INQUESTI

Truth Justice Accountability

Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination

Executive Summary



INQUEST

is an independent charity providing expertise on state related deaths and their investigation to bereaved people, lawyers, advice and support agencies, the media, and parliamentarians. This is informed by 40 years of specialist casework which 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.

Introduction

This executive summary outlines the key points of our detailed evidence-based report, *Deaths of racialised people in prison 2015 – 2022: Challenging racism and discrimination.*

Firstly, it sets out the need for research and analysis of the deaths of racialised people in prison. It then presents the circumstances of three of those deaths, highlighting some of the human stories behind the statistics and the significant issues which they raise. Subsequently, it lays out the key findings of our report around data, thematic concerns, and post-death investigations. Finally, it presents five recommendations to enact fundamental, long-term, and structural change to contribute towards social and racial justice and equality.

The full report goes into further depth about this important issue. It throws into sharp relief the fatal consequences of institutional racism in prison – an issue that has been overlooked for too long.



We are grateful to the charitable trusts and funders who have supported our work on the deaths of racialised people in prison. This report was produced by INQUEST with financial support from the Barrow Cadbury Trust. Note: the content of reports funded by Barrow Cadbury Trust do not necessarily reflect the trust's views. See the full report for all the credits and thanks.



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Front page artwork credit: Look Through My Window, HM Prison Glenochil, Patrick Holmes Platinum Award for Watercolour and Gouache, 2017. Image courtesy of Koestler Arts Published October 2022 © INQUEST 2022. All Rights Reserved. INQUEST Charitable Trust Registered Charity No. 1046650. Registered Company No. 03054853

Deaths of racialised people in prison

Over INQUEST's 40 year history, we have continuously supported bereaved families whose relatives have died in prison. Our evidence-based work has highlighted that the deaths of racialised people are a particular area of concern, as they are among some of the most contentious, violent and neglectful of all deaths in prison. Many are premature and preventable.

We have collaborated with bereaved families, campaigners and human rights lawyers to shine a light on the systemic issues involved in the deaths of racialised people behind prison walls.

Despite these efforts, too often these deaths have been dismissed, the issues they raised ignored and the people that died forgotten by many. The deaths have rarely received the due concern and scrutiny that INQUEST believes they deserve.

The failure of post-death investigations to examine the potential role that racism and discrimination played in the treatment and care of the person who died renders these issues invisible. As a result, the opportunity to acknowledge and address racial injustices and inequalities is lost. This has contributed to an acute lack of knowledge and research about the relationship between structural racism, state violence and neglect in the context of deaths in prison.



We have written this report to address this the significant void of knowledge and research and bring to light the pressing issue of institutional racism in the prison estate and the need for action.



Tariq Dalton was a 42 year old mixed-race man of Pakistani and Irish heritage, with complex mental and physical health issues.

Prison staff identified a need for Tariq to be seen by a doctor, but on four occasions GPs failed to see Tariq in person. The prison repeatedly prescribed him with the anti-inflammatory drug meloxicam. However, the prison had not obtained Tariq's community GP records which included two previous incidents of haematemesis (vomiting blood).

At the inquest, every prescribing clinician stated they would not have prescribed meloxicam to a patient with a history of haematemesis. Tariq was at a high risk of experiencing gastro-intestinal irritation which could lead to ulcers and internal bleeding as a side-effect of meloxicam.

The co-prescription of a proton-pump inhibitor might have been able to alleviate this, but this was not prescribed.

In the 36 hours before his death, Tariq complained of vomiting blood, blood in his faeces and internal bleeding. Witnesses reported that he looked very pale and unwell and that they saw fresh blood in the toilet on the morning of his death. Despite these alarming signs, he was not physically seen by a doctor and he did not receive any medical attention. He died on 19 November 2018.

The inquest found that, on the balance of probabilities, the continued prescription of meloxicam and the failure of GPs to assess Tariq in person in the healthcare unit made material contributions to his death. They also concluded that his apparent mental health issues may have affected the care he received.

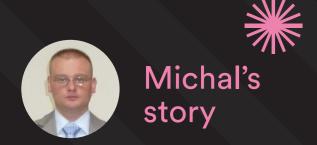


They May Have My Body But... They Will Never Have My Mind, Stirling Council Criminal Justice Social Work Service, John Crockett Highly Commended Award for Painting, 2018. Image courtesy of Koestler Arts.

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What hurts the most after hearing five weeks of evidence at the inquest was the lack of compassion and empathy you would expect a health professional employed within the prison to give a patient and fellow human being.

Tarig's sister, Sonya Dalton



Michal Netyks was a 35 year old man and Polish national who was notified on 7 December 2017, the morning he was due to be released, that he would remain detained pending possible deportation to Poland.

The documents from the Home Office were only provided to him in English, and the immigration officer who was present in the prison that day did not speak to Michal so his right to appeal was not explained. A few hours later, Michal jumped from a landing, and consequently died due to a head injury. The inquest jury concluded that Michal's death was the result of suicide, which was in part contributed to by the immigration deportation process.

Michal's death was a blow that shattered both our lives. To this day we find it extremely difficult to cope with the absence of our beloved son from our lives and keep wondering about the circumstances of his death.

Michal's parents, Róża and Ryszard Netyks

Data on the deaths of racialised people in prison

Publicly available data concerning the deaths of racialised people in prison is extremely limited. This led INQUEST to file Freedom of Information requests to the Ministry of Justice to obtain data concerning the ethnicity of those that died in prison over a seven-year period from 1 January 2015 - 31 December 2021. As a result, for the first time we are presenting an in-depth analysis of those who died in prison, not only by racialised group, but also by gender, nationality, age and death category.

2,220 people died in prison between 1 January 2015 - 31 December 2021. In the graphs adjacent, we present the deaths of racialised people by total numbers and percentage. In terms of total numbers. the data shows that, of all the racialised groups, the highest number of deaths occurred amongst Black and mixed-race people and Asian and mixed-race people respectively.

The data also shows that the percentage of selfinflicted deaths was highest amongst people of Eastern European nationality, Mixed Other people, and White Gypsy or Irish people, respectively, and lowest amongst Black and mixed-race people and White people.

The highest percentage of natural causes deaths occurred amongst White people, whilst the highest percentage of other non-natural deaths occurred amongst White Irish people.

Across the seven year period, White people died at the highest average age, whilst Mixed Other people and people of Eastern European nationality died at the lowest average ages respectively.

Figure 1^a

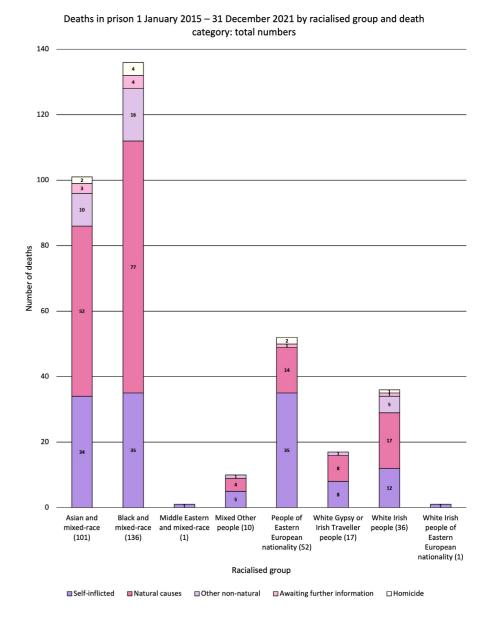
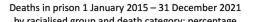
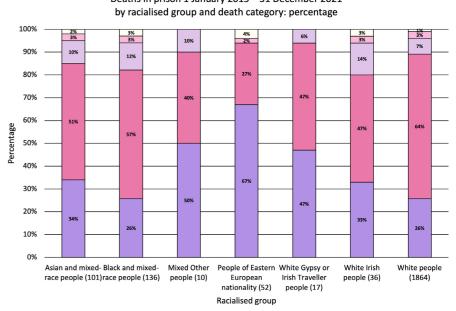


Figure 2^b

^aThis graph does not include the deaths of two people whose ethnicity was listed as 'Not stated/ unknown'. Furthermore, in order to highlight the deaths of racialised people, it does not present the 1864 deaths of White people. The 1864 deaths of White people are broken down as follows: 483 self-inflicted; 1188 natural causes; 123 other non-natural; 55 awaiting further information: and 15 homicide

^bWe have not included the one self-inflicted death of a Middle Eastern and mixed-race person and the self-inflicted death of a White Irish person of Eastern European nationality in this graph, as we felt it was misleading given the small numbers.





■ Self-inflicted ■ Natural causes ■ Other non-natural ■ Awaiting further information

Thematic concerns in the deaths of racialised people

We analysed the deaths of 22 racialised people in prison and identified seven critical issues in the deaths of racialised people in prison.

• Inappropriate use of segregation

The cases spotlight the prison system's inappropriate use of segregation. Poor treatment in segregation, as well as a lack of or inadequate assessments prior to and during segregation, surfaced as specific issues. The cases show that the inappropriate use of segregation occurred mostly among Black and mixed-race prisoners.

Racial stereotyping

Prisoners, predominantly Black and mixed-race prisoners, were consistently racially stereotyped as aggressive and seen as a discipline and control problem. Racial stereotyping often justified inhumane and disciplinary treatment and in specific cases gave rise to a culture of disbelief.

Hostile environment

The Home Office's inherently discriminatory hostile environment policy encourages the continued detention and deportation of foreign nationals. The cases show how the possibility of continued indefinite detention and deportation (and of notice of this – especially combined with its untimely and poor delivery and the lack of advice) has harmful effects on mental health and can increase the likelihood of self-harm and self-inflicted death. All four of the deaths of immigration detainees and foreign nationals were self-inflicted deaths, with three of those prisoners of Eastern European nationality.

Neglect of physical health

The cases highlight a culture of disbelief, dismissal and inaction regarding the physical health of prisoners, even when prisoners, their families and prison staff raise concerns. This culture allows for physical ill health to worsen to the point of no return. It is exacerbated by the inadequate healthcare in prison, more generally, and failures in communication between hospitals, community GPs, prison healthcare staff and prison staff. This issue was most marked amongst Asian and mixed-race and Black and mixed-race prisoners.

Neglect of mental health

The neglect of prisoners' mental ill health was a defining feature of many of the deaths. In particular, the inadequacy or lack of assessment and management of prisoners' mental health, and its link to suicide, emerged as a key issue. Issues relating to the neglect of mental health primarily affected people of Eastern European nationality, Black and mixed-race people and Asian and mixed-race people.

• Failure to respond to warning signs

The cases highlight the prison system's failure to respond to warning signals, especially relating to Black and mixed-race prisoners, including the activation of emergency cell bells and visible signs that the prisoner's wellbeing might be under threat.

Bullying and victimisation

The cases reveal several severe incidents of bullying, especially of Black and mixed-race men, one of whom was Muslim. Two of the men who were bullied took their own life, whilst the other was killed by another prisoner.





Annabella's story

Annabella Landsberg was a 45 year old mixed-race woman of White and Black African heritage with HIV, type 2 diabetes and a brain injury as a result of tuberculosis.

In May 2017 Annabella was transferred from another prison to HMP Peterborough. Prison staff described Annabella's behaviour as challenging and consequently she was often placed in the segregation unit.

The PPO investigation into her death stated that the decision to segregate Annabella, for what would be the last time, may not have been "proportionate to the risk she posed". On the evening of 2 September 2017, prison officers restrained Annabella. From this point on, she was observed to be unresponsive lying on

the floor of the segregation unit for the next 21 hours. During this period, discipline and healthcare staff considered that she was faking illness.

On the afternoon of 3 September, staff observed Annabella appeared to have wet herself and called a nurse to assess her. Instead, the nurse threw a cup of water over Annabella believing her to be faking illness. Later that day, Annabella was taken to hospital where she was found to be severely dehydrated and suffering from multiple organ failure. On 6 September 2017, Annabella was pronounced dead. The inquest found serious failings across the prison contributed to her death.



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It was very distressing to learn that my sister was left on her cell floor for so long when she was so unwell, repeatedly considered to be 'faking it'.

Annabella's sister, Sandra Landsberg

Post-death investigations

The role of post-death investigations in scrutinising and challenging racism in prisons is crucial, yet the extent to which they do this is questionable. We examined whether the race or ethnicity of the prisoner, or the potential role of racism or discrimination in the death, were addressed in post-death investigation processes. We conducted a review of the PPO investigations (fatal incident reports), record of inquests and any Prevention of Future Death (PFD) reports associated with the deaths of the 22 racialised people featured in our report.

Our review concluded that none of these investigations addressed the race or ethnicity of the deceased, nor the potential role of racism and discrimination in any of the deaths. The absence of consideration does not mean that racism or discrimination was not a factor in their death. Given the evidence of racialised people's experiences and of institutional racism in the prison estate,

as documented in the full report, we consider it unlikely that racism or discrimination was not a feature in any of the deaths. Therefore, we consider the current approach by PPO investigations, inquest proceedings and PFD reports to be inadequate: there should be a presumption of relevance in the context of how racialised people die in prison.



Our review concluded that none of the investigations addressed the potential role of racism or discrimination in the death.



Recommendations

Treatment of racialised people in prison

We cannot allow racialised people in prison to continue to die in contentious, violent and neglectful circumstances, as outlined in the full report. The specific issues in the deaths of racialised people evidenced in the full report must be addressed by the Ministry of Justice, Department of Health and Social Care and Government. Therefore, we urge the relevant government bodies to develop a detailed action plan to address the distinct issues in the deaths of racialised people in prison.

Government data on prison deaths

It is unacceptable that INQUEST has had to file Freedom of Information requests to obtain data on the specific ethnicity of those who died in the prison estate and the death category (self-inflicted, natural causes, other non-natural, awaiting further information and homicide). Therefore, we call on the on the Ministry of Justice to ensure that Safety in Custody publications publish data disaggregated by ethnicity on all types of death in prison. Further, the Ministry of Justice should include White Irish people, White Gypsy or Irish Traveller people and people of Eastern European nationality in addition to the existing ethnicity categories they use in any ethnicity analysis.

Post-death investigations and scrutiny of deaths in prison

It is unacceptable that INQUEST found no meaningful consideration of the race or ethnicity of the deceased nor of the potential role of racism or discrimination in any of the PPO investigations, coroner's inquests or PFD reports we examined. Therefore, the PPO and the coroner's service should ensure that they meaningfully consider the race or ethnicity of the those who die in prison as well as the potential role of racism or discrimination in their death. This should inform monitoring and inspectorate bodies such as HMI Prisons, the Independent Monitoring Boards and the Care Quality Commission.

Establish National Oversight Mechanism

When the processes work as they should, recommendations arising from post-death investigations and inquiries are invaluable. They are intended to prevent future deaths, but there is currently no oversight of these recommendations nationally and no mechanism to follow them up. Therefore, the government must establish a new and independent body tasked with the duty to collate, analyse and monitor learning and implementation arising out of post-death investigations and inquiries.

Transformative social change

The decision to imprison the 22 racialised people featured in this report ended up being a death sentence. Imprisonment is ineffective in reducing crime and instead perpetuates harm and violence, with racialised and marginalised groups worst affected. In order to end the heightened criminalisation, intensified policing, disproportionate imprisonment and deaths of racialised people in prison, we must halt prison building and decrease investment into the criminal justice system more broadly. We must redirect resources from the criminal justice system to welfare, health, housing, education and social care.



Unknown 3, Guernsey Prison, Keith Bromley Platinum Award for Photography, 2021. Image courtesy of Koestler Arts.





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