INQUEST

TRUTH, JUSTICE & ACCOUNTABILITY

INQUEST submission to Commission on Race and Ethnic Disparities

30 November 2020

1. INQUEST is the only charity providing expertise on state related deaths and their investigation. We provide expertise to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in prison and police custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question such as the Hillsborough football disaster and the Grenfell Tower fire. INQUEST's Executive Director, Deborah Coles, sits on the cross-government Ministerial Board on Deaths in Custody and is a member of the Independent Advisory Panel on Deaths in Custody.

2. For three decades, INQUEST has documented a pattern of cases synonymous with state violence, neglect, structural racism, impunity and injustice. We have seen how a disproportionate number of Black people, in particular Black men, have died as a result of use of force by police officers. Others have died as a result of neglect. Our work with bereaved families documents repeated failures to uphold the right to life, the right to live free of discrimination, and the state's duty to protect life and prevent ill treatment.[1]

3. We approach this call for evidence from a position of immense frustration at the lack of progress to take forward the recommendations on tackling racism from countless public inquiries, commissions, reviews, parliamentary inquiries, inquests, inspections and investigations that already exist. Bereaved families have engaged with these processes in good faith, sharing their traumatic experiences time and time again; INQUEST has submitted evidence and provided its expertise on countless occasions. We therefore approach yet another review and yet another set of questions with reluctance and scepticism. The starting point of this Commission must be to analyse the overwhelming body of evidence and recommendations from all of these previous reviews.

4. This evidence confirms that across society, structural racism persists. For too long, there has been acceptance of ethnic disparities and disproportionalities and a failure to tackle the reality of institutional and structural racism: real change is long overdue. Unless this Commission sets out a clear roadmap for addressing these deeply-rooted problems, which are experienced day in day out by Black people and other racialized groups when they come into contact with the criminal justice and health systems, it will have failed.

[1] We focus particularly on Article 2 (the right to life), Article 3 (the prohibition of torture and inhuman and degrading treatment) and subsequently Article 14 (the protection of all rights without discrimination)

5. We answer below questions 1 and 10 from the call for evidence.

Question 1: What do you consider to be the main causes of racial and ethnic disparities in the UK, and why?

6. This Commission must grasp the fact that evidence points to deeply rooted structural racism, which cannot be reduced to a discussion of "racial and ethnic disparities". There is a continuum of pervasive racial bias in the criminal justice system. Deaths in police custody or following police contact represent the extreme, but too often real, end of this continuum. This point was affirmed by the UN Special Rapporteur on Racism: "Deaths of persons belonging to racial and ethnic minorities while in police custody or in prison reinforce these communities' experience of systemic and structural racism, over-policing and criminalization".[2]

7. Extensive evidence underscores this problem, including:

- In 2018/2019 Black people were 9.5 times more likely than White people to be stopped and searched by police in England and Wales.[3]
- In 2018/2019 known rates of detention under the Mental Health Act for Black or Black British people were four times higher than for White British people.[4]
- As of June 2020 7.7% of the prison population[5] were Black despite the comprising 3.4% of the population in England and Wales.[6]
- In 2019-2020, 5% of men and 7% of women surveyed in prison by HM Inspectorate of Prisons reported being from a Gypsy, Roma or Traveller background,[7] while accounting for just 0.1% of the resident population in England and Wales.[8]
- The use of remand to prison is more pronounced for Black women than white women. In magistrates courts in 2019, 59 per cent of white women

[2] UN Special Rapporteur on Racism, *Visit to the United Kingdom of Great Britain and Northern Ireland: Report of the Special Rapporteur on contemporary forms of racism, racial discrimination, xenophobia and related intolerance*, 27 May 2019, A/HRC/41/54/Add.2, paragraph 42.
[3] Ministry of Justice (2020) Stop and Search https://www.ethnicity-facts-figures.service.gov.uk/crime-justice-and-the-law/policing/stop-and-search/latest#by-ethnicity
[4] Care and Quality Commission (CQC) (2019) Monitoring the mental health act https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf
[5] Ministry of Justice (2020) Prison Population: 20 June https://www.gov.uk/government/statistics/offender-management-statistics-quarterly-january-to-march-2020--2
[6] According to the 2011 National Census https://www.ethnicity-facts-figures.service.gov.uk/uk-population-by-ethnicity/national-and-regional-populations/population-of-england-and-wales/latest#by-ethnicity
[7] HM Inspectorate of Prisons Annual Report 2019-2020, p155
[8] Office of National Statistics, What does the 2011 Census tell us about the characteristics of Gypsy or Irish travellers in England and Wales, 21 January 2014.

remanded in custody did not go on to receive an immediate prison sentence, compared with 73 per cent of Black women.[9]

8. Racial inequalities are further aggravated in state custody and detention:

    - In 2018/2019 Black people were more than five times as likely to have force used against them by police as White people and were subject to the use of Tasers at almost eight times the rate of White people.[10]
    - Black and minority ethnic prisoners report a more negative experience than white prisoners about many areas of prison life and report feeling marginalised and that staff failed to challenge inappropriate or racist behaviour.[11]
    - People of Black, Black British, Black African and Black Caribbean ethnicity and those of mixed ethnic heritage are proportionately more likely to be subject to the use of force in mental health settings than other ethnic groups.[12]
    - The data on use of force in prisons is not centrally collated so a national picture cannot be reported. However, evidence from local data suggests there is disproportionality in the number of use of force incidents against Black males across the estate, especially younger Black males.[13]
    - There have been 57 of deaths of immigration detainees since 2000, of which over one third (22) have been of Black African, Black Caribbean or other Black ethnicities.[14]

9. These issues must be seen in their broader context of social and economic inequalities. As evidenced by the UN Special Rapporteur on racism, "austerity measures in the United Kingdom are reinforcing racial subordination."[15]

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[9] https://www.gov.uk/government/statistics/criminal-justice-system-statistics-quarterly-december-2019

[10] Home Office (2019) Police use of force statistics, England and Wales: April 2018 to March 2019 https://www.gov.uk/government/statistics/police-use-of-force-statistics-england-and-wales-april-2018-to-march-2019

[11] HM Chief Inspector of Prisons for England and Wales Annual Report 2018-2019 and Annual Report 2019-2020 https://www.justiceinspectorates.gov.uk/hmiprisons/inspections?s&prison-inspection-type=annual-reports

[12] https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-bulletin/2018-19-annual-report

[13] HMPPS (2019) Equality Analysis, Use of Force http://www.prisonreformtrust.org.uk/Portals/0/Documents/PAVA/Use%20of%20Force%20Equality%20Analysis.pdf; further demonstrated in a report by Runnymede and the University of Greenwich (2017) which analysed the use of force data at one adult prison and found it was much higher amongst those of Black ethnicity *(5.4 per 100 amongst Black prisoners compared to 1.7 per 100 White) (p23)*

[14] INQUEST casework and monitoring 2020

[15] UN Special Rapporteur para 34.

10. Many of the cases INQUEST has worked on have presented a disturbing picture of violence, racism and inhumane attitudes towards people in distress; ascribing stereotypical characteristics of extraordinary strength, dangerousness and criminality to Black people. The racial stereotype of 'big, black and dangerous,' 'violent' and 'volatile', when woven into the culture and practice of the police and in other detention settings, can lead to the disproportionate and sometimes fatal use of force and neglect.[16] We set out here a small selection of relevant examples from our casework:

- **Kingsley Burrell**, 29, died in 2011 following a prolonged restraint by police whilst he was a detained patient under the Mental Health Act. Kingsley was forcibly restrained by means of rear cuffs, leg straps multiple times in the space of four days. When the medical staff observed that his respiration had dropped to a worrying rate, no one entered the room. When they finally did, they found that Kingsley had suffered a cardiac arrest. Further delays followed in locating a functioning defibrillator and in calling an ambulance. In 2015, the inquest concluded neglect and unreasonable police force contributed to his death, amidst a raft of other highly critical findings including that police officers lied about the circumstances in which Kingsley was left in seclusion.

- **Kevin Clarke**, 35, died in 2018 following restraint by Metropolitan Police officers while experiencing a mental health crisis. In 2020 an inquest jury concluded that his death was contributed to by restraint and highlighted serious failures involving Metropolitan Police Officers, the London Ambulance Service, South London and Maudsley NHS Trust (SLaM) and Jigsaw, an assisted housing provider. The jury found that opportunities for earlier, less restricted intervention were missed by SLaM and Jigsaw, and that the use of restraints by police were 'a high risk option' which 'escalated the situation to a medical emergency'. During the restraint, which lasted 33 minutes, Kevin told officers 'I can't breathe' and 'I'm going to die', but they said they did not hear him. Despite this, the jury concluded that it was 'highly likely' that at least one officer heard Kevin say 'I can't breathe'.

- **Annabella Landsberg**, 45, died in 2017, following severe dehydration and organ failure relating to Type 2 diabetes. Annabella was critically unwell, lying unresponsive on the floor of her cell at HMP Peterborough for 21 hours with prison and healthcare staff failing to recognise her condition. A nurse was called to assess Annabella but instead of conducting any physical observation, threw a cup of water over Annabella believing her to be faking

[16] See, among others, INQUEST's submission to the UN Regional Meeting on the International Decade for People of African Descent, 2017: https://www.ohchr.org/Documents/Issues/Racism/WGEAPD/RegionalMeetingEurope/Deborah%20Coles%20Paper%20-%20JUSTICE.pdf

illness. The inquest jury highlighted a catalogue of serious failures in the management and healthcare systems at the Sodexo run prison.

- **Olaseni Lewis** (Seni), 23 died following prolonged restraint by Metropolitan Police officers at Bethlem Royal Hospital in 2010. In 2017 an inquest jury unanimously condemned the actions of police and healthcare staff who watched on as Seni was restrained by 11 police officers. The inquest found the force used was excessive, disproportionate, and contributed to Seni's death. Police officers involved in the restraint of Seni told the inquest: *"The sound and tone didn't suggest he had difficulty in breathing, more something on the inside of him, an aggression and a ferociousness that couldn't be controlled." "We didn't immediately call a doctor [when he became unresponsive] because we weren't 100 per cent sure if he was definitely unconscious or not breathing. We left the room in case he was feigning, passing out as a ploy to escape."*

- **Sarah Reed,** 32, died in 2016 at HMP Holloway. She had been held on remand for over three months, solely for the purpose of obtaining two psychiatric reports to confirm whether she was fit to plead, for an alleged offence which took place whilst she was a sectioned inpatient at a mental health unit. The inquest concluded that her death was self-inflicted, and that unacceptable delays in psychiatric assessment and failures in care contributed. Sarah had been previously assaulted by a police officer in 2012, an experience which aggravated her mental ill health.

11. We are concerned by the culture of acceptance around evidence that points to ethnic disparities, by the very bodies that should be interrogating it. For example, the annual reports of HM Inspectorate of Prisons consistently identify that prisoners from a Black or minority ethnic background report to them a more negative experience in most areas of prison life than white prisoners, yet they have conducted limited work to interrogate the reasons for this.[17] Similarly, we note that while CQC's Mental Health Act annual report does acknowledge the disproportionate detention of Black and minority ethnic groups[18], it provides little exploration of the reasons for this, which is an inadequate response to an issue of this scale.

12. The continuum of racial bias is further perpetuated by the longstanding failures of accountability and persistent impunity in cases where state agents have been responsible for neglect or abuse. Many inquests into state-inflicted deaths, including some of those referred to above, have returned conclusions highly critical of the 'unlawful' and 'excessive' or 'disproportionate' force used, or found serious neglect.

[17] See HMIP annual report 2019-20 p42 https://www.justiceinspectorates.gov.uk/hmiprisons/wp-content/uploads/sites/4/2020/10/HMI-Prisons_Annual-Report-and-Accounts-2019-20-WEB.pdf
[18] Care and Quality Commission (2019) Monitoring the mental health act in 2018/2019 https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf

However disciplinary action and/or criminal charges are rare and criminal convictions rarer still. Since 1990 there has been no successful prosecution for murder or manslaughter. Such disciplinary processes as there have been rarely result in effective sanctions against the officers involved. In addition, the various iterations of the police watchdog over the years have consistently failed to address race adequately or at all in their investigations.

The experiences of bereaved families

"I didn't want the perception of the public, oh they've got a chip on their shoulder because he's Black…I knew it was there just didn't highlight it. It was also not highlighted by the IPPC" - Marcia Rigg, sister of Sean Rigg

"With my nephew I haven't made reference to race at all and I've deliberately done that as well. Everything I have put in writing I've just challenged the facts as they see and asked for proof for everything they've said that they believe is fact" - Anonymous family member

"When it comes to racism… they expected her to be as a Black woman mad and angry and loud and aggressive, where my niece was very soft, very gentle" - Anonymous family member

"It might be more of a deterrent if police were genuinely concerned about facing charges. They pretend there isn't institutional racism in the police, but we all know it's there. Police need to admit mistakes. Officers need to be prosecuted." – Aji Lewis, mother of Seni Lewis

"The narrative from the beginning is racist, right from the get-go. They look for things to demonise your loved one. They try to get out a narrative to the press that is demonising, its racist, its dehumanising. That is their agenda" - Anonymous family member

"His character is completely destroyed and that's what they do. Instead of looking at what the police have done all the police background, they are busy looking at what my son's done and its them that have killed him" - Anonymous family member

Q10: Can you suggest other ways in which racial and ethnic disparities in the UK could be addressed? In particular, is there evidence of where specific initiatives or interventions have resulted in positive outcomes? Are there any measures which have been counterproductive and why?

13. As indicated above there has already been significant scrutiny and interrogation of systemic issues and individual cases resulting in the recognition of institutional and structural racism, and making authoritative recommendations for change. [19] We urge this Commission in the strongest terms to see its task as pushing for the implementation of these.

14. This is because it is sadly all too common for reports and recommendations to be left to gather dust and their recommendations forgotten, even when these have been commissioned by government in the first place. Many bereaved families engage with these reviews in good faith, investing time, energy and emotion: they feel betrayed by the failure to make progress and the cyclical nature of reviews, reports and recommendations. The continued failure in progress on racism and disproportionality is a failure in the state's human rights obligations to act to prevent future deaths.

15. A key example is the government's response to the Angiolini review in 2017 and progress report in 2019, which make virtually no reference to racism, ethnicity,[20] disproportionality or discrimination, despite the Angiolini review having put forward nine recommendations specifically referencing institutional racism, race or discrimination.[21] Our monitoring shows that since the Angiolini review was published in November 2017, there have been a further six deaths of Black men in police contact, three of which featured restraint.

16. In some instances, a report that should have been a catalyst for progress have in fact failed to step further deterioration. This is the case with the Lammy Review, which raised the alarm on this issue, yet since publication of this review numbers have increased, with Black and minority ethnic people making up 27% of the prison population and 50% of children and young people in child prisons/young offender institutions. In the year ending March 2019, 27.8% of people in youth custody were Black.

17. There is an urgent need to strengthen the consistency of data across all detention and custody settings, and for this to include disaggregated data about race and

[19] These include the Stephen Lawrence Inquiry (1997), the Independent Inquiry into the death of David Bennett (2003), the Zahid Mubarek Inquiry (2006), the Casale Review (2013), the Angiolini Review (2017) and the Independent Review of the Mental Health Act (2018).

[20] Home Office (2017) Deaths and serious incidents in police custody: government response https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody-government-response. In the government's response to the review in 2017 ethnicity is only referenced in relation to data being collected and published in relation to police use of force. See also Department of Health and Social Care, Home Office and Ministry of Justice (2018) Deaths in police custody: progress update https://www.gov.uk/government/publications/deaths-in-police-custody-progress-update

[21] Including that IPCC investigators should consider if discriminatory attitudes have played a part in restraint related death, that national policing bodies and police forces should implement mandatory and refresher training on the nature of race issues to confront discriminatory assumptions and stereotypes and that police training should include an understanding of institutional racism.

ethnicity. In particular there is a longstanding failure to provide detailed information about deaths of people in the care of the state in mental health and learning disability settings[22]. Without this data, it is impossible for policy-makers and detaining authorities to understand and act on the issues before them, and for other stakeholders – including Parliament, NGOs, academics, activists – to hold them to account for making progress. In relation to deaths specifically, INQUEST recommends the introduction of an agreed, coherent set of published statistics which includes disaggregated information necessary to provide an overview of the number and features of these deaths, including ethnicity.[23]

18. A further step that would help understand racial and ethnic disparities, or indeed bias or racism, the publication of all inquest jury and coroner's reports in a searchable format, including the ability to search according to ethnicity. This would enable all those engaged in thinking about, and legislating for social, health and criminal justice policy to track the progress, or lack of progress, in addressing structural racism.

19. Finally, INQUEST believes that there is an overwhelming case for the creation of a national oversight mechanism tasked with the duty to collate, analyse and monitor learning and implementation arising out of state-related deaths. This is the only way to secure proper cross-sector learning and public transparency. [24] Such a mechanism should allow state bodies and those that hold them to account to develop a cross-sector picture of reoccurring issues impacting the deaths of Black people in state care and custody.

[22] Data on the deaths of Black people in mental health setting is not publically available as the CQC does not disaggregate the ethnicities within 'Black and Minority Ethnic' https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf

[23] As recommended in our 2015 report Deaths in Mental Health Detention: An investigation framework fit for purpose? https://www.inquest.org.uk/deaths-in-mental-health-detention

[24] This recommendation has been previously endorsed by the Joint Committee on Human Rights in the interim report on Mental Health and Deaths in Prison (2017) https://publications.parliament.uk/pa/jt201617/jtselect/jtrights/893/893.pdf