ACHIEVING RACIAL JUSTICE AT INQUESTS

A PRACTITIONER'S GUIDE

JUSTICE

INQUEST

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JUSTICE is a legal reform charity working to build a fair, accessible justice system that respects the rights of all. Over our 67-year history we have transformed the legal landscape for the better, led by evidence, expertise, and a focus on practical solutions. Our work spans the justice system - from criminal justice to housing disputes and family law - touching the lives of people across the country.

INQUEST is the only charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media and parliamentarians. Our specialist casework includes deaths in police and prison custody, immigration detention, mental health settings and deaths involving multi-agency failings or where wider issues of state and corporate accountability are in question.

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When an individual dies in state custody, a fair and effective inquest is crucial for bereaved families, public confidence, and to ensure that lessons can be learnt and further harm avoided. In some cases, securing truth and accountability will involve acknowledging the possible role of race or racism in a death. (The most recently published statistics show that in 2022, a total of 534 deaths which occurred in state detention were reported to coroners. Of this, the numbers of cases of deaths in prison custody were 300 and in police custody 12).

Practitioners and coroners must be equipped to recognise, raise and investigate issues of race or racism when they arise, sensitively and without reticence. This important guide equips practitioners, coroners and others involved in post death investigations with the tools to do this. It is an invaluable resource, not only for promoting racial justice, but for improving fact finding, increasing racial awareness, and providing better representation to families. I congratulate those who have contributed to the guide.I am sure it will be well appreciated by all those involved in post death investigations.

His Honour Judge Mark Lucraft KC,
Recorder of London,
(Chief Coroner of England & Wales 2016-2020).

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FOREWORD

With over three decades dedicated to practising in the field of inquests, I have encountered numerous cases involving the controversial and often tragic deaths of young Black men and women in police custody. These cases, sometimes marked by their violent nature and a dearth of independent witnesses, demand the most rigorous public scrutiny, as do all fatalities at the hands of the state.

In grappling with these complex scenarios, the issue of race, at times glaringly apparent and at others subtly embedded, has been a persistent challenge. Recognising the elephant in the room, however, posed a dilemma — how to raise the matter as a pertinent issue. The response varied: some loved ones of the deceased urged its consideration, while others approached it with apprehension. The mere suggestion of introducing race into the discourse I and others have found often elicited a negative response from coroners, and state agents occasionally dismissed it incredulously, as if considering the role of race was an affront.

In navigating these intricacies, the practitioner has to wrestle with the strategic nuances of addressing race, especially when confronted with a limited understanding of the complexities involved. This guide emerges from the acknowledgment that many in the field — coroners, practitioners, the bereaved and state agents alike — may benefit from a comprehensive resource to illuminate, understand, and strategically address the multifaceted issues surrounding race in deaths in state custody.

This guide aims to contribute to a more nuanced and informed approach to investigating these deaths fully and fearlessly. By providing practical insights and a structured framework, it aspires to enhance understanding, encourage strategic thinking, and foster open dialogue among stakeholders. If, through these collective efforts, we can more accurately determine if race played a role in a death and articulate this finding in a methodical and forensic manner, we take a significant step toward achieving a fair and just process. May this guide serve as a valuable tool in promoting transparency, justice, and the pursuit of truth in the challenging terrain of deaths in state custody.

I wish to extend my gratitude to JUSTICE and INQUEST, whose commission of this report reflects a commitment to advancing the understanding of issues surrounding deaths in state custody, with a particular emphasis on the intersection of race and justice. This report builds on the previous invaluable work of INQUEST, including inter alia their groundbreaking 2023 report 'I Can't Breathe,' contributing to a growing body of knowledge aimed at fostering positive change.

Finally, I want to express my heartfelt thanks to the advisory board for this guide who generously contributed their time and expertise to produce this guide. Special recognition is due to Emma Snell at JUSTICE and Deb Coles and Jessica Pandian at INQUEST for their pivotal role in pulling this guide together. Their collective efforts have played a crucial role in making this guide a reality.

Professor Leslie Thomas KC

INTRODUCTION

INQUEST's casework and monitoring, conducted over the last 40 years, has shown that "Black and racialised people experience some of the most violent, neglectful and contentious deaths" in state custody.[1] This concurs with evidence, spanning decades, from numerous state-commissioned reports, reviews and public inquiries.[2]

State violence against Black and racialised people has prompted significant community disquiet and uprisings. For instance, the protests following the mistaken police shooting of Black woman Cherry Groce in 1985,[3] and the death of Cynthia Jarrett during a police search of her home one week later;[4] the death of Wayne Douglas in police custody in 1995;[5] and the shooting of Mark Duggan by police in 2011.[6] This has been a long-standing and persistent problem in Britain. While certain communities have always recognised this, national and international attention to racial injustice and state violence reached heightened levels following the murder of George Floyd by a police officer in the United States in 2020.[7]

In response to this death, the United Nations High Commissioners for Human Rights set up an inquiry into law enforcement and racism against people of African descent. In its contribution to this report, INQUEST highlighted that although Britain has a seemingly advanced framework for investigating deaths in state custody, INQUEST's monitoring of deaths of Black and racialised people shows that issues of race and racism do not feature in the post-death investigation process.[8] This reflected the concerns of lawyers consulted for JUSTICE's 2020 report When Things Go Wrong: the response of the justice system, which made recommendations aimed at reforming institutional responses to state-related deaths.[9]

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1 INQUEST. (2023). I can't breathe': Race, death and British Policing.; INQUEST. (2022). Deaths of racialised people in prison 2015-2022: Challenging racism and discrimination.

2 See Annex 1 for a list of government reviews, reports and public inquiries that address the role of race in state-related deaths.

3 The police shooting of Cherry Groce has been widely reported as sparking the 1985 Brixton riots. See BBC News. (1985). Riots in Brixton after police shooting. INQUEST. (2014). Inquest into the police shooting of Cherry Groce in Brixton in 1985 begins on Monday 30th June 2014. See also Lawrence, L. (2020). The Louder I Will Sing: A story of racism, riots and redemption. Sphere.

4 The death of Cynthia Jarrett was found to be a catalyst for the 1985 Broadwater Farm riot in Tottenham. See Gifford, T. (1986). The Broadwater Farm Inquiry: report of the Independent Inquiry into disturbances of October 1985 at the Broadwater Farm Estate, Tottenham.

5 This death has been reported as sparking the 1995 Brixton Riots. See BBC News. (1995). Riots break out in Brixton.

6 The shooting of Mark Duggan by police in Tottenham has been reported as a trigger for the 2011 riots in London, Birmingham, Manchester, Salford, Liverpool and Nottingham. See Lewis, P. et al. (2011). Reading the Riots: Investigating England's summer of disorder. LSE Research Online.

7 See Dougla, D., Chrisafis, A., and Mohdin, A. (2021). One year on, how George Floyd's murder has changed the world. The Guardian.

8 INQUEST. (2020). INQUEST evidence submission to the United Nations High Commissioner for Human Rights report on "systematic racism, violations of international human rights law against Africans and people of African descent by law enforcement agencies especially those incidents that resulted in the death of George Floyd and other Africans and people of African descent, to contribute to accountability and redress for victims.

9 JUSTICE. (2020). When Things Go Wrong: The response of the justice system.

Following this, in 2023, INQUEST published a report highlighting the views of lawyers and bereaved families on their understanding of the absence of race from official post-death investigations. Both groups felt that the absence of issues of race and systemic racism in inquests meant that a crucial part of the picture was not being explored. This was found to undermine the ability of an inquest to establish the truth about the death, and offer a measure of catharsis for bereaved families,[10] who were often acutely aware of the role racism played in the death of their loved one.[11]

This guide seeks to address barriers and give practitioners and coroners the confidence to address and investigate racism

Additionally, by not investigating the possible role of race and systemic racism in state custody deaths, post-death investigatory processes risk obscuring discriminatory practices, attitudes and cultures within the state institutions where these deaths take place. This makes it impossible to issue recommendations to address them. The result is that these dangerous practices, attitudes, and cultures go unaddressed, increasing the risk faced by Black and racialised people in state custody.

The importance of including issues of race and racism in post-death investigations was recognised by the United Nations Working Group of Experts on People of African Descent, which in 2023 urged that:

"Oversight authorities must confront the role of race in the actions and misconduct of public officials. The role of race and systemic racism should be added to the terms of reference of all inquests, investigations, and other reviews where race or systemic racism is a prominent issue."[12]

Practitioners consulted during the development of this guide highlighted several reasons for the failure to investigate issues of race and racism at inquests. There remains an entrenched discomfort around raising issues of race and racism.[13] Practitioners expressed concern about the potential challenges in addressing racial aspects during inquests, fearing that coroners may not always be receptive to such representations.

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10 Per the Explanatory Memorandum to the Coroners (Inquests) Rules 2013 one of the policy objectives of the Coroners and Justice Act 2009 was "to put the needs of bereaved people at the heart of the coroner system." The Court of Appeal in Chief Constable West Yorkshire Police v Dyer & Assistant Coroner for West Yorkshire [2020] EWCA Civ 1375 recognised that, given this policy objective, the need for family members to achieve catharsis is an important matter to be considered by coroners. See §101. See also Lord Bingham in R(Amin) v. Secretary of State for the Home Department [2003] UKHL 51 at §31 referring to the common law duty to investigate deaths of those in custody: In this country ... effect has been given to that duty for centuries by requiring such deaths to be publicly investigated before an independent judicial tribunal with an opportunity for relatives of the deceased to participate. The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the(own emphasis).

11 INQUEST. (2023). I can't breathe': Race, death and British Policing.

12 United Nations Working Group of Experts on People of African Descent. (2023). End of mission statement by the United Nations Working Group of Experts on People of African Descent following its country visit to the UK (18-27 January 2023), containing its preliminary findings and recommendations.

13 This discomfort is echoed elsewhere in the justice system, and in wider society. For instance, HM Inspectorate of Prisons and HM Inspectorate of Probation have found that prison and probation staff are not comfortable with or able to discuss race and racism with people in prison or on probation. HM Inspector of Prisons. (2022). The experiences of adult black male prisoners and black prison staff; HM Inspectorate of Probation. (2023). Race equality in probation follow-up: A work in progress. pp.12, 21,38, 41.

There is a shared desire among legal professionals and bereaved family members to navigate these discussions effectively without the fear of unintended repercussions. Building a supportive environment for addressing racial discrimination is crucial to ensure a more inclusive and just inquest process.[14]

There remains an entrenched discomfort around raising issues of race and racism

This guide seeks to address these barriers and give practitioners and coroners the confidence to address and investigate racism at inquests into the deaths of Black and racialised people in state custody.

PART 1 provides an overview of racism in key state institutions: the criminal justice system, immigration system, and mental health system.

PART 2 provides guidance for practitioners on case strategies and considerations.

PART 3 provides guidance for practitioners on raising racial discrimination at inquests, including bringing issues of racism in scope and the arguments that can be run.

PART 4 provides guidance for practitioners on identifying and evidencing issues of race and racism at inquests.

PART 5 provides specific guidance for coroners, including guidance on developing racial awareness, reasons for investigating racism, and conducting thorough investigations.

SCOPE AND POTENTIAL FOR WIDER APPLICATION

This guide focuses on providing guidance for practitioners and coroners on raising and investigating issues of race and racism at inquests into deaths of Black and racialised people in state custody.

We have decided to focus on deaths in state custody for the following reasons:

- Deaths in state custody have a notable frequency of violence, neglect, and contentious incidents surrounding the death. State agents are often the only witnesses. Focusing on deaths in state custody allows us to address crucial issues within state institutions where accountability and scrutiny are of paramount importance. State custody often serves as a focal point for examining systemic challenges and fostering improvements in care.
- Deaths in state custody will almost always result in an Article 2 inquest, which requires coroners to consider the wider circumstances in which the death occurred. The broad remit of Article 2 inquests provides significant scope for issues of race and racism to be investigated, compared with the more limited ambit of a non-Article 2 inquest.

While our primary focus is on deaths in state custody, we recognise that there are state-related deaths outside this context that also raise significant issues of racism. Disparities in maternal mortality rate for Black and racialised women have persisted for decades.[15]

14 INQUEST. (2023). I can't breathe': Race, death and British Policing.

15 Women and Equalities Committee. (2023). Third Report of the Session 2022-23, Black maternal health. HC 94, p.3; Knight, M., et al. (Eds.). (2022). Saving Lives, Improving Mothers' Care Core Report – Lessons learned to inform maternity care from the UK and Ireland Confidential Enquiries into Maternal Deaths and Morbidity 2018-20. National Perinatal Epidemiology Unit, University of Oxford. p. 19.

A 2022 NHS-commissioned Rapid Review found "stereotyping, disrespect, discrimination, and cultural insensitivity," in maternity care.[16] Similarly, the death of 2-year-old Awaab Ishak, linked to prolonged exposure to mould, underscores how racism can contribute to deaths in the housing context. A Housing Ombudsman review identified "wholly unacceptable" assumptions about refugees and asylum seekers in Awaab's case.[17]

Most of the learning in this guide can apply equally to these and other contexts, particularly where it is arguable that the death could trigger an Article 2 inquest.

Similarly, while this guide focuses on practitioners and coroners in the inquest context, much of the learning can also apply to other post-death investigations and investigators. For instance, we anticipate this guide being an important resource for Independent Office for Police Conduct investigators and Prison and Probation Ombudsman investigators.[18]

The guide promotes an intersectional perspective,[19] urging practitioners and coroners to consider how factors like gender, age, class, and disability can compound risks for Black and racialised individuals in state custody. Achieving racial justice requires addressing all forms of injustice. This guide serves as a starting point for practitioners and coroners to raise and investigate discriminatory practices in whatever form they take.

TERMINOLOGY

The following sets out and defines some key terminology used throughout the guide. However, we recognise that language concerning race and racism is continuously evolving. It is important to reflect on this and update our language to make sure it is appropriate, sensitive and respectful.[20]

'Black and racialised people'

We have chosen to use the term '**Black and racialised**' throughout the guide because we think it currently best reflects the different groups of people to whom this guide refers, while also recognising that the deaths of Black people in state custody represent some of the most acutely violent, neglectful and contentious.

'**Black**' describes people of African and African Caribbean background. We include mixed-race African and African Caribbean people within this group to acknowledge the way they are racialised as Black within state institutions and wider society.

'**Racialised**' means being subjected to racism and the process of racialisation, where races are constructed as "real, different, and unequal" in ways that matter in everyday life.[21] While referred to separately for the purpose of this guide, Black people are also racialised.

Although white people can be racialised, in the context of the UK White-British people have historically been able to define themselves as

16 Kapadia, D., et al. (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory. p.13.

17 Housing Ombudsman. (2023). Housing Ombudsman Special Report on Rochdale Boroughwide Housing. p.9.

18 The section in Part 3 on why preliminary investigations should investigate discrimination is of direct relevance, as well as some of the strategies for evidencing and identifying racism in a case in Part 4. Beyond that, investigators will also benefit from the awareness raising sections of the guide in Part 1, as well as guidance on taking an anti-racist approach to cases involving Black and racialised people. Inquiry teams will also find the guide useful.

19 For a definition of intersectionality see p. 11 of this guide.

20 INQUEST. (2022). Deaths of racialised people in prison 2015-2022: Challenging racism and discrimination.p.8.

21 The European Commission against Racism and Intolerance has recognised the importance of the term 'racialisation' in aiding the understanding of the processes underpinning racism, and how the process of racialisation serves to "spread prejudices, deepen inequalities and legitimise exclusion and hostility against specific groups". See European Commission against Racism and Intolerance. (2021) ECRI's opinion on the concept of "racialisation" (adopted at ECRI's 87th plenary meeting on 8 December 2021). Council of Europe.

the 'raceless norm.'[22] Moreover, the racialisation of non-White-British people in society is typically negative and brings with it hostility and exclusion,[23] and therefore the specific experiences and concerns that this guide is intended to address.

It is for this reason that we are focusing on the experiences of other racialised groups. Some examples of racialised groups in the UK include:

- Asian people,[24] including those of mixed heritage.
- Middle Eastern people, including those of mixed heritage.
- Eastern European people.
- Irish Traveller and Gypsy and Roma people.

'Racism'

This guide draws a distinction between interpersonal (or individual), structural, and institutional racism.

Interpersonal (or individual) racism refers to discriminatory beliefs, attitudes and behaviour directed towards an individual or group based on their race. Interpersonal racism can be unintentional, or it can be wilful and overt, taking the form of bigotry, hate speech or racial violence.[25]

Structural racism refers to a systemic form of discrimination embedded in established practices, policies and norms, which perpetuates unequal opportunities and outcomes for racialised groups.[26]

Institutional racism refers to practices and cultures of an organisation that discriminate against and produce unequal outcomes for Black and racialised people. Institutional racism was described by the Macpherson Report as:

"The collective failure of an organisation to provide an appropriate and professional service to people because of their colour, culture, or ethnic origin. It can be seen or detected in processes, attitudes and behaviour which amount to discrimination through unwitting prejudice, ignorance, thoughtlessness and racist stereotyping which disadvantage minority ethnic people."[27]

While **interpersonal**, **structural** and **institutional** racism refer to distinct concepts, it is important to recognise that interpersonal racism can, and often does, go hand in hand with institutional and structural racism.[28]

'Intersectionality'

Intersectionality refers to the interconnected nature of characteristics such as race, class, gender, and disability in creating overlapping disadvantages.[29] Intersectionality provides a framework for analysing some of the injustices in the criminal justice, immigration, and mental health systems explored in **Part 1** of this guide. When approaching a case involving a Black or racialised person in state custody, it is important to consider how characteristics such as class, gender and disability may serve to compound racial injustice and create new intersectional harms.

22 Calgary Anti-Racism Education. (2020). Racialization. Alberta Civil Liberties Research Centre.

23 European Commission against Racism and Intolerance. (2021) ECRI's opinion on the concept of "racialisation" (adopted at ECRI's 87th plenary meeting on 8 December 2021). Council of Europe.

24 This includes South Asian, East Asian and Southeast Asian people. For definitions see Dr. Fujiwara, D. et al. (2021). Experiences of racism amongst East and Southeast Asian communities. besea.n. See also Minority Rights Group International. (2022). United Kingdom: South Asians.

25 Un-named authors. (2021). Equity vs. Equality and Other Racial Justice Definitions. The Annie E. Casey Foundation.

26 Alexander, M. (2010). The New Jim Crow: Mass Incarceration in the Age of Colorblindness. The New Press.

27 MacPherson, W. (1999). The Stephen Lawrence Inquiry, Cm 4262-I. Stationery Office Limited. para. 6.34.

28 Solomos, J. (2003). Race and Racism in Britain (3rd ed.) Palgrave Macmillan.

29 Crenshaw, K. (1989). Demarginalizing the Intersection of Race and Sex: A Black Feminist Critique of Antidiscrimination Doctrine, Feminist Theory and Antiracist Politics. University of Chicago Legal Forum, 1(8).

PART ONE

RACE AND DEATHS IN STATE CUSTODY

Understanding the role of race in the deaths of Black and racialised people in state custody requires examining these deaths within their institutional contexts. This section provides an overview of how race impacts the experiences of Black and racialised people within immigration, criminal justice, and mental health care systems. It highlights how racial stereotypes, rooted in institutional racism, shape interactions and affect treatment.

By raising awareness of institutional racism, the section aims to help participants at inquests view individual deaths within this framework – rather than as either unrelated to race or as simply a result of individual bias or a "few bad apples."[30] Additionally, awareness of the role of race is crucial for fostering receptivity to the needs of bereaved families.[31]

THE IMMIGRATION SYSTEM

Racism has played a key role in the development of modern-day immigration law.[32] A report commissioned by the Home Office and leaked in 2022 found that "during the period of 1950-1981, every single piece of immigration citizenship legislation was designed at least in part to reduce the number of people with black or brown skin who were permitted to live and work in the UK."[33] This continued through the 1990s and 2000s, with a series of legislation and policies intended to stem the number of asylum applications; increase the powers of immigration officers to arrest and detain; and limit individuals' rights to challenge decisions against them.[34]

Significantly, the hostile environment policy, introduced in 2012, has been found to discriminate against and facilitate the racial profiling of Black and racialised people, including UK citizens.[35] The hostile environment and policies stemming from it contributed to the Windrush scandal, which saw hundreds of people of Caribbean heritage living and working in the UK wrongly detained and deported.[36] In 2023, a Home Office commissioned equality impact assessment of the policy found that it disproportionately impacts those who "are visibly not white", particularly people from Black or Southeast Asian backgrounds.[37]

Despite this, the hostile environment remains in full force, and new policies designed to limit the access of immigrants to basic services, and increase their detention and deportation continue to be introduced.[38] Government and media rhetoric on immigration has become increasingly hostile, fuelling racist anti-migrant sentiment across the UK and putting migrants or those perceived to be migrants at risk.[39]

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30 Williams, P., White, L., and Joseph-Salisbury, R. (2023). Omission, erasure and obfuscation in the police institutional killing of Black men. Mortality, 28(2), 250-268, p. 260; Younis, T. (2021). The muddle of institutional racism in mental health. Sociology of Health and Illness, 43(8).

31 see Angiolini, E. (2017). Report of the Independent Review of Deaths and Serious Incidents in Police Custody.; INQUEST. (2023). "I can't breathe': Race, death and British Policing"; INQUEST. (2022). Deaths of racialised people in prison 2015-2022: Challenging racism and discrimination; Pemberton, S. (2008).Demystifying Deaths in Police Custody: Challenging State Talk, Social & Legal Studies, 17(2), 237-262; El-Enany, N. (2023). From Love to Justice: Families' Interrogation of Racial State Violence. Social & Legal Studies, 32(1), 55 - 74.

32For an overview see Yeo, C. (2020). Race, racism and immigration in the United Kingdom: Black Lives Matter. Free Movement; Thomas, L and Neale, D. (2021). The Immigration Act 1971: Celebrated or Flawed? Gresham College; El-Enany, N. (2023). From Love to Justice: Families' Interrogation of Racial State Violence. Social & Legal Studies, 32(1), 55 - 74; Weber, F. (2018). The Embedding of State Hostility: a background paper on the Windrush Scandal. Institute for Race Relations; Taylor, B., Girvan, A., and Matthews, L. (2018). A History of Immigration Detention in the UK (1914-2018). Right to Remain.

33 Gentleman, A. (2022). Windrush scandal caused by '30 years of racist immigration laws' - report. The Guardian; Abbot, D. (2022). The truth is out: Britain's immigration system is racist, and always has been. Now let's fix it. The Guardian.

34 For an overview see Griffiths, M., and Yeo, C. (2021), The UK's hostile environment: Deputising immigration control. Critical Social Policy, 41(1); Weber, F. (2018). The Embedding of State Hostility: a background paper on the Windrush Scandal. Institute for Race Relations, ch. 3.

35 Home Office (2023). Compliant environment: overarching equality impact assessment.; Williams, W. (2018). The report of the Windrush Lessons Learned Independent Review.; JUSTICE. (2021). Reforming the Windrush Compensation Scheme.; Qureshi, A., Morris, M., and Mort, L. (2020). Access Denied: The Human Impact of the Hostile Environment. Institute for Public Policy Research.

36 Williams, W. (2018). The report of the Windrush Lessons Learned Independent Review.; JUSTICE. (2021). "Reforming the Windrush Compensation Scheme."

37 Home Office (2023). Compliant environment: overarching equality impact assessment. Indian, Pakistani, Nigerian and Bangladeshi nationals were most likely to be affected, and more so than being found to be illegally present in the UK.

38 Dugan, E. and Syal, R. (2023). New hostile environment policies show Windrush lessons 'not been learned'. The Guardian; Shah, F. (2022). Most racist law to come to Britain': Protestors voice anger over Nationality and Borders Bill outside Parliament. The Independent; Ahmad, M. et al. (2023). Stoking the Flames. HOPE not hate.

39 Athwal, H. (2015). 'I don't have a life to live': deaths and UK detention. Race & Class, 56(3), 50–68. Taylor, D (2021). Home Office records 70 racist incidents by far right at asylum accommodation. The Guardian.

A hostile immigration system geared towards the detention and removal of racialised people has required the creation and expansion of an immigration detention estate. Immigration detention disproportionately impacts Black and racialised people:

- Black and racialised detainees spend longer in immigration detention than White detainees. Black, Asian and Mixed/Other detainees are more likely to spend over 24 months in immigration detention.[40]
- Of the 26 deaths in immigration detention between 2012 and 2022 the majority involved individuals from Black African, Black Caribbean and South Asian backgrounds.[41]

Mistreatment of migrants held in immigration detention, in particular those from racialised backgrounds and those suffering mental ill health, is well documented. As of 2023, there have been 7 High Court cases finding inhuman and degrading treatment of immigration detainees in breach of Article 3 of the European Convention on Human Rights .[42,43] Stephen Shaw's 2016 review, commissioned by the government in response to the first 5 High Court cases, found "underlying systemic failings" contributing to the mistreatment of vulnerable individuals in immigration detention.[44]

Immigration detention disproportionately impacts Black and racialised people

The report of the public inquiry into the conditions at Brook House Immigration Centre, published in 2023, found that detainees were routinely subjected to degrading treatment, inappropriate and disproportionate use of force, and racist derogatory language by G4S staff - the private company that runs the centre.[45] The report raised concern that the outsourcing of immigration detention to private companies and the further sub-contracting of healthcare provision shifts the chain of responsibility and reduces government accountability, making it difficult to address racist mistreatment, policies and practices.[46] Similar allegations have been made in respect of other immigration detention settings.[47]

40 From analysis of Home Office data and data obtained through freedom of information requests.

41 Analysis of data from Home Office; data obtained through freedom of information requests; INQUEST monitoring data; Institute of Race Relations archive; and Prison and Probation Ombudsman Reports. See **Annex 2: Data**.

42 S v Secretary of State for the Home Department [2011] EWHC 2120 (Admin); BA v Secretary of State for the Home Department [2011] EWHC 2748 (Admin); HA (Nigeria) v Secretary of State for the Home Department [2012] EWHC 979 (Admin), D v Secretary of State for the Home Department [2012] EWHC 2501 (Admin); R (MD) v Secretary of State for the Home Department [2014] EWHC 2249 (Admin); R (VC) v Secretary of State for the Home Department [2018] 1 WLR 478 (appeal to Supreme Court conceded on basis of article 3 breach); R(ARF) v Secretary of State for the Home Department [2017] EWHC 10 (QB); Goodman, A. (2023, December 6). The Brook House Inquiry: Continuing Pressure for Reform of the Article 3 Systems Duty. Brook House Inquiry Conference, Garden Court Chambers.

43 See also Council of Europe. (2023). Report to the United Kingdom Government on the ad hoc visit to United Kingdom carried out by the European Committee for the Prevention of Torture and Inhuman or Degrading Treatment or Punishment from 25 to 28 November 2022.

44 Shaw, S. (2016). Review into the welfare in detention of vulnerable persons: a report to the Home Office by Stephen Shaw.

45 Eves, K. (2023) The Brook House Inquiry Report, Volume 1, HC 1789-I. pp.4,10, 12, 149, 243.; Eves, K. (2023). The Brook House Inquiry Report, Volume 2, HC, 1789-II. p.133-174, 227.

46 Eves, K. (2023). The Brook House Inquiry Report, Volume 2, HC, 1789-II.

47 For instance, un-named author. (2005). Detention Undercover - The Real Story exposes evidence of racism and violence at the heart of the UK's asylum system. BBC News; Prison and Probation Ombudsman. (2005). Report into allegations of racism and mistreatment of detainees at Oakington immigration reception centre and while under escort.; HM Chief Inspector of Prisons. (2006). Report on an announced inspection of Harmondsworth Immigration Removal Centre. p.5; Townsend, M (2013). Detainees at Yarl's Wood immigration centre 'facing sexual abuse'. The Guardian.

APPROACHING DATA

While statistical evidence is useful in highlighting stark injustices and identifying acute issues, caution is advised in interpreting such statistics. Aggregate data may only capture part of the picture due to limitations in data gathering or the absence of certain groups from datasets.[48] The absence of statistical evidence of racial disproportionality in a specific setting does not negate the role of racism in deaths. Qualitative evidence, including the experiences of bereaved families, is crucial.

Practitioners should critically reflect on data sources, consider how racialised groups are defined, and contextualise data within the framework of structural and institutional racism. Simplification may reinforce misconceptions, and practitioners are encouraged to explore alternative data sources and recognise the nuances within racialised groups.

POLICING

Institutional racism in the UK police gained widespread attention with the publication of the Macpherson Report in 1999, following the murder of Stephen Lawrence.[49] Subsequent reviews and inquiries have affirmed the persistence of racism within the police and the wider criminal justice system.[50] In 2023, Baroness Casey's review of the Metropolitan Police found ongoing institutional racism, misogyny and homophobia,[51] and highlighted over-policing and disproportionate use of force against Black communities in particular.[52]

Statistical data indicates that in England and Wales, Black and racialised individuals face disproportionate involvement in the criminal justice system due to discriminatory policing practices:

- In the year ending in March 2022 Black people were 5.2 times more likely than White British people to be stopped and searched.[53] Individuals categorised as "Asian other" were 3.9 times more likely to be stopped as searched.[54] Individuals categorised as Gypsy or Irish Traveller were 1.75 times more likely to be stopped and searched.[55] Around 70 per cent of stop and searches lead to no further action.[56]

48 For instance, lack of robust data on Gypsy, Roma and Traveller people and the experiences of racialised women. HM Chief Inspector of Prisons for England and Wales. (2021). Annual Report 2020-2021, p.12; Prison Reform Trust. (2017). Counted Out: Black, Asian and minority ethnic women in the criminal justice system, p. 5; also Judicial College. (2023). Equal Treatment Bench Book, p.222.

49 MacPherson, W. (1999). The Stephen Lawrence Inquiry, Cm 4262-I. Stationery Office Limited.

50 Lammy, D. (2017). The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System.; Angiolini, E. (2017). Report of the Independent Review of Deaths and Serious Incidents in Police Custody.; Commission on Race and Ethnic Disparities (2021). Commission on Race and Ethnic Disparities: The Report.; Joint Committee on Human Rights. (2020). Eleventh Report of Session 2019–21,Black people, racism and human rights. HC 559 and HL Paper 165; Greater Manchester Police. (2021). Achieving Race Equality Report; Ministry of Justice. (2013). Race Review 2008: Implementing Race Equality in Prisons – Five Years On.

51 Casey, L. (2023). Final Report: An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service. p.7 and Ch. 9.

52 *ibid*. p.19.

53 This includes Black African, Black Caribbean or Other Black backgrounds. This reflects ethnicity reported when stopped and searched. The government recognises that the circumstances of a stop and search might affect the accuracy of the ethnicity information recorded. Ethnicity Facts and Figures (2023) Stop and search. This disproportionality has persisted over time, see also previous years statistics.

54 Ethnicity Facts and Figures (2023) Stop and search. This disproportionality has persisted over time, see also previous years statistics.

55 *ibid*

56 Home Office. (2023). Police powers and procedures: Stop and search, and arrests, England and Wales, year ending 31 March 2023. See also previous years.

- Most searches are officially justified on the basis of finding drugs.[57] Drug searches of racialised people have a higher rate of weak recorded grounds than equivalent searches on white people, "despite evidence that there is no correlation between ethnicity and drug use."[58]
- Black people are disproportionately likely to appear on gang databases. A 2017 report by Amnesty International found that Black people accounted for 78% of gang nominals on the Metropolitan Police's gang matrix.[59]
- Programmes like the Home Office's Prevent strategy, which has been found to disproportionately target South Asian and Muslim communities[60] including by Amnesty International and the UN,[61] further increase police surveillance of racialised people.[62] Gypsy, Roma, Traveller ("GRT") ethnicity has similarly been found to be treated as a 'risk factor' justifying higher levels of response by police.[63]

Black people in particular are disproportionately likely to experience police violence:

- In the year ending March 2023, individuals perceived as Black had force used against them by the Metropolitan police at a rate 3.5 times higher than those perceived as white. In the rest of the country, Black individuals were subject to police force at a rate 3.3 times higher than white individuals.[64]
- Analysis undertaken in 2020 revealed that Black people were 7.7 times more likely than white people to have Tasers used against them.[65] Black people were also more likely to be tasered for longer. [66]
- For the years 2012-13 to 2021-22 Black people were 6 times more likely to die than white people following the use of police force.[67] Analysis by INQUEST found that Black people were 7 times more likely to die than white people following police restraint in particular.[68]

Individuals with mental health problems also face an elevated risk. From 2012-13 to 2021-22, 57.8% of deaths following police use of force involved an individual identified as having mental health concerns. Of these 25% were from racialised backgrounds, and 16% were Black.[69]

57 *ibid*

58 HM Inspectorate of Constabulary and Fire & Rescue Services. (2021). Disproportionate use of police powers: A spotlight on stop and search and the use of force.

59 Amnesty International. (2017). Trapped in the Matrix; Research conducted by Patrick Williams and others in 2016 found that Black and racialised people made up 89% of gang nominals on Greater Manchester Police's gang matrix. Black people accounted for 81% of nominals, despite accounting for only 6% of serious youth violence. Williams, P., and Clarke, B. (2016). Dangerous associations: Joint enterprise, gangs and racism. Centre for Crime and Justice Studies.

60 Murtuja, B., and Tufail, W. (2017), Rethinking Prevent: A Case for an Alternative Approach. Just Yorkshire; Qurashi, F. (2018). The Prevent strategy and the UK 'war on terror': embedding infrastructures of surveillance in Muslim communities. Palgrave Commun, 4, 17.

61 See comments of Professor Fionnuala D. Ní Aoláin in J, Holmwood., and L, Aitlhadj. (2022). The People's Review of Prevent, pp.x -xi; Amnesty International. (2023). 'This is the Thought Police' The Prevent duty and its chilling effect on human rights.

62 Joseph-Salisbury, R., Connelly, L., and Wangari-Jones, P. (2021). "The UK is not innocent": Black Lives Matter, policing and abolition in the UK. Equality, Diversity and Inclusion: An International Journal, 40 (1), 21-28; Qurashi, F. (2018). The Prevent strategy and the UK 'war on terror': embedding infrastructures of surveillance in Muslim communities. Palgrave Commun, 4, 17.

63 The Traveller Movement. (2018). Policing by Consent.

64 Home Office. (2023). Police use of force statistics, England and Wales: April 2022 to March 2023.

65 Busby, M. (2020). Rights groups quit police body over stun gun use against BAME people. The Guardian.

66 The review of cases from 2015-2020 found that 60% of Black people who were subject to Taser discharge endured them for more than five seconds, compared with 29% of white people. Dodd, V. (2021). Black people more likely to be Tasered for longer, police watchdog finds. The Guardian.

67 From freedom of information data obtained by JUSTICE in 2023. This includes deaths involving physical restraint, restraint equipment, taser, baton, CS/PAVA spray and stun grenade. It includes deaths in custody and "other deaths following police contact" as categorised by the Independent Office for Police Conduct. For breakdown of deaths by race and type of force see Annex 2: Data.

68 INQUEST. (2023). "I can't breathe': Race, death and British Policing"

69 From freedom of information data obtained by JUSTICE in 2023. This includes deaths involving physical restraint, restraint equipment, taser, baton, CS/PAVA spray and stun grenade. It includes deaths in custody and "other deaths following police contact" as categorised by the Independent Office for Police Conduct. For breakdown of deaths by race and type of force see Annex 2: Data.

THE PRISON SYSTEM

Black and racialised people are, and have consistently been, disproportionately represented in the prison estate.[70] While in prison, Black and racialised people are more likely to be subject to negative treatment and have poorer outcomes. Official data shows that:

- Black and racialised people entering prison are less likely to have vulnerabilities – such as substance misuse, mental ill health or learning disabilities – identified.[71]
- Black prisoners are consistently overrepresented in the prison adjudication process, despite adjudications against Black prisoners being less likely to be proven.[72]
- Black and racialised prisoners are more likely to be subject to Basic Incentives and Earned Privilege status – the lowest level of privileges.[73]

While the government doesn't routinely publish data on the use of force and segregation in prison broken down by race, available data suggests that Black and racialised individuals are disproportionately affected by these measures:

- Between 2019 and 2022 Black prisoners were 7 times more likely to have PAVA spray used against them than white prisoners.[74] Prisoners who identified as Asian, Asian British, mixed, or other ethnic group were 3 times more likely than white prisoners to have PAVA spray used against them.[75]
- Black male prisoners are more likely to have spent time in segregation than other ethnic groups– 15% compared to 9% - with Black Muslim prisoners most likely to report being subject to segregation or use of force.[76]

THE MENTAL HEALTH SYSTEM

The role of institutional racism in the mental health system first received state recognition following the death of David (Rocky) Bennett, a young Black Caribbean in-patient who died after ward staff applied excessive physical restraint against him.[77] The report of the inquiry into his death found that "institutional racism has been present in the mental health services, both NHS and private, for many years."[78]

In 2022, almost 20 years later, a rapid review by the NHS Race and Health Observatory, found persistent inequalities in healthcare in the UK, including mental health care, "rooted in experiences of structural, institutional, and interpersonal racism."[79]

In particular, Black and racialised people are disproportionately likely to be subject to coercive mental health interventions and detention.

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70 In 2022, Black and racialised people made up 28% of the prison population, despite making up just 18% of the population as a whole. Black people made up 13% of the prison population, despite making up 4% of the general population. The proportions of people in prison by ethnicity have remained fairly static since 2013. Ministry of Justice. (2022). Her Majesty's Prison and Probation Service Offender Equalities Annual Report 2021/2022, p.5.

71 Lammy, D. (2017). The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System. pp.45-48.

72 HM Chief Inspector of Prisons. (2022). Thematic review: The experiences of adult black male prisoners and black prison staff. p.64; Ministry of Justice. (2019). Adjudications: England and Wales, 2011-2018. p.6.

73 Ministry of Justice. (2022). Her Majesty's Prison and Probation Service Offender Equalities Annual Report 2021/2022, p.14-15.

74 HM Chief Inspector of Prisons. (2022). Thematic review: The experiences of adult black male prisoners and black prison staff, p.8.; un-named author. (2023). Race gap in use of pepper spray. Inside Time Reports.

75 un-named. (2023). Race gap in use of pepper spray. Inside Time Reports.

76 HM Chief Inspector of Prisons. (2022). Thematic review: The experiences of adult black male prisoners and black prison, p. 65.

77 The report of the inquiry into his death found that "there was evidence of incidents of institutional racism from time to time through the lengthy period that David Bennett was suffering from mental health problems…They indicate that institutional racism has been present in the mental health services, both NHS and private, for many years."Blofeld, J., (2003). Independent Inquiry into the death of David Bennett, p.25.

78 *ibid.*

79 Kapadia, D., et al. (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory, p.10.

- In 2021 – 2022, Community Treatment Orders were used for the 'Black or Black British' group at over 11 times the rate for the white group.[80] Black patients are also over represented in assertive outreach services.[81]
- Black and racialised people are disproportionately likely to experience compulsory detention under the Mental Health Act compared to their White British counterparts. For the year 2020-2021 Black or Black British people were detained at 4 times the rate of white people; mixed ethnicity groups at 1.8 times the rate; and Asian or Asian British people at 1.2 times the rate.[82]
- Black patients and those in the "White other" group are also more likely to have had contact with the police or criminal justice system. Conversely, they are less likely to have had contact with a general practitioner prior to admission to hospital.[83]

Once in detention evidence suggests that Black are racialised people are also more likely to be subject to violence and mistreatment.

- For the year 2021-22 Black or Black British patients were subject to restrictive interventions, including physical, chemical and mechanical restraint, and seclusion,[84] at 5.3 times the rate of White British patients. Patients categorised as Black Other were subject to restrictive interventions at 12 times the rate of White British patients. Individuals in the Gypsy/ Traveller group were subject to restrictive interventions at 1.7 times the rate.[85]
- Evidence indicates that Black Caribbean people are 1.45 times more likely to be restrained in the prone position in mental health settings than their white counterparts,[86] and that patients from Black African, Black Caribbean, Black Other and Mixed ethnic backgrounds are nearly twice as likely to be put in seclusion compared with white patients.[87]
- These disparities exist despite Seni's Law, formally known as the Mental Health Units (Use of Force) Act 2018, which was introduced in recognition of the wide-spread and disproportionate use of restraint against Black people in mental health settings.[88]
- Qualitative studies reviewed by the NHS rapid review, found evidence of Black people being beaten on wards, with Black patients expressing feeling unsafe due to abuse from staff and other patients.[89]

80 Care Quality Commission. (2022). Monitoring the Mental Health Act in 2021/22, p.39.

81 Nazroo, B. et al. (2020). Where next for understanding race/ethnic inequalities in severe mental illness? Structural, interpersonal and institutional racism, p.271.

82 UK Parliament POST. (2022). Mental Health Act Reform – Race and Ethnic Inequalities, p.2. In 2022, the NHS Rapid found strong evidence of persisting inequalities in compulsory admission to psychiatric wards, particularly affecting Black, Mixed Black and white, and South Asian people. Studies have also show persistent disproportionality in admission rates for individuals categorised as "White other." Kapadia, D., et al., (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory; Halvorsrud, K. et al. (2018). Ethnic inequalities and pathways to care in psychosis in England: a systematic review and meta-analysis,BMC Med 16.

83 Kapadia, D., et al., (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory; UK Parliament POST. (2022). Mental Health Act Reform – Race and Ethnic Inequalities, p.2.

84 NHS Digital. Definitions of restrictive interventions for use in Assuring Transformation.

85 NHS Digital (2019). Mental Health Bulletin: 2021-22 Reference Tables, tab 18.

86 Payne-Gill, J., et al. (2021). The relationship between ethnic background and the use of restrictive practices to manage incidents of violence or aggression in psychiatric inpatient settings. Int J Ment Health Nurs. 30(5), 1221; Kapadia, D., et al., (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory, p.39, 44, 88

87 Payne-Gill, J., et al. (2021). The relationship between ethnic background and the use of restrictive practices to manage incidents of violence or aggression in psychiatric inpatient settings. Int J Ment Health Nurs. 30(5), 1221.

88 INQUEST. (2018). Family celebrate lasting legacy as 'Seni's Law' receives Royal Assent.

89 Kapadia, D., et al., (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory, p.44.

- Black African and Caribbean communities, in particular, have expressed a real fear of death when interacting with the mental healthcare system.[90]

Research also suggests that Black and racialised people in the mental health system are subject to racial stereotyping.

For instance, while South Asian women have comparatively high suicide and self harm rates,[91] studies suggest that stereotypes of South Asian communities "look[ing] out for their own" lead to a lack of recognition of their mental healthcare needs.[92] The embedding of counter-terrorism policies such as Prevent in mental health settings also entrenches racial stereotypes.[93] Two-thirds of NHS referrals to Prevent come from Mental Health Trusts. From a sample of NHS trusts,[94] Muslims were found to be at least eight times more likely than non-Muslims – and Asians at least four times more likely than non-Asians – to be referred to Prevent.[95]

THE ROLE OF RACIAL STEREOTYPING IN DEATHS IN CUSTODY

As set out above, racial stereotyping of Black and racialised people is a prominent issue within each of the different custody settings. INQUEST's casework has also repeatedly highlighted how racial stereotyping can result in disciplinary treatment and bring about a culture of disbelief.

Analyses of deaths in prison[96] and police custody[97] have identified how these institutions often engage in the stereotyping of Black and racialised people as 'aggressive', 'risky' and dangerous'. The racial stereotyping of Black men as being extraordinarily big and possessing excessive strength is a consistent theme, particularly in reference to deaths in police custody.[98] Additionally, prisons and police often emphasise Black and racialised people's real or imagined link to criminality, typically through a gangs narrative which underscores drugs and weapons, while Muslim people in prison are often stereotyped through the lens of terrorism.[99]

90 Wessely, S., et al. (2018). Modernising the Mental Health Act: Increasing choice, reducing compulsion – Final report of the Independent Review of the Mental Health Act 1983. p. 98.

91 Lawrence, V., McCombie, C., Nikolakopoulos, G., & Morgan, C. (2021). Navigating the mental health system: Narratives of identity and recovery among people with psychosis across ethnic groups.Social Science & Medicine, 279; and Abel, K., & Newbigging, K. (2018). Addressing unmet needs in women's mental health. British Medical Association. p.4; Bignall, T. et al. (2019). Racial disparities in mental health: Literature and evidence review. Race Equality Foundation, p.15; Husain, M. et al. (2006) Self-harm in British South Asian Women: Psychosocial Correlates and Strategies for Prevention. Annals of General Psychiatry.

92 Barr, J., (2002). Cultural stereotypes of women from South Asian communities: mental health care professionals' explanations for patterns of suicide and depression.

93 Home Office. (2023). Prevent duty guidance: Guidance for specified authorities in England and Wales, p.47-52; NHS England. (2017). Guidance for mental health services in exercising duties to safeguard people from the risk of radicalisation, p.12; and Nursing Times. (2022). Prevent: the role of mental health nurses in counter-terrorism programmes; Abu-Hayyeh, R. (2018). The Prevent duty in the NHS: implementation and impacts.

94 Heath-Kelly, C., and Strausz, E. (2018). Counter-terrorism in the NHS: Evaluating Prevent Duty Safeguarding in the NHS. University of Warwick, p.58.

95 Aked, H. (2020). False positives: the Prevent counter-extremism policy in healthcare, p.10.

96 HM Chief Inspector of Prisons. (2022). Thematic review: The experiences of adult black male prisoners and black prison staff, p.8, 25-26, 64; INQUEST. Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination. pp.45, 63-4; Clinks (2020). Submission to the Joint Human Rights Committee Inquiry on Black People, Racism and Human Rights, p.2; Cox, J., and Sacks-Jones, K. (2017). "Double disadvantage" The experiences of Black, Asian and Minority Ethnic women in the criminal justice system, p.7.; Prison Reform Trust. (2017). Counted Out: Black, Asian and minority ethnic women in the criminal justice system, p. 29.

97 INQUEST. (2023). 'I can't breathe': Race, death and British Policing; Angiolini, E. (2017). Report of the Independent Review of Deaths and Serious Incidents in Police Custody; Casale, S. (2013). Report of the independent external review of IPCC investigation into the death of Sean Rigg.

98 *ibid.*

99 Williams, P., and Clarke, B. (2016). Dangerous associations: Joint enterprise, gangs and racism. Centre for Crime and Justice Studies; HM Chief Inspector of Prisons. (2022). Thematic review: The experiences of adult black male prisoners and black prison staff; Mohammed, R., and Nickolls, L. (2020). Time to end the silence: The experience of Muslims in the prison system. Maslaha.

Black and racialised people in immigration detention settings can be impacted by further stereotyping surrounding illegality. A criminal trial into the restraint death of Jimmy Mubenga on a deportation plane to Angola exposed 'grossly offensive and undoubtedly racist' text messages on the phones of two G4S security guards involved in his death. The text messages were 'racist about immigration', using descriptions such as 'free-loading, benefit grabbing... non-English speaking... and... bomb making'.[100]

Black and racialised people with mental health issues are subject to additional stereotyping around 'madness' which can result in being met with discipline rather than care.[101] For example, the inquest into the death of Sean Rigg, a Black man in a mental health crisis, found that the failure to recognise Sean as a vulnerable person at the point of arrest and take him to an Accident and Emergency department rather than a police station contributed to his death.[102]

Sean's death also raises how racial stereotyping can contribute to a culture of disbelief, characterised by a refusal to accept symptoms of vulnerability or distress as genuine.[103] After Sean had been subject to eight minutes of prone restraint by police officers, he was taken to a custody suite where he slumped onto the floor with his eyes closed. Police officers said he was 'faking' unconsciousness.[104] After Olaseni Lewis, a Black man in a mental health crisis, collapsed after restraint by eleven police officers, police officers said they left the room 'in case he was feigning, passing out as a ploy to escape'.[105]

Racial stereotyping can contribute to a culture of disbelief, characterised by a refusal to accept symptoms of vulnerability or distress as genuine

100 Booth, R. (2014). Jimmy Mubenga: Judge refused to allow jury to hear about guards' racist texts. The Guardian.

101 Angiolini, E. (2017) Report of the Independent Review of Deaths and Serious Incidents in Police Custody.; Bruce-Jones, E. (2021). Mental health and death in custody: the Angiolini Review. Race & Class, 62(3), 7–17; Baker, D., and Pillinger, C. (2020). 'These people are vulnerable, they aren't criminals': Mental health, the use of force and deaths after police contact in England. The Police Journal: Theory, Practice and Principles, 93(1), 65–81; United Nations (2018). UN human rights experts says deaths in custody reinforce concerns about 'structural racism' in UK.

102 INQUEST. (2012). Jury condemns actions of the police and mental health trust in verdict over death of Sean Rigg.

103 See also Athwal, H., and Bourne, J. (2015). Dying for Justice. Institute of Race Relations.; Cox, J. and Sacks-Jones, K. (2017). "Double disadvantage": The experiences of Black, Asian and Minority Ethnic women in the criminal justice system. Agenda. INQUEST. (2018). Still Dying on the Inside: examining deaths in women's prisons.

104 Independent Office for Police Conduct. (2023). The circumstances of Sean Rigg's death, and the history of the IPCC and IOPC involvement. p.1

105 INQUEST. (2020). INQUEST submission to the joint committee on human rights inquiry into black people, racism and human rights. p.13.

PART TWO

APPROACHING A CASE AS A PRACTITIONER

This section provides guidance on how to approach a case concerning the death of a Black or racialised person in state custody.

Given the social and historical context surrounding racism in state institutions, and the disparities that exist concerning the treatment and deaths of Black and racialised people in state custody, practitioners should always approach a case from the position that racism may have played a role in that death.

When approaching a case practitioners should:

- **Recognise** institutional and structural racism.
- **Recognise** biases and system limitations.
- **Listen** to bereaved families.
- **Be creative and strategic** in pursuing issues of racism.

Taking these steps will enable practitioners to (i) identify and better understand the racial and intersectional dynamics that may have contributed to an individual's death, (ii) centre the voices of the families, (iii) exercise discretion to ensure raising issues of race aligns strategically with the case and does not inadvertently undermine its effectiveness (iv) challenge the tendency to be overly cautious merely to avoid upsetting the coroner or jury, and instead prioritise the pursuit of justice and truth (v) provide better representation to bereaved families and empathise more closely with them.[106]

Much of this checklist is also relevant to those investigating the death, for instance, Independent Office for Police Conduct or Prison and Probation Ombudsman investigators. For specific guidance for coroners see **Part 5: Guidance for Coroners.** Moreover, it can apply to other state-related deaths beyond those in a state custody context.

RECOGNISING INSTITUTIONAL AND STRUCTURAL RACISM

As set out in Part 1 of this guide, the deaths of Black and racialised people in state custody must be viewed within the systems and structures in which they occur.

When approaching a case, it is therefore important that practitioners develop an understanding of:

- How structural and institutional racism shapes the experiences of the specific racialised group(s) to which the individual in the case belongs.
- The experiences of that racialised group within the institutional context in which the death occurred, including disparities that exist in relation to the treatment of members of that group.
- How race intersects with other identity characteristics, such as gender, class, and disability, to further entrench disadvantage.

Developing an understanding of institutional and structural racism, and how it might manifest in a particular case will require dedicated research.

When approaching a particular case, the family of the individual who has died may provide valuable insights into their and their loved one's experiences of racism. Practitioners should listen to these insights. However, bereaved family members should not be expected to educate practitioners on racism.

Practitioners should also remember that while developing an understanding of racism is key to recognising it, if they are not from the same racial background as the individual in the case, they are unlikely to fully understand their experiences. Even where practitioners are from the same racial background as the deceased, the intersection of race and class, for example, may mean that they cannot fully appreciate the experiences of the deceased.[107]

106 Influenced by Chapter Five: Anti-racist lawyers in B, Malkani. (2023). Racial Justice and the Limits of the Law. (unpublished).

107 Howard League for Penal Reform. (2021). Making Black lives matter in the criminal justice system: a guide for anti racist lawyers.

RECOGNISING BIASES AND LIMITATIONS

The legal profession, historically dominated by individuals from white and middle-class backgrounds, may inadvertently perpetuate biases and prejudices.[108] Encouraging self-awareness, constructive self-criticism, and regular self-examination is vital in fostering a culture that challenges biases.[109] This involves practitioners recognising where prejudices may arise, and understanding the limitations of the systems they work within.[110]

Recognising biases

When approachingw a case concerning a Black or racialised person, practitioners should be vigilant about potential biases that might influence their perspective. This includes avoiding stereotypical assumptions about the deceased, their family and friends, or their culture and background.

Practitioners need to consider how biases might impact their views of Black and racialised families raising issues of race. Bereaved families consulted by INQUEST expressed hesitation in addressing race during inquests due to concerns about being perceived as 'playing the race card.'[111]

While biases may be unintentional, they can influence decision-making and behaviour.[112] Acknowledging unintentional biases is the first step toward mitigation.[113]

CHECKLIST FOR REFLECTING ON AND ADDRESSING BIAS

TO MITIGATE BIAS, PRACTITIONERS SHOULD:

- ☑ Acknowledge the influence of unintentional bias on decisions and behaviour.
- ☑ Reflect on potential preferences for 'official' or 'state-sanctioned' accounts and examine underlying reasons for this.
- ☑ Consider the perspective and experiences of the deceased person or their family.[114]
- ☑ Identify and challenge biased assumptions and responses.
- ☑ Examine and replace stereotypes attached to the deceased and their family to ensure a non-stereotyping approach. For instance, practitioners should avoid assuming that Black and racialised families raising race-related issues are merely 'playing the race card,' and instead recognise the validity of their concerns about their loved one's death.[115]

108 L, Thomas. (2021). Racial equality and diversity in the legal profession. Bar Standards Board; A, Johnson. (2020). We Must Challenge Racism in The Courtroom. Each Other.

109 B, Malkani. (2023). Racial Justice and the Limits of the Law. (unpublished).

110 *ibid*.

111 INQUEST. (2023). I can't breathe': Race, death and British Policing.

112 For an overview of studies in this area see Annotated Bibliography Implicit Bias Studies in K, Henning., et al. Racial Justice for Youth: A Toolkit for Defenders. Georgetown Juvenile Justice Clinic & Initiative and The Gault Centre: Defenders of Youth Rights.

113 D, Atewologun., T, Cornish., F, Tresh. (2018). Unconscious bias training: An assessment of the evidence for effectiveness. Equality and Human Rights Commission.

114 A, Lindsey et al. (2014). The Impact of Method, Motivation, and Empathy on Diversity Training Effectiveness.J Bus Psychol 30.

115 This list is influenced by the training developed by Professor Kristin Henning at the Georgetown University Law Centre. See Youth Justice Legal Centre. (2021). Fighting Racial Injustice: Background, childhood, legal representation and trauma. Youth Justice Legal Centre. p.10. And also resources available through K, Henning., et al. Racial Justice for Youth: A Toolkit for Defenders. Georgetown Juvenile Justice Clinic & Initiative and The Gault Centre: Defenders of Youth Rights.

Recognising system limitations

It is also important to reflect on the limits of the coronial system in combating racial injustice, and the challenges practitioners may face in raising issues of race and racism. While there are strong legal reasons for raising issues of racism at inquests (see **Part 3: Raising Issues of Race and Racism**) this task is often far from straightforward.[116]

First, there appears to be a discomfort among some coroners about including issues of race in the scope of their investigations.[117] Several practitioners interviewed by INQUEST found that some coroners took issue with attempts to argue for its inclusion in inquests and considered suggestions that racial stereotyping had played a role in a person's death as "rude," "offensive", or "casting character aspersions."[118] This discomfort reflects wider negative attitudes towards naming racism in British society.[119]

Second, there appears to be a lack of understanding amongst some coroners of the structural and institutional dimensions of racism, and how these manifest in deaths in state custody cases.[120] This lack of understanding means that in the absence of overt racism or discrimination, for instance, the use of racist language, coroners may not see the relevance of race to the death.[121] However, most deaths in state custody do not involve this kind of racism. In these cases, practitioners have found it hard to persuade coroners to look at systemic racism as part of the circumstances in which the death occurred.[122]

The hesitance of some coroners to investigate the role of race in a death can create challenges when raising such issues at an inquest. Lawyers and bereaved family members have expressed concerns that discussing race might harm their case and add additional stress to an already difficult process.[123] Similar reservations have been voiced by practitioners in relation to juries. In particular, there's a concern that suggesting race played a role could lead to a negative jury response, potentially overshadowing crucial aspects of the case.[124]

However, although practitioners must be aware of these limitations, they should not be paralysing. As noted by one practitioner, raising issues of race and racism "will always be distasteful unless somebody takes a position."[125] Moreover, the more practitioners leave issues of race out of their representations, the more the legal system fails to acknowledge and address the role of racism in deaths in state custody. Practitioners have a responsibility to raise race and racism where appropriate.

Acknowledging the above limitations does, however, make it critical that practitioners listen to and work collaboratively with the family of the deceased and those individuals and organisations that support them to develop strategies for approaching issues of race effectively.

116 INQUEST. (2023). I can't breathe': Race, death and British Policing.
117 *ibid,* p.118.
118 *ibid.*
119 *ibid.* p. 62.
120 *ibid.*
121 *ibid.*
122 *ibid.*
123 *ibid.*
124 *ibid.* p.119.
125 *ibid.* p.120.

LISTENING TO BEREAVED FAMILIES

When approaching a case concerning the death of a Black or racialised person in state custody practitioners should listen to and ensure the interests of their family remain central.

If a family member believes that race was a factor in their loved one's death, practitioners should attach significant weight to this. They are likely to have a more informed understanding of the experiences of the person who has died in state custody, and the racism they may have faced in their interactions with the state, both historically and to the present. Practitioners should take time to learn why family members consider racism to have been a factor, and what role they consider it to have played in the death of their loved one.

Sometimes family members will not have considered whether race may have played a role in the death. Bereaved family members may not, for instance, be aware of there being a pattern of deaths of Black and racialised people in the institutional setting in which their loved one died. In this circumstance, it may be appropriate to draw attention to the potential role of race in the death of their loved one. This will allow families to make an informed decision about whether they wish to pursue this at the inquest or investigation into the death. Moreover, it will ensure that families are not blind-sided should evidence indicating racism arise further down the line.[126]

Particular care should be taken when highlighting the potential role that race may have played. For some, learning that race could have been a factor in the death may reduce feelings of isolation, and provide a sense of solidarity and connection with other bereaved families,[127] and may help them make sense of the treatment their loved one was subjected to. For others, learning that the death of their loved one is part of a wider pattern may be highly distressing.[128]

There may also be times when family members do not believe that race played a role in the death, even once this is suggested. Equally, there may be families who decide that they do not wish to raise race at the inquest or investigation, despite believing that it did play a role. In these situations, it is also important to respect and listen to their views.[129] Pursuing issues of race at an inquest without the support of the family is likely to do more harm than good.[130] Practitioners must make sure they do not disempower their clients by placing their pursuit of racial justice over and above the views and interests of the client.[131]

However, as INQUEST caseworkers have found, the views of bereaved families do sometimes change, particularly as new evidence comes to light. Practitioners should continue to present evidence of racism to the family when it arises – while being sensitive to the trauma this can cause. Practitioners should make clear that family members are entitled to change their views and should give them the opportunity to do so throughout the process.
For guidance on speaking to bereaved families about raising issues of race and racism see **Checklist 1.**

126 From conversations with the INQUEST Casework Team.

127 *ibid*. See also El-Enany, N. (2023). From Love to Justice: Families' Interrogation of Racial State Violence. Social & Legal Studies, 32(1), 55 - 74

128 The INQUEST Casework Team highlighted the role of collective trauma in contributing to the distress of bereaved family members in this context. For a definition of collective trauma see Collective Trauma in American Psychological Association. (2023). Culturally Informed Trauma and Grief Recovery Toolkit.

129 See B, Malkani. (2023). Racial Justice and the Limits of the Law. (unpublished); Kraemer, T., and Patten, E. (2014). Establishing a Trauma-Informed Lawyer-Client Relationship (Part One). ABA Child Law Practice, 33(10), 197 - 202, p. 199.

130 *ibid* and INQUEST Casework Team.

131 B, Malkani. (2023). Racial Justice and the Limits of the Law. (unpublished).

STRATEGIC APPROACHES TO ADDRESSING ISSUES OF RACE AND RACISM

As set out earlier, there are various challenges associated with addressing issues of race and racism at inquests. Successfully navigating these obstacles requires practitioners to approach these issues with creativity and strategic thinking. Each case presents unique opportunities for such approaches, and this guide may not capture all possibilities.

For instance, since deaths in state custody may not always involve explicit racism, such as racial slurs, practitioners must discern how issues of race and racism manifest in a case. Developing creative strategies to demonstrate their relevance becomes crucial. Specific guidance on raising and evidencing racism at inquests or other post-death investigations is detailed in **Part 3** and **Part 4** of this guide.

In developing strategies, practitioners may also benefit from the experience of organisations such as INQUEST and others working within the community. Such organisations may have useful information on the area in which the death occurred, and on previous cases which raised similar issues.

PART THREE

RAISING ISSUES OF RACE AND RACISM

This section provides guidance for practitioners on how to raise issues of race and racism at an inquest into a death of a Black or racialised person in state custody. This includes:

- Guidance on when to raise issues of race or racism.
- Legal arguments which might be used to encourage a coroner and others responsible for post-death investigations to investigate the role of race.
- Legal arguments that can be utilised to encourage a coroner to draw inferences of racism from the surrounding facts of the case.
- Specific guidance on preliminary investigations; their importance; and why issues of race and racism ought to be in their terms of reference.

Checklist 2 provides a practitioner's checklist for raising issues of race and racism.

WHEN TO RAISE THE ISSUE OF RACE AND RACISM

There are two routes by which an inquest may need to investigate discrimination. The first is that Article 2 of the European Convention of Human Rights may require the coroner to investigate it. The second is that, if the Coroner decides that alleged discrimination falls within "how" or "how and in what circumstances" the deceased came by their death, then the inquest will be obliged to investigate it. These are explained in more detail below.

Generally speaking, it will be prudent to get issues of race and racism investigated as early as possible in the post-death investigation process. Coroners will often rely on preliminary investigations, such as those carried out by the Independent Office for Police Conduct or the Prison and Probation Ombudsman, when deciding the scope of the inquest. This means that race is more likely to be addressed at an inquest if it was included in the initial investigation. Additionally, inquests often take place years after the death, by which time certain evidence indicating the role of race in the death might not be available.

Race is more likely to be addressed at an inquest if it was included in the initial investigation

As for the inquest itself, practitioners will normally wish to get issues of race and racism in the scope of the investigation. This will require raising these issues at the Pre-Inquest Review. However, practitioners consulted have expressed some caution about this. If issues of race and racism are expressly excluded from the scope of the investigation at this stage, then it may not be possible to raise these issues at the inquest itself. Practitioners may, therefore, opt to defer raising issues of race until the inquest itself. This will involve finding constructive ways to bring these concerns within the framework established during the Pre-Inquest Review, or persuading the coroner to expand the inquest's scope sufficiently to accommodate discussions of race and racism later on. Additionally, it may entail devising innovative strategies to ensure that essential witnesses are called and relevant evidence is disclosed to support claims of racism during the inquest itself.

When deciding whether to raise issues of race and racism at the Pre-Inquest Review, practitioners should consider whether there are factors that may make it difficult to get race in scope at that stage. For instance, practitioners may feel that they do not have enough evidence at the Pre-Inquest Review to demonstrate the relevance of race to the death. Equally, practitioners may decide that there may be less contentious ways of getting the relevant evidence investigated by coroners, and may therefore decide not to raise it and run the risk of the issue being excluded entirely.

OVERVIEW OF ARTICLE 2 ECHR

Article 2 of the European Convention on Human Rights (ECHR) is the right to life. It contains a procedural duty, which arises in the context of certain deaths, which requires the state to bring about an independent and effective official investigation. This is sometimes referred to as "the enhanced procedural duty". It arises where there is a "particularly compelling reason" for the state to account for the death because of potential "state responsibility" for it: R (on the application of Maguire) v HM Senior Coroner for Blackpool & Fylde and another [2023] UKSC 20 at §15 and 17. In certain circumstances, the duty arises automatically. Where the duty is not automatic, it can nevertheless be arguable – when there is a credible allegation that the authorities breached one or more of the substantive Article 2 duties.

Whether or not the enhanced procedural duty is raised in a discrete case can be a complicated question; addressing those intricacies is outside the scope of this guide. However, the leading case is R. (on the application of Middleton) v HM Coroner for West Somerset [2004] 2 A.C. 182: see §2-3, for example. Further guidance can be

found in the LAG book Inquests – a Practitioner's Guide by Thomas et al; and the Article 2 chapter in the Sweet and Maxwell encyclopaedia Human Rights Practice.

Article 2 also requires the investigation of any violent or suspicious death, even if there is no allegation that the state had any responsibility for it. That is:

"this obligation requires that there should be some form of effective official investigation when there is reason to believe that an individual has sustained life-threatening injuries in suspicious circumstances... the authorities must act of their own motion once the matter has come to their attention. They cannot leave it to the initiative of the next-of-kin either to lodge a formal complaint or to request particular lines of inquiry or investigative procedures... Although there was no State involvement in the death of the applicants' relative, the Court considers that the above-mentioned basic procedural requirements apply with equal force...": Angelova v Bulgaria (2008) 47 EHRR 7 at §92-98, and Menson v United Kingdom (47916/99) 6 May 2003.

This is sometimes referred to as the "Menson duty".

INTERROGATING THE ISSUES: EXPLORING RACE AND RACISM

There are strong legal reasons for coroners to investigate the role of race and racism during an Article 2 inquest into the death of a Black or racialised person in state custody. The first stems from the Article 2 duty to investigate credible suspicion that there was a racially induced or discriminatory motive in the treatment leading to death. The second stems from the coroner's discretion. In an Article 2 inquest, the coroner has the discretion to investigate any issues they deem are within the 'means and in what circumstances' the deceased died. The following will outline both routes.

Article 2 duty to investigate discrimination

The Article 2 investigative duties, which are outlined above, include a duty to investigate any credible suspicion that there was a racially induced or discriminatory motive for treatment leading to the deprivation of life. In Nachova v Bulgaria,[132] the Grand Chamber explained:

"160 "... States have a general obligation under Article 2 of the Convention to conduct an effective investigation in cases of deprivation of life.

That obligation must be discharged without discrimination, as required by Article 14 of the Convention ... [W]here there is suspicion that racial attitudes induced a violent act it is particularly important that the official investigation is pursued with vigour and impartiality, having regard to the need to reassert continuously society's condemnation of racism and ethnic hatred and to maintain the confidence of minorities in the ability of the authorities to protect them from the threat of racist violence...

... [W]hen investigating violent incidents and, in particular, deaths at the hands of State agents, State authorities have the additional duty to take all reasonable steps to unmask any racist motive and to establish whether or not ethnic hatred or prejudice may have played a role in the events. Failing to do so and treating racially induced violence and brutality on an equal footing with cases that have no racist overtones would be to turn a blind eye to the specific nature of acts that are particularly destructive of fundamental rights...

Admittedly, proving racial motivation will often be extremely difficult in practice. The respondent State's obligation to investigate possible racist

132 (43577/98 and 43578/98) 6 July 2005.

overtones to a violent act is an obligation to use best endeavours and not absolute (see, mutatis mutandis, Shanaghan v. the United Kingdom, no. 37715/97, § 90, ECHR 2001-III, setting out the same standard with regard to the general obligation to investigate). The authorities must do what is reasonable in the circumstances to collect and secure the evidence, explore all practical means of discovering the truth and deliver fully reasoned, impartial and objective decisions, without omitting suspicious facts that may be indicative of a racially induced violence."

161. The Grand Chamber would add that the authorities' duty to investigate the existence of a possible link between racist attitudes and an act of violence is an aspect of their procedural obligations arising under Article 2 of the Convention..."

This has been repeated in subsequent ECHR authorities, e.g., Angelova v Bulgaria §115; Ciorcan v Romania (29414/09) 27 January 2015, §158-159; and Sabalic v Croatia (50231/13) 14 January 2021, §94-96.

Thus, as part of the Article 2 investigative duty, read with the prohibition of discrimination in Article 14 ECHR, the investigative authorities are under a duty to take all reasonable steps to unmask any racist or discriminatory motive and establish whether prejudice played a role in the death. Although Nachova concerned violence by a state agent, the duty above applies equally when the suspicious death was caused by a member of the public: Angelova §98, Menson and Sabalic v Croatia §96.[133]

The duty to explore possible discrimination extends not only to discrimination solely based on a person's race,[134] but also where race was one of more than one mixed motives; and where discrimination was based on the victim's perceived race or association with a minority. In Skorjanec v Croatia (25536/14) 28 March 2017, at §55-56, the ECtHR held:

"perpetrators may have mixed motives, being influenced as much or more by situational factors as by their biased attitude towards the group to which the victim belongs... the obligation on the authorities to seek a possible link between racist attitudes and a given act of violence... concerns not only acts of violence based on a victim's actual or perceived personal status or characteristics but also acts of violence based on a victim's actual or presumed association or affiliation with another person who actually or presumably possesses a particular status or protected characteristic"

The duty to explore possible discrimination extends where race was one of more than one mixed motives

The duty is not limited to violent acts, but extends to other ill-treatment or neglect which led to a death. The authorities are under a duty to take all reasonable steps to effectively ascertain whether or not prejudice or bias might have played a role in any of the events: Sabalic v Croatia §98(i).

The substantive duties in Articles 2 and 3 ECHR may be violated by a discriminatory failure to protect the victim: Identoba v Georgia (73235/12) 12 May 2015, at §72-74 and 80. For the reasons given above, an arguable breach of those substantive duties should be investigated.[135]

133 Some of the caselaw concerns the investigative duty in Article 3 ECHR, which concerns the investigation of serious violence. However, that duty overlaps with the duty in Article 2 ECHR, which means that the principles regarding the investigation of discrimination in the context of Article 3 apply equally to the investigative duties in Article 2: Stoyanova v Bulgaria (56070/18), 14 June 2022 §63; Sabalic v Croatia §96; and SM v Croatia (60561/14), 25 June 2020 §309 and 311. That approach is plainly correct: it would be surprising if the investigation of discrimination leading to a death were any less diligent than the investigation of discrimination leading to serious harm.

134 'Race' is used here in the sense described in the ECHR authorities. It includes race, ethnicity and ethnic origin: e.g., Biao v Denmark [2017] 64 EHRR 1, §94.

135 R (on the application of Middleton) v HM Coroner for West Somerset [2004] 2 A.C. 182, §3.

The role of the inquest and other investigations in satisfying the Article 2 duties

The inquest is the primary means by which the state discharges the enhanced procedural duty, and the coroner should normally assume the inquest should satisfy relevant aspects of that duty: Middleton §47.[136] That applies equally to the Menson duty. This means that, insofar as Article 2 requires the investigation of discrimination, the inquest should ordinarily discharge that requirement.

However, there are some respects in which an inquest is not capable of satisfying the requirements of the Article 2 investigative duties, including where those requirements must be satisfied during pre-inquest investigations (such as that by the IOPC or PPO); or in respect of the imposition of penalties and criminal punishment: R (Birks) v Commissioner of Police of the Metropolis [2015] ICR 204 at §52; and see Ramsahai v Netherlands (2008) 46 EHRR 43. In those circumstances, the other investigations will be required to comply with the relevant aspect of the procedural duty (see **Preliminary Investigations**).

Discrimination and the coroner's discretion

The other route by which a coroner in any inquest may decide to investigate issues of race and racism in a death is as follows. The coroner must decide the scope of the inquest: that is they must decide what issues fall within "how… the deceased came by his or her death" in s.5(1) of the Coroners and Justice Act 2009. In an Article 2 case "how" includes not only "by what means" but also "in what circumstances". If the coroner decides that arguable discrimination formed part of "by what means" or "in what circumstances" the deceased came by his or her death, s.5 would impose a duty to seek to ascertain whether there was discrimination.

The coroner's judgment or discretion as to whether arguable discrimination did fall within "by what means" or "in what circumstances" the deceased came by their death should be exercised having regard to the maintenance of public confidence and the public interest: In R v South London Coroner, E p Thompson (1982) 126 SJ 625 (a pre Art 2 case) the Court concluded that "The function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires." An allegation that race could have played a role in the circumstances of a controversial death in custody will be a matter of significant and serious public interest, which would strongly support that allegation being investigated at the inquest. For an outline of the general public interest in issues of race being investigated at an inquest see **Exercising Discretion in the Public Interest** in **Part 5: Guidance for Coroners**.

In the event the coroner considers that racial discrimination (whether direct, indirect, or otherwise), falls within 'by what means and in what circumstances' the deceased died, the coroner should include it within the scope of the inquest. It will be for practitioners to demonstrate why the issues of race and racism are relevant to the circumstances of the death (see **Part 4: Evidencing Racism** and **Part 5: Guidance for Coroners**).

Moreover, while the scope of an investigation is to be determined by the coroner alone, they should take into consideration the needs of the family in exercising their discretion: The Explanatory Memorandum to the Coroners (Inquest) Rules 2013 indicates that the policy objective of the 2009 coronial reforms was to put the needs of bereaved people at the heart of the coroner system; see also Chief Constable West Yorkshire Police v Dyer & Assistant Coroner for West Yorkshire [2020] EWCA

136 "In the absence of full criminal proceedings, and unless otherwise notified, a coroner should assume that his inquest is the means by which the state will discharge its procedural investigative obligation under article 2."

Civ 1375 at §101. If the family believes that race played a role in the death of their loved one and wishes these issues to be investigated at the inquest, this may serve as an additional reason for the coroner to exercise their discretion in favour of investigating the role of race in the death. Practitioners should raise this issue with the deceased family as early as possible and encourage the family to include their concerns about the potential role of race in their statements provided to the investigation.

The inquest determination (verdict) cannot make a determination of civil liability, due to the prohibition in s.10(2) Coroner and Justice Act 2009. But that is a narrow prohibition which applies only to the determination, not to the scope of the investigation (R v. Coroner for North Humberside and Scunthorpe, ex p Jamieson [1995] QB 1), and the determination may point very strongly towards a conclusion that civil liability exists (Jordan v Lord Chancellor [2007] 2 AC 226, §38 and 39). It often forms the basis of a swiftly compromised civil claim.

HOW TO INVESTIGATE ISSUES OF RACE AND RACISM: INFERENCES

There are clear legal reasons why coroners should, and sometimes must, investigate the role of race and racism in the death of a Black or racialised person in state custody. However, there is no case law at the coronial level about how a coroner should conduct such investigations, and what factors might be relevant.[137] Strasbourg's case law is also not especially well-developed.

There is however a great deal of case law in the context of employment tribunals and civil claims of discrimination which has grappled with how to investigate discrimination. Important examples are the recognition of the basic general principles that:

1. individuals may act for more than one motive;
2. discrimination is normally unconscious; and
3. in consequence the court should draw inferences from the surrounding facts in deciding whether prejudice or discrimination played a role.

Some of the caselaw about those points is as follows.

In Anya v. University of Oxford [2001] ICR 847 the Court of Appeal noted: "Very little direct discrimination is today overt or even deliberate." §11. "Evidence of racial discrimination does not have to be overt. Most commonly it is not." §28. A person may not realise their act is discriminatory. A protected ground may be a subconscious or unconscious reason for the less favourable treatment. Similarly, Nagarajan v London Regional Transport [2000] 1 AC 501, pp. 511-512 concluded "Direct evidence of a decision to discriminate on racial grounds will seldom be forthcoming. Usually, the grounds of the decision will have to be deduced, or inferred, from the surrounding circumstances." See also R (E) v Governing Body of JFS [2009] UKSC 15; [2010] 2 AC 728, §64.

In consequence, in deciding whether an act was discriminatory, or motivated by race, the courts should draw inferences from the surrounding facts: Anya §11 and 28; and Igen v. Wong [2005] ICR 931. In that case, the Court of Appeal concluded (in its general conclusions):

"(3) It is important to bear in mind in deciding whether the claimant has proved such facts that it is unusual to find direct evidence of sex discrimination. Few employers would be prepared to admit such discrimination, even to themselves. In some cases, the discrimination will not be an intention but merely based on the assumption that "he or she would not have fitted in".

137 Straw, A. (2021). Legal Action Group Inquest Training: The investigation of discrimination.

"(4) In deciding whether the claimant has proved such facts, it is important to remember that the outcome at this stage of the analysis by the tribunal will therefore usually depend on what inferences it is proper to draw from the primary facts found by the tribunal." See also general conclusions §7-8.

The court can draw inferences from surrounding facts: West Midlands Passenger Transport Executive v Singh [1987] ICR 837; and [1988] 1 WLR 730; Rihal v. Ealing LBC [2004] IRLR 642 (CA), para 31; Chattopadhyay v. Headmaster of Holloway School [1981] IRLR 487.

This can include evidence of discriminatory conduct or attitudes elsewhere in the institution. Case law provides that authoritative material showing that discriminatory conduct or attitudes are widespread in an institution may make it more likely that the conduct allegedly occurred, and/or that a racially discriminatory motive was operative and members of the group in question will be treated in the same way: Chief Constable of Greater Manchester Police v Bailey [2017] EWCA Civ 425 §99.

To take an example, in an inquest into the death of a Black man killed in police custody, those surrounding facts may include:

1. 'Similar fact' evidence of how the state agent(s) treated those of the deceased's racial background on other occasions.
2. Similarly, statistical evidence showing a discernible pattern of treatment, or discriminatory practice, involving the people from the deceased racialised background. For example, black people are disproportionately more likely to be treated with violence; killed; stopped and searched; etc by the force in question.
3. Qualitative evidence showing discriminatory practice, racial stereotyping, or a culture of discrimination towards people from the deceased racialised background. For example, in a case involving the Metropolitan Police, the findings indicating institutional racism made by the Casey Review.[138]
4. Only a small proportion of those who work for the force are Black.
5. The police force's training or guidance regarding race is lacking or deficient.
6. Inconsistent reasons given by the aggressor or their employer as to why the event occurred: Veolia Environment Services UK v Gumbs [2014] Eq LR 364.

For guidance on identifying surrounding facts from which racism can be inferred see subsection **Identifying surrounding facts**.

Regarding the first two categories above, in the context of a civil claim for damages, 'similar fact evidence' is admissible. This is evidence of what the defendant, or someone linked to them, did on other occasions, which is probative of whether they acted as alleged in the instant case: O'Brien v Chief Constable of South Wales [2005] 2 AC 534, §53. The rules of evidence in an inquest are more relaxed than in a civil claim, so a coroner would be perfectly entitled to apply the O'Brien approach at an inquest.

A wide range of factors, falling within the surrounding circumstances, can be relied on for the purpose of drawing inferences of discrimination or prejudice. The coroner or other investigator is entitled to draw inferences from any of the facts as their common sense dictates:

"So far as possible, tribunals should be free to draw, or to decline to draw, inferences from the facts of the case before them using their common sense": Efobi v Royal Mail Group [2021] 1 WLR 3863, §41.

138 Casey, L. (2023). Final Report: An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service.

Discrimination may be institutional and conducted by several different police officers, as in Hendricks v. Commissioner of Police of the Metropolis [2003] ICR 530.

The principles relied on above are generic: **they are not based on the specific requirements of the Equality Act 2010 but reflect general principles of rational or common-sense analysis**. For that reason, they apply equally to the coroner's (or other body's) duty to investigate discrimination under Article 2 of the ECHR, or to the coroner's decision to investigate such issues as falling within the circumstances of the death. Two other reasons support the conclusion that the investigator may draw such inferences as they consider appropriate, from the surrounding facts.

Firstly, there is a general principle regarding Article 2 ECHR that inferences may be drawn.[139] Secondly, in terms of these general principles for the investigation of a discriminatory motive, the approach under the ECHR and domestic law is equivalent.[140]

Given the prohibition in s.10(2) of the Coroner and Justice Act 2009, when making submissions regarding the role of race in a death, practitioners should present the surrounding facts and the inferences to be drawn from them in a way that does not allocate blame to an individual or suggest civil liability.[141] For an example of how this can be done see the closing submissions of the Bayoh family in the Sheku Bayoh inquiry.[142] While this example comes from a Scottish public inquiry, similar prohibitions on determining civil or criminal liability apply.[143] In addition, this case demonstrates how including race in the terms of reference of an investigation can have positive impacts, and highlights the importance of addressing issues of race and racism effectively in the investigation process.

PRELIMINARY INVESTIGATIONS

When a person dies in police custody a preliminary investigation will be undertaken by the Independent Office for Police Conduct. When a person dies in prison or immigration detention this investigation will be carried out by the Prison and Probation Ombudsman. There is no equivalent independent body charged with investigating deaths in mental health detention. Preliminary investigations are carried out by the NHS trust responsible for the deceased care. These internal investigations are often called Serious Incident Investigations or Root Cause Analysis and vary a lot from trust to trust.[144] In some instances, an investigation may be commissioned and undertaken independently of those responsible for the deceased care.[145]

It is important, if possible, to get the potential role of race into the terms of references of these preliminary investigations. If this is included

139 See Kakoulli v Turkey (2007) 45 E.H.R.R. 12 at §112; Ognyanova v Bulgaria (2007) 44 E.H.R.R. 7 at §96–101; and Al Nashiri v Poland (2015) 60 E.H.R.R. 16 at §375, 387, 395 and 487.

140 Much of domestic law is derived from EU equal-treatment law, and to that extent that it is, it should be interpreted consistently: Essop v Home Office [2017] UKSC 27; [2017] 1 WLR 1343, para 19-23. Likewise, the general approach to equal treatment law in the EU and the ECHR is equivalent: Bosphorus Hava Yollari Turizm Ve Ticaret Anonim Sirketi v Ireland (2006) 42 EHRR 1 at §165.

141 Per s.10(2) CJA 2009 coroners are prohibited from making determinations of civil or criminal liability.

142 Sheku Bayoh Inquiry. (2023). SBPI-00349 - Bayoh Family Interim Closing Submissions June 2023.

143 Inquiries Act 2005, s.2.

144 The lack of an independent system for carrying out pre-inquest investigations into deaths in mental health settings has been criticised by INQUEST. Bereaved families and practitioners representing them find it harder to be involved in internal investigations. See INQUEST. (2023). Family Consultation Day Report on deaths of people with mental ill health, a learning disability or autism; INQUEST. (2015). Deaths in Mental Health Detention: An investigation framework fit for purpose?.

145 Independent investigations may be commissioned and managed by the commissioner of the care in which the death (or other serious incident) occurred or, in some cases, by NHS England regional investigation teams, with input from an Independent Investigation Review Group. For guidance on the commissioning of an independent investigation following a death in mental health custody see NHS England. (2015). Serious Incident Framework: Supporting learning to prevent recurrence. p. 18 and appendix 3: Independent Investigation (level 3).

in the terms of reference, investigators will be required to gather evidence on the role of race in the deaths as part of their investigation. Such evidence may not be available by the time of the inquest, which often takes place years after the death. Moreover, the inquiries made by the coroner at an inquest are often shaped by the investigation which preceded it, meaning that race is more likely to be addressed at an inquest if it was included as an issue in the initial investigation.

There are strong reasons why preliminary investigations should investigate discrimination. As set out above, while an inquest is the primary means by which the state discharges the enhanced procedural duty, there are some respects in which an inquest is not capable of satisfying these requirements, including where those requirements must be satisfied during pre-inquest investigations: R (Birks) v Commissioner of Police of the Metropolis [2015] I.C.R. 204 at §52; and see Ramsahai v Netherlands (2008) 46 E.H.R.R. 43. In those circumstances, the other investigations will be required to comply with the relevant aspect of the procedural duty, including any requirement to investigate discrimination (see **Article 2 duty to investigate discrimination**).

Moreover, in cases involving controversial deaths in state custody, the preliminary investigation by the IOPC, PPO or otherwise can take a long time, and the coroner may not begin work until after it has finished. It is well recognised that the passage of time may make an investigation less effective, whether because evidence is lost, witnesses move away, recollections fade, or otherwise (see, for example, R (JL) v Secretary of State for Justice [2009] 1 A.C. 588, §74 and 94). This indicates that, in this type of case, it will be necessary for the preliminary investigation itself to gather evidence relevant to the question (where it arises) of discriminatory motive. That may be necessary, to ensure that there is an effective investigation, as required by Article 2. Otherwise, by the time the coroner begins work the evidence may be lost.

In particular, the preliminary investigation may be required to secure the evidence relevant to whether or not discrimination may have played a role in the death, including by obtaining evidence of any of the surrounding facts which might form a basis for inferences of discrimination (see above and also **Identifying surrounding facts**).

Preliminary investigation may be required to secure evidence relevant to whether or not discrimination may have played a role in the death

Finally, state bodies responsible for preliminary investigations, must have regard to the Public Sector Equality Duty and whether it requires an investigation into issues of race and racism. At inquest, it may be possible to draw adverse inferences from a failure by preliminary investigators to take account of the Public Sector Equality Duty or to follow guidance on investigations, where that guidance has itself taken account of the Public Sector Equality Duty.

Requirements on the Independent Office for Police Conduct

In addition to the above, there are other reasons why a preliminary investigation may be required to investigate discrimination. The IOPC, for instance, should investigate any allegation of unlawful discrimination involved in a death or serious injury, or any allegation of unfairness.

The IOPC is required to investigate and make a determination about whether a person has a case to answer in respect of misconduct or gross misconduct (see, e.g. Police Reform Act 2002, sch.3, para 21A and 23). Misconduct means a breach of the Standards of Professional Behaviour (para 29). Those

standards are currently set out in Schedule 2 to the Police (Conduct) Regulations 2020. They include: "Police officers act with fairness and impartiality. They do not discriminate unlawfully or unfairly."

Unlawful discrimination includes direct and indirect discrimination, contrary to s.13 and 19 of the Equality Act 2010, and also Article 14 ECHR: IPCC guidelines for handling allegations of discrimination ("the guidelines") §1.5 and 1.238. Thus, the IOPC is required to examine and make a determination about an allegation that a police officer discriminated unlawfully contrary to the Equality Act 2010 and/or Article 14 ECHR.

Unlawful discrimination includes direct and indirect discrimination

Unfair discrimination covers discrimination against other identifiable groups that are not protected under the Equality Act. This could include, for example, homeless people or young people and children: IPCC guidelines for handling allegations of discrimination §1.7. The IOPC is also required to examine unfair discrimination. This may be pertinent where, for instance, race discrimination interacts with other characteristics not protected by the Equality Act, for instance, short-term mental illness.

The IOPC's guidelines contain detailed provisions as to how it should investigate discrimination. A failure by the IOPC's investigator to follow those guidelines will itself be unlawful unless there is a good reason for that failure: R (Hemmati) v Secretary of State for the Home Department [2021] AC 143, §50 and 69.

Case law on unlawful discrimination

In deciding whether an officer discriminated unlawfully, contrary to the Equality Act 2010 and/or Article 14 ECHR, the IOPC should apply the case law that has been developed by the courts about what amounts to unlawful discrimination in those contexts. This law is complicated and detailed and beyond the scope of this guide.[146] But four very brief examples of points which may be relevant are as follows.

Firstly, the IOPC should apply the general principles expressed in the case law in the above section **How to investigate issues of race and racism: Inferences**, which recognises that most discrimination is unconscious, and that in deciding whether there was discrimination it will be necessary to draw inferences from the surrounding facts.

Secondly, the IOPC should apply the reverse burden of proof that applies to discrimination contrary to the Equality Act 2010: Efobi.

Thirdly, there is direct discrimination if race (as defined in s.9 of the Equality Act 2010) had a significant influence on the less favourable treatment at issue, even if it was not the primary cause of it: Nagarajan v London Regional Transport [2000] 1 AC 501, p513B; and Chief Constable of Norfolk v Coffey [2019] EWCA Civ 1061; [2020] 2 All ER 490, §9.

Fourthly, indirect discrimination is defined by s.19(1) and (2) of the Equality Act 2010; and separately in Article 14 ECHR (the leading case on Article 14 indirect discrimination is DH v Czech Republic (2008) 47 EHRR 3, §175-210. See also R (SC) v Secretary of State for Work and Pensions [2022] AC 223, §51 and 53). The definitions are somewhat different. It is worth noting that Article 14 includes systemic, institutional and structural discrimination without needing to comply with the rigid framework in the Equality Act 2010.

146 Examined in Straw, A. (2022). Discrimination in Public Law. Legal Action Group.

PART FOUR

EVIDENCING RACISM

Evidencing the role of racism in the death of a Black or racialised person in state custody will often be challenging and will involve a considerable amount of work for the practitioners representing the family. While some deaths will involve explicit racism, such as the use of racist language or slurs by the agents involved, direct evidence of this kind of racial discrimination is rare.[147] State agents are also very unlikely to admit that the race of the deceased affected their treatment of them.[148] Indeed, the state agent(s) involved may not themselves be aware of the role race played in their conduct or inaction.

147 INQUEST. (2023). 'I can't breathe': Race, death, and British Policing. p.112.

148 *ibid.*

However, the absence of evidence of explicit racism does not mean that the race of the deceased wasn't a significant factor in thir death.[149] Raising issues of race and racism will often involve encouraging the coroner, or other post-death investigators, to make inferences from the surrounding facts (see above **How to investigate issues of race and racism: Inferences**). Evidencing the role of racism in a death therefore requires practitioners to be creative in identifying and demonstrating surrounding facts that indicate that race could have played a role in the death. The below provides guidance on this.

Checklist 3 provides a checklist for evidencing issues of race and racism at an inquest or other post-death investigation.

IDENTIFYING SURROUNDING FACTS

The deaths of Black and racialised people in custody do not always involve explicit interpersonal racism, such as the use of racist language on behalf of the state agent/agents involved. In inviting a coroner to investigate issues of race and racism, it will often be useful for practitioners to do all they can to identify relevant surrounding facts from which the coroner can draw inferences.

Practitioners wishing to raise issues of race and racism at inquests will therefore need to think creatively about the factors that could indicate the role of race and racism within a case. The following provides a list of factors to consider, as well as the possible relevance of these factors in demonstrating that the race of the deceased may have played a role in their death.

The list is non-exhaustive and is intended to provide a starting point for practitioners to develop a set of surrounding facts from the specific case at issue, which together or separately indicate that race played a role in the death.

EVIDENCING RACISM PRE-INQUEST

Practitioners should be aware that during a pre-inquest review hearing, when urging a coroner to include race in the scope of investigations, access to certain information, such as details obtained through disclosure, might be limited. However, this limitation should not necessarily deter practitioners from raising these crucial issues at this early stage.

In such instances, practitioners can rely on publicly available information, witness statements, and details emerging from preliminary investigations to establish credible suspicion or persuade the coroner to exercise their discretion in investigating the potential role of race in the death. To maximise effectiveness, practitioners should proactively gather evidence as early as possible, ensuring thorough preparation for engaging with the coroner. This proactive approach also applies to efforts aimed at persuading preliminary investigators to include race in their terms of reference.

149 *ibid.*

ONE: DOES THE DEATH FORM PART OF A PATTERN OF VIOLENCE AND/OR NEGLECT.

1. Is the death part of a wider social and historical context of violence against and/or neglect of Black and racialised people.[150]

2. Is the death part of a pattern of conduct or inaction by the state institution involved. For instance:
   - Have there been other deaths of Black or racialised people in similar circumstances
   - Are Black or racialised people disproportionately more likely to be killed; die by suicide; be subject to use of force or segregation; be subject to street level coercive powers (if police); be subject to coercive mental health care (if mental health custody); be subject to disciplinary measures (if mental health, prison or immigration detention) by the institution in question.
   - Is there evidence of prior instances of neglect of the mental and/or physical health of Black or racialised people within that institution, including failure to act on warning signs.
   - Does the institution receive a disproportionate number of complaints from Black and racialised individuals.

3. Is the death part of a pattern of conduct or inaction by the state agent or agents involved. For instance, is there evidence of disproportionate use of force or coercive powers etc by the state agent/s involved against Black or racialised people.

4. Is the death part of a pattern of conduct or inaction against the deceased. For instance, had the deceased or the deceased family raised previous concerns/complaints about their or their loved one's treatment. If so:
   - Was any action taken.
   - Does the institution have a policy for responding to complaints/concerns and was it followed.

5. Is there evidence of systemic or institutional policies that may contribute to racial disparities in outcomes within the state institution. For instance:
   - Do policies related to use of force, disciplinary measures, and mental health care within the institution disproportionately impact Black or racialised individuals.
   - Are these policies consistent with human rights standards and principles of equality.

TWO: DOES THE INSTITUTION IN QUESTION LACK FAIR AND ROBUST ACCOUNTABILITY MECHANISMS:

1. How has the institution responded to previous deaths of Black and racialised people. Have steps been taken to implement recommendations stemming from previous inquests or other post-death investigations into the deaths of Black and racialised people.

2. How has the institution responded to complaints of discrimination or mistreatment made by Black or racialised people. Are complaints by Black and racialised people less likely to be investigated or upheld.

150 See for instance, Report by the Assistant Deputy Coroner Karon Monaghan KC Under the Coroners Rules 1984, Rule 43, Inquest into the Death of Jimmy Kelenda Mubenga. (2013). para 48.

3. Does the institution have transparent and inclusive representation in its decision-making bodies.
    - Is there diversity among the institution's key decision-makers, including executive leadership and review boards.
    - To what extent are individuals from diverse backgrounds, particularly Black and racialised individuals, involved in shaping policies, procedures, and accountability mechanisms.
4. Does the institution engage in any form of race-based data collection and reporting. If so:
    - How is this data used to inform policies and practices.
    - Is the data publicly accessible and utilised in public discourse.
    - How does the institution respond to discrepancies revealed by this data, such as disparities in the use of force or deaths in custody.

THREE: DOES THE INSTITUTION TAKE ACTIVE STEPS TO PROMOTE RACIAL INCLUSION AND COMBAT RACISM WITHIN ITS WORKFORCE.

1. What is the racial composition of the workforce relative to the local ethnic demographics.
2. Is there evidence of bullying, discrimination or harassment against Black and racialised staff. For instance, a high number of complaints of bullying by Black and racialised staff.
3. Does the institution provide training for its personnel that specifically addresses cultural competency, diversity and anti-racism. If so, does it evaluate the effectiveness of these programs in promoting understanding, tolerance, and fair treatment of Black and racialised individuals.
4. Does the institution have a clear and accessible strategy for equality, diversity and inclusion, with clear actionable goals. If so, does the organisation conduct regular audits to ensure the achievement of these goals.
5. Does the institution have robust vetting systems to prevent the recruitment of individuals with prejudiced attitudes and beliefs. If so, how long have these systems been implemented.
6. Are the institution's measures against racism, including training and strategies, publicly accessible for transparency and accountability.

FOUR: IS THERE EVIDENCE TO SUGGEST THAT RACIST TROPES OR STEREOTYPES MAY HAVE PLAYED A ROLE IN THE DEATH?

1. In response to the death, has the institution or its agents employed racist tropes or engaged in victim blaming. Specific areas of consideration include:
    - Appealing to the deceased's purported risk of violence to justify conduct or inaction.
    - Appealing to the untrustworthiness or unreliability of the deceased to justify conduct or inaction.
    - Attempts to 'other' the deceased, such as associating them with criminal activity or drug use, highlighting their immigration status or use of the welfare system, or making references to 'cultural practices' in explaining the death.

2. Is there any other evidence of a tendency within that institution to attach racist tropes or stereotypes to Black and racialised people. For examples in each of Police, Prison, Immigration and Mental Health Custody see **The role of racial stereotyping in deaths in custody** in **Part 1: Racism and Deaths in State Custody**.

3. How does the media report on deaths within that institution. For instance, does it employ racist tropes or stereotypes.

FIVE: IS THERE ANY EVIDENCE THAT THE STATE AGENT/S INVOLVED HELD CONSCIOUSLY RACIST BELIEFS OR ATTITUDES

1. Have complaints been made by Black or racialised people against the specific agent/s in question.

2. Do the communications of the agent/s involved in the death demonstrate explicit racist attitudes. These could be private communications (for instance on text, or email) or public communications, (such as posts on Facebook or other social media sites). These could be communications relating directly to the death, or broader conversations between the agents involved and other staff members.[151]

With regards to this, It is important to remember that evidence of consciously held racist attitudes or beliefs by agents of a state institution will often also be indicative of a more pervasive racism within that institution. Evidence of conscious racist attitudes or beliefs should be presented in light of surrounding facts about the culture and practices of the institution in question, rather than as evidence of a few "rotten apples."[152]

EVIDENCING RACISM

Some surrounding facts pointing towards the role of racism in a case, may be ascertainable through open-source research. For instance, in many contexts there will be considerable information available online setting out the statistical background and wider social context. Practitioners may also have to ask the coroner to obtain disclosure of evidence about the surrounding facts. The families may in some cases provide evidence of the above, for instance where the family raised previous concerns with the institution about their loved one's treatment. Finally, there may be instances where it will be beneficial for a witness with expertise in race issues to be called to enable a broader understanding of systemic and structural racism and its potential relevance to a death.

The below sets out guidance on introducing publicly available reports and statistics to evidence racism; obtaining disclosure of evidence on surrounding facts; and asking the coroner to call an expert to talk to issues of race and racism, and their relevance to the case. These are just examples of some of the ways practitioners might go about demonstrating racism within a case – as with the above set of possible surrounding facts, they are not intended to be exhaustive.

151 Note that private communications between state agents will have to be obtained by the coroner through disclosure of evidence. Practitioners will therefore have to persuade the coroner that the evidence is relevant and proportionate to the scope of the inquest. This may be more challenging when asking for disclosure of broader private communications. However, there is at least one example of a case where a coroner has considered racist material and messages found on the private mobile phones of the agents involved. This included material sent by third persons, and material not directly referencing the events. In this case the text messages were used, in tandem with other surrounding facts, to indicate both a pervasive racist culture within the workforce. See Report by the Assistant Deputy Coroner Karon Monaghan KC Under the Coroners Rules 1984, Rule 43, Inquest into the Death of Jimmy Kelenda Mubenga. (2013).

152 e.g. ibid paras 39-52.

Reports and statistical evidence

Statistics form a very significant part of the evidence that coroners might rely on. The introduction of statistical evidence will often be useful in supporting claims of racism within a case. For instance, statistical evidence can be helpful for establishing patterns of violence against or neglect of Black or racialised people by the state institution within which the death occurred, establishing patterns in complaints handling, and establishing the racial composition of the workforce compared with the population.

Introducing statistical evidence may also be useful in demonstrating potential racist views and attitudes within a particular institution, or the reliance on stereotypical perceptions. Qualitative reports, highlighting concerns about racism or racial disproportionality within a particular institution might also be useful in evidencing this.[153]

Some of this information is likely to be publicly available online, for instance, data collected or reports written by government departments, bodies that carry out independent investigations into complaints and deaths in state custody, government-commissioned reviews, supranational-national organisations, and NGOs. This guide contains a data annex which provides some data relevant to cases involving deaths in state custody (**Annex 2: Data**). **Part 1** of this guide also provides further useful information and references.

There isn't any guidance at the coronial level on the use of publicly available reports and statistical data as evidence at inquests, less guidance on the use of such resources to evidence the possible role of the deceased race or racist motives in the death. However, there have been several Strasbourg cases concerning the duty to investigate possible discriminatory motives under Article 2 and Article 3 and Article 14 ECHR, where statistical data has been appealed to and accepted by the court. These cases provide an indication of the wide range of statistical evidence that could be relevant to demonstrating possible discriminatory motive.

For example, in the case of Lingurar v. Romania, third-party interveners appealed to reports and surveys showing an increase in anti-Gypsy attitudes in Europe, from the international and local NGOs.[154] The interveners also drew attention to concerns about racial stereotyping and racist hate crimes against Roma in Romania expressed by: the UN Committee on the Elimination of Racial Discrimination, the UN Committee against Torture, and the Council of Europe's Commission against Racism and Intolerance.[155] Research conducted by the UN Special Rapporteur on extreme poverty, indicating that Romania lacked a relevant comprehensive data collection system was also introduced. The Court accepted that these supported the argument that stereotypical perceptions of the Roma as anti-social and criminal existed within Romania's police force.[156]

Some of the information going to the "surrounding facts" set out above, or other relevant surrounding facts, will not be publicly available. Evidence of them will therefore have to be obtained by asking the coroner for disclosure of evidence. Practitioners will have to show coroners that such evidence is relevant to the scope of the inquest. Annex 4 provides a list of possible disclosure requests relevant to establishing the surrounding context of the death.

153 Case law provides that authoritative material showing that discriminatory conduct or attitudes are widespread in an institution may make it more likely that the conduct alleged occurred, and that it was racially discriminatory and that members of that group will be treated in the same way: Chief Constable of Greater Manchester Police v Bailey [2017] EWCA Civ 425 at §99.

154 See also Nachova and others v. Bulgaria (43577/98 and 43579/98) 6 July 2005; Ciorcan and others v. Romania (29414/09 and 44841/09) 27 January 2015; DH v Czech Republic (2008) 47 EHRR 3.

155 Ciorcan and others v. Romania (29414/09 and 44841/09) 27 January 2015; DH v Czech Republic (2008) 47 EHRR 3.

156 For examples of the use of statistical data and reports to demonstrate discriminatory motives, outside of the race discrimination context see Identoba and others v. Georgia (73235/12) 12 May 2015; M.C. and A.C. v. Romania (12060/12) 12 July 2016; Opuz v. Turkey (33401/02) 9 June 2009.

Expert Witnesses

Practitioners trying to evidence the role of racism in a death may wish to persuade the coroner to call a "race" expert who can support this claim. That is, someone with specific expertise in the social and historical context of racism, and how it shapes the experiences of Black and racialised people, either at large or within a specific institution.

Such expert evidence would constitute opinion evidence designed to assist with matters outside the experience or common knowledge of the coroner or (where relevant) jury. Coroners have broad discretion regarding the calling of expert witnesses, and broad discretion to determine whether the evidence of an expert is appropriate to consider.[157]

In asking the coroner to call such a witness, practitioners will need to be able to put the substance of the witness's evidence before the coroner "so that the coroner may be able to decide whether or not it is appropriate."[158] For this reason, asking a coroner to call an expert witness, may in and of itself also be useful in demonstrating that race could have played a role in the death.

Why coroners should consider calling "race" experts

Issues surrounding race and racism are complex. Coroners—who have a busy and challenging job with limited resources —may lack prior knowledge of the broader issues of concern after a death of a Black or racialised person in state care. With a majority of coroners being white,[159] personal experiences of racism may be limited, making it challenging to comprehend the racial nuances shaping the experiences of Black and racialised individuals with the state. This knowledge gap may be even more pronounced among juries.

In light of these challenges, engaging a race expert can be crucial. Such an expert can navigate and elucidate complex issues of race and racism, offering insights beyond the typical experiences of the coroner or jury. The expertise provided can help draw connections between the general experiences of the group, such as patterns of violence and neglect, and the unique circumstances surrounding the deceased.[160]

For example, a race and racism expert can:

- Explain the concept of institutional racism and its manifestations in a specific institutional setting.
- Provide data on racial disproportionality and its broader context.
- Outline the history of violence perpetrated by a particular state institution against a specific group.
- Illuminate the likely impact of the individual's racial background on their experience within a particular state institution.
- Identify institutionally racist practices that might have contributed to the death.[161]

The utility of expert evidence on racism has been acknowledged in various domestic legal proceedings. In criminal cases, experts have successfully provided insights into Black trauma, the history of the Black Lives Matter movement, institutional racism within

157 Chief Coroner. (2015). Law Sheet No. 5: The Discretion of the Coroner. Courts and Tribunals Judiciary.

158 R (Takoushis) v Inner North London Coroner [2006] 1 WLR 461, at §61.

159 Thomas, C., and McGuinness, T. (2021). 2020 Coroner Attitudes Survey. UCL Judicial Institute. pp. 54-5.

160 This has been recognised in the other legal contexts in which "race" expert evidence is used. See just below.

161 To develop this list, a review was conducted of the use of race expert evidence at inquests in other jurisdictions. The review identified key areas where such evidence was considered useful by the courts.

the police, racist narratives concerning rap music and racial prejudice in the use of 'gang evidence.'[162] In education cases, experts have addressed data on disproportionality in school exclusions and the role of racial stereotyping in driving such disproportionality.[163]

Similar practices are observed in other jurisdictions like Australia and Canada, where experts, including academics with race relations expertise and professionals with lived experience, are routinely called to provide evidence regarding the role of racism at inquests.[164] In many cases, expert evidence has been deemed crucial for examining the impact of the deceased's race on their death and formulating recommendations to prevent similar occurrences in the future. In some instances, experts were invited to contribute recommendations during the inquest proceedings.[165]

Choosing an expert

Practitioners may wish to provide the coroner with names of some suitable experts. It is vital that any experts suggested to the coroner are viewed as credible, reliable, and free from bias.

Academics with permanent academic positions and a strong track record of relevant peer-reviewed work may be good candidates. Similarly, those who have consulted or advised on race equality and racial justice, or held positions in relevant NGOs may also be suitable.

Individuals working on relevant issues at supra-national organisations such as the UN, or Council of Europe have also been suggested as appropriate candidates.

When choosing an expert witness practitioners should consider:

- The expert's CV, including positions held and academic qualifications.
- Whether the expert has the requisite expertise in the relevant area.
- Whether the expert's work is peer-reviewed.
- Whether they are a member of a professional body.
- Whether they have given evidence before in legal proceedings.
- If so, whether they have been subject to adverse judicial comment.
- Whether they have any relevant training as an expert witness.
- Whether there is any reason to doubt their credibility. For instance, have they ever been subject to disciplinary proceedings.

Ideally experts should be a member of an accrediting body for expert witnesses. Practitioners should encourage suitable experts in issues of race and racism to get accreditation.

162 As per practitioners consulted in the development of this guide.

163 *ibid.*

164 For instance see, Inquest into the death of Tanya Louise Day; Inquest into the death of Kumanjayi Walker; Inquest into the death of Kevin Francis Bugmy; Inquest into the death of Naomi Williams; Inquest into the Death of Julieka Ivanna; Inquest into the death of LAK; Inquest into the death of Ivan Leo Goolagong; Inquest into the Death of Frederick Arthur James Row Row; Inquest into the death of Mulrunji (also known as Cameron Doomadgee); Re Blair, 2022 CarswellOnt 19587 (Inquest into the death of Delilah Sophia Blair); Re Jeffrey, 2022 CarswellOnt 2534 (Inquest into the death of Mark King Jeffrey).

165 See for instance, Statement of Leanne Liddle at the Inquest into the death of Kumanjayi Walker; Inquest into the death of Ivan Leo Goolagong; Inquest into the Death of Frederick Arthur James Row Row.

PART FIVE

GUIDANCE FOR CORONERS

This section provides specific guidance for coroners investigating the deaths of Black and racialised people in state custody. This includes guidance on ensuring racial sensitivity at inquests; guidance on why coroners should and sometimes must investigate issues of race and racism in cases; and guidance on how to effectively investigate and draw conclusions regarding race during an inquest. This section also sets out why including issues of race and racism in narrative conclusions and Prevention of Future Death Reports ("PFD reports") is so important and provides guidance on how to do this in a way that is compatible with the legal duties on a coroner.

ENSURING RACIAL SENSITIVITY AT INQUESTS

When approaching a case involving a Black or racialised person, coroners must ensure that they exercise racial awareness and sensitivity. This is vital to ensuring that inquest proceedings are carried out fairly.[166]

Developing racial awareness and sensitivity requires coroners to:

- Recognise institutional and structural racism.
- Recognise and address biases.
- Listen to the family and local community.

Following these steps will assist coroners in ensuring that bereaved families are treated with respect and dignity and that their needs and views are appropriately considered. It will also help ensure that the racism faced by Black and racialised people within state institutions does not continue in the coronial system.

Taking these steps will enable coroners to identify and better understand the racial dynamics that could contribute to a death. As set out above, this will allow them to determine whether and how to investigate issues of race and racism within a specific case. It will also allow them to identify ways that racism can manifest within a case. This will help to develop a fuller picture of the possible factors contributing to a death and ensure vital parts of the picture are not overlooked.

Recognising institutional and structural racism

When approaching a case involving a Black or racialised person, it is important to be aware of the possible role of institutional and structural racism in shaping that person's experiences with the state. A lack of understanding about this broader context will make it difficult for coroners to identify how and when race could have contributed to a death, and to empathise with the deceased's family.[167]

Additionally, a lack of understanding of the experiences of Black and racialised people increases the risk of bias.[168] It is therefore for coroners to be properly informed about and aware of institutional and structural racism, both in general and as it applies in a particular case.[169]

When approaching a case concerning the death of a Black or racialised person in state custody, coroners should reflect on:

- How structural and institutional racism shapes the experiences of the specific racialised group(s) to which the individual in the case belongs.
- The experiences of that racialised group within the institutional context in which the death occurred, including disparities that exist in relation to the treatment of members of that group.
- How race intersects with other identity characteristics, such as gender, class, and disability, to further entrench disadvantage.

Developing an understanding of institutional and structural racism, and how it might manifest in a particular case will require dedicated research.

Part 1 of the guide, and the resources it refers to, provide a starting point for coroners wishing to learn about institutional and structural racism. Coroners may also benefit from seeking the opinion of experts on institutional or structural racism (see also **How to investigate issues of race and racism** below).

166 See Equal Treatment Bench Book (2023), pp. 5,8.

167 *ibid*, p.209.

168 *ibid*. para 35.

169 *ibid*.

The family of the deceased may provide insights into their and their loved one's experience of racism. Coroners should always listen to these insights. Failing to do so will likely limit the family's ability to participate in the investigation and make it difficult for coroners to appropriately consider their needs.

Coroners may also find it useful to engage with community-led organisations about the racism experienced by particular groups in particular settings in the local area (see **Listening to the local community** below).

Recognising and addressing biases.

As set out in the equal treatment bench book, recognising prejudices is "essential to preventing wrong decisions and erroneous assumptions about the credibility or actions of those with different backgrounds."[170]

Coroners must therefore reflect on any biases that they bring to a case involving a Black or racialised person. Such biases may include making stereotypical assumptions about the deceased, their family and friends, or their culture or background. These biases may be unintentional, impacting decision-making and behaviour without the holder of the biases realising it.[171] However, just because a bias is held unintentionally does not mean that it cannot be mitigated against.[172]

Coroners should be particularly mindful of how biases might affect their views of Black and racialised families who wish to raise issues of race. Bereaved families consulted by INQUEST expressed a reluctance to raise issues of race at inquests or during investigations because they feared being seen to "play the race card."[173] Practitioners from Black and racialised backgrounds have also expressed similar concerns that making representations concerning race could be interpreted as predictable or them "having a chip on their shoulder."

Coroners should also consider whether they are uncomfortable about issues of race and racism being raised during inquest proceedings. Bereaved families and practitioners have identified an apparent reticence amongst some coroners to acknowledge or investigate issues of race and racism at inquests. Some noted the difficulties they faced in persuading coroners of the possible relevance of race in a case, particularly where this issue had not been addressed in preliminary investigations. Others reported that some coroners appeared to consider suggestions that racial stereotyping had played a role in the person's death "rude", "offensive", or "casting character aspersions."[174]

Coroners should reflect on where discomfort about recognising issues of race and racism within a case might come from. For instance, it has been suggested that coroners may view issues of race and racism as being too "political" or "subjective". However, this perception must be challenged. Racism is a Human Rights issue[175] and has been recognised as such by supra-national organisations and the UK.[176] All public bodies have a responsibility to eradicate racism

170 *ibid*, para 33.

171 D, Atewologun., T, Cornish., F, Tresh. (2018). Unconscious bias training: An assessment of the evidence for effectiveness. Equality and Human Rights Commission.

172 *ibid*.

173 INQUEST. (2023). "I can't breathe': Race, death and British Policing" p. 63.

174 INQUEST. (2023). "I can't breathe': Race, death and British Policing" p. 118.

175 With thanks to Ife Thompson, barrister at Garden Court and founder of Black Learning Achievement and Mental Health (BLAM) UK, for articulating this.

176 The UK is signatory to various international conventions recognising racism as a Human Rights Issue.See, for example: International Convention on the Elimination of All Forms fo Racial Discrimination; Durban Declaration and Programme of Action.

and racial discrimination.[177] The existence and impact of racism on Black and racialised people is also well documented and evidenced.[178] Coroners should also consider whether they might harbour any biases in favour of "official" or "state-sanctioned" accounts of events and reflect on why this might be.

Reflecting on biases and assumptions will enable coroners to identify them when they arise in state narratives or evidence[179] and to highlight any risk of possible bias to juries (see **Jury Management**).

Listening to the local community

Coroners exercise their jurisdiction by reference to geographical areas and historically have always had a particularly close relationship with local communities.[180] Coroners should strive to understand the experiences of the communities they serve, including the specific experiences of Black and racialised people within the community.

To do this, coroners should consider conducting outreach with Black and racialised communities within their jurisdictions. This could include:

- Seeking views on the challenges faced by different racialised groups in the local community in relation to specific state institutions, including experiences of racism within these institutions.
- Inviting feedback from individuals on their experiences of the coronial process, and how this could be improved.

Conducting effective community outreach will often involve identifying and working collaboratively with community-led organisations and those representing different groups within the community. For example, NGOs, grassroots organisations, faith groups, and community centres.

Coroners should consider conducting outreach with Black and racialised communities within their jurisdictions

There are multiple benefits of conducting outreach and putting the learning from it into practice:

- Understanding the experiences of Black and racialised people will assist coroners in recognising how racism can manifest and when and whether issues of race and racism might be relevant to a specific death.
- Learning about these experiences and taking on board feedback will assist coroners in developing racially sensitive practices. Such practices are vital in ensuring effective investigations, where bereaved families feel respected and able to participate.
- Conducting outreach may improve relationships between the coronial system and Black and racialised people. Learning about the lives and experiences of Black and racialised people, will help coroners identify and address biases or misconceptions. Equally, engaging with the community may foster trust in the coronial system amongst Black and racialised communities.

177 International Convention on the Elimination of All Forms fo Racial Discrimination

178 See **Part 1: Racism and Deaths in State Custody at p. 12** of this guide and also resources in **Annex 1**.

179 See **The role of racial stereotyping in deaths in custody at p. 19** of this guide.

180 See H, Hill. (2021). The Legal Basis of the Duty to Investigate (1): Domestic and International (Non-ECHR) Law. Public Law Project.

TO GUARD AGAINST BIAS, CORONERS SHOULD:

- **Recognise the Power of Bias**: Acknowledge the influence of bias, both intentional and unintentional, in shaping decisions and behaviour..[181]
- **Understand Racist Stereotypes**: Invest time in learning about how racist stereotypes and assumptions are created and perpetuated by state institutions. Stay informed on evolving narratives.[182]
- **Engage in Perspective Taking**: Put yourself in the shoes of the deceased person or their family. Consider their experiences and viewpoints to foster empathy.[183]
- **Challenge Stereotypes**: Actively evaluate and reconsider any stereotypes attached to the deceased or their family. Replace these stereotypes with responses that avoid perpetuating bias.
- **Reflect on Personal Bias**: Actively consider whether personal biases against raising issues of race exist, and challenge the assumptions underlying these biases.
- **Extend Reflection to Others**: Use the process of reflecting on and addressing personal biases as an opportunity to identify and challenge potential biases and assumptions in others. This includes biases in state narratives and biases that may exist within juries.
- **Promote Open Dialogue**: Encourage open discussions about bias and assumptions within the legal process. Foster an environment where these issues can be addressed constructively.
- **Stay Informed**: Regularly update your knowledge on issues related to race and racism. Attend training sessions or workshops to enhance cultural competence and awareness.
- **Seek External Perspectives**: Consider seeking external perspectives, such as engaging with diverse advisory groups or inviting external experts to provide insights on potential biases.
- **Review and Revise Practices**: Regularly review and revise practices to ensure they are inclusive and free from bias. This may involve updating protocols, procedures, or training programs.
- **Encourage Diversity in Decision-Making**: Advocate for diversity within the legal system to bring varied perspectives to the decision-making process.

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181 M, Thuraisingham. (2013). The Secret Life of Decisions - How Unconscious Bias Subverts Your Judgement. Routledge.

182 See for instance, **Part 1: Racism and Deaths in State Custody at p. 12** of this guide.

183 A, Lindsey., et al. (2014). The Impact of Method, Motivation, and Empathy on Diversity Training Effectiveness. J Bus Psychol 30.

WHY INVESTIGATE ISSUES OF RACE AND RACISM [184]

Article 2 duty to investigate discrimination

There will be some circumstances where coroners are required to investigate the role of race and racism in a death. Article 2 with Article 14 ECHR places a duty on coroners to investigate any credible suspicion that there was a racially induced or discriminatory motive for the treatment leading to the deprivation of life. This duty is not limited to violent acts but extends to other ill-treatment, including failure to protect the deceased (for the law on this see **Part 3: Raising Issues of Race and Racism**).

In cases involving a Black or racialised person in state custody there will often be at least a credible suspicion that a racially induced or discriminatory motive was a factor in the death. As set out in Part 1 of the guide, racism and racial stereotyping is a feature of many Black and racialised peoples' experiences within the state. Moreover, factors such as a lack of accountability, insufficient training on issues of race, and poor staff diversity can create a culture where individual racist attitudes and beliefs, conscious or unconscious, can flourish unchallenged. This may increase the likelihood of these beliefs manifesting in individual state agents' treatment of Black and racialised people.

For many of the state institutions where deaths in custody take place, there is significant publicly available evidence of racism or race-based discrimination within the institution.[185] Coroners should approach cases with an awareness of how this could manifest in the specific case before them.

In short, institutional racism can be found in state institutions such as the criminal justice system, immigration system, and mental health system. Institutional practices serve to generate negative stereotypes of Black and racialised people, which may influence how state agents treat them. This may result in violent or neglectful treatment, sometimes leading to death. Additionally, the policies and practices of these institutions can create environments where discriminatory attitudes and beliefs persist unchallenged, heightening the risk of race-based mistreatment.

While this does not necessarily prove that the treatment leading to a specific individual's death in a particular case was racially induced or motivated, in the absence of evidence to the contrary, it does raise a credible suspicion that this could have been the case. This credible suspicion obliges the Coroner to investigate the potential role of race and racism as a contributing factor in the death.

Discretion of the Coroner

Aside from the above, coroners can also exercise their discretion in favour of investigating the possible role of race and racism in a death of a Black or racialised person in state custody. Including issues of race and racism in the scope of an inquest is open to the Coroner so long as the race of the deceased could fall under "by what means and in what circumstances" they died. For the reasons set out above and absent evidence to the contrary, it will nearly always be at least arguable that issues of race or racism may have contributed to a death of a Black or racialised person in state custody.[186]

184 See also **Checklist 4: Coroner's checklist for determining whether to investigate issues of race and racism**.

185 See, for instance, resources cited in **Part 1: Racism and Deaths in State Custody at p. 12** of this guide.

186 Coroners' have discretion to investigate issues which may have contributed towards the death but not those which cannot even arguably be said to have contributed. Speck v HM Coroner for District of York & Ors [2016] 4 W.L.R. 15.

There are further reasons why coroners may wish to exercise their discretion in favour of investigating the possible role of race and racism. These stem from a consideration of the wider purposes of investigations into deaths in custody; the requirement to exercise discretion in the public interest; and the needs of the families.

The wider purpose of deaths in custody investigations

When determining how to exercise their discretion, coroners should consider the broader purpose of investigations into deaths in custody. Referring to the state's common law duty to investigate deaths in custody Lord Bingham in R(Amin) v. Secretary of State for the Home Department provided that:

"The purposes of such an investigation are clear: to ensure so far as possible that the full facts are brought to light; that culpable and discreditable conduct is exposed and brought to public notice; that suspicion of deliberate wrongdoing (if unjustified) is allayed; that dangerous practices and procedures are rectified; and that those who have lost their relative may at least have the satisfaction of knowing that lessons learned from his death may save the lives of others."[187]

Investigating the role of racism in the death will often be vital to fulfilling the above functions. First, given the undeniable significance of race in Black and racialised people's interactions with the state, and therefore the relevance it may have in the death of a Black and racialised person in state custody, by failing to investigate the role of race and racism in a death, the coroner risks missing a crucial part of the factual picture surrounding the person's death.

Second, investigating the role of race and racism may assist in allaying suspicion that racist attitudes or treatment played a role in the death, or at least allaying suspicion that the coronal system is stacked against a particular community. Third, examining the role of race and racism in a death may result in the uncovering and acknowledgement of racist policies and practices that contributed to the death, increasing the likelihood of these practices being rectified. This also generates strong public interest reasons for investigating the role and race and racism in a death, as set out below. Relatedly, investigating the possible role of race and racism in a death will often be important to providing the family with a measure of comfort. This too is set out in greater detail below.

Exercising discretion in the public interest

Coroners should exercise their discretion having regard to the public interest. "The function of an inquest is to seek out and record as many of the facts concerning the death as [the] public interest requires": R v South London Coroner, Ex p Thompson (1982) 126 SJ 625. In the death of a Black or racialised person, there will often be significant public interest in investigating the role of race and racism in that death.

First, in many instances the death of a Black or racialised person in state custody forms part of a pattern of race-based violence or neglect. In such instances, it is in the public interest to investigate whether any institutional policies or practices could be contributing to an increased risk of violence against, or neglect of, Black and racialised people. Investigating the role of race in a death means that, where appropriate, coroners will be able to directly refer to dangerous racist attitudes and behaviours, and the practices that allow these to flourish in narrative conclusions and PFD Reports. The result of this is that racist practices and policies are publicly acknowledged, with patterns and trends identified, increasing the likelihood of them being addressed by state institutions.

187 At § 31. For case law on the purpose of Article 2 inquests see R. (on the application of Middleton) v HM Coroner for West Somerset [2004] 2 A.C. 182.

Second, acknowledging the possible role of race and racism in the scope of an investigation into the death of a Black or racialised person in state custody is important to ensure public confidence in the coronial system. That race could have played a role will often be obvious to bereaved families and the communities that they are part of.[188] Interviews conducted with bereaved families have highlighted that failure to recognise this significantly undermines confidence in the post-death investigation process.

Aji Lewis, the mother of Seni Lewis – a Black man who died following police restraint in mental health custody – spoke of the Coroner's refusal to allow an investigation of whether racial stereotypes impacted the officers' actions, despite later referring to race as "the elephant in the room."[189] The apparent contradiction failed to surprise her: "It confirmed what we already knew: that there is no accountability. They know. It's staring them in the face, but they just don't acknowledge it."[190] This sentiment has been reflected over and over again in the testimony of other bereaved families and community groups.[191]

Investigating the possible role of racism in death will be of acute public interest where there is significant mistrust between the community, and the state institution in question. Lack of trust is a key feature of Black and racialised communities' relationships with mental health services, the police, prison and immigration officials.[192] Failure to investigate race means that there is no way of allaying suspicion of race-based mistreatment, exacerbating distrust between racialised communities and the state.This may lead to a further erosion of trust, and even to certain communities withdrawing from certain public services for fear of discriminatory treatment.[193]

COMPATIBILITY WITH S.10(2) CORONERS AND JUSTICE ACT 2009

It is possible for coroners to investigate issues of race and racism without falling foul of the prohibitions on making determinations of civil liability in s. 10(2) CJA 2009. First, the prohibition is a narrow one which applies only to the determination, not the scope of the investigation (R v. Coroner for North Humberside and Scunthorpe, ex p Jamieson [1995] QB 1). Second, s. 10(2) does not prohibit determinations which point very strongly towards a conclusion that civil liability exists (Jordan v. Lord Chancellor [2007] 2 AC 226, §38 and 39). For guidance on making determinations regarding race and racism see **Prevention of Future Death Reports**.

188 INQUEST. (2023). "I can't breathe': Race, death and British Policing"; See also various INQUEST family listening day reports.

189 INQUEST. (2023). "I can't breathe': Race, death and British Policing.

190 *ibid.*

191 *ibid* p. 77.; See also various INQUEST family listening day reports.

192 See for instance Lammy, D. (2017). The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System, p.18; Kapadia, D., et al. (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory, p.44; Equality and Human Rights Commission. (2016). England's most disadvantaged groups: Migrants, refugees and asylum seekers, p. 5.

193 INQUEST. (2023). "I can't breathe': Race, death and British Policing. p. 127.

Putting bereaved families at the heart of the coronial system

"Putting the needs of bereaved families at the heart of the coroner system" was a key policy objective of the reforms introduced by the Coroners and Justice Act 2009.[194] Thus, while the scope of an inquest is entirely a matter for the Coroner, coroners should take into consideration the needs of the deceased family in deciding whether to include issues of race and racism in the scope of their investigation.

Where a bereaved family indicates that they believe that race played a role in their loved one's death, coroners should give weight to this. The Court of Appeal in Chief Constable West Yorkshire Police v Dyer & Assistant Coroner for West Yorkshire recognised that the needs of the family include the need for catharsis.[195] This is unlikely to be achieved if a family feels its views are not being taken on board. This is especially true as bereaved families are likely to have significant insight into the possible role of race and racism in their loved one's death. When coroners fail to recognise this by refusing to investigate this issue at an inquest, they deny a key aspect of the families' understanding of what happened to their loved one.

Finally, without an investigation into issues of race and racism, there is no prospect of accountability for race-based mistreatment, or the policies and practices that enabled it. A primary concern of bereaved families is that others will not have to suffer a similar death as their loved ones. When issues of race and racism are not investigated, accountability for these issues can never be achieved, meaning that people continue to die in similar circumstances, and the trauma of the family never ends.[196]

EXAMPLE: DRAWING INFERENCES

In an inquest into the death of a Black man in prison following use of force, the following surrounding facts may arise:

1. Black men in prison are stereotyped by white prison staff as presenting a higher risk of violence.
2. The length of time of the restraint and the use of force used e.g multiple prison officers, use of PAVA spray etc.
3. The workforce at the prison was majority white.
4. The prison had limited diversity training, and the majority of officers including the agents involved, had not received any diversity training.

These facts served to increase the risk of disproportionate use of force by the officers in question against a Black prisoner at the time of the event. From these facts it would be possible to draw the inference that in the specific case force was used disproportionately on account of the deceased race.

The above facts would be ascertainable through a mix of publicly available reports and statistics, and information obtained through disclosure. An expert witness may be useful to explain the role of stereotyping in Black men's experiences of prison, and how this stereotyping can translate into an increased risk of use of force.

194 Explanatory Memorandum to the Coroners (Inquests) Rules 2013.

195 [2020] EWCA Civ 1375 at §101.

196 INQUEST. (2023). "I can't breathe': Race, death and British Policing.

HOW TO INVESTIGATE ISSUES OF RACE AND RACISM AT AN INQUEST

At the coronial level, there is no established case law governing how a coroner should conduct an investigation into racism or racial discrimination and the relevant factors to consider. Nonetheless, there exists extensive case law in the sphere of employment tribunals and civil claims of discrimination, which has addressed the methods of investigating discrimination. Key principles recognised in this context include:

1. Individuals may act for more than one motive.
2. Discrimination is typically unconscious.
3. Consequently, the court is encouraged to draw inferences from surrounding facts when determining whether prejudice or discrimination played a role.

These principles are generic, and there is no valid reason for them not to be equally relevant to investigations conducted by coroners. For a comprehensive overview of the pertinent case law, refer to "**How to Investigate Issues of Race and Racism: Inferences**" in **Part 3**.

When scrutinising whether race and racism had a role in the death of a Black or racialised person in state custody, coroners should assess if there are any surrounding facts indicating racism or the deceased's race as potential contributing factors. Similar to other risk assessments, coroners are entitled to evaluate whether racism or the race of the deceased likely played a part, based on these facts. In broad terms, surrounding facts that could suggest possible racism within a case might encompass:

1. Evidence indicating the death as part of a pattern of violence and/or neglect by either the institution or the involved state agent.
2. Absence of fair and robust accountability mechanisms within the state institution.
3. Failures by the institution to foster racial inclusion and combat racism in its workforce.
4. Indications that racist tropes or stereotypes may have played a role in the death.
5. Evidence pointing to consciously racist beliefs or attitudes held by the state agent/s involved.

See **Identifying surrounding facts** in **Part 4** for more detailed guidance. Other factors such as failure to wear or record on a body-worn camera, or inconsistent reasons given by the state agents involved as to why the action/inaction occurred may also be relevant to determining whether the deceased race was a factor in the death.

At the coronial level, there is no established case law governing how a coroner should conduct an investigation into racism or racial discrimination

A wealth of different types of evidence may be relevant to whether race or racism contributed to the death of a Black or racialised person in state custody. For instance, publicly available statistical evidence and reports may be useful for establishing whether the death of the individual in question forms part of a pattern of violence or neglect against people of the deceased's racial background. Similarly, statistical evidence relating to, for instance, the composition of the workforce, or an institution's

complaints handling process, may also be pertinent. This may require the Coroner to obtain disclosure from the state.

When investigating the role of race and racism in the death of a Black or racialised person in state custody, coroners may find it useful to call an expert to speak to such issues. An expert on race and racism will be able to explain complex issues of race and racism, which are likely to be outside the experiences of the coroner or (where relevant) jury. Evidence from such an expert will also be useful in helping the Coroner or jury to draw connections between the general experiences of members of the group, for instance patterns of violence and neglect, and the experiences of the individual in question. See **Evidencing Racism** in **Part 4** for more detail on the use of reports and statistics to evidence racism, and on calling expert witnesses to give evidence on race and racism. See also **Checklist 3** and **Annex 4**.

JURY MANAGEMENT

Combatting biases

When conducting an inquest in front of a jury, coroners should be mindful of, and where appropriate, attempt to mitigate against biases or assumptions on the part of the jury.

Concerns about the response of the jury have been raised by practitioners as a potential barrier to raising issues of race and racism at inquests.[197] Some described making a difficult decision to exclude the matter in certain cases, "If you think [raising race] will ultimately detract from getting the right conclusion [on other points], that comes into your decision as to whether to explore the issue of race. Lawyers do that all the time. I've been guilty of that thinking. And there's been a number of cases where I should have run race and I didn't. And that's to my eternal shame."[198]

Fairness requires that practitioners are able to raise relevant issues, without running the risk of this negatively influencing the jury's view of their position. Where race and racism are relevant issues coroners must take steps to ensure that the raising of these issues does not reflect negatively in the minds of the jury.

Coroners must also remain vigilant to potential biases directed towards the deceased. Racial stereotyping is not confined to state institutions; it permeates various spheres, including media and political narratives. For example, Black and racialised individuals are often unjustly linked to "gang" violence[199] or terrorism,[200] while immigrants and immigrant communities may be unfairly portrayed as "liars" or "scroungers."[201] Consequently, these stereotypes have become ingrained in public consciousness.

Coroners must also remain vigilant to potential biases directed towards the deceased

In a case involving the death of a Black or racialised person, the acceptance of such stereotypes has the potential to neutralise empathy for the deceased and their families.

197 INQUEST. (2023). "I can't breathe': Race, death and British Policing.p. 20.

198 INQUEST. (2023). "I can't breathe': Race, death and British Policing.p. 120.

199 Clarke, B., and Williams, P.(2020). (Re)Producing Guilt in Suspect Communities: The Centrality of Racialisation in Joint Enterprise Prosecutions' International Journal for Crime, Justice and Social Democracy, 9(3). See also Williams, P. (2018). Being Matrixed: The (over)policing of gang suspects in London. StopWatch; Gunter, A. (2017) Race, Gangs and Youth Violence: Policy, Prevention and Policing. Bristol University Press.

200 Murtuja, B., and Tufail, W. (2017), Rethinking Prevent: A Case for an Alternative Approach. Just Yorkshire; Qurashi, F. (2018). The Prevent strategy and the UK 'war on terror': embedding infrastructures of surveillance in Muslim communities. Palgrave Communications, 4(17).

201 Bansal, N., et al. (2022). Understanding ethnic inequalities in mental healthcare in the UK: A meta ethnography. PLOS Medicine, 19(12).

Moreover, confirmation bias[202] – defined as the unconscious tendency to look for evidence that confirms our biases - may result in juries giving undue weight to official narratives that confirm pre-held prejudices. It has been shown, however, that highlighting a risk of bias or prejudice can help guard against its effects.[203]

In the interests of fairness, and to ensure juries are not unduly influenced by stereotypical responses to Black and racialised people, coroners should consider highlighting to the jury the need for them to consider and address any possible biases they might hold towards the deceased or the deceased family.

This could be expressed in general terms, at the start of an inquest, for instance:

"This case concerns the death of a [Black or racialised person] in [prison/police custody/ mental health institution/other]. When hearing the evidence and you must, as far as possible, ensure that your judgement is not impacted by bias or stereotypical assumptions, be they conscious or unconscious, towards any of the individuals involved in this case, including the deceased, the deceased family, [state agents]."

Coroners may also wish to warn against the possibility of bias when summing up, for instance:

"In order for you to decide the facts, you must make an assessment of the evidence. It is up to you what you make of each witness, in terms of their credibility and reliability. You should however make sure that any assessment of the evidence, or the credibility and reliability of witnesses, is not impacted by bias or stereotypical assumptions."

Where appropriate, coroners may also wish to flag specific stereotypes as they arise in the case.[204] For instance, in a case concerning the death of a Black man in police custody who was claimed to be violent or aggressive, the Coroner may wish to alert the jury that Black men are commonly stereotyped as such and encourage the jury to be led by the evidence.[205] For instance, in their summing up, the Coroner could include something to the effect of:

"[The State] in their evidence said that they found [name of deceased] to be acting in a violent and aggressive manner. You should be aware that Black men are commonly stereotyped as more likely to be violent or aggressive. In reaching your conclusion you must not fall back on stereotypical assumptions but should come to a true conclusion according to all available evidence."

Coroners may also wish to flag specific stereotypes as they arise in the case.

Leaving issues of race to the jury

Coroners should not shy away from leaving issues of race and racism to the jury to include in a narrative conclusion. Coroners should be mindful that it is also open for them to leave to the jury, for the purpose of a narrative conclusion, circumstances which are possible (i.e. more than speculative) but not probable causes of death. Narrative conclusions can also include factual findings on matters which are possible but not probable causes of death where those findings will assist a coroner in a Regulation 28 Report.[206]

202 Casad, B. (2024). Confirmation Bias. *Britannica.*

203 UK Parliament POST. (2015). Unintentional Bias in Court.

204 This mirrors the approach taken by the CPS to tackling myths and stereotypes about rape. Prosecutors are encouraged to challenge any assumptions the jury might have about the perpetrator or victim. See CPS. (2021). Rape and Sexual Offences – Annex A: Tackling Rape Myths and Stereotypes.

205 Williams, P., and Clarke, B. (2016). Dangerous associations: Joint enterprise, gangs and racism. Centre for Crime and Justice Studies, p.16.

206 Chief Coroner. (2021).Guidance No. 17 Conclusions: Short-Form and Narrative. Courts and Tribunals Judiciary.

When leaving issues of race or racism to a jury, coroners should remind juries that they are entitled to make inferences from surrounding facts. The Coroner will have to make sure that any conclusions drawn by the jury do not fall foul of the prohibitions on suggesting civil or criminal liability in s.10(2) CJA 2009. However, a conclusion in an Article 2 inquest may be a 'judgemental conclusion of a factual nature [on the core factual issues], directly relating to the circumstances of deaths,' without infringing s. 10(2).[207] Words denoting causation such as "because" and "contributed to" are permissible.[208]

Coroners should make clear to juries that there is a distinction between blame allocation and findings of fact. Coroners should provide examples of possible narrative conclusions acknowledging the role of race or racism in the death, without allocating blame or suggesting liability.

Similarly, if the coroner chooses to provide the jury with written questions they should avoid language that allocates blame or suggests liability.

PREVENTION OF FUTURE DEATH REPORTS

Where issues of race and racism arise during the inquest, or earlier during the investigation, coroners should consider including these concerns in a PFD Report. If the issues raise a risk of future deaths, it is only by including them in a PFD Report that the role of race and racism in state-related deaths can be acknowledged and addressed (see above **Exercising discretion in the public interest**).

Including concerns about the risk of future deaths by reason of race is important because, by doing so, the institutions involved must respond and explain what steps will be taken to address practices which may contribute to the future deaths of Black and racialised people in custody. When including concerns about issues of race and racism coroners must express the factual basis for the concern in "neutral and non-contentious terms," and must make sure not to apportion blame or be defamatory.[209]

An example of racism being included in a PFD Report followed the 2013 inquest into the death of Jimmy Mubenga, a Black man who died while being restrained by G4S staff on a plane during his deportation to Angola. While each case raises different issues, this provides some indication of the kind of language that might be permissible and the way race can be acknowledged.

In that report, the Assistant Deputy Coroner Karon Monaghan KC made a recommendation that the Home Office review its contractual arrangements to ensure that (i) provisions directed at incentivising removals promote safe removals, (ii) contractors adopt pay schemes that do not incentivise removal at the expense of safety. In the context of that recommendation, the Coroner acknowledged the importance that race may have played in the treatment of Jimmy Mubenga.[210]

While the recommendation itself does not specifically call a particular practice or policy racist, or reference the need to address a "racist" practice, the report is still able to highlight that a practice should be addressed, while acknowledging that addressing this practice is necessary and important to prevent deaths of Black and racialised people in particular.

207 *ibid.*

208 *ibid.*

209 For detailed guidance see Chief Coroner. (2020). Revised Guidance No. 5: Reports to Prevent Future Deaths. Courts and Tribunals Judiciary.

210 Report by the Assistant Deputy Coroner Karon Monaghan KC Under the Coroners Rules 1984, Rule 43, Inquest into the Death of Jimmy Kelenda Mubenga. (2013). See, for instance, paras. 46, 48, 49, 51.

FAMILY AFTERWORD

The race of our loved ones affected the treatment they received at the hands of the state. We, along with many other families, felt this profoundly but were left feeling bitterly disappointed, but not surprised, when we realised that the role of racism would not be investigated at the inquest. The fundamental absence of racism in the scope of the inquest has left many of us with questions that will never be answered and denied us of the opportunity to truly know how and why our loved ones died. As such, the inquest process delayed our grieving process and deprived us of the possibility to gain closure.

In evidencing racial inequality through statistics, qualitative research, and the testimonies of bereaved families, and putting forward legal arguments for the inclusion of race and potential racism in the inquest, this guide ensures that race can no longer be swept under the carpet. Though we cannot change that the role of racism was sadly overlooked by the courts in our loved one's deaths, we greatly hope that this guide will remedy this injustice so other families will not suffer as we did. Whilst the guide in and of itself is significant, the real power will be in its implementation.

Firstly, we want this guide to give lawyers and coroners the confidence to fully consider whether the race of the deceased affected their treatment and to raise the potential role of racism in state-related deaths. In so doing, we hope this guide will serve as both a vital educational tool for experienced practitioners to sharpen their craft, and a source of inspiration for the new generation of lawyers and coroners to confidently raise and evidence racism. Not only would this make a tangible difference to bereaved families' experiences at inquests, but it could also spark wider legal and policy action to address and overcome issues of race and racism.

Secondly, by encouraging lawyers and coroners to become more racially aware, sensitive, and knowledgeable, we hope that bereaved families will feel more comfortable in sharing their concerns surrounding race and racism with their legal representation, leading to greater family involvement at inquests.

In these ways, it is our hope that this guide can make a meaningful contribution towards racial justice and equality in broader British society.

We urge lawyers and coroners to stand alongside bereaved families by equipping themselves with this essential guide that we know, above all, has the power to fulfil bereaved families' shared ambition of preventing other people from dying in the same circumstances as our loved one by ensuring that the issues involved in previous deaths are identified and acted upon.

Signed by

Louise Rowland
Aji Lewis
Marcia Rigg

ACKNOWLEDGEMENTS

JUSTICE and INQUEST would like to thank members of the Advisory Group for all their hard work, commitment and insight over the course of this project.

Particular thanks goes to the group's chair Professor Leslie Thomas KC for his invaluable guidance, and to Adam Straw KC for his leading role in drafting Part 3 of the guide.

We are immensely grateful to corporate partners Morrison Foerster LLP and Skadden, Arps, Slate, Meagher & Flom (UK) LLP for their pro bono research assistance. Thanks are also due to Koji Benstead and Josh Barton from Bloomberg for their data analysis and visualisation. We are also grateful to the Matrix Causes Fund and the Law Society Charity for their generosity in supporting this project.

We are grateful to Senior Lawyer Tyrone Steele for his oversight during the project, as well as Linklater Fellows Nandini Mitra and Nobuhle Sibanda, and Pro Bono Fellow Molly Higginson for their research and drafting assistance. Additional thanks go to JUSTICE interns Jardine Barrington-Cook and Farzana Salik. Our thanks also go to Rachel Carr, for design and formatting.

Finally, we are grateful to the following people for sharing their time and expertise:

Keir Monteith KC, Garden Court Chambers

Tom Wainwright, Garden Court Chambers

Ife Thompson, Garden Court Chambers and Black Learning, Achievement and Mental Health (BLAM) UK.

Dr Laura Janes, GT Stewart

Anita Sharma, INQUEST

Jodie Anderson, INQUEST

CHECKLISTS

CHECKLIST ONE

CHECKLIST FOR SPEAKING TO BEREAVED FAMILIES ABOUT RAISING ISSUES OF RACE AND RACISM

- ☑ Before speaking to the family make sure you are aware of the issues of racism the case might raise.
- ☑ Ask the family directly whether they think race could have been a factor in their loved one's death.
- ☑ Respect and listen to the families' views on the role of racism in the death of their loved one – whatever these views may be. Strive to understand why they have these views.
- ☑ Be open and honest about the potential role of race in their loved one's death. However, don't act like you know better than the family.
- ☑ Talk tactically with the family. Be honest about the potential risks of raising race at an inquest. However, if the family wishes to raise the issue of racism, work with them to develop creative strategies for doing so.
- ☑ If the family believes race played a role in the death of their loved one, you should encourage them to put this in their witness statement.
- ☑ **IMPORTANT**: When discussing the role of racism in a death or presenting evidence of racism be mindful of the trauma that this might cause the family. Learn about collective trauma and make sure you can sign-post families to relevant support services. See **Annex 3: Support resources and organisations for bereaved families**.

CHECKLIST TWO

CHECKLIST FOR RAISING ISSUES OF RACE AND RACISM

When raising issues of race and racism at an inquest into a death in state custody practitioners should:

☑ (Where relevant and possible) make efforts to get issues of race and racism into the scope of preliminary investigation, such as those carried out by the IOPC, PPO or the NHS trust responsible for the deceased care (see **Preliminary Investigations**).

☑ Think tactically about whether to encourage the coroner to include issues of race and racism within the scope of the inquest at the Pre-Inquest Review (see **When to raise the issue of race and racism**.)

Practitioners seeking to encourage the coroner to investigate issues of race and racism should:

☑ Consider whether there is arguably a credible suspicion that there was a racially induced or discriminatory motive for the treatment leading to the deprivation of life.

- If such a credible suspicion is arguable then a practitioner may wish to argue that the coroner has a duty to investigate this under Article 2 (see **Article 2 duty to investigate discrimination**).

☑ Consider encouraging the coroner to exercise their discretion to investigate issues of race and racism. It is open for the coroner to do this provided issues of race and racism, in the coroner's judgement, fall within "by what means and in what circumstances" the death occurred (see Discrimination and the coroner's discretion)

- If a practitioner decides to take this approach they will have to demonstrate why issues of race and racism are relevant to "by what means and in what circumstances" the deceased died.
- In encouraging the coroner to exercise their discretion in favour of investigating issues of race and racism, practitioners should highlight that:
  - Coroners should exercise their discretion in the public interest.
  - Consider the needs of the family in exercising their discretion.

Practitioners wishing to argue that race was relevant to the circumstances in which the deceased died, or that there was a discriminatory motive for the treatment leading to deprivation of life should:

CHECKLIST TWO CONT.

☑ Encourage coroners to apply the following basic principles on investigating discrimination:

- Individuals can act for more than one motive.
- Discrimination is often unconscious.
- Therefore, coroners should draw inferences from the surrounding facts.

Practitioners should make sure that their submissions regarding issues of race and racism are written in a way that does not allocate blame to an individual or suggest civil liability (see **How to investigate issues of race and racism: inferences**)

CHECKLIST THREE

CHECKLIST FOR EVIDENCING ISSUES OF RACE AND RACISM

When determining how to evidence the role of racism in a death in state custody practitioners should:

☑ Recognise that direct evidence of racism, such as the use of racist language or slurs by the state agent(s) involved, is rare. However, this does not mean that the race of the deceased wasn't a significant factor in the death.

☑ Identify surrounding facts that indicate, either together or separately, that race or racism played a role in the death (see **Identifying surrounding facts**).

In order to identify and demonstrate relevant surrounding facts practitioners should:

☑ Consider evidence from the deceased's family.

☑ Examine and draw on publicly available statistical information and reports (see **Reports and Statistical Evidence**).

☑ Ask the coroner for disclosure to obtain evidence about relevant surrounding facts (see Annex 4). Practitioners will have to demonstrate that the evidence requested is relevant to the scope of the inquest.

☑ Consider asking the coroner to call a witness with expertise in race and racism to support claims that race could have played a role in the death (see **Expert Witnesses**).

CHECKLIST FOUR

CORONER'S CHECKLIST FOR DETERMINING WHETHER TO INVESTIGATE ISSUES OF RACE AND RACISM

When determining whether to include issues of race and racism within the scope of their inquiries' coroners should:

☑ Consider whether there is a credible suspicion that there was a racially induced or discriminatory motive for the treatment leading to the death.

- This criterion will likely be met in many cases concerning Black and racialised people in state custody (see **Article 2 duty to investigate discrimination**). Where there is a credible suspicion of racially induced or discriminatory motive, coroners must investigate that.

☑ Consider exercising their discretion in favour of investigating the role of race and racism in a death.

- Absent evidence to the contrary, it will almost always be at least arguable that race could have played a role in the death of a Black or racialised person. Coroner should bear in mind:
  - That investigating issues of race and racism will often help fulfil the broader purposes of an inquest.
  - There will often be a strong public interest in investigating issues of race and racism.
  - The views of the bereaved family with regard to the role of race and racism in the death of their loved one.

ANNEXES

ANNEX 1: GOVERNMENT AND SUPRANATIONAL RECOGNITION OF THE ROLE OF RACE OR RACISM IN STATE-RELATED DEATHS AND MISTREATMENT.

Criminal Justice

Angiolini, E. (2017). Report of the Independent Review of Deaths and Serious Incidents in Police Custody.

Casey, L. (2023). An independent review into the standards of behaviour and internal culture of the Metropolitan Police Service.

Goldstone, C. (2022). The Jermaine Baker Public Inquiry, HC 377.

HM Chief Inspector of Prisons. (2022). The Experiences of Adult Black Male Prisoners and Black Prison Staff.

Holland, C. (2013). The Report of The Azelle Rodney Inquiry, HC 552.The Stationary Office.

Keith, B. R. (2006). The Zahid Mubarek Inquiry (Vols.1 and 2), HC 1082.The Stationary Office

Lammy, D. (2017). The Lammy Review: An independent review into the treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System.

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OHCHR. (2023). Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice. A/HRC/54/66.

OHCHR. (2021). Promotion and protection of the human rights and fundamental freedoms of Africans and of people of African descent against excessive use of force and other human rights violations by law enforcement officers through transformative change for racial justice. A/HRC/47/53

The Independent Police Complaints Commission. (2013). Report of the independent external review of the IPCC investigation into the death of Sean Rigg.The National Archives.

UN Working Group of Experts on People of African Descent. (2023). Report of the Working Group of Experts on People of African Descent

in its visit to the United Kingdom of Great Britain and Northern Ireland. A/HRC/54/67/Add.1

Healthcare

Blofeld, J. (2003). Independent Inquiry into the death of David Bennett,

House of Commons Women and Equalities Committee. (2004). Black Maternal Health Third Report of Session 2022–23, HC 94

Kapadia, D., et al. (2022). Ethnic Inequalities in Healthcare: A Rapid Evidence Review. NHS Race & Health Observatory.

Wessely, S., et al. (2018). Modernising the Mental Health Act: Increasing choice, reducing compulsion – Final report of the Independent Review of the Mental Health Act 1983.

(2019) Independent Review of the Mental Health Act 1983: Supporting documents.

Housing

Housing Ombudsman. (2023). Housing Ombudsman Special Report on Rochdale Boroughwide Housing, p.9.

Immigration

Eves, K. (2023). Brook House Inquiry Report, HC 1789-I-III.Open Government License

Williams, W. (2022). Windrush Lessons Learned Review: Independent Review, HC 93

Multi-focus reports

Joint Committee on Human Rights. (2020). Black People, Racism and Human Rights Eleventh Report of Session 2019-21 Report, Together with Formal Minutes Relating to the Report, HC 559 HL Paper 165.

ANNEX 2: ADDITIONAL DATA

This Annex provides additional data that can be used to evidence racial disproportionality in the immigration, mental health, and criminal justice settings. It comprises a mixture of publicly available data and data gathered through requests made under the Freedom of Information Act 2000. Most of the data is "official data" gathered by government departments. Where this is not the case this is flagged in the notes.

Further data and charts concerning the deaths involving the use of force, and deaths in prison can be found in INQUEST's reports: INQUEST. (2023). "I can't breathe': Race, death and British Policing"; INQUEST. (2022). Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination.

IMMIGRATION

Deaths in Immigration Detention

The following sets out the numbers of deaths of Black and racialised people in immigration detention during the period 2012-2021, and as a percentage of total deaths compared with the proportion of the population each racialised group represents.[1]

DATATABLE: DEATHS IN IMMIGRATION DETENTION BY RACE

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Grand Total	Population[2] [England & Wales]
Asian	**0**	**2**	**1**	**1**	**2**	**1**	**0**	**0**	**0**	**0**	7	5515420
Black	**1**	**0**	**2**	**1**	**1**	**1**	**1**	**1**	**0**	**0**	8	2409278
Other/ Unknown	**0**	**0**	**0**	**0**	**1**	**1**	**1**	**0**	**1**	**0**	4	2973595
White	**0**	**1**	**0**	**0**	**0**	**4**	**1**	**0**	**0**	**1**	7	48699249
	1	3	3	2	4	7	3	1	1	1	26	59597542

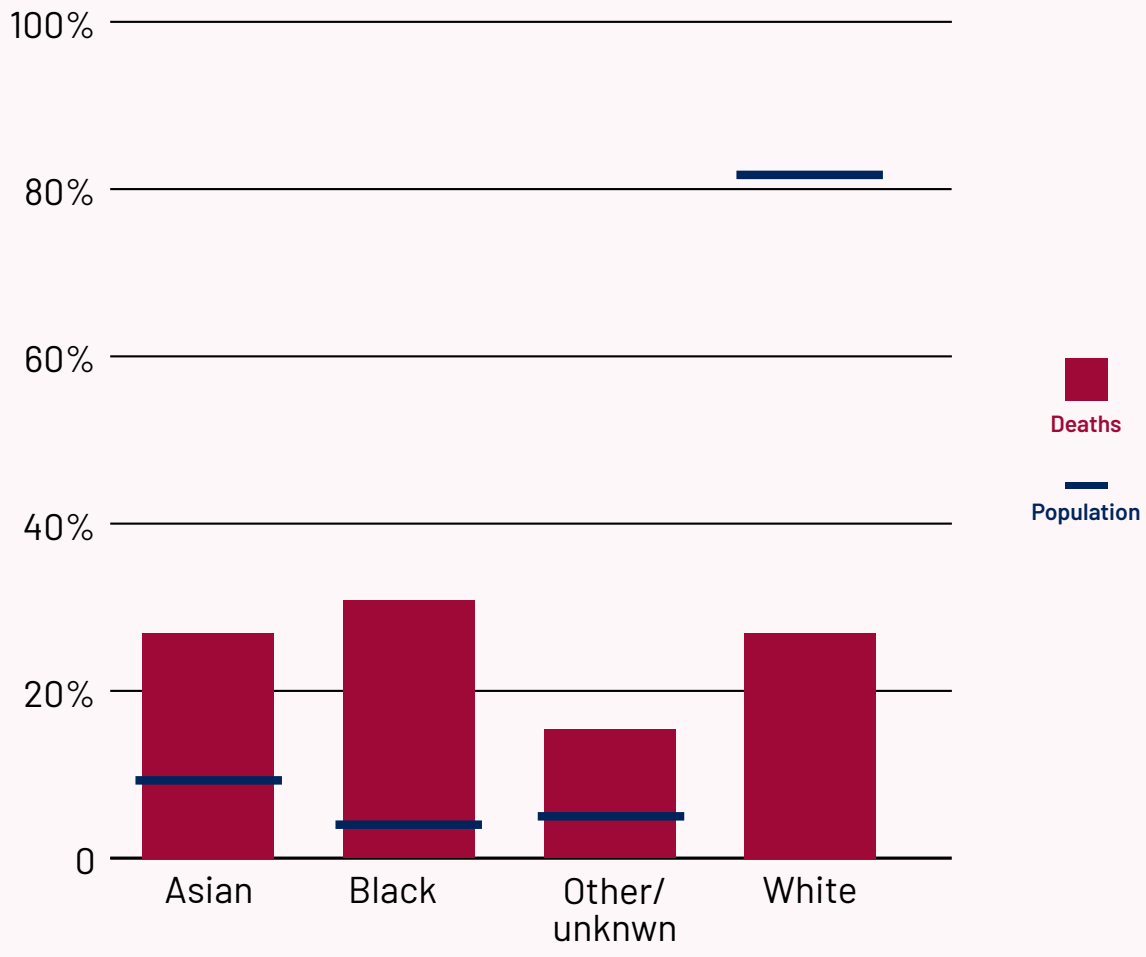
1 The data in this section includes deaths in immigration removal centres (IRC), short-term holding facilities (STHF), pre-departure accommodation (PDA) or under escort, or after leaving detention if the death was the result of an incident occurring while detained or where there is some credible information that the death might have resulted from their period of detention. It does not include deaths of individuals being detained solely under immigration powers in prisons. This reflected the way the Home Office records deaths of individuals detained under Immigration Act Power. The underlying data was provided by the Home Office, this data was cross referenced with Prison and Probation Ombudsman fatal incident reports, and data collected by NGOs, including INQUEST and the Institute for Race Relations, to establish, where possible, the race of the deceased.

2 Population data taken from Office for National Statistics 2021 Census.

DATATABLE: DEATHS IN IMMIGRATION DETENTION BY RACE (%)

	2012	2013	2014	2015	2016	2017	2018	2019	2020	2021	Grand Total	Population[3] [England & Wales]
Asian	0%	66.7%	33.3%	50%	50%	14.3%	0%	0%	0%	0%	26.9%	5515420
Black	100%	0	2	50%	25%	14.3%	33.3%	100%	0%	0%	30.8%	2409278
Other/ Unknown	0%	0%	0%	0%	25%	14.3%	33.3%	0%	100%	0%	15.4%	2973595
White	0%	33.3%	0%	0%	0%	57.1%	33.3%	0%	0%	100%	26.9%	48699249
	1	3	3	2	4	7	3	1	1	1	26	59597542

CHART: DEATHS IN IMMIGRATION DETENTION COMPARED TO PERCENTAGE OF THE GENERAL POPULATION[4] (2012-21).



3 Population data taken from Office for National Statistics 2021 Census.

4 Assuming constant demographic profiles over the period considered.

POLICING

Handling of Allegations of Race Discrimination by the Independent Office for Police Conduct

The below sets out data from the years 2020-21 to 2022-23[5] on the handling of allegations of race discrimination made against the police to the Independent Office for Police conduct.

This includes the number and percentage of allegations investigated, broken down by investigatory procedure, and the outcomes of these investigatory procedures.

DATATABLE: INVESTIGATIONS OF ALLEGATIONS OF RACE DISCRIMINATION

	2020-21	2021-22	2022-23	Grand Total
Not Formally Investigated	**1,638**	**1,513**	**2,103**	**5,254**
Formal Investigation - Not subject to special procedures[6]	**550**	**642**	**244**	**1,436**
Formal Investigation - Subject to special procedures	**78**	**66**	**28**	**172**
Grand Total	100%	100%	100%	100%

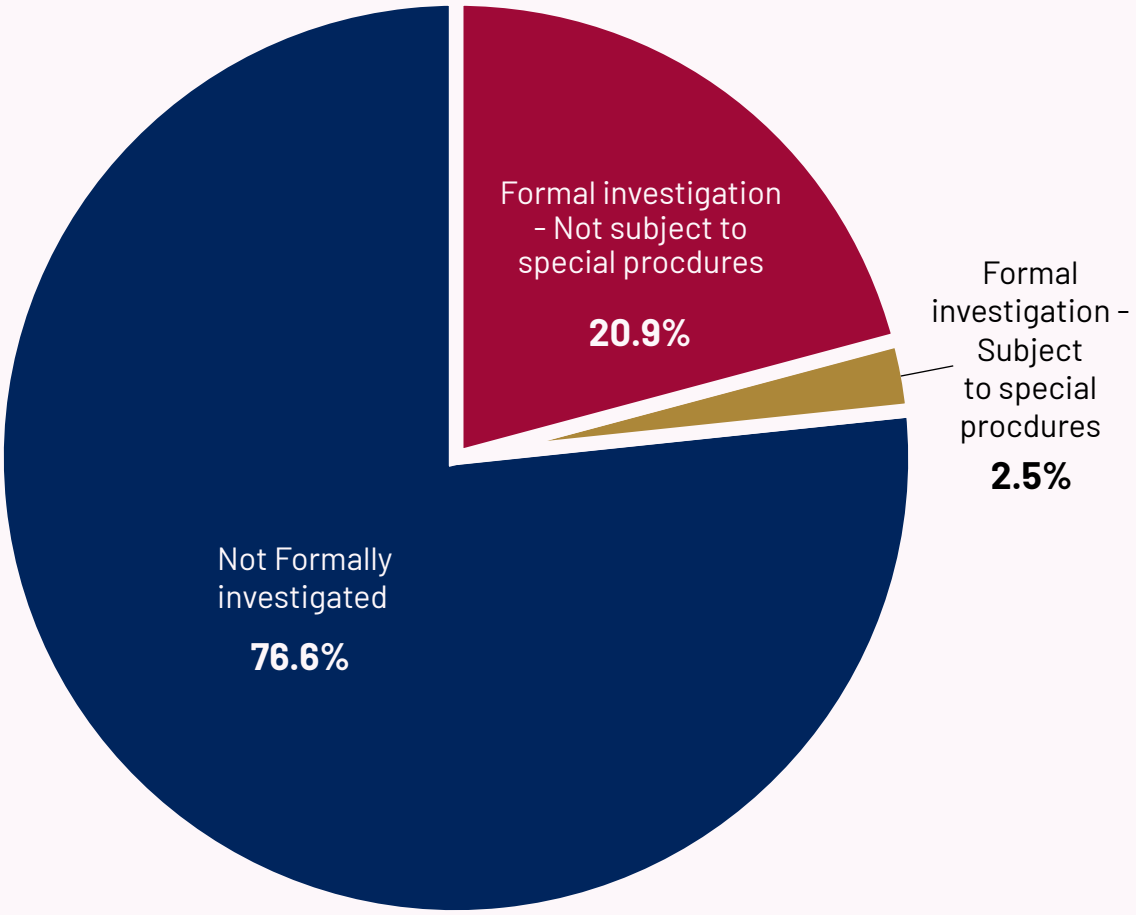
DATATABLE: INVESTIGATIONS OF ALLEGATIONS OF RACE DISCRIMINATION (%)

	2020-21	2021-22	2022-23	Grand Total
Not Formally Investigated	**72.3%**	**68.1%**	**88.5%**	**76.6%**
Formal Investigation - Not subject to special procedures	**24.3%**	**28.9%**	**10.3%**	**20.9%**
Formal Investigation - Subject to special procedures	**3.4%**	**3.0%**	**1.2%**	**2.5%**
Grand Total	100%	100%	100%	100%

5 The data in this section covers this period only as legislation change effective from February 2020 changed the way that data is collected and what is available, prior to this data on allegations of discrimination broken down by type of discrimination is not available. Data relating to the outcomes of special requirements investigations (special procedure investigations post 2020) is also not available.

6 Investigations subject to special procedures result in a different range of outcomes than those not subject to special procedures. See tables and charts below.

CHART: INVESTIGATIONS OF ALLEGATIONS OF RACE DISCRIMINATION (2020-21 - 2022-23)



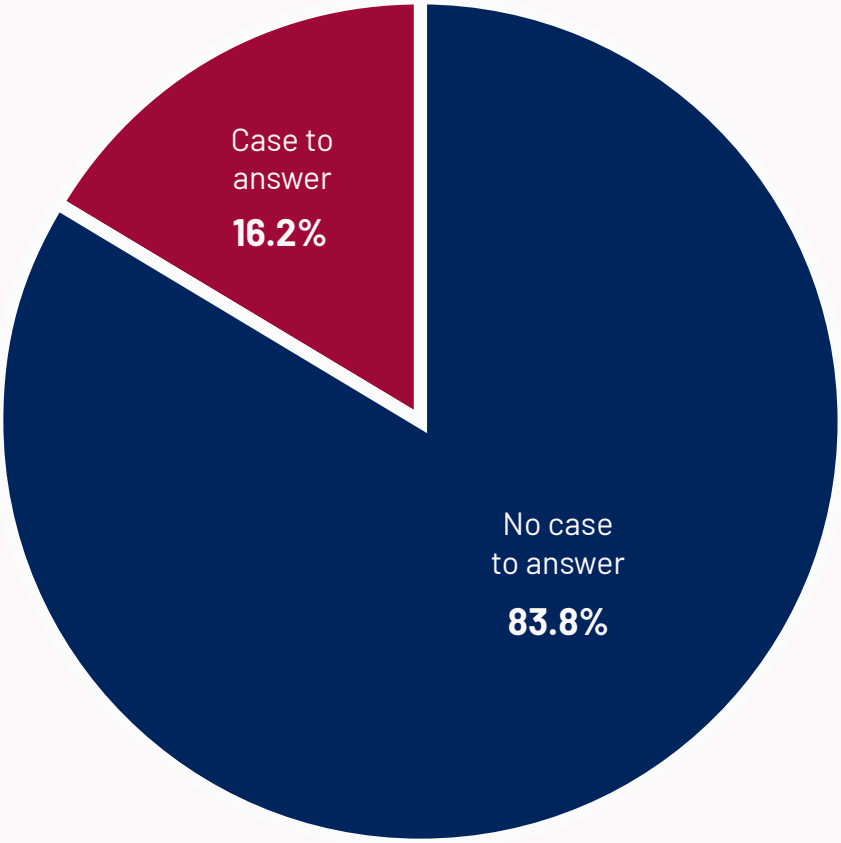
DATATABLE: OUTCOME OF RACE DISCRIMINATION ALLEGATIONS SUBJECT TO SPECIAL PROCEDURE

	2020-21	2021-22	2022-23	Grand Total
Case to answer	**5**	**4**	**15**	**24**
No case to answer	**48**	**54**	**22**	**124**
Grand Total	53	58	37	148

DATATABLE: OUTCOME OF RACE DISCRIMINATION ALLEGATIONS SUBJECT TO SPECIAL PROCEDURE (%)

	2020-21	2021-22	2022-23	Grand Total
Case to answer	**9.4%**	**6.9%**	**40.5%**	**16.2%**
No case to answer	**90.6%**	**93.1%**	**59.5%**	**83.8%**
Grand Total	100%	100%	100%	100%

CHART:OUTCOME OF RACE DISCRIMINATION ALLEGATIONS SUBJECT TO SPECIAL PROCEDURE (2020-21 - 2022-23)



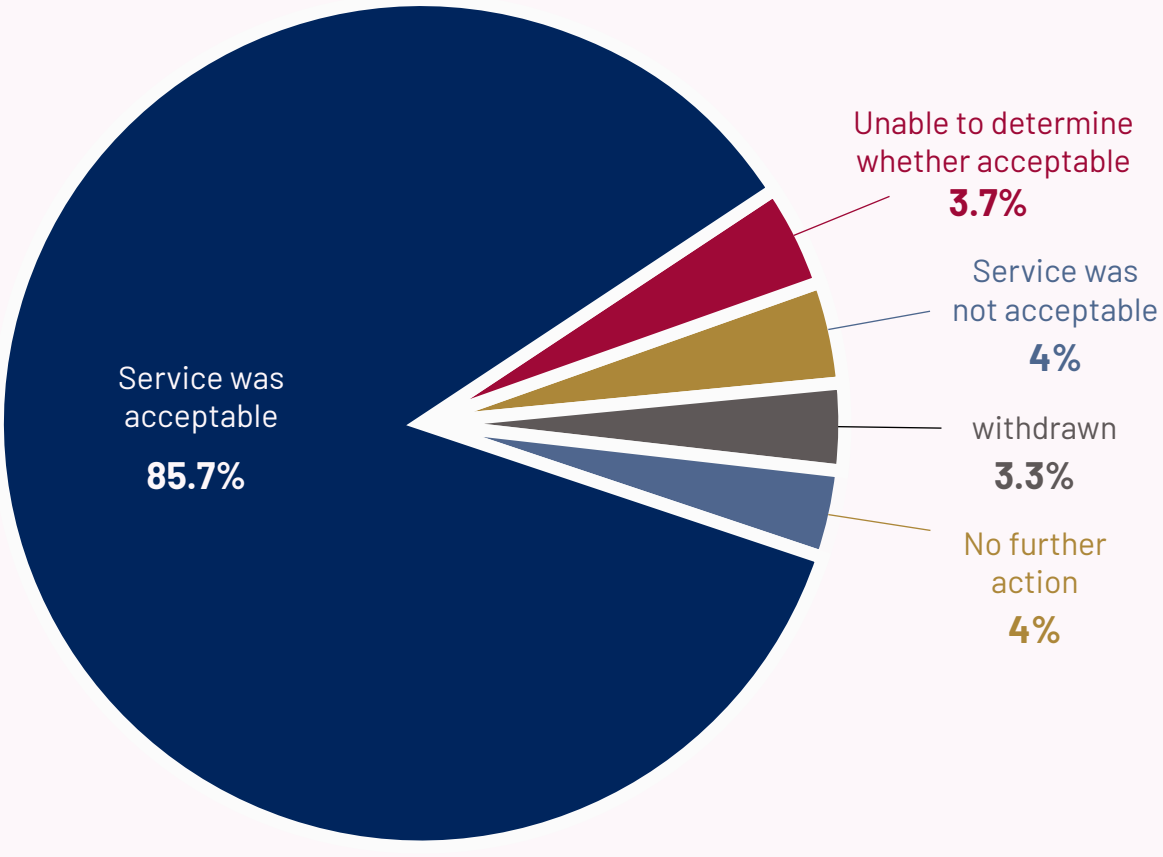
DATATABLE: OUTCOME OF RACE DISCRIMINATION ALLEGATIONS NOT SUBJECT TO SPECIAL PROCEDURE

	2022-23	2021-22	2020-21	Grand Total
No further action	**18**	**63**	**17**	**98**
Service was acceptable	**469**	**520**	**205**	**1194**
Service was not acceptable	**22**	**19**	**7**	**48**
Unable to determins whether acceptable	**20**	**23**	**9**	**52**
Withdrawm	**18**	**12**	**6**	**36**
Grand Total	547	637	244	1428

DATATABLE: OUTCOME OF RACE DISCRIMINATION ALLEGATIONS NOT SUBJECT TO SPECIAL PROCEDURE (%)

	2022-23	2021-22	2020-21	Grand Total
No further action	**3.3%**	**9.9%**	**7%**	**6%**
Service was acceptable	**85.7%**	**81.6%**	**84%**	**83.6%**
Service was not acceptable	**4%**	**3%**	**2.9%**	**3.4%**
Unable to determins whether acceptable	**3.7%**	**3.6%**	**3.7%**	**3.6%**
Withdrawm	**3.3%**	**1.9%**	**2.5%**	**2.5%**
Grand Total	100%	100%	100%	100%

CHART:OUTCOME OF RACE DISCRIMINATION ALLEGATIONS NOT SUBJECT TO SPECIAL PROCEDURE (2020-21 - 2022-23)



Deaths involving use of force[7]

The following sets out the number of deaths of Black or racialised people involving police use of force for the time period 2012/13 to 2021/22, and as a percentage of total deaths involving use of force. It also provides this data broken down by race and type of force involved in the death i.e. baton, PAVA spray, physical restraint, restraint equipment, stun grenade, taser.

DATATABLE: DEATHS INVOLVING POLICE USE OF FORCE (2012-13 TO 2021-22).

	Total	Population [England & Wales][8]
Black or racialised people	**35**	**9,642,674**
Black	25	2,409,278
Asian	6	5,515,420
Mixed	4	1,717,976
White	**92**	**48,699,249**
White	92	48,699,249
Other or Unknown	**1**	**1,255,619**
Other	0	1,255,619
Unknown	1	0
Grand Total	**128**	**59,597,542**

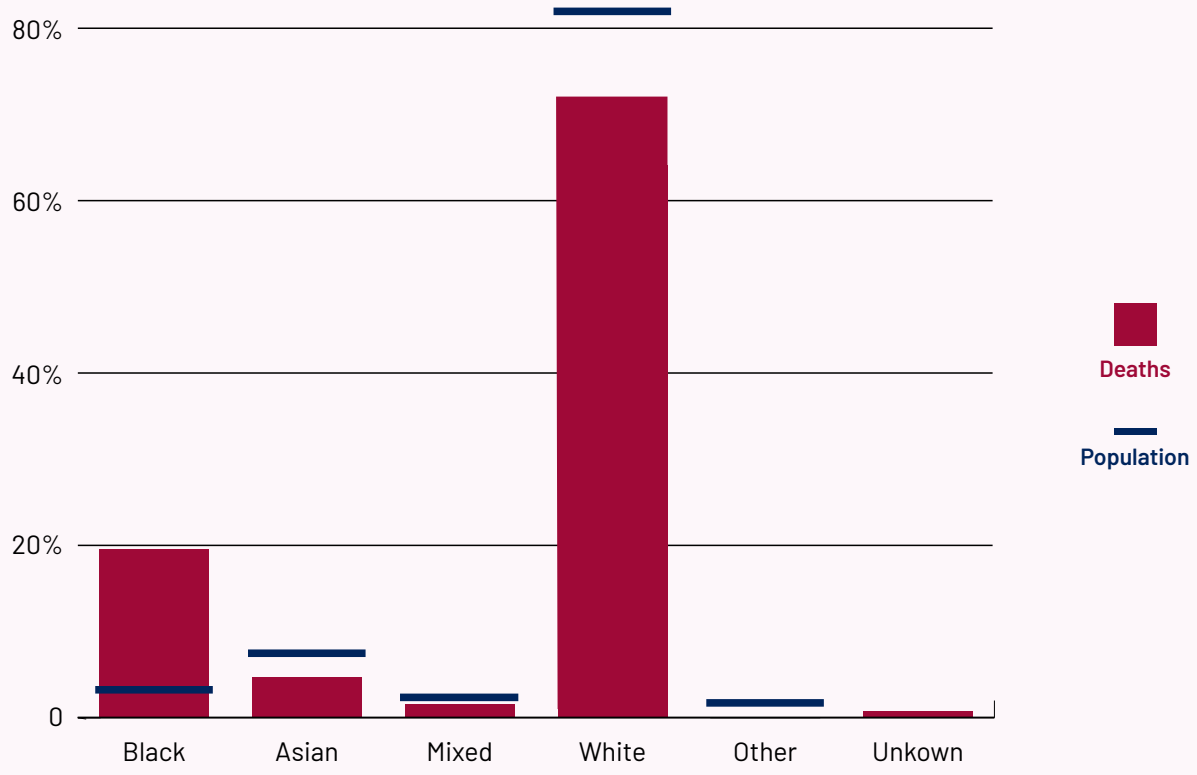
7 This includes deaths during or following police contact, and other deaths involving police contact as defined by the Independent Office for Police Conduct.

8 Population data taken from Office for National Statistics 2021 Census.

DATATABLE: DEATHS INVOLVING POLICE USE OF FORCE (%) (2012-13 TO 2021-22).

	Total	Population [England & Wales]
Black or racialised people	**27.3%**	**16.2%**
Black	19.5%	4%
Asian	4.7%	9.3%
Mixed	3.1%	2.9%
White	**71.9%**	**81.7%**
White	64.1%	81.7%
Other or Unknown	**0.8%**	**2.1%**
Other	0%	2.1%
Unknown	0.8%	0%
Grand Total	**100%**	**100%**

CHART: PERCENTAGE OF DEATHS INVOLVING USE OF FORCE COMPARED TO PERCENTAGE OF THE GENERAL POPULATION[9] (2012-13 TO 2021-22).



9 Assuming constant demographic profiles over the period considered.

DATA TABLE: DEATHS BY TYPE OF USE OF FORCE (2012-13 TO 2021-22)[10]

	Baton	CS / PAVA spray	Physical Restraint	Restraint equipment	Stun grenade	Taser	Total	Population [England & Wales][11]
Black or racialised people	**5**	**3**	**33**	**13**	**1**	**7**	**62**	**9,642,674**
Black	5	3	23	7	1	6	45	2,409,278
Asian	0	0	6	3	0	1	10	5,515,420
Mixed	0	0	4	3	0	0	7	1,717,976
White	**3**	**13**	**83**	**28**	**0**	**10**	**137**	**48,699,249**
White	3	13	83	28	0	10	137	48,699,249
Other or Unknown	**0**	**0**	**1**	**0**	**0**	**0**	**1**	**1,255,619**
Other	0	0	0	0	0	0	0	1,255,619
Unknown	0	0	1	0	0	0	1	0
Grand Total	**8**	**16**	**117**	**41**	**1**	**17**	**200**	**59,597,542**

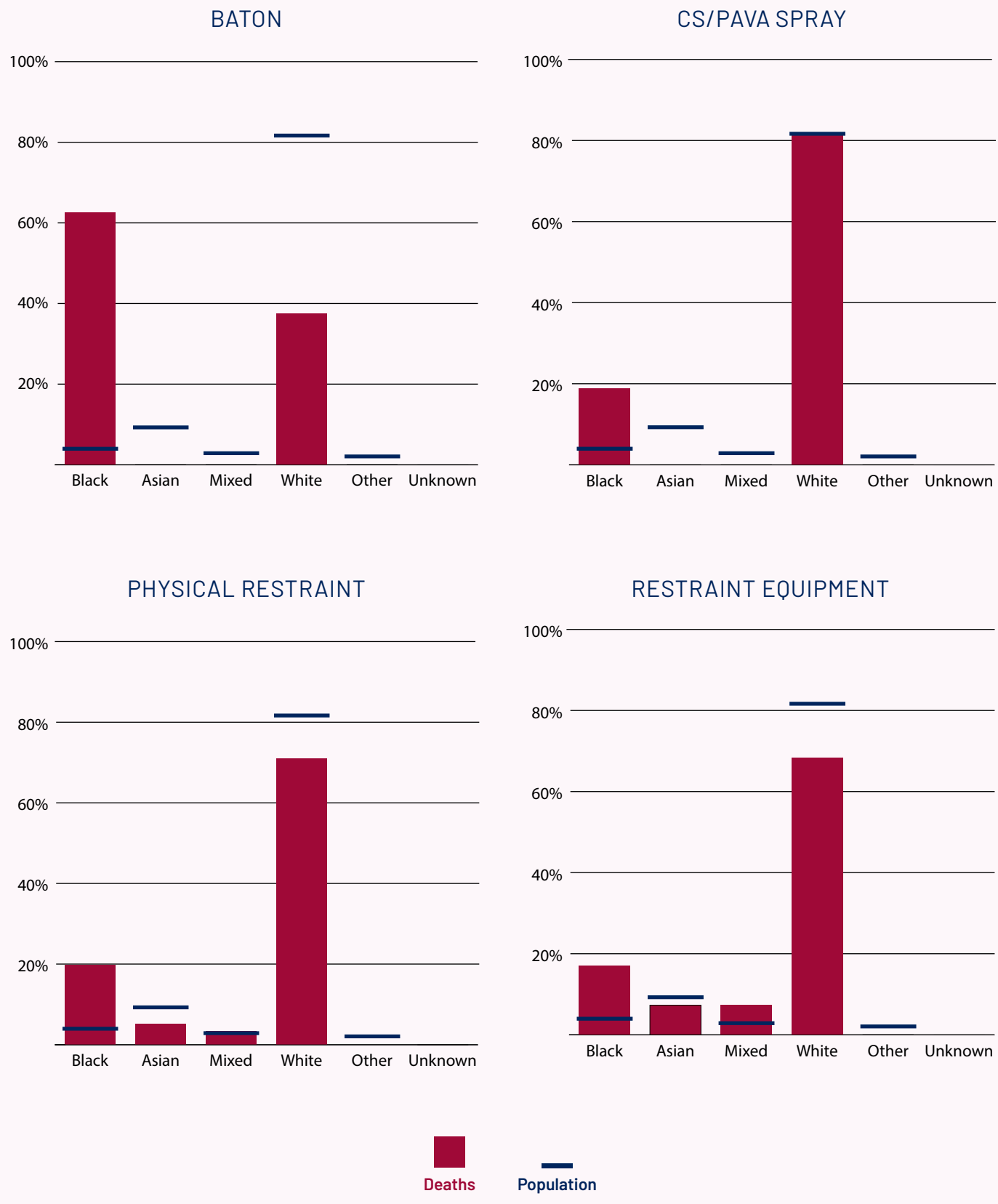
DATA TABLE: DEATHS BY TYPE OF USE OF FORCE (%) (2012-13 TO 2021-22)

	Baton	CS / PAVA spray	Physical Restraint	Restraint equipment	Stun grenade	Taser	Total	Population [England & Wales]
Black or racialised people	**62.5%**	**18.8%**	**28.2%**	**31.7%**	**100%**	**41.2%**	**31%**	**16.2%**
Black	62.5%	18.8%	19.7%	17.1%	100%	35.3%	22.5%	4%
Asian	0%	0%	5.1%	7.3%	0%	5.9%	5%	9.3%
Mixed	0%	0%	3.4%	7.3%	0%	0%	3.5%	2.9%
White	**37.5%**	**81.3%**	**70.9%**	**68.3%**	**0%**	**58.8%**	**68.5%**	**81.7%**
White	37.5%	81.3%	70.9%	68.3%	0%	58.8%	68.5%	81.7%
Other or Unknown	**0%**	**0%**	**0.9%**	**0%**	**0%**	**0%**	**0.5%**	**2.1%**
Other	0%	0%	0%	0%	0%	0%	0%	2.1%
Unknown	0%	0%	0.9%	0%	0%	0.0%	0.5%	0%
Grand Total	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**	**100%**

10 This data includes deaths during or following police contact, and other deaths involving police contact as defined by the Independent Office for Police Conduct.

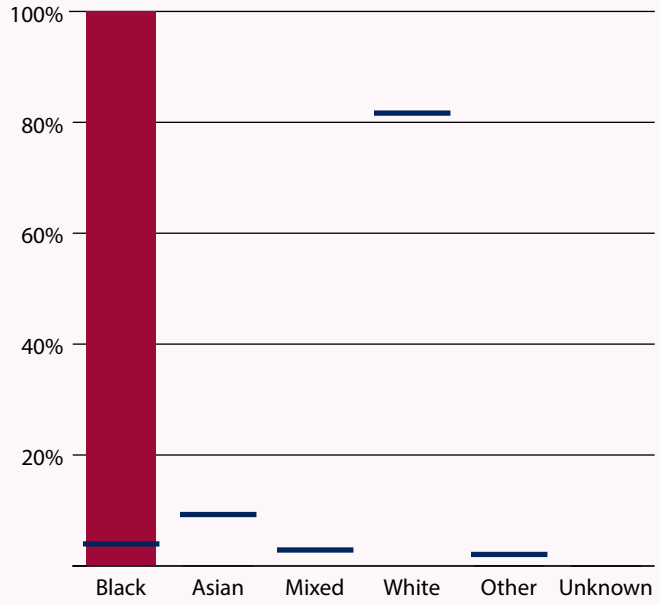
11 Population data taken from Office for National Statistics 2021 Census.

CHART(S): PERCENTAGE OF DEATHS BY TYPE OF FORCE COMPARED TO PERCENTAGE OF THE GENERAL POPULATION (2012-13 TO 2021-22).[12]

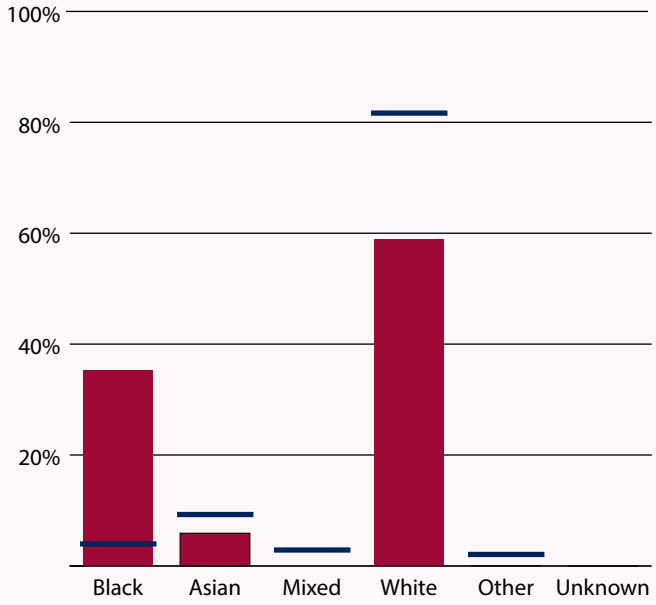


12 Assuming constant demographic profiles over the period considered.

STUN GRENADE



TASER



Deaths Population

MENTAL HEALTH

Detentions

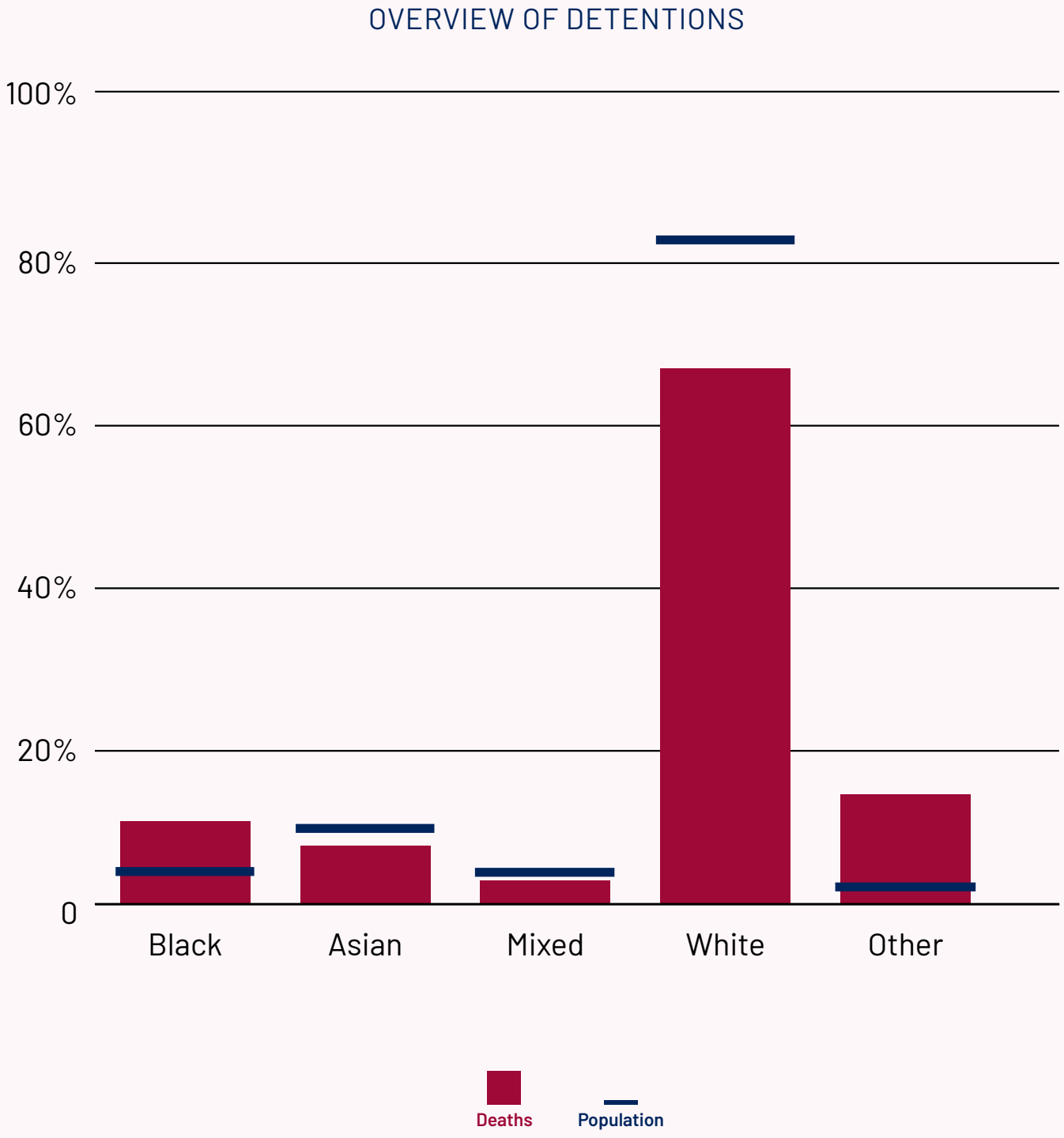
The following provides the proportion of detentions under the Mental Health Act 1983 involving Black and racialised people during the period 2016/17-2021/22, compared to the proportion of the population represented by each racialised group.[13]

DATA TABLE: DETENTIONS UNDER THE MENTAL HEALTH ACT (%)

	2016-17	2017-18	2018-19	2019-20	2020-21	2021-22	Grand Total	Population [England & Wales]
Asian	**6.8%**	**6.7%**	**7.4%**	**7.4%**	**7.2%**	**7.6%**	**7.2%**	**9.3%**
Any Other Asian Background	1.9%	1.9%	2.0%	2.1%	2.1%	2.1%	2.0%	1.6%
Bangladeshi	0.9%	0.9%	1.0%	0.9%	1.0%	1.0%	1.0%	1.1%
Chinese	0.4%	0.3%	0.4%	0.3%	0.4%	0.4%	0.4%	0.8%
Indian	1.6%	1.4%	1.8%	1.8%	1.7%	1.8%	1.7%	3.1%
Pakistani	2.1%	2.2%	2.2%	2.2%	2.0%	2.2%	2.1%	2.7%
Black	**9.9%**	**9.7%**	**10.3%**	**10.5%**	**10.7%**	**10.6%**	**10.3%**	**4.0%**
African	3.5%	3.5%	4.0%	3.9%	4.6%	4.6%	4.0%	2.5%
Any Other Black Background	3.2%	3.2%	3.1%	3.4%	3.0%	3.0%	3.2%	0.5%
Caribbean	3.2%	3.0%	3.2%	3.2%	3.1%	3.0%	3.1%	1.1%
Mixed	**2.7%**	**2.6%**	**3.3%**	**3.1%**	**3.2%**	**3.2%**	**3.0%**	**2.9%**
Any Other Mixed Background	1.0%	1.0%	1.5%	1.3%	1.4%	1.4%	1.3%	0.8%
White and Asian	0.4%	0.4%	0.3%	0.4%	0.4%	0.4%	0.4%	0.8%
White and Black African	0.4%	0.4%	0.4%	0.4%	0.5%	0.4%	0.4%	0.4%
White and Black Caribbean	0.9%	0.8%	1.0%	1.0%	0.9%	1.0%	1.0%	0.9%
Other	**13.0%**	**14.0%**	**11.7%**	**12.4%**	**14.1%**	**16.1%**	**13.6%**	**2.1%**
Any Other Ethnic Group	3.2%	2.8%	2.7%	3.0%	3.1%	3.0%	3.0%	1.6%
Arab	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.6%
Ethnicity not stated/invalid	9.9%	11.3%	9.0%	9.4%	11.0%	13.1%	10.6%	0.0%
White	**67.6%**	**67.0%**	**67.4%**	**66.7%**	**64.8%**	**62.5%**	**66.0%**	**81.7%**
Any Other White Background	6.2%	6.2%	6.2%	6.3%	6.4%	6.2%	6.3%	6.4%
White British	60.4%	59.9%	60.3%	59.6%	57.7%	55.5%	58.8%	74.4%
White Irish	0.9%	0.9%	0.9%	0.8%	0.8%	0.7%	0.8%	0.9%
Grand Total	100%	100%	100	100%	100%	100%	100%	100%

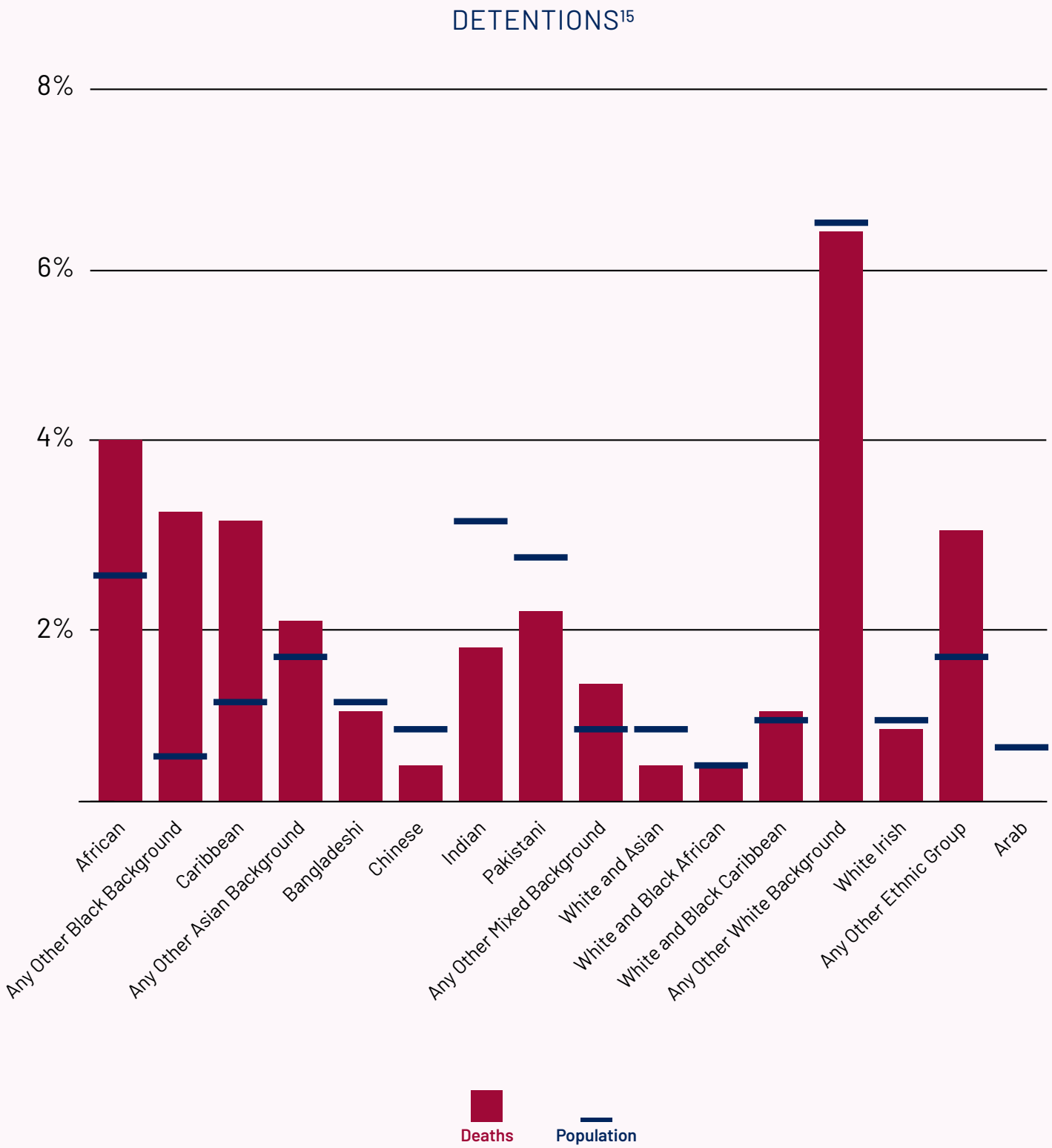
13 Raw numbers available through NHS Digital, Mental Act Statistics Data Tables.

CHART(S): PERCENTAGE OF DETENTIONS UNDER THE MENTAL HEALTH ACT COMPARED TO PERCENTAGE OF THE POPULATION (2016-17 - 2021-22).[14]



14 Assuming constant demographic profiles over the period considered.

CHART(S): PERCENTAGE OF DETENTIONS UNDER THE MENTAL HEALTH ACT COMPARED TO PERCENTAGE OF THE POPULATION (2016-17 - 2021-22).



15 As the percentage of individuals from the White British group is high, this group has been excluded from the chart for ease of visualisation. The percentage of White British people compare to their representation in the general population is 58.8% to 74.4%.

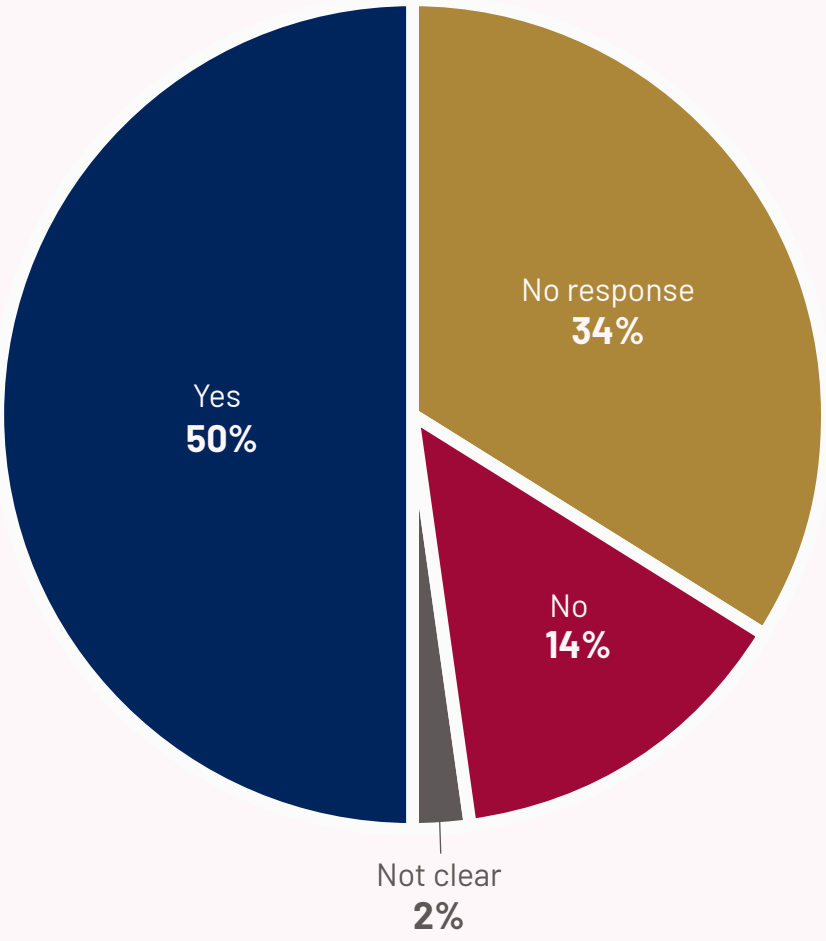
Data collection

The following provides data on the extent to which NHS Mental Health Trusts centrally record the race of individuals who died whilst receiving inpatient care - either as a patient detained under the Mental Health Act 1983, or as a voluntary patient.

DATATABLE: CENTRAL RECORDING OF RACE DATA OF PATIENTS DETAINED UNDER THE MENTAL HEALTH ACT WHO DIED WHILST IN INPATIENT CARE

	Count	Percentage
No	**8**	**14.3%**
No Response	**19**	**34.0%**
Not Clear	**1**	**2.0%**
Yes	**28**	**50.0%**
Total	**56**	**100%**

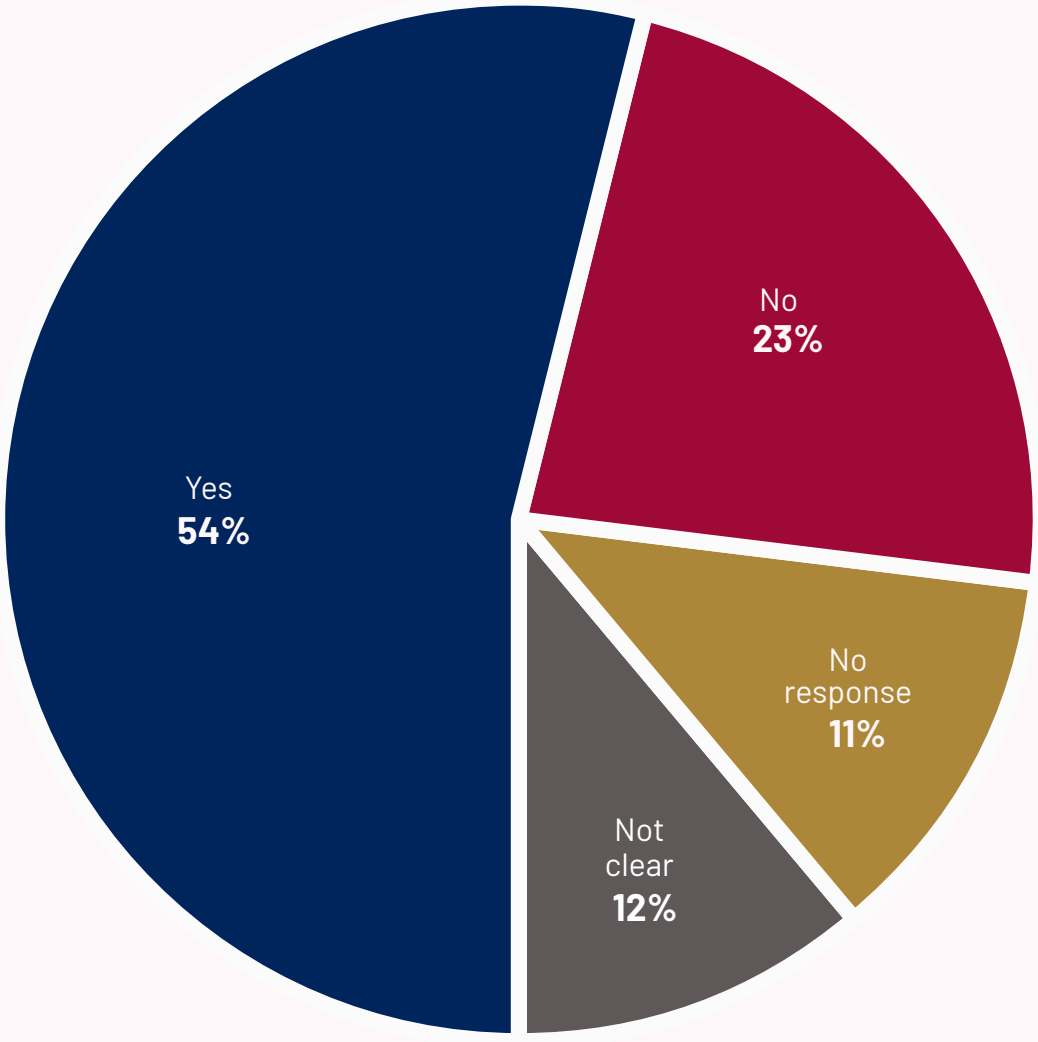
CHART: CENTRAL RECORDING OF RACE OF DETAINED PATIENTS WHO DIED WHILST IN INPATIENT CARE



DATATABLE: CENTRAL RECORDING OF RACE DATA OF VOLUNTARY PATIENTS WHO DIED WHILST IN INPATIENT CARE

	Count	Percentage
No	13	23.2%
No Response	6	10.7%
Not Clear	7	12%
Yes	30	53.6%
Total	56	100%

CHART: CENTRAL RECORDING OF RACE OF DETAINED PATIENTS WHO DIED WHILST IN INPATIENT CARE



ANNEX 3: SUPPORT RESOURCES AND ORGANISATIONS FOR BEREAVED FAMILIES

Please note that the organisations and resources listed below are support organisations. They do not replace specialist medical and healthcare advice and support.

You may wish to consult with your general practitioner and seek their help. Your GP may be able to assist with access to medication, psychological therapy, counselling services, or other sources of support.

Your workplace, school or university may also offer access to counselling and support services.

If you are worried that you or a loved one is feeling in crisis or is at risk, please call Emergency Services at **999** and/or attend your local hospital's Accident and Emergency department, where they can arrange for an assessment with medical and nursing staff.

ORGANISATIONS AND RESOURCES

Coroners' Courts Support Service

The Coroners' Courts Support Service (CCSS) is an independent voluntary organisation whose trained volunteers offer emotional support and practical help to bereaved families, witnesses and others attending an inquest at a Coroner's Court.

The CCSS have produced a leaflet providing information on attending an inquest at a Coroner's Court.

National helpline: 0300 111 2141
Email: helpline@ccss.org.uk

Cruse Bereavement Care

Cruse Bereavement Care provides one-to-one and other support to people bereaved, including specialist services for children and young people. It has over 80 local branches delivering local support services across England, Wales and Northern Ireland.

Helpline: 0808 808 1677

INQUEST

INQUEST is an organisation which provides free and independent advice on the inquest process and related investigations following a death in state detention or care in England and Wales, and in some other cases where the conduct of the state or corporate bodies is in question. It is entirely independent of government.

It provides a specialist casework service, expert advice and assistance on cases involving deaths in prison; in police custody; in immigration detention; and in mental health settings, as either a voluntary or detained inpatient.

INQUEST has produced a free Handbook and Skills and Support Toolkit. INQUEST states that "[t]he handbook gives you detailed information on the investigation and inquest procedures after a death. The Skills and Support Toolkit encourages the development of specific skills and knowledge with the aim of empowering families beyond the inquest process."

Further information:
https://www.inquest.org.uk/our-services

Lafiya Health

Lafiya Health is a Black-led organisation that was established with the intent to talk about issues that have an effect on the physical and mental health within minority communities. Their work is in recognition that a lot of issues disproportionately impact minority groups, especially those with African and Caribbean ancestry.

Lafiya Health aims to provide inclusive psychological well-being support, including educational resources, mental health forums, and access to therapy.

It hosts free monthly grief forums to provide a space for bereaved people to access peer support.

Further information: https://www.lafiyahealth.co.uk/services.
Email: info@lafiyahealth.co.uk

Ministry of Justice

The Ministry of Justice has produced a Guide to Coroner Services for Bereaved People is "intended for bereaved people and others who may be affected by a coroner investigation or are attending a coroner's inquest".

Rethink Mental Illness

Rethink Mental Illness is an organisation advocating for equality, rights, fair treatment and maximum quality of life for all those affected by mental illness, their carers, family and friends.

They have produced an Inquests Factsheet for people who have lost loved ones to suicide in England. It explains what an inquest is, what it will be like, and the rights of the bereaved during the investigation.

They also have an Advice Service which offers practical help on issues such as the Mental Health Act, community care and welfare benefits, living with mental illness, medication and care.

Freephone advice service: 0808 801 0525

Support of Bereavement by Suicide

Support of Bereavement by Suicide (SOBS) is the only UK-based organisation offering peer-led support to adults impacted by suicide loss.

National support line: 0300 111 5065

The Compassionate Friends

The Compassionate Friends (TCF) is a charitable organisation of bereaved parents, siblings and grandparents dedicated to the support and care of other similarly bereaved family members who have suffered the death of a child (of whatever age, including adult children) or children from a month old and from any cause.

TCF has produced leaflets for those bereaved, including a leaflet for those bereaved following the death of an adult child. This covers topics including the emotions felt; practical things to consider; and next steps.

Helpline: 0345 123 2304
Email: helpline@tcf.org.uk

The United Families and Friends Campaign

The United Families and Friends Campaign (UFFC) is a coalition of campaigners advocating for bereaved families after deaths in police, prison and psychiatric custody. Its campaign demands include:

- Prison deaths be subject to a system of properly funded investigation that is completely independent of the prison service;

- Officers involved in custody deaths be suspended until investigations are completed;
- Prosecutions should automatically allow unlawful killing verdicts;
- Police forces be made accountable to the communities they serve;

Legal aid and full disclosure of information is available to the relatives of victims;

Officers responsible for deaths should face criminal charges, even if retired.

Contact: contactuffc@gmail.com

ANNEX 4: LIST OF POSSIBLE DISCLOSURE REQUESTS RELEVANT TO THE STATISTICAL CONTEXT

1. Index to all material held by IOPC/PPO/ Mental Health Trust including unused and sensitive material.

2. Disciplinary records for [NAME or all officers/employees named as witnesses to the death], limited to records of any complaints or investigations of discrimination [and/or the use of force], whether proven or not, and including matters of unsatisfactory performance as well as misconduct and/ or gross misconduct. In the case of police witnesses, this should include printouts from the Centurion and/or Tribune databases and/or HR files.

3. Training records for [NAME or all officers/ employees named as witnesses to the death] showing their participation in, and the content of, any local or force-wide training concerned with discrimination, race, diversity and/or inclusion.

4. Statistical information showing the ethnicity of all the police officers in the force implicated in this death, expressed as percentages relative to the ethnicity of the population of the area covered by that force.

5. [If police] Records of all S1 PACE stops conducted by [NAME or all officers/ employees named as witnesses to the death] in the 6/12 months preceding this death, where the parameters for searching the relevant database(s) should include for each stop the Date of Birth, Apparent Age, EA Code, SDE code and gender of the subject, as well as the location, the object of the search and its outcome.

6. Records of all s136 detentions by [NAME or all officers/employees named as witnesses to the death] in the 6/12 months preceding this death, by the ethnicity of the subject.

7. Any force data on the use of street-level coercive powers (eg s1 PACE, s23 MDA, s163 RTA, s136 MHA etc) by its officers generally, broken down by the ethnicity of the subject, and expressed as a percentage of the ethnicity of the population covered by that force.

8. Any account recorded by any officer or police staff member relating to this incident, including in connection with the complaint or in relation to the supervision of the officers/ employees involved, and in any format ie electronic or hard copy (eg notebooks), and on any platform including WhatsApp, SMS messages and Outlook, on any service issue phone or record saved to personal folders on police servers or any document management system such as HOLMES. [If MPS ask for disclosure of any material referencing the deceased and/or this incident saved on either the S or H drives as well.]

INQUEST