less torturous or exempt such cruelty from constitutional proscription (*People v Anderson* 493 P 2d 880 (Cal. 1972) 894-5).

This has all been argued to cause intense mental suffering with socio-psychological studies existing which describe the grave stresses which prisoners suffer as a result of such uncertainty (see Hood, 1996). For example, the reaction of death row inmates has been found to be similar to those of terminally ill hospital patients, but further exacerbated due to the physical conditions of cellular confinement; restricted visits and in many states, no access to education, employment, religious services or other recreational facilities. Such conditions have been described as 'an austere world in which condemned prisoners are treated as bodies alive to be killed' (Hood, 1996: 137). Personal communications from prisoners have also been used to highlight the mental suffering which is experienced by death row inmates. In May 1990, Robert Alton Harris wrote:

> I have been here on Death Row since November 15, 1984. I have had seven execution dates . . . I don't have any friends here on Death Row. It don't pay to have one, because it's no telling when he might get executed . . . Like we are lock down for twenty three hours a day. We get to go outside three days a week for one hour. Every

> time I'm out of my cell, I'm handcuff. I'm in a one-man cell. Even on the yard, I'm separate from the rest.
>
> The rules here are very hard. The cell that I'm in is right in front of the light and it stay on 24 hours a day. Like, since I been here, I have seen men lose their mind. I lost count on how many got executed. The guy in the next cell from me, he talks to his self and he answer his self. Like, it's hard to hold on here, but I'll make it.

A month later:

> A guy named Tyrone; he got a date for execution. Everyone is trying not to think what might happen. It get worse when it get within the last few days, because they start checking to see if the chair work, and sometimes the lights go dim . . . What it all come down to is this. We are just here.

And then in one of his final letters before his own execution:

> The only real problem I have is that if I do die here would they come and get my body. I don't want to be layed to rest in a prison yard. That would mean that in the after world, I'll still be a prisoner . . . tell me, how can a man be happy with the thought of his life being ended with the push of a button? (Davies, 1992).

2.3 Effects of Death Row Syndrome

Death row syndrome is therefore the mental effects of being held in solitary conditions under sentence of death. Due to the fact that it is a condition (although one which is not medically recognised) brought on by the dehumanising conditions of death row, it is accepted that it will affect prisoners in many different ways and that one person may suffer more severely than another. As Shalev (2008) explains, when talking about solitary confinement in general:

> The extent of psychological damage varies and will depend on individual factors (e.g. personal background and pre-existing health problems), environmental factors (e.g. physical conditions and provisions), regime (e.g. time out of cell, degree of human contact), the context of isolation (e.g. punishment, own protection, voluntary/ non voluntary, political/criminal) and its duration (10).

To illustrate how the syndrome can affect individuals, one case study[3] will be described here although the prisoner's identity will be kept anonymous (another case study that of Michael Ross, is described by Blank, 2006). The prisoner in question is currently on death row at Sussex State Penitentiary, Virginia and has been held in solitary confinement since his murder conviction in 2000. Prior to his arrest and subsequent detention, the offender had pre-existing traits associated with mental retardation and mental illness, although was judged to be marginally competent for trial purposes, and thus tried and judged on this basis. The inmate spends approximately 23 hours a day in his 7 x 9 feet cell, with one hour of solitary exercise, followed by the opportunity to shower. The only human contact experienced, apart from being taken to and from the exercise yard, is when his meals are delivered on a plastic food tray, which is pushed through a small portal in the cell door. Visitation rights include one hour of family non-contact, to be taken at weekends and one face-to-face meeting every three months; although for this particular prisoner his only visits are from his legal

representatives. When a visit is arranged, he is led out of his cell by a leash, hands shackled behind his back and ankles bound together.

Everything, apart from a metal sanitation unit, is grey concrete; including the bed, stool and walls. There is one slim window but this provides so little natural light that the cell is illuminated by strip lighting. Although the prisoner spoke about conditions being sometimes eerily silent, he also described how it could also be unbearably noisy; the sound of keys rattling, toilets flushing, pipes gargling and prisoner's voices echoing through the labyrinth of cells. Other prisoners complained that the sudden clashes and bangs that penetrated their walls caused them to feel constantly unnerved; their unease owing partly to the fact that they did not know where the noises were originating from.

Since living on death row, the prisoner has shown increasingly severe mental health problems, including symptoms of chronic depression and active psychosis. Whilst, it cannot be categorically proven that he would not have suffered such deterioration in any event, his mental health team think this is unlikely; with them stating that his condition has been exacerbated by the psychological effects of the sensory and social deprivation which solitary confinement causes. Psychological and psychiatric professionals have noted how his behaviour has become increasingly bizarre, including paranoid delusions and hallucinatory thoughts. A clinical psychologist describes his speech as tangential and rambling, his manner, at times, as intensely subdued, and at others as, manic and disorganised. In one outburst in court he shouted: "my name is Howard Warner Brothers Theronland, Beron, McKennedy, McHoover Esquire the First, and they know it. And they're keeping my ski resort. They're keeping me off my land and everything else". Following the outburst, he was removed from the court room. The court appointed physician has also commented that not only is his medication not working, it may actually be worsening his condition. He no longer has the mental capacity to meaningfully assist his legal representatives in their preparation of his case, nor participate in social interaction. The 'experiential component' (Smith, 2008: 240) of his death sentence has thus led to a sharp decline in his already fragile psychological state.

The inmate's attorneys are currently arguing that due to the conditions on death row, the delay between conviction and execution and his pre-existing problems; he is experiencing death row phenomenon in general and death row syndrome in particular, and that it is due to all of these factors that his mental health is deteriorating. Despite such arguments, as of yet, these have not been accepted by the courts and the prisoner is still facing execution.

Whilst this is only one case study and by no means proves that death row phenomenon and death row syndrome actually exist, it does aid in an understanding of what the concepts might mean. Death row phenomenon can therefore be understood to encapsulate the experience of living under solitary conditions in conjunction with the other debilitating circumstances of being on death row; with death row syndrome being the psychological effects which are experienced by individuals who live within such environments. Despite the fact that it would appear that death row phenomenon and death row syndrome exist as concepts, the more important question is whether the conditions to which they refer to are real or whether they are spurious medical inventions designed to free inmates from state enforced death. If they are real conditions then the consequential question is whether they affect the legality of capital punishment. These two fundamental questions are the focus of the second part of this article.

Medical Legitimacy

Despite extensive research it has been impossible to confirm, from a medical viewpoint, whether death row syndrome is an actual medical condition, and as previously noted it is not recognised as a mental disorder by the APA. Whilst its legitimacy as a medical illness is thus in question, it must be borne in mind that medical conditions are in themselves mere human constructions, in that they do not exist until they have been proposed, described and then recognised (Conrad and Schneider, 1980). Such illnesses also vary across cultures with obesity, for example, seen as an infirmity in the UK but as a norm amongst the Papago Indians of the American Southwest (Conrad and Schneider, 1980). Time has also seen many subjects being medicalized with examples including diet, contraception, exercise and child development; issues which a century ago would have had no relation to the medical sciences. Box (1980) argues that there has therefore been a medicalization of social problems, whereby professionals propose 'definitional shifts of moral, ethical and political problems into medical conditions' (96). This he argues is done so that conflicts, disputes and disagreements implicit in the former can be avoided by stating that a defined individual is ill. Attention is thus diverted away from the structural, social or cultural changes which are actually needed to rectify the problem and refocused towards medical injunction (Box 1980).

An example of this has been seen with the recent explosion of child developmental conditions including hyperactivity, attention deficit hyperactivity disorder, and dyspraxia. Whilst these did not exist in the first half of the twentieth century, they are now common conditions which children are increasingly being labelled as suffering from. Whilst the intention is not to suggest that such conditions do not exist, Box (1980) argues that one of the reasons why they were created was so that bad behaviour could be made attributable to a medical condition; which arguably diverts attention from how to control and address such behaviour. If there is a pressing social problem, such as poor behaviour in the classroom, it is therefore argued that a medical condition is created and then readily accepted because the existence of the condition helps with the creator's original purpose. Following on from this, death row syndrome is therefore an attempt to medicalize a moral and social problem (i.e. death row conditions) in an effort to justify legal intervention, in the knowledge that if it did not have a medical basis and was not disguised in science, it is unlikely that intervention would be justified on purely humanitarian grounds. Whether it becomes a fully fledged condition, using the criterion as set out by Conrad and Schneider (1980), above, would therefore seem to depend on whether it achieves acceptability. Whether this has occurred is evaluated next.

Death Row Phenomenon and its Affect on the Legality of Capital Punishment

As previously mentioned, death row phenomenon and death row syndrome are relatively new concepts and so it is unsurprising that there is very little legal precedent concerning them. What follows therefore is a discussion of how the concepts have been recognised by the courts in relation to death penalty cases, both in the US and in other international arenas. In particular this section questions the potential affect death row phenomenon and death row syndrome could have on the legality of capital punishment.

4.1 The US Constitution

The US Bill of Rights, created in 1791 by James Madison, refers to the first ten amendments of the US Constitution. The Eighth Amendment prohibits the Federal government from

imposing excessive bail, excessive fines or cruel and unusual punishments. It is this last proviso that is of primary concern here. Over time Supreme Court judgements have limited, controlled and set the parameters of the application of the Eighth Amendment, with some punishments being categorically forbidden such as drawing and quartering, public dissecting, burning alive, and disembowelling (*Wilkerson v. Utah*, 99 U.S. 130 (1878)). Other punishments are forbidden when they are considered excessive; either when compared to the crime, or when measured against the competence of the perpetrator, for example the ban on the use of the death penalty for mentally retarded offenders. Also of importance is the development in *Trop v. Dulles* (356 U.S. 86 (1958)) where Chief Justice Warren stated that 'The Amendment must draw its meaning from the evolving standards of decency that mark the progress of a maturing society' (101). This means that courts must take into account important societal developments that have taken place, such as the development of new execution methods; changing notions of decency and morality or the publication of relevant research evidence.

More recently the Court in *Gregg v. Georgia* (428 U.S. 153 (1976)), following the moratorium imposed in *Furman v. Georgia* (408 U.S. 238 (1972)), made the infamous decision that 'the punishment of death does not invariably violate the Constitution' (168), although it did impose guidelines on when it could be unconstitutional, for example when the method used included 'the unnecessary and wanton infliction of pain' (173). Furthermore, *Re Kemmler* (136 U.S. 436 (1889)) noted that punishments are cruel in nature 'when they involve torture or lingering death' (447). Arguably the solitary conditions of death row combined with the number of uncertain years spent awaiting execution (i.e. death row phenomenon), are tantamount to the kind of cruel and unusual punishment that protection offered in the Eighth Amendment covers and thus prohibits.

In relation to the use of solitary confinement in general (i.e. without the other debilitating effects of the death row environment), the US Supreme Court in *Re Medley* (134 U.S. 160 (1890), recognised the extreme deprivations that accompany it. In considering a habeas corpus action, the Court noted that the use of solitary confinement caused 'immense mental anxiety amounting to a great increase in the offender's punishment' (172). Despite this, US courts have not specifically acknowledged the existence of either death row phenomenon or death row syndrome, although the anguish of a protracted stay on death row was the foundation for abolishing California's death penalty in the 1970s (*People v. Anderson*, 493 P.2d 880 (Cal.1972), see quote above). Furthermore, Supreme Court Justices have since suggested that extended durations on death row, prior to execution, are a significant matter for constitutional deliberation (*Thompson v. McNeil* 129 S. Ct. 1299 (2009); Foster *v. Florida* 123 S. Ct. 470 (2002); *Knight v. Florida* 120 S. Ct. 459 (1999); *Lackey v. Texas.* 514 U.S. 1045 (1995)) but no case has yet actually declared that such delay is unconstitutional. So despite the fact that Justices are meant to take into account 'evolving standards of decency' (*Trop v. Dulles* 356 U.S. 86 (1958)), this does not appear to be occurring with regards to death row phenomenon. One habitual problem for defence lawyers has been proving the 'unusual' element of the Eighth Amendment as the practice of solitary confinement for those on death row is widespread across the US, and as mentioned above, is also widespread in supermax prisons for many non-capital prisoners. However, death row phenomenon is more than just solitary confinement, being also the experience of other debilitating effects of living upon death row. Furthermore, just because the practice of keeping inmates in solitary, under death row conditions is common, does not automatically mean that it is any less inhumane, and should therefore be internationally accepted or worse emulated.

4.2 The European Convention on Human Rights

The legality of solitary confinement has, however, been examined in more detail by the European Court of Human Rights (ECtHR) with a mixed response to the argument that it is inhuman or degrading punishment or treatment under Article 3 of the European Convention on Human Rights (ECHR). In *Hilton v. UK* ((1976) 4 D & R 176) the majority decision of the European Commission of Human Rights was that imprisonment in solitary confinement for 23 hours a day which had turned a normal prisoner into one who would roll around in his own excrement, was not a breach of the Convention; although four other Commission members did argue that such conditions were unacceptable. Furthermore, in *Krocher and Muller v. Switzerland* ((1982) 34 D & R024), the applicants were contained in permanently lit cells measuring 8.4 metres square and kept under constant CCTV surveillance. For the first month they were denied contact with either family or legal representatives and for six months were without access to newspapers, radio or television. Holding that this did not breach Article 3, the Commission argued that, due to a lack of medical information, they were not convinced that severe suffering had been caused. Similarly in *Rhode v. Denmark* (Application no 69332/01, 21 July 2005), no violation of Article 3 had occurred where a man had gone insane following a period of almost, but not quite, one year in solitary confinement.

In *Soering v. UK* ((1989) 11 E.H.R.R. 439), an arguably broader approach was taken. The case involved a German national whose extradition from the UK was sought by the US due to allegations that he had murdered his girlfriend's parents. The applicant claimed that if he was extradited, he ran the risk of being sentenced to death and that the risk of exposure to the death row phenomenon would constitute a breach of Article 3. Soering's complaints regarding conditions on death row related to the length of detention before execution, his pre-existing mental condition, his young age and the general living environment he would experience on death row. The ECtHR admitted that such stringent conditions may be justified due to the needs of security, but that the severity of the regime was made worse by the fact that it had to be endured for an average of six to eight years. As a result, the court unanimously declined to extradite Soering, stating that to do so would cause 'the condemned prisoner . . . to endure for many years the conditions on death row and the anguish and mounting tension of living in the ever-present shadow of death' (440-1). The court concluded:

> having regard to the very long period of time spent on death row in such extreme conditions, with the ever-present and mounting anguish of awaiting execution of the death penalty, and to the personal circumstances of the applicant, especially his age and mental state at the time of the offence, the applicant's extradition to the United States would expose him to a real risk of treatment going beyond the threshold set by Article 3 (478).

This gave, as Hudson (2000) explains, 'a seed of legitimacy for the doctrine [of death row phenomenon] in tribunals around the world' (838).

Soering was later reaffirmed in *Çinar v. Turkey* (App. No. 17864/91, (1994) 79A DR 5(1994)), although the facts here were distinguished from those in *Soering* as Çinar was being held in Turkey where state executions were not actually taking place. Thus the Commission felt that although he was being held in solitary conditions, the threat of death

was not real and thus this could not be seen as breaching Article 3. This would then suggest that for the courts to acknowledge death row phenomenon, the inmate must be subject to harsh containment conditions, but must also be facing actual state execution and indeed this would back up the aforementioned understanding of what death row phenomenon is. *Soering* has also been recognised by the Zimbabwean courts in *Catholic Commission for Justice and Peace in Zimbabwe v. Attorney General* (14. HUM. R.T.S. L. J. 323 (1993)), where the court ruled that prolonged imprisonment on death row amounted to inhuman or degrading punishment contrary to section 15(1) of Zimbabwe's constitution. As a result the execution of four prisoners who had been detained in solitary confinement awaiting execution for between four and six years was forbidden.

4.3 The International Covenant on Civil and Political Rights

In addition to rights provided by and protected by domestic and European law, there are also a number of international declarations and covenants including the International Covenant on Civil and Political Rights (ICCPR). Whilst the UK has largely ratified this, it is acknowledged that this has little practical domestic effect in the US. The covenant is monitored by the Human Rights Committee who presides over cases that concern the rights contained in the instrument. One of the first Committee rulings to touch upon the issue of death row phenomenon was *Kelly v. Jamaica* ((No. 253/1987), UN Doc. A/46/40 241 (1991)), where the Committee held that the harsh conditions experienced on death row in Jamaica, particularly those relating to medical care, did violate Article 10 (all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person).

Additionally in *Kindler v. Canada* (Comm. No. 470/1991, U.N. Doc. CCPR/C/48/D/470/1991 (1993)), the Committee went one step further and actually recognised the existence of death row phenomenon. Kindler, a US national and convicted murderer, fled to Canada having escaped incarceration in Philadelphia. When presiding over the question of whether, if established, death row phenomenon would violate Article 7, (no one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment) the Committee examined domestic precedent as well as international case law. It distinguished the case from *Soering* on the basis that there was no evidence to support the claim that a prolonged delay in the execution could be harmful (para 15.3). In addition the Committee observed how the conditions on death row in Virginia (where Soering would have been held), when compared to Pennsylvania, were markedly harsher, as well as noting the difference in age and mental state of the respective offenders. Article 7 was thus deemed not to have been breached, although the court did agree that death row phenomenon could amount to a violation of Article 7 when applied to other facts.

In *Cox v. Canada* (*Comm.* No. 539/1993, U.N. Doc. CCPR/C/52/D/539/1993, (1994)) the Committee were again asked to consider the extradition of a suspected murderer whose alleged accomplices had been sentenced to life imprisonment. The Committee noted a number of factors, including the relatively progressive confinement conditions in Pennsylvania, when compared to Virginia and again the difference in the applicant's age and mental condition as contrasted with Soering's. Whilst the Committee found no violation of Article 7, it did again reiterate that death row phenomenon could amount to a violation when applied to other facts. This was finally seen in the case of *Francis v. Jamaica* ((No. 606/1994), UN Doc. CCPR/C/54/D/06/1994 (1995)), where violations of both Articles 7 and

10 were found due to sub-standard conditions on death row, including the fact that the prisoner was regularly beaten and ridiculed, and the fact that his mental condition had deteriorated so much that he no longer behaved as a normal human being (Hudson 2000). Protracted lengths of imprisonment in addition to extreme conditions of confinement were also held to amount to a violation of Article 7 in *Edwards v. Jamaica, Comm*. No. 529/1993, U.N. Doc. CCPR/C/60/D/529/1993), although here the prisoner was serving a life sentence rather than living on death row.

4.4 The Privy Council

The Judicial Committee of the Privy Council has acknowledged the existence of death row phenomenon, but rather than concentrating on the harsh conditions of solitary confinement, it has focused its opinion on the delay experienced between sentence and execution. In *Pratt v. Attorney General of Jamaica* ([1994] 2 A.C. 1), for example, the Council agreed that due to a fourteen year delay, to execute a man after this time would amount to torture.

> . . . a state that wishes to retain capital punishment must accept the responsibility of ensuring that execution follows as swiftly as practicable after sentence, allowing a reasonable time for appeal and consideration of reprieve . . . If the appellate procedure enables the prisoner to prolong the appellate hearings over a period of years, the fault is to be attributed to the appellate system that permits such delay and not to the prisoner who takes advantage of it. Appellate procedures that echo down the years are not compatible with capital punishment. The death row phenomenon must not become established as a part of our jurisprudence . . . To execute these men now after holding them in custody in an agony of suspense for so many years would be inhuman punishment (*Pratt v. Attorney General of Jamaica* [1994] 2 A.C. 33).

The Council held that it was torture, far more cruel that death itself, for a person to be kept on death row in a state of suspended animation, knowing that on any day the authorities could carry out their announced intention to deliberately extinguish life. This was affirmed in *Guerra v. Trinidad and Tobago* ([1996] A.C. 397), where the Council also found a four year and 10 month delay to be unconstitutional. The Council in *Pratt* additionally noted how the use of solitary confinement was never intended for such protracted lengths of time, stating that incarceration on death row for periods of 'more than five years after sentence' was held to constitute 'strong grounds' for the presumption of a constitutional violation (*Pratt v. Attorney General of Jamaica* [1994] 2 A.C. 1-2).

Following the decision in *Pratt,* it can be argued that similar practices taking place in the US could amount to a violation of the Eighth Amendment, as the terminology 'cruel and unusual' was derived directly from the English Bill of Rights. Indeed, in the case of *Riley v. Attorney General for Jamaica* ((1983) 1 A.C. 719) which preceded *Pratt,* Lord Scarman expressed his minority view that 'Indeed, there is a formidable case for suggesting that execution after inordinate delay would have infringed the prohibition against cruel and unusual punishments to be found in section 10 of the Bill of Rights 1689' (734). This was subsequently affirmed when the decision in *Riley* was overturned by *Pratt*.

4.5 Is there sufficient protection?

Although such cases would suggest that there is some legal recognition of death row phenomenon, Murdoch (2006) argues that human rights protection still does not go far

enough. Indeed he thinks that the ECtHR has a 'lack of imagination, or at least of judicial understanding of the impact of solitary confinement upon prisoners and too-ready an acceptance of state interests' (255) although he does acknowledge that through case law (for e.g. *Ramirez Sanchez v. France* Grand Chamber, 4 July 2006; *Yurttas v. Turkey* Grand Chamber 27 May 2004) the ECtHR is beginning to show a greater understanding of the effect that solitary confinement can have. Whilst the ECtHR could be criticised for failing to react in practice to cases where there have been concrete finding of solitary conditions and their negative effects, at least it has begun to recognise that concepts such as death row phenomenon and death row syndrome exist; which is in stark contrast to the courts in the US. When looking at the standards which international conventions and covenants impose, it is worth noting that these principles are the bare minimum, and so signatory states should endeavour to provide much better containment conditions for those under its authority. Whilst it is accepted that there are some prisoners who need to be kept in solitarily conditions, this does not necessarily mean that all those on death row fall into this classification. Even those who do need complete solitary confinement do not need to be kept in 2x2 metre cells, with limited sunlight and with no social contact or sensory stimulation.

Perhaps recognising this, there has been the creation of *The Istanbul Statement of the use and effects of solitary confinement*. Adopted on 9 December 2007, the Statement reiterates the negative effects of solitary confinement, emphasising how it can be harmful to those prisoners who were not previously mentally ill and exacerbate the conditions of those who are. The Statement declares that solitary confinement should be kept at all times to a minimum, and when it does need to be used great effort should be taken to increase meaningful social contact for the prisoner involved. Furthermore it recommends that there should be opportunities for the prisoner to undertake both purposeful in cell and out of cell activity. The Statement concludes by stating that solitary confinement 'should be absolutely prohibited in the following circumstances:

- For death row and life-sentenced prisoners by virtue of their sentence
- For mentally ill prisoners
- For children under the age of 18' (see http://solitaryconfinement.org/istanbul, last accessed 4 February 2010).

Efforts such as the Istanbul Statement have therefore attempted to limit the use of solitary confinement. Whilst the Statement only relates to solitary confinement and not death row phenomenon *per se;* any finding of human rights violation in relation to solitary confinement potentially also apply to death row phenomenon cases on the basis that arguably the effects of death row syndrome are worse because of the added addition of living under a sentence of death. Despite early pessimism from international courts, more recent decisions may have caused the tide to turn and the harsh conditions of death row phenomenon may finally be acknowledged and lessened. If the Istanbul Statement achieves what it sets out to do then such action will occur and in time we may see solitary containment, in certain circumstances, amounting to violations of human rights instruments. When the UN Special Rapporteur on Torture has 'strongly encourage[d] States to reflect upon the Statement as a useful tool in efforts to promote the respect and protection of the rights of detainees' (Scharff Smith, 2009: 11), it would appear that such hope is both widespread and perhaps more importantly achievable. If this can be achieved then there would appear to be no reason why that extra step cannot be taken to further conclude that such violations could also apply to cases where death row phenomenon and death row syndrome are found to exist.

Conclusion

Death row phenomenon and death row syndrome may therefore be useful concepts by which the legitimacy of capital punishment may be undermined. Although relatively new and not formally medically recognised, they are beginning to be recognised in other fields and arguably in some legal arenas their effects have been held to breach international human rights. Such recognition has however, only appeared to have taken place in courts whose instruments apply to, or have been ratified by abolitionist countries. Indeed no such acknowledgment has, to date, taken place in the US either in its state or federal courts; even though applications of this nature have been brought before them. This reluctance to acknowledge the harsh conditions in which death row inmates exist is probably the reason why professionals have created and defined death row syndrome as a medical concept, believing that if accepted, a medical condition will have more affect than legal argument alone. In essence what appears to be happening is that lawyers are using medical language for something which arguably isn't really medical. This may be because it is thought that medicine and science have more power than legal language, or because the aim is to be purposely vague, so that this deflects from the question of whether the inmate is suffering from a recognisable medical condition. The effects of medically colonising social and legal issues also need to be considered. For example, if death row phenomenon cases succeed it will be at the cost of real political issues (for example the need and costs involved in improving conditions in correctional facilities) and as such there will be a medicalisation of morals, whereby a medical condition has been invented to cover detention conditions which are not palatable to all members of the public. If the existence of death row syndrome was ever held to amount to a breach of human rights in the US, the state would have to either reduce the time inmates were held in such conditions (which may interfere with due process requirements); drastically improve such conditions or commute all death sentences to that of life. When it is doubtful that the US is prepared to do any of these things, it is for this reason that in all likelihood, it will continue to deny that death row phenomenon and its resulting syndrome exists.

Notes

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[1] For example there are a number of different solitary confinement regimes, including pre-trial solitary confinement; disciplinary solitary confinement and solitary confinement on death row. All such regimes are likely to have different effects on those experiencing them.

[2] For more information on the effects of solitary confinement see Shalev (2008); Scharff Smith (2006); Haney (2003).

[3] One of the authors spent the summer of 2008 at a law firm in Virginia, US working on death row cases.

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