INQUEST

Submission to the United Nations High Commissioner for Human Rights for their 2024 report on the protection of human rights by people of African descent in relation to law enforcement

March 2024

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

2. Over the past 40 years, INQUEST has exposed the UK Government's failures to uphold the right to life, the right to live free of discrimination, and the state's duty to protect life and prevent ill-treatment. INQUEST's work highlights a pattern of state violence, neglect, institutional and structural racism, impunity and injustice.

3. Responding to the UN's call for input on the Human Rights Council's resolution 47/21 on the '*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 and equality*', this submission focusses on measures to contribute to accountability following state related deaths. Specifically, we summarise the content of a joint guide by INQUEST and JUSTICE, titled 'Achieving Racial Justice at Inquests: a practitioner's guide',[1] published in February 2024. It provides guidance to lawyers representing families bereaved by deaths in police custody, prisons, immigration detention, and mental health settings with the legal expertise to raise the potential role of race and racism at inquests. It also provides knowledge and strategies to coroners on how to ensure they satisfy their duty in fully investigating the circumstances involved in a death in state custody.

4. This submission also builds upon previous INQUEST submissions to various UN bodies, including the Office of the High Commissioner for Human Rights (OHCHR)

[1] INQUEST and JUSTICE report (2024) 'Achieving Racial Justice: a practitioner's guide' https://www.inquest.org.uk/achieving-racial-justice-at-inquests-guide

on their report on systemic racism against people of African descent by law enforcement agencies in 2020[2] and 2023;[3] the UN Independent Expert Mechanism to Advance Racial Justice and Equality in Law enforcement;[4] and the Working Group of Experts on People of African Descent in advance of the country visit to the United Kingdom.[5]

Background and context to 'Achieving Racial Justice: a practitioner's guide'

5. INQUEST and JUSTICE's guide builds on INQUEST's previous research on racism. Our 2022 report,[6] which analysed the deaths of Black and racialised people in prison, and our 2023 report[7] which analysed the deaths of Black people in and following police custody, found that none of the post-death investigations (the 22 analysed in the prison report nor the five analysed in the police report) addressed the race of the deceased or the potential role of racism in the death. This renders racism invisible in the official narrative of the death and precludes the possibility of accountability and change, and most significantly, the prevention of future deaths.

6. INQUEST, JUSTICE and many of the families we work with find it unacceptable that official investigations into state-related deaths do not address the race of the deceased nor the potential role of racism, despite INQUEST's casework having consistently highlighted the deaths of Black and racialised people as among some of the most violent, neglectful, and contentious of all deaths in state custody *and* that numerous government inquiries and reports have identified the existence of racism in state institutions.[8]

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[2] INQUEST submission (2020) to OHCHR on systemic racism and law enforcement https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=e98ae5e6-a33a-4257-94d2-7db6c656d653

[3] INQUEST submission (2023) to OHCHR on systemic racism and law enforcement https://www.ohchr.org/sites/default/files/documents/issues/racism/cfis/res4721/NGO-INQUEST-1_0.pdf

[4] INQUEST submission (2022) on policing data disaggregated by race to the Independent Expert Mechanism to Advance Racial Justice and Equality in the context of Law Enforcement https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=1939ebb6-78e0-429a-9943-9db7f03cb319

[5] INQUEST submission (2023) to the Working Group of Experts on People of African Descent in advance of the country visit to the United Kingdom https://www.inquest.org.uk/Handlers/Download.ashx?IDMF=9a9d9011-8957-474f-9027-fda3a773d9d6

[6] INQUEST report (2022) 'Deaths of racialised people in prison 2015 - 2022' https://www.inquest.org.uk/report-deaths-of-racialised-people-in-prison-2015-2022

[7] INQUEST report (2023) "I can't breathe': Race, Death and British Policing' https://www.inquest.org.uk/i-cant-breathe-race-death-british-policing

[8] Macpherson report (1999) https://assets.publishing.service.gov.uk/media/5a7c2af540f0b645ba3c7202/4262.pdf; Angiolini Review (2017) https://www.gov.uk/government/publications/deaths-and-serious-incidents-in-police-custody; Zahid Mubarek inquiry (2006) https://assets.publishing.service.gov.uk/media/5a7b846ce5274a7202e17add/1082.pdf;Lammy review (2017) https://assets.publishing.service.gov.uk/media/5a82009040f0b62305b91f49/lammy-review-

Key points in the guide

6. The guide provides guidance for lawyers on how to approach a case concerning the death of a Black and racialised person in state custody. It acknowledges that the deaths of Black and racialised people do not always involve explicit racism, such as the use of racist language on behalf of the state agent(s) involved. In inviting a coroner to investigate issues of race and racism, it will often be useful for lawyers to do all they can to identify relevant surrounding facts from which the coroner can draw inferences. For example:

    A. When approaching a case, lawyers should:
        - Recognise institutional and structural racism.
        - Recognise biases and system limitations.
        - Listen to bereaved families.
        - Be creative and strategic in pursuing issues of racism.

    B. When approaching a case, lawyers should 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.

7. The guide also 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. For example:

    A. 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. Developing racial awareness and sensitivity requires coroners to:
        - Recognise institutional and structural racism.

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final-report.pdf; Casey Review (2023) https://www.met.police.uk/SysSiteAssets/media/downloads/met/about-us/baroness-casey-review/update-march-2023/baroness-casey-review-march-2023a.pdf

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

8. In addition, the guide outlines the main rationale for coroners to investigate the role of race and racism in relation to their duties in discharging investigations under Article 2 of the Human Rights Act, i.e., the right to life. For instance, the guide makes clear there is an Article 2 duty to investigate credible suspicion that there was a racially induced or discriminatory motive in the treatment leading to death and that 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.

9. The guide provides statistical analysis on racial inequality and racial disproportionately through analysing statistics collated from various sources that lawyers and coroners can refer to in order to provide contextual information on racism in state institutions. For the specific sources, please refer to Annex 2 in the guide.[9]

10. The statistics show the deaths of people of Asian, Black and other/unknown ethnicities are disproportionate in immigration detention between 2012-2021. Asian people make up 27% of all deaths despite accounting for 9% of the general population, Black people make up 31% of all deaths despite accounting for 4% of the general population, and other/unknown people make up 15% of all deaths.

11. The statistics also show that Black people account for 19.5% of deaths involving police use of force despite only making up 4% of the population between 2012 /13 – 2021/22. When analysing deaths by specific type of force, racial disproportionality concerning Black people is especially high for stun grenade deaths, baton deaths and taser deaths.

12. The statistics confirm previous evidence that Black people are disproportionately detained under the Mental Health Act. Black people made up 10% of mental health detentions 2016/17 – 2021/22 despite only accounting for 4% of the population.

13. The statistics reveal that more than 3/4ths of allegations of race discrimination by the police 2020/21 – 2022/23 were not investigated.

[9] INQUEST and JUSTICE report (2024) 'Achieving Racial Justice: a practitioner's guide' https://www.inquest.org.uk/achieving-racial-justice-at-inquests-guide

14. The voices of bereaved families are included throughout the guide. For example, Louise Rowland sat on the advisory group of the guide and is the bereaved sister of Joseph Phuong, a man in mental health crisis who died following contact with the Metropolitan police and mental health services. Other bereaved family members helped draft the afterword to the guide, including Aji Lewis who is mother of Seni Lewis, a man in a mental health crisis who died after being subjected to police restraint in a mental health hospital and Marcia Rigg, the bereaved sister of Sean Rigg, a man in a mental health crisis who died following police restraint. Their testimony details the families' experiences of going through the inquest process, and how the race of the deceased nor the role of racism was addressed at any of the inquests. It also makes clear how this guide can make a tangible difference to the experience of bereaved families at inquests by encouraging lawyers to become more racially aware, sensitive and knowledgeable. More broadly, the families' state that they hope the guide can make a meaningful contribution towards racial justice and equality in broader British society.