SHEKU BAYOH INQUIRY

CONTEXTUAL LITERATURE REVIEW – RACE AND POLICING

Background, purpose and scope

1. The Sheku Bayoh Inquiry's Terms of Reference require it to establish: "*the extent (if any) to which the events leading up to and following Mr Bayoh's death, in particular the actions of the officers involved, were affected by his actual or perceived race and to make recommendations to address any findings in that regard*."

2. Whilst the relevance of race has been integrated into every block of the Inquiry's hearings, the Inquiry will also hold a standalone block of hearings to consider race on 4-7 June and 19 June – 5 July 2024.

3. The purpose of this contextual literature review is to provide – both to Core Participants and members of the public – an overview of the themes drawn from relevant research literature, inquests, reviews and inquiries undertaken previously covering the subject of race and policing.

4. This thematic review is intended to be concise and accessible: its aim is not to be exhaustive of all the extensive material available about race and policing.

5. The material analysed for the purpose of preparing this thematic review is listed at **Annex A**.

Themes arising

6. The following eight (8) themes have been identified by this contextual literature review. These themes are covered in the paragraphs below:

   (a) **Race being raised (or not raised) as a potential factor in the incident or death occurring** (paragraphs [7] to [36]);

   (b) **Use of restraint (and disproportionate restraint)** (paragraphs [37] to [58]);

   (c) **Use of the terms "Excited Delirium" and "Acute Behavioural Disturbance"** (paragraphs [59] to [67]);

   (d) **Identification and response (or failure to so identify or respond) to a medical emergency** (paragraphs [68] to [74]);

   (e) **Deficiencies in family liaison and post-incident management** (paragraphs [75] to [86]);

   (f) **Collection of ethnicity data** (paragraphs [87] to [99]);

(g) **Culture and a representative police workforce** (paragraphs [100] to [102]); and

(h) **The need for further (or improved) training to be undertaken by police officers** (paragraphs [103] to [128]).

THEMES

(a) Race being raised (or not raised) as a potential factor in the incident or death occurring

7. The report of the inquiry led by Sir William Macpherson (the "Lawrence Inquiry"), published twenty-five years ago in 1999, has been described as "*truly ground-breaking*"[1], "*seminal*"[2] and a "*watershed moment in the history of the police and race relations*".[3]

8. The Lawrence Inquiry was tasked with inquiring into the matters arising from the murder of Stephen Lawrence on 22 April 1993 and to identify in particular the lessons to be learned for the investigation and prosecution of racially motivated crimes.

9. The Lawrence Inquiry did not hear evidence of overt racism or discrimination. However, it did conclude from the evidence heard that the investigation of the murder of Mr Lawrence was marred by a combination of professional incompetence, institutional racism and a failure of leadership by senior police officers.[4] In the Inquiry's view, the "*conclusion that racism played its part in* [that] *case* [was] *fully justified*"; mere incompetence could not of itself account for the whole catalogue of failures, mistakes, misjudgements and lack of direction and control which bedevilled the investigation.[5]

10. Institutional racism was, the Inquiry held, "*primarily apparent*" in: (a) the actual investigation (including e.g., the treatment of the Lawrence family); (b) countrywide in the disparity in stop and search figures; (b) countrywide in the significant under-reporting of "racial incidents" occasioned largely by a lack of confidence in the police and their perceived unwillingness to take such incidents seriously; and (d) in the identified failure of police training (not a single officer questioned by the Inquiry had

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[1] SBPI-00503 *The Macpherson Report: Twenty-two years on*: House of Commons Home Affairs Committee, Report (30 July 2021). See Summary, paragraph 24 (chapter 1) and paragraph 1 (conclusions and recommendations).
[2] SBPI-00513 *I can't breathe: Race, death & British policing*: INQUEST (20 February 2023) at page 33 (introduction).
[3] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017) at paragraph 5.1 (Chapter 5, Ethnicity).
[4] SBPI-00480 *The Stephen Lawrence Inquiry – Report by Sir William Macpherson of Cluny* (February 1999). Paragraph 46.1, Chapter 46 (Conclusion and Summary).
[5] *Ibid*. Paragraph 6.44, Chapter 6 (Racism).

received any training of significance in racism awareness and race relations throughout their careers).[6]

11. The Lawrence Inquiry's earlier finding of institutional racism was repeated in 2023 by the independent review conducted by Baroness Casey of Blackstock DBE CB into the standards of behaviour and internal culture of the Metropolitan Police Service ("MPS") (the "Casey Review"). The Casey Review held:

> "… [T]*he description of institutional racism should come as no surprise. The Review has stood on the shoulders of others, allowing us to clearly see a landscape where, in particular, London's Black communities have been over-policed and under-protected by the force that are supposed to protect them, whilst not asking itself if there is any connection between that and the failure to recruit and retain Black officers and staff."*[7]

12. In the material examined for this review, the later cases of Mouayed Bashir and Jermaine Baker were also identified as more recent examples of where race has been raised as a potential factor in the deaths which occurred. However, whilst acknowledged as a potential issue in these cases, race does not appear to have been given particularly detailed consideration, at least in terms of the written findings publicly available.

13. In the case of **Mouayed Bashir**, an investigation by the Independent Office for Police Conduct ("IOPC") found that the force used by Gwent Police officers on Mr Bashir was reasonable prior to his death in Newport in 2021. The IOPC investigated police interaction with the individual and his parents on the morning of 17 February 2021, after officers responded to an emergency call from his family. The IOPC also investigated several complaints from the individual's family about police involvement that morning and their treatment by police officers, including that officers' actions may have been influenced by race.

14. Based on the evidence gathered, the IOPC considered that the officers' actions were driven by their assessment of the risks the individual posed to himself and others and did not suggest Mr Bashir was treated less favourably because of his race. Nor did the evidence gathered suggest that the individual's parents were treated less favourably by police because of their race. The IOPC considered that "*difficult exchanges*" between police officers and the parents may have fed into that perception of racial bias and that there were times when the police should have shown greater compassion.

15. In the case of **Jermaine Baker**, a public inquiry was held into his death on 11 December 2015, with a report published in July 2022 (the "Baker Inquiry"). Mr Baker was shot dead by a Counter Terrorism Special Firearms Officer ("CTSFO") known to the Inquiry as W80. This incident occurred as part of a major police operation (Operation Ankaa) by the MPS concerning an organised crime network ("OCN") known as the Tottenham Turks. Mr Baker was shot and killed whilst occupying the front passenger seat of a vehicle. Mr Baker was not carrying a weapon. The vehicle was later searched and an imitation firearm found in the rear of the car.

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[6] *Ibid*. Paragraph 6.45, Chapter 6 (Racism). On the subject of police training, please see section (h) below. In particular see paragraph 112 regarding the possible limitations of, for example, unconscious bias training.
[7] SBPI-00514 *Independent Review into the standards of behaviour and internal culture of the Metropolitan Police Service:* Baroness Casey of Blackstock DBE CB (March 2023) at page 331. See also pages 17 and 329.

16. The Baker Inquiry gave express consideration to the issue of race in a section of its report, stating that it would be dealt with "*at the outset as it* [was] *so important*."[8] Based on evidence heard by the Inquiry and census figures, the Inquiry noted that black citizens were as much as four times as likely to be shot by the MPS as their white counterparts and as much as three times as likely to die, the reasons for that being "*unclear and probably complex*".[9] The Inquiry nevertheless concluded "*without hesitation*" that race played no part in Mr Baker's death,[10] giving two main reasons.[11] First, there was eye-witness evidence that those present at the scene of Mr Baker's death thought he appeared to be of "Turkish" origin, which would, the Inquiry held, have fitted in with the likely profile of a recruit to this particular OCN. Second (and conclusively in the Inquiry's view), the speed with which the police officer in question fired his weapon – having previously been unable to see Mr Baker from outside the vehicle used by the conspirators - precluded him from having taken into account the race of Mr Baker before firing. The consideration of race in the Baker Inquiry's report was confined to these matters.

Race <u>not</u> raised or considered as a potential factor in an incident or death occurring

17. Also noteworthy of attention are instances where there is the absence of race being raised or considered as a potential factor in a particular incident or death (and what the underlying reason(s) for that omission might be). The *Independent Review of Deaths and Serious Incidents in Police Custody* conducted by Lady Eilish Angiolini LT DBE PC KC (the "Angiolini Custody Deaths Review"), which published its report in 2017, described the concern that the issue of race is not always considered in investigations as "*a longstanding issue*" since the Lawrence Inquiry.[12] Two notable examples in the material seen for this review are the deaths of Sean Rigg and Olaseni Lewis.

18. **Mr Sean Rigg** died, aged 40, on the evening of 21 August 2008 after a period in police custody. Mr Rigg suffered from schizophrenia. He was apprehended, restrained, transferred by police van to Brixton Police Station, held in a van parked in the police station yard then detained in the "cage" area of the custody corridor, where he collapsed without having been admitted to the custody suite. Mr Rigg's handcuffs were removed only after he collapsed. Police officers attempted CPR whilst waiting for an ambulance to arrive. Mr Rigg was taken by ambulance to hospital, where he was pronounced dead.

19. One of the terms of reference of the Independent Police Complaints Commission ("IPCC") investigation triggered by the death of Mr Rigg concerned ethnicity (i.e., to establish whether any acts or omissions of any police officers were motivated by the ethnicity of Mr Rigg). The IPCC's own internal review found no evidence that this issue had been explored with the police officers concerned. However, the IPCC's investigation report did not address the issue of race. The inquest into the death of Mr

[8] SBPI-00511 *The Jermaine Baker Public Inquiry: Report*: Chairman His Honour Clement Goldstone QC (5 July 2022). Paragraphs 12.4 – 12.6.
[9] *Ibid.* Paragraph 12.6.
[10] *Ibid*. Paragraph 12.6.
[11] *Ibid*. Paragraph 12.5.
[12] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC (January 2017).* Paragraph 5.12.

Rigg led the IPCC to instruct an independent external review of its own investigation (the "Casale Review").

20. The Casale Review considered that the IPCC should have considered the issue of race, as included in the terms of reference of investigation. When questioned by the IPCC, one of the police officers had referred to "*people you come across in Brixton*". The Review found:

> "*It may be that* [the police officer in question] *had some reason other than race in mind, but the question was never asked. This needed to be pursued by the IPCC. The lack of reference to race throughout is not a sign of non-discrimination, but rather an indication of malaise and/or a lack of confidence about how to address racial issues appropriately*."[13]

21. **Mr Olaseni Lewis** died, aged 23, on 3 September 2010 after having been subject to prolonged restraint involving police officers at the Bethlehem Royal Hospital, Croydon. Hospital staff had requested police assistance and Mr Lewis was handcuffed by police officers and taken to a seclusion room. Whilst held in that seclusion room, the first period of police restraint lasted around ten minutes. The inquest jury found this period of restraint to be unnecessary and unreasonable, due to the length of time Mr Lewis was held in a prone position. A subsequent failure to close the seclusion room door led to a second prolonged period of restraint, lasting over twenty minutes. The inquest jury found the excessive force, pain compliance techniques and multiple mechanical restraints used to be disproportionate and unreasonable and on the balance of probability, to have contributed to the cause of Mr Lewis' death.

22. According to reports analysed as part of this review, the Coroner acknowledged race as "*the elephant in the room*", but declined to allow police officers to be asked about the role that race may have played in Mr Lewis' death. It was also not among the questions the inquest jury were asked to consider.[14] The issue of race does not feature in the Coroner's report to prevent future deaths dated 28 June 2017.

23. It has been suggested that the omission of race as a factor in such deaths could be attributable to an "*entrenched discomfort*" about such issues being raised at inquests.[15] For example, lawyers and bereaved families are said to have expressed concern that neither coroners nor juries may respond constructively to a discussion of race. There is also said to be a lack of understanding by some coroners of the structural and institutional dimensions of racism, meaning that in the absence of overt racism or discrimination, coroners may not see the relevance of race to the death in question.[16]

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[13] COPFS-02526 (a) *Report of the independent external review of the IPCC investigation into the death of Sean Rigg* (Casale Review) (2013). Page 71.
[14] SBPI-00513 *I can't breathe: Race, death and British policing*: INQUEST (20 February 2023) at page 72. See also SBPI-00515 *Achieving Racial Justice at Inquests: A Practitioner's Guide*: INQUEST & JUSTICE (February 2024) at page 52.
[15] SBPI-00515 *Achieving Racial Justice at Inquests: A Practitioner's Guide:* INQUEST & JUSTICE (February 2024) at page 8.
[16] *Ibid*. Page 24.

Scotland

24. In the case of Scotland, a 1991 report by Fife Regional Council investigating racism in Fife observed that:

> *"At the start of the research project, a common perception was that racism was not a problem in Fife; the numbers of minority communities were small, they were scattered, they did not complain. In his report of 13th June, 1989 the Chief Constable stated, "the presence of ethnic minority groups in Fife has not presented any real problems'."*[17]

25. However, the same report also remarked:

> "*Amongst the minority ethnic communities, however, the fact of racist abuse was never in dispute. At the public meeting it was generally accepted that it took place, and was almost so commonplace as to be not worth reporting."*[18]

26. As part of the research project leading to the publication of this 1991 report, group meetings were held. Some of the groups interviewed expressed specific concerns regarding the handling of racist incidents by the police. These concerns included: the length of time taken to respond to calls for assistance (some respondents felt racist incidents were given low priority); the suggestion that calls for assistance were ignored; and the perception that the police would side with the perpetrator.[19] A number of people mentioned being frightened to report incidents because they thought they might antagonise the police and were frightened to charge offenders in case they were victimised further.[20]

27. The report noted it to be of interest that those with few or no dealings with the police presumed them to be helpful and efficient, while those with a lot of dealings had most grievances. The report suggested that it was "*a matter of priority*" for Fife Constabulary to begin to monitor and evaluate its handling of racist incidents and the anti-racist element of its training programme if it was concerned to raise its credibility with minority ethnic groups in the region.[21]

28. In drawing together its main findings, that 1991 report found a number of facts to have been established by the research conducted, including that racism did affect the quality of life of black and minority ethnic groups in Fife.[22] The report stated:

> "*Perhaps the most striking finding of the research is that racist incidents are a regular occurrence. This, up till now, has been largely unrecorded and unrecognised other than by those few officials in close contact with individuals from minority groups, and it is essential that steps are now taken to alleviate the situation. There are clear implications for all the services*.

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[17] SBPI-00516 *Race Equality in Fife:* Chief Executive's Department, Fife Regional Council (June 1991). Paragraph 9.1.1 (Chapter 9, Racial Incidents). See also paragraph 10.2.2 regarding the views of service providers.
[18] *Ibid* at paragraph 9.1.3.
[19] *Ibid* at paragraph 6.2.4 (d) (Police) at page 38.
[20] *Ibid* at page 38.
[21] *Ibid.* Paragraphs 10.3.6 and 10.3.7 at page 62.
[22] *Ibid* at paragraph 12.1.1.(e).

…

The problems of racism and discrimination are no less real because the minority ethnic communities are relatively small and scattered."[23]

29. The 1991 report made seventeen (17) recommendations, including that departments of Fife Regional Council should review policies and practices in relation to equality of opportunity, with particular reference to, for example, the collection of data and staff training.[24] It was also recommended that Fife Constabulary should review policies and practices in relation to racial harassment, including having a clearly defined, well publicised policy.[25]

30. A subsequent 2001 report on stop and search spoke of, at least historically, an "*evident mythology in Scotland that there is little or no racism, despite considerable evidence from statistical and research sources … it would be reasonable to conclude that there is a significant measure of complacency among most Scots about the issue.*"[26]

31. The same 2001 report observed that much of the nature and impact of racism in Scotland was "*hidden*".[27] Two main reasons were said to underpin this finding. First, agencies did not routinely collect data on ethnicity in terms of issues such as service use, employment or racist incidents which would allow the impacts of racism to be accurately measured. Second, agencies were perceived not to be open to complaints from black and minority ethnic groups. Only a small proportion of racist incidents were ever reported to the police. The effect of this being – it is asserted - that there is an assumption that minority ethnic groups do not have any needs because they are small in number, invisible and silent.[28]

32. Insofar as I have been instructed by the Sheku Bayoh Inquiry, there was no similar report or research regarding racism in Scotland between the period of 2001 and 2020 available for inclusion in this contextual literature review.

33. However, the case of **Mr Simon San** was identified as one example of race not being considered by the police as a potential factor in his death. Mr San, aged 40, was employed as a delivery driver working for his sister at her take-away food premises. Mr San died having been attacked and assaulted by a group of youths in Edinburgh on the evening of 11 August 2010. He died the following morning from the injuries he sustained. Mr San's family subsequently complained about the service they had received from the police, both during the investigation and with regard to specific historical incidents reported by them to the police.[29] Mr San's family made a number

[23] *Ibid*. Paragraphs 12.1.2 and 12.1.4.
[24] *Ibid*. Recommendation 3 at page 69.
[25] *Ibid*. Recommendation 8 at page 70. See also paragraph 10.3.7 at page 62.
[26] SBPI-00487 *Police Stop and Search Among White and Minority Ethnic Young People in Scotland*, Reid Howie Associates Ltd & Scottish Executive Central Research Unit (November 2001), Annex 3 (racism and racist attacks in Scotland) at page 114.
[27] *Ibid*. Paragraph 1.30. See also Annex 3 (Racism and Racist Attacks in Scotland) at page 116.
[28] *Ibid*. Annex 3 (Racism and Racist Attacks in Scotland) at page 116.
[29] *PS18902 Executive Report – Lothian and Borders Police – Operation Waymark – An Inquiry into the questions and complaints raised by the San family* (28 June 2011) at paragraph 1.8.

of allegations, including a failure by Lothian and Borders police to recognise the attack on Mr San as racist.[30]

34. The complaint inquiry concluded that Lothian and Borders Police had failed to recognise that the attack on Mr San was racist, both at the outset of the investigation but also as it progressed.[31] Key elements identified as contributing to this failure included: a misguided assessment that the motive for the attack was robbery[32]; a lack of emphasis on precursor incidents and the historical background of the accused[33]; little emphasis being placed upon racist language used by the accused shortly after the attack on Mr San[34]; and not establishing the perception of the family.[35]

35. A later report in 2020, bringing together a collection of perspectives to assess the contemporary situation in Scotland, commented that studies continue to show that racial literacy and awareness in Scotland, from those in leadership positions to delivering services, is "*rudimentary at best*".[36] The report observed:

> *"If there is a lack of knowledge of race issues for those in leadership and policymaking spaces, then it is questionable how these same people can identify effective change in the area of race equality. Lack of knowledge also leads to a lack of confidence, and one of the consequences is that race issues become downplayed. 'It does not happen here' becomes a more comfortable narrative to operate within. This approach closes down spaces for discussing racism."*[37]

36. The same 2020 report remarked that there is a "*pressing sense that while police authorities elsewhere in the UK have made attempts to recognise institutional racism, Police Scotland has not*."[38] The same report stated that both covert and overt forms of systemic racism also persist in educational institutions across Scotland.[39]

(b) Use of restraint (and disproportionate restraint)

37. The use of physical restraint by the police featured heavily in the inquest material considered for this review. It is referenced repeatedly as a factor in deaths which have occurred; in several of the examples, restraint is described as prolonged, excessive or unnecessary.

38. In the case of **Sean Rigg**, the restraint lasted approximately eight minutes. Mr Rigg was in the prone position throughout the entire restraint. The inquest jury's view was that

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[30] *Ibid* at paragraph 3.1.
[31] *Ibid* at paragraph 6.4. See also paragraph 6.60.
[32] *Ibid* at paragraphs 6.11 to 6.21.
[33] *Ibid* at paragraphs 6.37 to 6.43.
[34] *Ibid* at paragraphs 6.45 to 6.52.
[35] *Ibid* at paragraphs 6.54 to 6.60.
[36] SBPI-00500 *Taking Stock Race Equality in Scotland* Runnymede Trust (2020) at page 8 (Lessons Learnt about 'Race' in Scotland).
[37] *Ibid.* See also SBPI-00505 *Racial Inequality and Mental Health in Scotland: A call to action: Mental Welfare Commission for Scotland* (September 2021) at page 92.
[38] *Ibid* at page 5 (Introduction: Taking Stock). See also page 20 (The Opportunities and Obstacles to a 'Scottish Approach' to Race Equality).
[39] *Ibid* at page 25 (Conversations about Racism and Whiteness Are Missing within Education in Scotland).

Mr Rigg was struggling, but not violently: the length of restraint in the prone position was therefore unnecessary. The majority view of the jury was that this more than minimally contributed to Mr Rigg's death.

39. In the case of **Olaseni Lewis**, the inquest jury concluded that the restraint of Mr Lewis was prolonged, disproportionate and unreasonable. The Coroner recorded as a matter of concern that the police were taught that prolonged restraint was dangerous, but had no idea what "prolonged" meant and were left to use their own judgement.

40. In the case of **Leon Briggs**, the medical cause of death was found to be amphetamine intoxication in association with prone restraint and prolonged struggling and ischaemic heart disease.

41. In the case of **Terrence** (**Terry) Smith**, the jury's narrative conclusion was that Mr Smith died as a result of an amphetamine-induced Excited Delirium (ED) in association with a number of factors, including prolonged and excessive restraint and a failure to understand that the resistance to the restraint - by the deceased - was leading to an ongoing depletion of oxygen and an increased level of adrenaline which sped up the effects of the ED in Mr Smith's body.

42. In the case of **Michael Powell**, the jury found that Mr Powell became more vulnerable to suffering death as a result of a number of factors, including being sprayed with CS gas, being struck by a baton and being restrained whilst suffering a psychosis.

Mental health

43. Previous reviews have also expressed their concern at the use of physical restraint upon those suffering from mental ill health.

44. An *Independent Commission on Mental Health and Policing* led by Lord Victor Adebowale CBE (the "Adebowale Commission") was set up in 2012 at the request of the Metropolitan Police Commissioner following campaigning from bereaved families, including those of Sean Rigg and Olaseni Lewis, and produced a report in May 2013.[40] The Adebowale Commission's brief was to review the work of the MPS with regard to people who had died or been seriously injured following police contact or in police custody and to make recommendations to inform MPS conduct, response and actions where mental health was, or was perceived to be, a key issue.

45. The Adebowale Commission's report described the tactics and behaviour used to restrain people with mental health issues as "*the most disturbing of our findings*" and "*one over which the police have the power to take complete control to improve their practice*."[41] Moreover, the Commission's report observed that in each case examined there was little evidence that de-escalation techniques were used or that opportunities were taken for alternatives to be tried.

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[40] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraph 4.15.

[41] SBPI-00493 Turning Point: Independent Commission on Mental Health and Policing Report: Association of Mental Health Providers (May 2013), page 25 of section 6 (The disproportionate use of force and restraint).

46. The Angiolini Custody Deaths Review (2017) also noted with "*particular concern*" the evidence that many of those who die following the use of physical restraint suffer from mental ill health.[42] Deaths involving mental health and restraint may follow from the use of restraint techniques designed for use on all detainees, and not tailored for people who may be mentally unwell.[43] That Review observed:

> *"Equating mental illness symptoms like agitation and disorientation with a propensity for violence can mean that the perceived risk posed by the detainee may obscure people to their vulnerability … In such circumstances the police officers may also use force and restraint in order to gain compliance to the exclusion of any focus on the wellbeing of the detainee which can ultimately lead to a medical crisis or death."*[44]

47. The Adebowale Commission recommended a set of principles for restraint, including that a safety officer must be responsible for the restraint throughout the period.[45]

48. The Angiolini Custody Deaths Review (2017) followed suit in recommending that a mandatory safety officer approach be implemented by all police forces similar to that used in the prison setting,[46] as well as the use of CCTV in police vans to monitor restrained detainees[47] and the national roll-out of body worn cameras to all police officers working in the custody environment or in a public facing role.[48]

Racial stereotyping

49. Previous reviews and reports have also identified racial stereotyping as a possible source of concern.

50. The Angiolini Custody Deaths Review (2017) commented:

> "*Racial stereotyping may or may not be a significant contributory factor in some deaths in custody. However, unless investigatory bodies operate transparently and are seen to give all due consideration to the possibility that stereotyping may have occurred or that discrimination took place in any given case, families and communities will continue to feel that the system is stacked against them.*"[49]

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[42] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraph 2.12.
[43] *Ibid*. Paragraph 2.50.
[44] *Ibid*. Paragraph 5.19.
[45] SBPI-00493 Turning Point: Independent Commission on Mental Health and Policing Report: Association of Mental Health Providers (May 2013) at page 45.
[46] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Recommendation 8.
[47] *Ibid.* Recommendation 9.
[48] *Ibid.* Recommendation 62. For discussion of the use of body-worn cameras in the context of complaints made against the police, see also paragraphs 27.2 – 27-16 of SBPI-00501 Final Report of the *Independent Review of Complaints Handling, Investigations and Misconduct Issues in relation to Policing: Dame Elish Angiolini QC* (November 2020).
[49] *Ibid*. Paragraph 5.17. See also paragraph 5.19 (quoted as paragraph 46 above).

51. It has been suggested that institutionalised racism within police culture and practice equates Black people with "dangerousness" and "criminality".[50] It is said that prisons and police emphasise Black and racialised people's real or imagined link to criminality, typically through a gangs narrative which underscores drugs and weapons.[51] The Angiolini Custody Deaths Review (2017) noted in this regard:

> "*The stereotyping of young Black men as 'dangerous, violent and volatile' is a longstanding trope that is ingrained in the minds of many in our society."*[52]

52. Another consistent theme is said to be the racial stereotyping of Black men as being extraordinarily big and possessing excessive strength, particularly in reference to deaths in police custody.[53] The Angiolini Custody Deaths Review (2017) observed:

> *"It is not uncommon to hear comments from police officers about a young Black man having 'superhuman strength' or being 'impervious to pain' and, often wholly inaccurately, as the 'biggest man I have ever encountered'.*"[54]

53. In the case of **Terrence (Terry) Smith**, the Coroner's report to prevent future deaths dated 21 February 2019 speaks of Mr Smith having demonstrated and resisted restraint with "*extreme strength*". It has also been suggested that other cases including **Sean Rigg** and **Roger Sylvester** – despite their deaths occurring nine years apart - bore similarities, with the police said to have relied in both cases upon the racial stereotype of both Black men possessing exceptional strength.[55]

54. The intersection of racialised tropes such as these with mental ill health – where people also face the stereotype of the mentally ill being labelled as "mad, bad and dangerous"[56] – is referred to in some reports as the "*double discrimination*" faced by Black people.[57]

55. The Adebowale Commission noted that the stereotyping of agitation and disorientation as violence was particularly pronounced in cases involving men from African and African Caribbean or a mixed-race heritage background.[58] The Commission found the

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[50] SBPI-00513 *I can't breathe: Race, death & British policing:* INQUEST (20 February 2023) at page 7 (foreword). See also SBPI-00515 *Achieving Racial Justice at Inquests: A Practitioner's Guide:* INQUEST & JUSTICE (February 2024) at page 19.
[51] SBPI-00515 *Achieving Racial Justice at Inquests: A Practitioner's Guide:* INQUEST & JUSTICE (February 2024) at page 19.
[52] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017) at paragraph 5.18.
[53] SBPI-00515 *Achieving Racial Justice at Inquests: A Practitioner's Guide:* INQUEST & JUSTICE (February 2024) at page 19. See also SBPI-00513 *I can't breathe: Race, death & British policing:* INQUEST (20 February 2023) at page 25.
[54] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017*)* at paragraph 5.19.
[55] *Ibid.* Paragraph 5.9.
[56] *Ibid*. Paragraph 5.18.
[57] SBPI-00513 *I can't breathe: Race, death & British policing:* INQUEST (20 February 2024) at page 7 (Foreword). See also SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraph 5.18.
[58] SBPI-00493 Turning Point: Independent Commission on Mental Health and Policing Report: Association of Mental Health Providers (May 2013) at page 19.

issue of restraint to be particularly concerning, "*seemingly compounded by stereotyped attitudes to race and mental health issues*."[59]

56. The Angiolini Custody Deaths Review (2017) summarised the cumulative effect of these stereotypes as follows:

> *"Such perceptions increase the likelihood of force and restraint being used against an individual who may be unwell. The detainee is effectively dehumanised."*[60]

57. In 2021, the Mental Welfare Commission for Scotland ("MWCS") produced a report concerning racial inequality and mental health in Scotland. That report found evidence that people who are Black were being considered at a greater risk to themselves and others than other ethnic groups.[61] Whilst the MWCS acknowledged that other factors could also be at play (such as age, types of illness and socio-economic disadvantage), it could not rule out biases in perception.[62] The report noted the potential impact of such a finding:

> *"The impact of a perception bias of greater risk can be significant. The UK mental health charity Mind's briefing paper into racism and mental health from 2020 cited the higher rates of restraints for people who are black in England. They suggest that the racial stereotyping and related perceived risk of violence of black people is a potential cause for the higher rates of detention."*[63]

58. The position in Scotland on this issue, however, was less clear cut given the lack of available data:

> "*Unfortunately we do not have data on restraint by health board that can be explored by ethnicity in Scotland. There does not appear to be any national collection of this data."*[64]

(c) Use of the terms "Excited Delirium" and "Acute Behavioural Disturbance"

59. The Angiolini Custody Deaths Review (2017) observed that the "*very existence of Excited Delirium is … strongly disputed amongst medical professionals*".[65] Given this lack of medical consensus, the Review noted that the use of that term was very controversial: some believe it is used as an attempt to explain away a death and deflect attention from the use of force.[66]

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[59] *Ibid* at page 26.
[60] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody, Dame Elish Angiolini QC* (January 2017). Paragraph 5.19.
[61] SBPI-00505 *Racial Inequality and Mental Health in Scotland: A call to action:* Mental Welfare Commission for Scotland (September 2021), at page 33. See also pages 9 (Summary of findings: Trends in detention related to ethnicity) and 31.
[62] *Ibid* at page 33.
[63] *Ibid* at page 34.
[64] *Ibid* at page 34.
[65] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraph 2.38.
[66] *Ibid*. Paragraph 2.39.

60. That Review recommended that the term "Excited Delirium" should never be used as a term that, by itself, can be identified as a cause of death. The Review also recommended that the use of that term in guidance to police officers should be avoided.[67]

61. The Angiolini Custody Deaths Review also observed that the term ED was often used interchangeably with the term Acute Behavioural Disturbance ("ABD").[68] An example of this in the material considered for this review was found in the case of **Terrence (Terry) Smith** who died on 13 November 2013 aged 32. The Coroner's report to prevent future deaths dated 21 February 2019 refers throughout to "ED/ABD" without any discussion of the meaning of those terms or of any distinction to be drawn between them.

62. In recording matters of concern, the Coroner expressed concern that the training material produced by Surrey Police included reference to ED/ABD being "*controversial*" when, in the Coroner's view, "*this* [was] *not the case*" and could risk trainees being misled into doubting the existence of ED/ABD and result in their failing to recognise or accept a presentation of ED/ABD. A number of officers who restrained Mr Smith had stated in evidence during the inquest that they believed the condition was controversial. The inquest jury concluded that Mr Smith had died as a result of an amphetamine-induced ED.

63. In the case of **Gerard McMahon,** the Coroner for Northern Ireland's report in relation to his death records the Police Service for Northern Ireland (PSNI) as having used the term ED in training material up until around 2018, but that the PSNI now used the term ABD.[69]

64. In the case of **Olaseni Lewis**, the MPS' response in 2017 to matters of concern identified in the report to prevent future deaths stated:

> *"It is widely recognised that the status of ABD remains a point of conjecture for many healthcare professionals. The police service in England recognised this rare but increasing phenomenon in the mid-90s and adopted the American terminology of Excited Delirium in mandatory training ... Leading pathologists and other healthcare professionals advised the police service to adopt the wider umbrella term of ABD. That term is accepted by the Royal College of Emergency Medicine and its use by police in London mirrors terminology used by the London Ambulance Service (LAS) in their training. This shared terminology has assisted in communication and understanding between the police officers and LAS when dealing with individuals displaying such symptoms.*
>
> *...*
>
> *The potential confusion this term may cause when working with other mental health service providers highlighted in your report is however acknowledged. The barrier can be reduced through improved working relations with the police and health care professionals."*

[67] *Ibid*. Recommendation 4 (Restraint).
[68] *Ibid.* See paragraphs 2.36 to 2.45.
[69] SBPI-00502 Inquest into the death of Gerard McMahon: NI Coroner 4 (2021), at paragraph [135].

65. An earlier MPS report on the subject of restraint and mental health – the product of a review ordered following the death of Roger Sylvester – recommended in 2004 that the term ED should be removed and replaced by ABD in all MPS documentation.[70] That report noted that between April 1998 and March 2003, there were four deaths in police custody where ED was given as the cause of death.[71] The report observed that expert opinion was "*polarised*" between those who believed in ED and those who did not, with front line officers being asked to recognise a syndrome whose very existence was in dispute among medical experts and whose name and definition were unclear.[72]

66. Against this background of a lack of medical consensus, the Angiolini Custody Deaths Review (2017) recommended that collaboration was required between pathologists, psychiatrists and emergency medical practitioners to clarify and standardise the medical understanding around restraint-related deaths involving mental health crises and this should underpin future police training.[73]

67. The findings of a study conducted to reach consensus on the criteria for the identification and management of ABD in the UK was published in September 2023.[74] The authors of that study – the Consensus on ABD in the UK ("CABDUK") study group - were assisted by stakeholder organisations such as the Royal College of Psychiatrists and Royal College of Emergency Medicine. The study observed that the term ABD was complicated by *"blurred boundaries*" with ED, the latter term being predominantly used in North America and widely considered as problematic. The study consensus concluded that ABD was not, in the UK, considered a diagnosis or syndrome. Rather, it was key that ABD should be understood as a presentation of an individual in a state of severe agitation, with numerous potential causes. The study noted a clear consensus that it was not helpful to separate guidance on ABD and agitation: this in turn raised the question of the value of using ABD terminology in policing and healthcare as opposed to a new term to identify patients presenting with agitation who are at greatest risk of experiencing a time-critical or physical health emergency. The study concluded that consideration should be given to using new terminology, such as "*red-flag agitation*" rather than ABD, to identify this group of agitated patients at highest risk of poor outcomes, who may require specialised management strategies.

(d) Identification and response (or failure to so identify or respond) to a medical emergency

68. The inquest material surveyed for this review identified a significant number of previous instances in which there were found to be failings by the police to identify and/or respond appropriately to a medical emergency, such as a mental health crisis or

[70] SBPI-00403 *Restraint and Mental Health Report*, Metropolitan Police (Sept 2004). Recommendation 1.
[71] *Ibid*. Section 3 (Medical) at page 6.
[72] *Ibid*.
[73] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Recommendation 109.
[74] SBPI-00483 *Consensus on Acute Behavioural Disturbance in the UK* – Report on Study Findings: CABDUK Study Group (September 2023).

a person under the influence of drugs or alcohol, or someone displaying symptoms that could be construed as ABD.[75]

69. In the case of **Sean Rigg**, who died on 21 August 2008 aged 40, the inquest jury's narrative verdict records that the police failed to identify that Mr Rigg was a vulnerable person at the point of arrest. The jury held that it was reasonable to expect the police to recognise there was cause for concern regarding Mr Rigg's mental and physical health, yet no assessment was undertaken before Mr Rigg became unconscious. He was taken back to a police station instead of an accident and emergency department or section 136 suite, despite information about him being readily available and accessible. The police failed to follow the mental health project team standard operating procedure. The Coroner's Rule 43 report requested that the MPS consider how best to address the apparent weakness in MPS handling of those with mental illness in custody, including in particular the adequacy of mental health training for police officers and call takers.

70. In the case of **Olaseni Lewis** who died on 3 September 2010 aged 23, the Coroner recorded as a matter of concern that the police officers involved had been taught about ABD but most of them did not recognise that Mr Lewis was suffering from it. The Coroner held that the training delivered on ABD appeared unnecessarily complicated and was not fully understood by officers. The inquest jury found that police training was also inadequate in its definition of "prolonged restraint" for people exhibiting signs of ABD.

71. In the case of **Leon Briggs** who died on 4 November 2013 aged 39, the inquest jury found that Mr Briggs was experiencing a psychotic disorder caused by exceptionally high use of amphetamines. This resulted in his erratic and irrational behaviour in Luton and subsequent detention by police officers under section 136 of the Mental Health Act 1983. The inquest jury found there to be an inadequate medical assessment of Mr Briggs and a failure to recognise him as a medical emergency who should have been transferred to hospital. The Coroner reflected as a matter of concern the lack of sufficient training for police officers, ambulance crew and other front-line responders. In the Coroner's view, it was clear from the evidence heard at inquest that there was insufficient or inadequate instruction of both police and ambulance crew about the critical issues of recognising and responding to a medical emergency and the effect of restraint including positional asphyxia.

72. In the case of **Terrence (Terry) Smith** who died on 13 November 2013 aged 32, the report to prevent future deaths states that it was established at the inquest that Mr Smith "*was displaying "textbook" signs and symptoms of the condition known as Excited Delirium or Acute Behavioural Disturbance*".[76] Mr Smith had taken amphetamines at his parents' home and began to behave in a bizarre manner. Mr Smith's parents telephoned 999 and asked for the attendance of the ambulance services. However, the Southeast Coast Ambulance Service call handler did not identify that Mr Smith was suffering from ABD or ED. The Police Sergeant who attended the scene alerted the other police officers present to the possibility that Mr Smith was suffering from ED. However, the police officers stated in evidence that their training had not made them

[75] Please see preceding section (c) above (Use of the terms "Excited Delirium" and "Acute Behavioural Disturbance") regarding the controversy surrounding terms such as ED or ABD.
[76] Please, however, see preceding section (c) above (Use of the terms "Excited Delirium" and "Acute Behavioural Disturbance") regarding the controversy surrounding terms such as ED or ABD.

aware that the condition constituted a medical emergency. Two emergency medical technicians had received no training at all on ABD or ED and did not recognise Mr Smith to be suffering the condition or that he was in a state of medical emergency. The police decided that Mr Smith should be taken to and detained at a police station rather than a hospital; this was not questioned by the two emergency medical technicians.

73. In the case of **Gerard McMahon** who died on 8 September 2016 in Belfast, the Coroner for Northern Ireland found that police officers did not realise Mr McMahon was suffering from ABD, should not be restrained and was to be treated as a medical emergency.[77] The Coroner expressed concern regarding the quality of training on recognition of ABD. A police officer who had been given that training just over twelve months prior to the incident involving Mr McMahon failed to recognise ABD, which was, the Coroner stated, a "*poor reflection*" on that training.[78]

74. In the case of **Moauyed Bashir** who died in Newport in February 2021 aged 29, the IOPC found it concerning that whilst police officers recognised that they were dealing with a medical emergency, ABD was not communicated as a potential impact factor in his ill-health to the ambulance service. The IOPC recommended a number of enhancements for Gwent Police to consider for officer training with regards to ABD and restraint.

(e) Deficiencies in family liaison and post-incident management

75. Of the material surveyed for this review, the report of the Lawrence Inquiry (1999) gives the earliest and to date perhaps most influential consideration of family liaison.

76. The Inquiry's report summarised the failings of the family liaison arrangements in relation to the murder of Mr Lawrence as follows:

> "*From the first contact with police officers at the hospital, and thereafter, Mr & Mrs Lawrence were treated with insensitivity and lack of sympathy. One of the saddest and most deplorable aspects of the case concerns the failure of the family liaison. Mr & Mrs Lawrence were not treated as they should have been. They were patronised. They were never given information about the investigation to which they were entitled. Family liaison failed, despite the good intentions of the officers allocated to this task. Senior officers never intervened to rectify the failure."*[79]

77. For example, the Inquiry criticised the fact that untrained officers unfamiliar with the guidelines on family liaison were allowed to take on that task: the two police officers were not able to get to grips with their delicate assignment.[80] Many things done by the officers seem to have made matters worse.[81] A fresh approach and fresh team ought to

[77] SBPI-00502 Inquest into the death of Gerard McMahon: NI Coroner 4 (2021). Paragraph [188].
[78] *Ibid*. Paragraph [185].
[79] SBPI-00480 *The Stephen Lawrence Inquiry – Report by Sir William Macpherson of Cluny* (February 1999). Paragraph 46.7.
[80] *Ibid*. Paragraph 26.7, Chapter 26 (Family Liaison).
[81] *Ibid*. Paragraph 26.20.

have been put into the role of family liaison very early on.[82] Another police officer did take over the family liaison role from 6 May 1993, but by then "*serious damage*" had been done to the relationship between Mr Lawrence's parents and the police and no proper steps were taken to "*mend the fences*" during the early weeks after the murder of Mr Lawrence.[83] The Inquiry found it to be a collective failure of the investigating team to treat Mr Lawrence's parents appropriately and professionally, because of their colour, culture and ethnic origin.[84]

78. Stemming from such findings, the Lawrence Inquiry's recommendations included that: (i) police services should ensure that at local level there are readily available designated and trained Family Liaison Officers ("FLO"); and (ii) that the training of those FLO should include training in racism awareness and cultural diversity, so that families are treated appropriately, professionally, with respect and according to their needs.[85]

Scotland

79. In Scotland, this issue of family liaison was considered by the internal report to the Lord Advocate (2000) by Dr Raj Jandoo (the "Jandoo report") reviewing the nature and quality of liaison arrangements between the police, procurator fiscal service and Crown Office with the next-of-kin and other relatives of the deceased, Surjit Singh Chhokar, who was murdered in 1998.[86]

80. A total of eighteen (18) conclusions and recommendations were made in the Jandoo report. These included that in all cases reported to the procurator fiscal involving death, the identity of the police FLO should be identified in the police report and that the police should identify to the procurator fiscal any problems which may be encountered with regard to liaison with next-of-kin or relatives of the deceased. It was also recommended that where the victim and/or their family belong to an ethnic or religious minority, that the police report should make reference to any particular needs arising with regard to funeral arrangements or other religious rights flowing from the death.[87] The police were also reminded of the need to identify in the police report whether an interpreter was required (and if so what type) for witnesses or next-of-kin.[88]

81. The Jandoo report also observed that the case took place before the commencement of departmental training on cultural awareness and did "*appear to demonstrate a lack of awareness and sensitivity at that particular point in time to the racial issues which may require to have been addressed in the case*."[89]

82. In the later case of **Simon San**, who died in 2010, a complaint inquiry concluded that there had been significant failings in the police inquiry into incidents previously

[82] *Ibid*. Paragraph 26.32.
[83] *Ibid*. Paragraph 26.35.
[84] *Ibid*. Paragraph 26.37.
[85] *Ibid*. Recommendations 23 and 24.
[86] SBPI-00525 Report of the Inquiry into the Liaison Arrangements Between the Police, the Procurator Fiscal Service and the Crown Office and the Family of the Deceased Surjit Singh Chhokar in Connection with the Murder of Surjit Singh Chhokar and the Related Prosecutions: Dr Raj Jandoo (2000).
[87] *Ibid*. Recommendation 4.
[88] *Ibid*. Recommendations 5 and 6.
[89] *Ibid*. Conclusion/recommendation 9.

reported by Mr San's sister and the investigation into the death of Mr San.[90] Mr San's family had not been listened to and some of their specific needs were not met.[91] The Deputy Chief Constable apologised to Mr San's family for these failings.[92] For example, the Lothian and Borders police team investigating the attack were found to have failed to communicate with the San family prior to a media release being distributed and media interviews being broadcast.[93] The first press releases were given several hours before family liaison officers held their initial meeting with the San family.[94] This failure to communicate – compounded by insensitive comments made in those media releases (for example, the phrase "*in the wrong place at the wrong time*" was used in a newspaper article) – were said to have caused unnecessary distress and offence to the San family.[95]

83. The San family also complained that on several occasions during the investigation into Mr San's death they had not been offered the use of an interpreter.[96] At that time, the police could consider the use of an interpreter without any consultation with the victim or witness and decide themselves when one was required.[97] In identifying areas for improvement, the inquiry into the questions and complaints raised by the San family recommended that consultation about the requirement for an interpreter be made with the victim or witness on every occasion with the decision regarding the need for one, or not, to be informed by them.[98]

Other examples

84. In the case of **Mouayed Bashir**, the IOPC stated that the evidence gathered revealed times when police officers should have shown greater compassion, but did not suggest that Mr Bashir's parents were treated less favourably by police because of their race. Whilst the IOPC found no grounds for bringing disciplinary proceedings against any of the officers involved, it did consider that communication with Mr Bashir's parents by some officers lacked empathy and compassion at certain times during the highly distressing incident.

85. In the case of **Jermaine Baker**, the Baker Inquiry regarded the decision of the MPS to allow officer W80 to work without formal restriction – a decision made on the same day that the Divisional Court quashed an IOPC decision directing the MPS to commence disciplinary proceedings against W80 - as one "*reached with great, and some might say indecent, haste*".[99] This was a decision reached without consultation or communication with Mr Baker's family. The Inquiry stated:

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[90] See paragraphs 33 to 34 above of this contextual literature review as regards the police failure to recognise that the attack on Mr San was racist.
[91] PS18902 *Executive Report – Lothian and Borders Police – Operation Waymark – An Inquiry into the questions and complaints raised by the San family* (28 June 2011) at paragraph 11.1.
[92] *Ibid* at paragraph 11.2.
[93] *Ibid* at paragraph 7.1.
[94] *Ibid* at paragraph 7.2.
[95] *Ibid* at paragraph 7.12. See also paragraphs 7.6 to 7.8.
[96] *Ibid* at paragraph 8.1.
[97] *Ibid* at paragraph 8.5.
[98] *Ibid* at Appendix 1, paragraph 5.
[99] SBPI-00511 *The Jermaine Baker Public Inquiry: Report:* Chairman His Honour Clement Goldstone QC (5 July 2022). Paragraph 11.31.

"*Regardless of whether the MPS was specifically required to consult further or communicate with Mr Baker's family, the failure to do either on this occasion, and the excuse provided, amounted to a massive own goal, did not assist the retention of public confidence, and does nothing to dispel my opinion regarding the one-sided approach of the MPS to this unhappy and difficult situation*."[100]

86. The Inquiry further added:

> *"Nothing that I have read has, however, allayed my concern about the way in which the family of Mr Baker were treated in relation to this matter after the original Divisional Court decision ... Whatever the precise terms of the regulations in relation to consultation may have been, it cannot seriously be suggested that the family of Mr Baker were anything other than an interested party, and if consulting them was going to be necessary to decide the status of W80 in October 2020, common standards of humanity required that the family be treated no differently 12 months later. The fact that they had made it clear in 2017 that they wished W80 to remain suspended was not a reason for dispensing with those standards."*[101]

(f) Collection of ethnicity data

87. The theme of inadequate data collection regarding ethnicity by relevant authorities appears to be a longstanding one; it featured regularly in the research literature examined for this review.

88. As of 1989/1990, a lack of available data about ethnic minority groups and racial incidents in Fife led to the appointment of a temporary researcher to undertake a qualitative study on this subject. This research culminated in the 1991 report by Fife Regional Council on race equality in Fife.[102]

89. In the context of stop and search, a 2001 report identified the lack of available data as at 2001/2002 on the extent, nature and experiences of Scotland's black and minority ethnic communities as an issue which needed to be addressed urgently: this lack of credible data impacted upon the extent to which the proportionate, or disproportionate, use of stop and search could be measured.[103]

90. In 2005, an independent review of policing and race relations in Scotland was conducted by the Commission for Racial Equality ("CRE"). A significant concern raised by that review related to the monitoring and reporting on key indicators of race

[100] *Ibid*. Paragraph 11.31.
[101] *Ibid.* Paragraph 11.39.
[102] SBPI-00516 *Race Equality in Fife:* Chief Executive's Department, Fife Regional Council (June 1991) – see section 1(introduction and context of research).
[103] SBPI-00487 *Police Stop and Search Among White and Minority Ethnic Young People in Scotland*, Reid Howie Associates Ltd & Scottish Executive Central Research Unit (November 2001), Executive Summary and paragraph 1.19.

equality. In particular, the CRE noted difficulties in obtaining national statistics as well as appropriately disaggregated data pertaining to employment.[104]

91. As of 2011, systematic collection of data in Scotland, whilst said to have improved, was still deemed to be inadequate given a lack of consistency in methodology and presentation between institutions.[105] As of 2012, there was said to be no evidence of the disproportionate use of stop and search powers against young black and ethnic minorities in Scotland because no current information was published at the national level.[106]

92. Concerns have continued to be expressed about transparent data collection by the police, including on stop and search[107] as well as deaths in police custody. For example, the consolidation of all minority ethnic groups into one "other" category when gathering statistics at national level can, it is argued, create the misleading impression that there is no ethnic disparity as regards stop and search.[108] Similarly, it is argued that data produced on deaths in or following police custody "*obscures the overall picture*" and "*makes the annual number of deaths appear lower than the reality*" when those in direct contact with the police prior to their death – but who were not arrested or detained – are excluded and placed in a much broader "other" category.[109]

93. Recent reviews and reports have also continued to highlight this issue of inadequate data collection.

94. The Angiolini Custody Deaths Review (2017) expressed the need for national mandatory recording of the use of force by the police service.[110] The MPS did not historically maintain a database of the frequency and circumstances in which force was used and therefore could not demonstrate whether its use of force was appropriate, proportionate and necessary. The Home Secretary instituted national data collection in April 2016.[111] The Review stated:

> "*Such data collection needs to record a range of variables, in particular ethnicity and mental health, in a consistent, systematic way across police forces. Only in this way can police forces have more confidence that their use of force and restraint is proportionate and necessary. It can also formally ascertain if force is used disproportionally on BAME people, and those suffering from mental illness*."[112]

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[104] SBPI-00489 *Policing In 21st Century Scotland From a Race Perspective*, CRER (November 2011) at section 6.4 (key statistics: what do they reveal?).
[105] *Ibid*. Concluding comment (ii) and paragraph 8.3.2 (conclusion).
[106] SBPI-00491 *Institutional Racism: Scotland Still Has Far to Go*, Carol Young, CRER (2012).
[107] See, for example, SBPI-00497 *Scottish Parliament Justice Sub-Committee on Policing*, transcript of evidence (26 October 2017) at page 10.
[108] SBPI-00517 *More transparency on stop and search and ethnicity in Scotland?:* Carol Young, CRER (August 2014).
[109] SBPI-00510 *Submission to United Nations international independent expert mechanism to advance racial justice and equality in the context of law enforcement on policing data disaggregated by race or ethnic origin*: INQUEST (May 2022).
[110] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraph 2.74.
[111] *Ibid*. Paragraph 2.75.
[112] *Ibid*. Paragraph 2.75. See also recommendations 102 – 108.

95. The subsequent *Independent Review of Complaints, Handling, Investigations and Misconduct Issues in Relation to Policing*, also led by Lady Eilish Angiolini LT DBE PC KC (the "Angiolini Complaints Review"), similarly noted that a proper understanding of issues related to race depends to some degree on having data that allows analysis, research and learning.[113] That Review further stated:

> "*To understand patterns and underlying issues it is vital that Police Scotland have demographic information. They also need to recognise that racism is not always overt and can be subtle*."[114]

96. In relation to those making complaints against the police in Scotland, the Angiolini Complaints Review found that Police Scotland did not capture ethnicity.[115] Police Scotland advised the Review that they recognised the need for meaningful data on complaints and misconduct in order to better understand any disproportionality in disciplinary and misconduct outcomes for Black, Asian and minority ethnic officers and staff. Police Scotland were liaising with the IOPC and others to understand the position in England & Wales and build on any learning from there.[116]

97. A 2021 report prepared by the MWCS concerning racial inequality and mental health in Scotland highlighted a lack of data on restraint:

> *"Unfortunately we do not have data on restraint by health board that can be explored by ethnicity in Scotland. There does not appear to be any national collection of this data."*[117]

98. The foreword to that MWCS report commented on this state of play:

> *"Time and again we found that information on ethnicity had not been recorded and reported. This related to people being treated for mental illness and also to staff working across mental health services.*
>
> *Poor quality data might seem simply a bureaucratic issue, but it is more than that – without gathering accurate information we cannot properly understand whether or not policies are being delivered for people or understand the extent of the disparities in health outcomes and interventions."*[118]

99. That MWCS report recommended that the Scottish Government mandate an appropriate agency to record and publish national data on restraint, stratified by protected characteristics by September 2022.[119]

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[113] SBPI-00501 Final Report of the *Independent Review of Complaints Handling, Investigations and Misconduct Issues in relation to Policing: Dame Elish Angiolini QC* (November 2020), paragraph 9.61. A preliminary report was also issued in June 2019 (SBPI-00499).
[114] *Ibid.* Paragraph 9.63.
[115] *Ibid*. Paragraphs 9.63 and 9.64.
[116] *Ibid*. Paragraph 9.65.
[117] SBPI-00505 *Racial Inequality and Mental Health in Scotland: A call to action:* Mental Welfare Commission for Scotland (September 2021), at page 34.
[118] *Ibid.* Foreword at page 6.
[119] *Ibid*. Page 36. See also Chapter 7 (conclusions).

(g) Culture and a representative police workforce

100. The Angiolini Complaints Review (2020) heard evidence that whilst there was a drive by Police Scotland to recruit from the Black, Asian and minority ethnic communities, the experiences of some recruits had caused them to leave the profession, often within three to five years. The Review was told during a focus group that ethnic minority officers were leaving because of the culture of the police and the way they were treated.[120] The Review stated:

> "*In order to encourage confidence in the police and a willingness to interact with them, a police service should be representative of the whole of the society that it serves and its members should be drawn from diverse sections of that society*."[121]

101. Some of the literature seen as part of this review states that a lack of representation of wider society within the police force has a knock-on effect across the criminal justice system, affecting how black and minority ethnic communities perceive Police Scotland and contributes to the perception and experience of institutional racism within Police Scotland.[122]

102. The recent Casey Review of the MPS looked at both the internal culture (i.e., how the MPS treats its own people of colour) and external culture (i.e., how the MPS interacts with different communities in London) of that organisation. The Casey Review observed:

> "*The two issues are inextricably linked. On one hand, how Black, Asian, and ethnic minority communities are represented at all levels of the Met workforce impacts how the Met understands, engages with and makes decisions affecting different communities.*
>
> *On the other, how the Met treats its officers and staff of colour impacts on how different communities view and interact with the organisation, as well as informing decisions such as whether they want to join the police."*[123]

(h) The need for further (or improved) training to be undertaken by police officers

103. Previous public inquiries, reviews and inquests have repeatedly made findings or recommendations that appropriate training for police officers should be undertaken as part of the response to the particular incident under scrutiny and/or they have

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[120] SBPI-00501 Final Report of the *Independent Review of Complaints Handling, Investigations and Misconduct Issues in relation to Policing: Dame Elish Angiolini QC* (November 2020). Paragraph 35, Executive Summary and paragraph 9.33.
[121] *Ibid*. Paragraph 9.31.
[122] SBPI-00495 *Racial Equality and Engagement with Police Scotland*: Evidence Submission from CRER (2017).
[123] SBPI-00514 *Independent Review into the standards of behaviour and internal culture of the Metropolitan Police Service:* Baroness Casey of Blackstock DBE CB (March 2023) at page 289.

highlighted the deficiencies in existing training being delivered. It is a recurring theme of the material examined in preparing this review.

104. The subject-matter of the training recommended (or highlighted as deficient) by previous inquiries, inquests or reviews has included: the delivery of basic first aid; responding to mental health crises; training in de-escalation and restraint; and racism awareness and valuing cultural diversity.

105. The recommendation of further (or improved) training for the police services in these particular areas may be unsurprising when read against the other themes identified by this review, as highlighted in sections (a) to (g) above. Training in some of these areas continues to be recommended, including by recent reviews and inquests.

Racism awareness, discrimination and valuing cultural diversity

106. The Lawrence Inquiry's report (1999) found that institutional racism on the part of the MPS was grounded by its findings in several areas, including in the identified failure of police training (not a single police officer questioned before the Inquiry had received any training of significance in racism awareness and race relations throughout the course of their careers). The Inquiry accordingly recommended that all police officers, including CID and civilian staff, should be trained in racism awareness and valuing cultural diversity.[124]

107. The subsequent Casey Review (2023) into the standards of behaviour and internal culture of the MPS stated:

> "*Met colleagues and members of the Black community report that following the Macpherson's report's publication, there was intense training for officers and the involvement of Black and other ethnic minority groups and leaders in that training, and very proactive engagement meant they believed things were better for a couple of years.*
>
> *However, now more than twenty years have passed. The Met must be prepared to take action to build trust and confidence in this community*."[125]

108. The Angiolini Custody Deaths Review (2017) accepted that progress had been made since the publication of the Lawrence Inquiry's report, some eighteen years earlier. However, institutional racism still appeared to be an issue within the police service.[126] It was clear that police training needed to include an understanding of institutional racism

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[124] SBPI-00480 *The Stephen Lawrence Inquiry – Report by Sir William Macpherson of Cluny* (February 1999). Recommendation 49.

[125] SBPI-00514 *Independent Review into the standards of behaviour and internal culture of the Metropolitan Police Service:* Baroness Casey of Blackstock DBE CB (March 2023) at page 311. As regards the position on training within the MPS more generally, see section 3.8 (training) at pages 85-88 and section 3.13 (conclusion) at page 105.

[126] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraph 5.7. See also SBPI-00514 *Independent Review into the standards of behaviour and internal culture of the Metropolitan Police Service:* Baroness Casey of Blackstock DBE CB (March 2023) at page 331.

and how it related to deaths of people from BAME communities in custody, as well as understanding of human rights and diversity.[127] The Review recommended that national policing bodies and police forces should implement mandatory and refresher training on the nature of discrimination, including on race issues, which aims to confront discriminatory assumptions and stereotypes.[128]

109. The Adebowale Commission stated that the evidence of persistent stereotyping of some minority ethnic groups, particularly black males, made it essential for training to address issues of race and culture (particularly given the stigma concerning race and mental health).[129]

Unconscious bias

110. The Angiolini Complaints Review (2020) recommended in its final report that all Police Scotland officers and staff should receive training on unconscious bias, equality legislation and diversity and this should be updated throughout their career, with the opportunity for refresher courses at regular intervals. In this context, the Review observed:

> "*Much of the evidence presented to me by some serving officers from Black and Asian minority ethnic communities was a chastening reminder that in the police service and in the wider community attitudes have not changed as much as they should have since 1999 – the year of the Macpherson report of the Stephen Lawrence Inquiry – or as much as we may like to believe that they have.*"[130]

111. The diversity training provided by Police Scotland had been described to the Angiolini Complaints Review as superficial, because it did not factor in unconscious bias and because training which used to be delivered over the course of a week had been condensed.[131]

112. It should be noted in this context that some organisations and commentators have suggested that unconscious bias training ("UBT") in and of itself has limitations in influencing behaviour. For example, the Equalities and Human Rights Commission ("EHRC") has reported that whilst most UBT raised awareness of and could reduce *implicit* bias, this training had less effect on *explicit* bias or discrimination, with limited evidence that UBT led to subsequent behaviour change.[132] The EHRC has recommended that organisations implementing UBT should undertake follow-up work to assess its effectiveness and ensure UBT was part of a wider organisational change programme where structures, policies and procedures were examined as well.[133]

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[127] *Ibid.* Paragraph 5.27 of Chapter 5 (Ethnicity).
[128] *Ibid*. Recommendation 88 (training).
[129] SBPI-00493 Turning Point: Independent Commission on Mental Health and Policing Report: Association of Mental Health Providers (May 2013) at page 40.
[130] SBPI-00501 Final Report of the *Independent Review of Complaints Handling, Investigations and Misconduct Issues in relation to Policing: Dame Elish Angiolini QC* (November 2020). Paragraph 34, Executive Summary.
[131] *Ibid.* Recommendation 66. See also paragraph 63 of the Executive Summary and paragraphs 22.23 to 22.26 and 22.77 of Chapter 22 of final report.
[132] SBPI-00503 *The Macpherson Report: Twenty-two years on*: House of Commons Home Affairs Committee, Report (30 July 2021) at paragraph 508. See paragraphs 505-519 more generally.
[133] *Ibid* at paragraph 508.

Another commentator and behaviour economist has also argued that there is limited evidence that UBT influences behaviour, with organisations instead needing to "design out" bias through different systems and processes.[134] A former President of the National Black Police Association stated in oral evidence to the House of Commons Home Affairs Committee in 2019 that UBT did not address racial inequality.[135]

First aid

113. The Lawrence Inquiry's report (1999) strongly criticised the training and retraining of police officers in first aid: in respect of Stephen Lawrence, no police officer did anything by way of first aid, apart from the small amount of testing to see whether Mr Lawrence was still breathing and whether his pulse was beating.[136]

114. The Inquiry recommended that first aid training for all "public contact" police officers should at once be reviewed and revised to ensure they have basic skills to apply first aid. That training was to include refresher training and should be annually reviewed.[137]

115. In the case of **Olaseni Lewis**, the inquest jury concluded that the police had failed to follow their training to administer basic life support. After Mr Lewis had collapsed following police restraint, police officers stated to the inquest that they had left the seclusion room in case he was feigning unconsciousness, passing out as a ploy to escape.[138]

Responding to mental health crises

116. The Adebowale Commission's report (May 2013) advocated, as a general principle, that mental health should be seen as a part of the core business of policing. Although focused on the MPS, the Commission expressed the view that the issues identified in its report were national and the recommendations likely to be applicable to all forces across the country.[139]

117. The Adebowale Commission found instances where the police had failed either to identify that the person before them was in a mental health crisis or, if they had, to know what to do.[140] Interagency working was also identified as deficient: areas of confusion and potential dispute between the MPS and NHS included transport, paperwork and where roles and responsibilities began and ended.[141]

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[134] *Ibid* at paragraph 509.
[135] *Ibid* at paragraph 511.
[136] SBPI-00480 *The Stephen Lawrence Inquiry – Report by Sir William Macpherson of Cluny* (February 1999). Paragraph 46.5. See also Chapter 10 (First Aid).
[137] *Ibid.* Recommendations 45-47.
[138] SBPI-00515 *Achieving Racial Justice at Inquests: A Practitioner's Guide*: INQUEST & JUSTICE (February 2024) at page 20.
[139] SBPI-00493 Turning Point: Independent Commission on Mental Health and Policing Report: Association of Mental Health Providers (May 2013), Executive Summary at page 6.
[140] *Ibid* at page 39. In this regard, see section (d) above of this contextual literature review.
[141] *Ibid* at page 50. See also recommendations 22 to 28.

118. The evidence led the Commission to conclude that the training provided by the MPS did not achieve the level of awareness or practical skills needed, particularly for street encounters and unplanned instances.[142] The Commission recommended that mental health awareness should be delivered face-to-face and be a rolling programme for all new officers and staff, with refresher training at regular intervals.[143] It was to include basic mental health awareness training, including the ability to recognise signs and symptoms of mental illness and ABD.[144]

119. Echoing the remarks of the Adebowale Commission, the Angiolini Complaints Review (2020) similarly observed that the prevalence and prominence of mental health issues in society should be reflected in the police service's ability to deal with them.[145] That Review accordingly recommended that Police Scotland officers should receive regular training inputs on how to deal effectively with individuals who display mental ill-health symptoms or related behaviours.[146]

120. The Angiolini Custody Deaths Review (2017) noted that there had been many reports looking at mental health training since the death of Roger Sylvester in 1999.[147] Those reports had called for increased and improved mental health training within the police service. Progress had, however, tended to be "*slow, not sustained, fragmented and with little national coordination*."[148] That Review recommended that national, comprehensive, quality assured mental health training should be given to all officers in front-line or custody roles.[149]

De-escalation training

121. The Angiolini Complaints Review (2020) noted that police officers in the course of their duties will encounter individuals who display florid, disturbed or aggressive behaviours. This would not, the Review noted, be confined to people in mental health crisis. Others without mental health issues could also present in a very unpredictable way due to intoxication, drugs, alcohol or be armed or suicidal. According to that Review, it was paramount that that the ability to de-escalate circumstances which may lead to a violent encounter was in the skillset of the individual officer.[150]

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[142] SBPI-00493 Turning Point: Independent Commission on Mental Health and Policing Report: Association of Mental Health Providers (May 2013), page 39.
[143] *Ibid*. Page 41.
[144] *Ibid*. Page 42.
[145] SBPI-00501 Final Report of the *Independent Review of Complaints Handling, Investigations and Misconduct Issues in relation to Policing: Dame Elish Angiolini QC* (November 2020). Paragraph 22.29 of Chapter 22 of final report. See also paragraph 22.28.
[146] *Ibid*. Recommendation 67. See also paragraph 64 of the Executive Summary and paragraph 22.29 of Chapter 22 of final report.
[147] On the circumstances of the death of Mr Sylvester, see for example *R (Anderson & Others) v HM Coroner for Inner North Greater London* [2004] EWHC 2729 (Admin).
[148] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraph 4.31.
[149] *Ibid*. Recommendation 87.
[150] SBPI-00501 Final Report of the *Independent Review of Complaints Handling, Investigations and Misconduct Issues in relation to Policing: Dame Elish Angiolini QC* (November 2020). Paragraph 22.30, Chapter 22 of final report.

122. The Review observed that training in this area was critical, not least because a number of instances had been identified in reports by the Police Investigations and Review Commissioner ("PIRC") in which it was asserted that an incident had gone beyond excessive force and should have been classed as an assault.[151] The Review observed:

> "[K]*nowing how to de-escalate a situation and knowing how to restrain people safely is essential for the officer and their safety, but the application of that knowledge is also vitally important to the safety* [of] *any such individual whom they do encounter."*[152]

Restraint

123. The Angiolini Custody Deaths Review (2017) argued that police practice must recognise that all restraint can cause death. The Review stated that recognition must be given to the wider dangers posed by restraining someone in a heightened physical and mental state, where the individual's system can become rapidly and fatally overloaded.[153]

124. There was, the Review noted, limited police recognition (with the exception of positional asphyxia, the risks of which were now embedded in police training) of the dangers of restraint involving a struggle with a person who is in a heightened physical and mental state.[154]

125. That Review made a number of recommendations in relation to restraint. This included, for example, that there should be mandatory and accredited national training for police officers in restraint techniques, including de-escalation and supervision of vital signs during restraint, with appropriate refresher training. There should be national consistency in approaches to the use of force.[155]

126. That Review also recommended that the grave dangers of prone and other forms of restraint in and of itself must be reiterated within forces in an effective manner and re-emphasised in training and re-training by all forces.[156]

127. The Review stated that national policing policy, practice and training must reflect the "*now widely evident position*" that the use of force and restraint against anyone in mental health crisis or suffering from some form of drug or substance induced psychosis poses a life-threatening risk.[157]

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[151] *Ibid*. Paragraph 22.33.
[152] *Ibid*. Paragraph 22.35.
[153] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Recommendation 1.
[154] *Ibid.* Paragraph 2.46.
[155] *Ibid.* Recommendation 2.
[156] *Ibid.* Recommendation 3.
[157] *Ibid.* Recommendation 5.

128. In discussing those deaths occurring following the use of physical restraint, the Angiolini Custody Deaths Review (2017) expressed its view in the following terms:

> "*There have been many highly publicised deaths over the years where restraint has been a significant factor in the cause of death … Such deaths have led to critical findings at inquests, and occasionally reviews, but the emergence of the same themes in many of these deaths is indicative of a failure to learn lessons*."[158]

Chris Stephen - Advocate

23 April 2024

[158] SBPI-00496 *Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC* (January 2017). Paragraphs 2.10 and 2.11. See also paragraph 45 of the Executive Summary.

ANNEX A: MATERIAL ANALYSED

Reports

1. SBPI-00480 The Stephen Lawrence Inquiry: Report by Sir William Macpherson, (February 1999);
2. SBPI-00525 Report of the Inquiry into the Liaison Arrangements Between the Police, the Procurator Fiscal Service and the Crown Office and the Family of the Deceased Surjit Singh Chhokar in Connection with the Murder of Surjit Singh Chhokar and the Related Prosecutions: Dr Raj Jandoo (2000);
3. SBPI-00403 Restraint and Mental Health Report, Metropolitan Police (Sept 2004)
4. PS18902 Executive Report Operation Waymark - An Inquiry into the questions and complaints raised by the San family: Lothian and Borders Police (28 June 2011);
5. SBPI-00493 Turning Point: Independent Commission on Mental Health and Policing Report: Association of Mental Health Providers (May 2013);
6. SBPI-00496 Report of the Independent Review of Deaths and Serious Incidents in Police Custody: Dame Elish Angiolini QC (January 2017);
7. SPBI-00499 Preliminary Report of the Independent Review of Complaints Handling, Investigations and Misconduct Issues in Relation to Policing: Dame Elish Angiolini QC - (June 2019);
8. SBPI-00500 Taking Stock Race Equality in Scotland: Runnymede Trust (2020);
9. SBPI-00501 Final Report of the Independent Review of Complaints Handling, Investigations and `Misconduct Issues in Relation to Policing: Dame Elish Angiolini QC(November 2020);
10. SBPI-00503 The Macpherson Report Twenty Two Years On: The House of Commons Home Affairs Select Committee (30 July 2021);
11. SBPI-00505 Racial Inequality and Mental Health in Scotland: A call to action: Mental Welfare Commission for Scotland (September 2021);
12. SBPI-00511 The Jermaine Baker Public Inquiry Report: Chairman - His Honour Clement Goldstone QC (5 July 2022);
13. SBPI-00513 I can't breathe: Race, death and British policing: INQUEST (20 February 2023);
14. SBPI-00514 Independent Review into the standards of behaviour and internal culture of the Metropolitan Police Service: Baroness Casey of Blackstock DBE CB (March 2023);
15. SBPI-00515 Achieving Racial Justice at Inquests: A Practitioner's Guide: INQUEST & JUSTICE (February 2024).

Inquest material

1. Roger Sylvester;
    a. SBPI-00538 Roger Sylvester – Inquisition, St Pancras Coroner's Court (8 September 2003)
2. Michael "Mikey" Powell;
    a. SBPI-00535 Mikey Powell – Inquisition Verdict: Bingham and Solihull Coroner's Court (November 2009);
3. Olaseni Lewis;

a. SBPI-00539 Olasenit Lewis – Record of Inquest and Narrative Conclusion: South London Coroner's Court (13 September 2010);
b. SBPI-00521 Olaseni Lewis – Report to Prevent Future Deaths: South London Coroner's Court (June 2017);
c. SBPI-00522 Olaseni Lewis – Response to Report to Prevent Future Deaths: South London and Maudsley NHS Trust (August 2017);
d. SBPI-00523 Olaseni Lewis – Response to Report to Prevent Future Deaths: Metropolitan Police (September 2017)
e. SBPI-00540 Olaseni Lewis – Coroner's Correspondence with the Secretary of State for Justice (June 2017 to February 2018);

4. Sean Rigg;
a. SBPI-00524 Sean Rigg – Inquisition Narrative Verdict: Southwark Coroner's Court (28 August 2008);
b. SBPI-00488 Independent Investigation into the Death of Sean Rigg Whilst in the Custody of Brixton Police: IPCC (2010);
c. COPFS-02526 (a) Report of the Independent External Review of the IPCC Investigation Into the Death of Sean Rigg (Casale Review) (2013);

5. Terrence (Terry) Smith;
a. SBPI-00498 Terry Smith – Report to Prevent Future Deaths: HM Senior Coroner for the Coroner Area of Surrey (February 2019);

6. Leon Briggs;
a. SBPI-00506 Leon Briggs – Report to Prevent Future Deaths: Bedfordshire & Luton Coroner's Court (October 2021);
b. SBPI-00507 Leon Briggs – Response to Report to Prevent Future Deaths: Association of Ambulance Chief Executives (November 2021);
c. SBPI-00508 Leon Briggs – Response to Report to Prevent Future Deaths: Bedfordshire Police (November 2021);
d. SBPI-00509 Leon Briggs – Response to Report to Prevent Future Deaths: East Anglia Ambulance Service (November 2021);

7. Gerard McMahon;
a. SBPI-00502 Inquest into the death of Gerard McMahon: NI Coroner (2021); and

8. Mouayed Bashir
a. SBPI-00534 Mouayed Bashir – Prevention of Future Deaths Report: Gwent Coroner's Court (February 2024).
b. SBPI-00561 Mouayed Bashir – Press Release: IOPC (2 February 2024)

<u>Research literature on race and policing and other documents</u>

1. SBPI-00516 Race Equality in Fife: Chief Executive's Department, Fife Regional Council (June 1991);
2. SBPI-00487 Police Stop and Search Among White and Minority Ethnic Young People in Scotland, Reid Howie Associates Ltd & Scottish Executive Central Research Unit, (November 2001);
3. SBPI-00537 R(Anderson & Others) v H.M. Coroner for Inner North Greater London (26 November 2004);
4. SBPI-00489 Policing In 21st Century Scotland From a Race Perspective, CRER (November 2011);

5. SBPI-00491 Institutional Racism: Scotland Still Has Far to Go, Carol Young, CRER (2012);
6. SBPI-00517 More transparency on stop and search and ethnicity in Scotland?: Carol Young, CRER (August 2014);
7. SBPI-00518 Institutional Racism – Officially Recorded Comments / Evidence from Engagement for Race Equality Framework for Scotland: CRER (2015);
8. SBPI-00494 Review of Our Scottish Strategic Police Priorities, Response from CRER, (12 February 2016);
9. SBPI-00519 Race Equality Framework for Scotland Community Ambassadors Programme Findings Summary for Police Scotland: CRER (May 2016);
10. SBPI-00520 Stop and Search Consultation, Summary of focus group at DGMA: CRER, (22 August 2016);
11. SBPI-00495 Racial Equality and Engagement with Police Scotland: Evidence Submission from CRER (2017);
12. SBPI-00497 Scottish Parliament Justice Sub-Committee on Policing, transcript of evidence (26 October 2017);
13. SBPI-00510 Submission to the United Nations International Independent Expert Mechanism to Advance Racial Justice and Equality in the Context of Law Enforcement on Policing Data Disaggregated by Race or Ethnic Origin: INQUEST (May 2022);
14. SBPI-00512 Police Complaints, Investigations and Misconduct: A Consultation on Legislation, CRER submission (August 2022); and
15. SBPI-00483 Consensus on Acute Behavioural Disturbance in the UK – Report on Study Findings: CABDUK Study Group (September 2023).