INQUEST

Truth Justice Accountability

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

Full report

Unlocking the truth for 40 years

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 multi-agency failings or where wider issues of state and corporate accountability are in question.

About this report

This report was written by Jessica Pandian. Louise Finer led the early stages of this report. We are also thankful to the many organisations and individuals who provided input to this report during the research stages. We would like to thank Dr Patrick Williams of Manchester Metropolitan University and Professor Joe Sim of Liverpool John Moores University for their insights and contributions. We would also like to thank Alice Kaerast, data analyst at Resistance Lab, for their support on the data analysis. We are also grateful to the following organisations who provided feedback in the preliminary stages of this report: The Traveller Movement, Women in Prison, Safeground, Hibiscus Initiatives, UNGRIPP, the Howard League for Penal Reform, the Zahid Mubarek Trust, Maslaha, the Prison Reform Trust and Prisoners' Advice Service.

And finally, we would like to extend our biggest thanks to the bereaved families who have agreed to let us share the stories of the deaths of their loved ones. We hope this report can honour their legacy and contribute to change to prevent future deaths.

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.

Barrow Cadbury Trust Charity No. 1115476
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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

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Foreword by Deborah Coles

The murder of George Floyd in May 2020 triggered renewed global interest in state violence and structural racism. Despite the surge in global engagement with these issues, there continues to be insufficient attention and awareness of the racial inequalities that pervade the UK prison estate, and much less is known of the deaths of racialised people in this country's prisons.

Over INQUEST's 40 year history, we have continuously supported bereaved families whose relatives have died in prison. Our evidence-based casework 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. Too many are premature and preventable.

We have worked alongside 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 our collaborative efforts, the deaths of racialised people in prison have seldom garnered attention on a national scale. 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 of racism or discrimination in these deaths renders racialised 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 significant void and bring to light the pressing issue of institutional racism in the prison estate.

To be clear, these deaths do not occur in isolation. Rather, they occur at the sharp end of a continuum of racialised state harm which includes the heightened criminalisation, intensified policing and disproportionate incarceration of racialised people. Accordingly, for many racialised people, incarceration is often not their first point of contact with the criminal justice system.

For example, the life and death of Sarah Reed[a], a mixed-race Black woman, in prison exemplifies how racialised state harm can impact someone throughout their life. Sarah had never recovered from the trauma of the death of her baby daughter. Her mental ill health was exacerbated after a brutal assault by a police officer, an offence for which he was found guilty. Sarah, and many other people featured in this report, have been subjected to the punitive and racially discriminatory hand of the state *outside* prison before they experience it *inside* prison.

In this way, many racialised people enter prison having already experienced racial trauma, which can be defined as the psychological impact of racialised people's experience of racism.[1]

[a] The death of Sarah Reed is included in greater detail later on in this report.

This report evidences the role of institutional racism in the prison estate from 2015 – 2022 through:

- A review of existing literature concerning racism in the UK prison estate
- An analysis of never-before-published data obtained by INQUEST through Freedom of Information requests on deaths in prison
- An examination of the deaths of 22 racialised people in prison
- A review of record of inquests, Prevention of Future Death (PFD) reports and Prisons and Probation Ombudsman (PPO) reports relating to the 22 deaths examined

By presenting this evidence, this report provides a unique insight into the inherent harms and dangers of imprisonment. It throws into sharp relief the fatal consequences of institutional racism in prison, a previously overlooked matter. At the end, it provides recommendations to enact fundamental and long-term change. The impact of austerity, rising inequality and the expansion of the criminal justice system will cause disproportionate harm to racialised people. Now, more than ever, we must stand together with bereaved families to demand the structural change needed to pursue social and racial justice.

Terminology and scope of the report

We acknowledge that the language concerning race and racism is continuously evolving. We believe this is important as it allows us to reflect upon and update our vocabulary to ensure we are using appropriate, sensitive and respectful language.

This report is primarily concerned with the deaths of racialised people in prison. Though we include deaths of immigration detainees in prison, we do not include deaths that occur in immigration removal centres.

We have chosen to use the term 'racialised' because we think it currently best reflects all the different groups of people with whom this research is concerned. We use the term to refer to people who face racism and are subject to the process of racialisation, which is the complex process through which societies "construct races as real, different and unequal in ways that matter to economic, political and social life".[2] In the context of the UK, though White British people can also be racialised, historically, they have held the social, political and economic power to define themselves as the 'raceless norm' and to racialise others in society.[3] Furthermore, the racialisation of non-White British people in society is typically negative. It is for these reasons that we have excluded White British people in our definition of racialised people.

Throughout this report, we group racialised people as follows:

- Asian and mixed-race people
- Black and mixed-race people
- Middle Eastern and mixed-race people
- People of Eastern European nationality
- White Irish people
- White Gypsy or Irish Traveller people

Please refer to the appendix to read more about how we have decided to name and group each racialised group.

Lastly, we would like to make clear that we try to be as consistent as possible with regards to language. However, in circumstances where we refer to data or research from external sources, we use their terminology. This would include terms such as Black, Asian and Minority Ethnic (BAME), Black and Minority Ethnic (BME), ethnicity, ethnic minority and racial minority, amongst others.

Historical overview

Whilst this report covers the time period between 2015 and 2022, the deaths of racialised people in prison are not a new phenomenon. In fact, the deaths of racialised people in prison were central to the formation of INQUEST in 1981. The death of Richard 'Cartoon' Campbell in Ashford Remand Centre, the third Black person to die in the centre between 1973 and 1980, was a particularly contentious death which caused great concern at the time.

Throughout the late 1980s, 1990s and early 2000s, INQUEST supported families following a series of deaths of Black men and boys who died after prison officers restrained them, often with their face down in the prone position.[b] Germain Alexander,[4] a 58 year old Black man, was reportedly the first person to die of restraint in prison in the history of the UK. He died in 1989. Then followed the restraint-related deaths of Jay Austin, a 61 year old Black Caribbean man in 1991, and Omasese Lumumba, a 32 year old Black asylum seeker who had fled torture and persecution in Zaire (now the Democratic Republic of the Congo) in 1993 and was unlawfully killed by prison officers in HMP Pentonville. In late 1995, Dennis Stevens, Kenneth Severin and Alton Manning died of asphyxia following restraint by prison officers within three months of each other, with the death of Kenneth Severin provoking allegations of rampant racism and violence in prisons in England and Wales.[5]

During the inquest into the death of Dennis Stevens, which highlighted the dangers of positional/restraint asphyxia and the use of body belts, the coroner withdrew the verdict of unlawful killing from the jury, which Dennis' family believed was a travesty of justice. In the contemporary context of the Black Lives Matter movement, the words of Dennis Stevens' family during his inquest could not be more pertinent.[6] His sister, Velma Knight, said:

> If it was discovered that an animal had died in the barbaric way in which my brother has, there would be a public outcry. Somebody would be held responsible and no doubt punished. The message I get from the authorities is that Blacks don't matter.

Kenneth Severin was reported as being the seventh Black prisoner to die during restraint in the UK.[7] Kenneth[8] was a man with 'paranoid schizophrenia' who prison staff disciplined when he began to appear distressed. They handcuffed him, stripped him naked and restrained him face down. The prison officers involved in restraining him used racist tropes as they commented on the "superhuman" and "incredible strength" of Kenneth, whilst the Parliamentary Ombudsman described Kenneth's distressed behaviour in the moments prior to his death as "aggressive".[9]

The restraint-related death of Alton Manning, who was 33 years old when he died after the use of a neck hold, was found by an inquest jury to be an unlawful killing. Following the inquest, the then-head of the prison service, Richard Tilt, speaking broadly about the succession of restraint-related deaths of Black men, claimed that "Afro-Caribbean people are more likely to suffer positional asphyxia than Whites", suggesting that this may be attributed to sickle cell disease which predominantly affects Black people. Deborah Coles, INQUEST's then and current director, said at the time that it was "reminiscent of the sort of scientific racism we used to get in the last century".[10] Furthermore, INQUEST[11] pointed out that:

> The comments made by Richard Tilt in relation to this death were false and inherently racist with not a shred of scientific evidence to support them. We view this as yet another attempt to blame the victim and deflect attention away from what the key issues are in relation to the disproportionate numbers of Black people dying in custody; the extent of force and violence

[b] It is important to note that whilst restraint-related deaths of Black men in prison occurred quite frequently in the late eighties, nineties and early 2000s, they continue to happen in the present day. For example, INQUEST is aware of a death of a Black man in prison following restraint in 2022. We are also aware of a death of a Black man in prison in 2021 in which the police are investigating the possible use of restraint.

> used; the nature of the training prison officers receive, and the institutionalised racism within the prison system as [a] whole.

Just as the murder of Stephen Lawrence in 1993 proved to be a watershed moment in acknowledging institutional racism in the police force, the murder of Zahid Mubarek seven years later marked a ground-breaking moment in the recognition of institutional racism in the prison estate. Zahid Mubarek was a 19 year old Muslim teenager of Pakistani background who was murdered at Feltham Young Offender Institution (YOI) in 2000 by his cellmate, a known racist with a history of mental ill health who had previously written to a friend saying that he wanted to commit the first murder of the millennium.[12]

The murder and subsequent campaigning by the Mubarek family precipitated a chain reaction of investigations and inquiries concerning racism in the prison estate. The Prison Service's internal investigation catalogued the significant failings that led to the racist and violent behaviour of Zahid's murderer being overlooked[13] and concluded that Feltham YOI was institutionally racist.[14] Additionally, the Commission for Race Equality's investigation into racism at HMP Brixton, Feltham YOI and HMP & YOI Parc in 2003 identified several findings of unlawful discrimination and that the staff's use of "discretion" negatively affected BAME prisoners.[15] Significantly, the government's public inquiry into the death of Zahid Mubarek, published in 2006, labelled the prison estate in England and Wales as "institutionally racist".[16] It also recommended that the Home Office recognise the concept of "institutional religious intolerance".[17] Zahid's family maintained that his death was "institutional murder",[18] a view that INQUEST openly endorsed.[19]

In 2017, the publication of David Lammy's *Independent Review into the Treatment of, and outcomes for, Black, Asian and Minority Ethnic individuals in the Criminal Justice System*[20] marked a critical moment as it brought the issue of racism in the criminal justice system to the fore and highlighted the overrepresentation and differential treatment of BAME people in prison.

Nevertheless, in other areas, the report fell short: it did not name institutional nor structural racism; for the most part it did not examine the issues faced by specific groups included within the BAME group; and it did not consider deaths in custody. Though the Ministry of Justice state that they have implemented all the recommendations from the Lammy Review, there is no evidence of any significant policy development, including on addressing racism in prisons.[c] David Lammy himself said[21] in 2021:

> "I get so upset about my review because it has got worse, not better, since doing the review. The recommendations have not been fully implemented. If I was publishing the review today, I would go further than when I was commissioned to do the review five years ago.

The lack of concrete progress should be seen within successive governments' broader political project which has undermined the existence of racism in this country; pushed through the blueprint for the vast expansion of the criminal justice system; and is currently implementing legislation that will negatively affect equalities. To illustrate, in 2022, the government introduced the Police, Crime, Sentencing and Courts Act and the Nationality and Borders Act, both of which will inevitability strengthen the criminalisation of racialised groups.

In 2021, the government-commissioned report by the Commission on Race and Ethnic Disparities denied the existence of structural racism and suggested that institutional racism does not exist in the UK.[22] [23]Despite the report having been widely discredited[24] for its lax

[c] The policy framework for challenging racism and discrimination in prisons dates back to 2011 and was only updated in 2020. It is entitled 'Ensuring Equality'.

approach to evidence, it laid the foundations for the disappearance of matters of institutional and structural racism in government policy.[25] Meanwhile, in December of the same year, the government published their Prisons Strategy White Paper[26] which outlined plans for the biggest prison building programme in more than 100 years, with 18,000 new and 2,000 temporary places to be created that will raise the prison population to close to 100,000 by 2026,[27] despite the fact that the UK prison population has already risen by 70% in the past 30 years.[28] The latest plan for prison expansion fits into a broader pattern of significant investment into the prison estate. Between 2015/2016 and 2019/2020, identifiable expenditure on prisons was over £18 billion, with the overall cost per prisoner amounting to £42,670 in 2019/2020.[29]

Considering the general inaction on advancing progress and equalities in prison since the Lammy Review, and the broader political aversion to addressing structural and institutional racism, it appears that neither the government nor the Prison Service view challenging institutional racism in the prison estate as a genuine area of political or operational commitment. The present-day deaths of racialised people in prison should be contextualised by both the broader historical context and the ongoing failure to acknowledge and address racism in the prison estate.

December 1989:
Germain Alexander,
a 58 year old Black man with mental ill health, is reportedly the first person to be restrained to death in prison.

October 1993:
Omasese Lumumba,
a 32 year old Black asylum-seeker who fled Zaire to Europe after being imprisoned for 18 months without trial and ill-treated, is restrained and stripped by five to seven prison officers and dies during the process.

October 1995:
Dennis Stevens,
a 29 year old Black man, is placed in the prone position for 20 or more minutes by prison officers before being placed in a body belt - a thick leather belt fastening around the waist with iron cuffs. Dennis is found dead 24 hours later, still in the body belt.

November 1995:
Kenneth Severin,
a mentally ill 25 year old Black man, dies after being restrained face-down by eight prison officers.

December 1995:
Alton Manning,
a 33 year old Black man, is restrained by eight prison officers and dies.

March 2000:
Zahid Mubarek,
a 19 year old of Pakistani background, dies following a brutal attack by his cellmate who had a history of violent and racist behviour.

November 2000:
The Prison Service publish part 1 of their damning two-part internal investigation into the death of Zahid Mubarek. It looks at the information learnt from the criminal trial of Zahid Mubarek's murderer.

January 2001:
The Prison Service publish part 2 of their damning internal investigation into racist attitudes and behaviour at Feltham YOI.

December 2003:
The Commission for Racial Equality publish their critical formal investigation into racism in HMP Brixton, YOI Feltham, and HMP & YOI Parc.

April 2004:
Shahid Aziz,
a 30 year old Asian man, is strangled and has his throat cut half an hour after being put in a cell with a cell mate who had objected to the idea of White and Asian prisoners sharing cells.

April 2004:
Gareth Myatt,
a 15 year old mixed-race Black boy, is restrained by three G4S officers in a child prison and dies of positional asphyxia.

January 2005:
Godfrey Moyo,
a 25 year old Black man of Zimbabwean nationality with a history of epilepsy, is restrained in the prone position by prison officers for 30 minutes. After prison officers restrain him, Godfrey begins to suffer the effects of positional asphyxia. Godfrey is taken to the prison's health care centre. Nurses fail to monitor him, and he dies soon after.

June 2006:
Aleskey Baranovsky,
a 33 year old Ukranian national, repeatedly self-harms in protest at his impending deportation upon release, and dies from anaemia due to chronic blood loss and under-nutrition.

June 2006:
The highly critical public inquiry into the death of Zahid Mubarek is published. It labels the prison estate in England and Wales as 'institutionally racist'.

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The experiences of racialised groups in prison

Racialised people are often some of the most marginalised people in society. Considering the intersections between race and class, many racialised people in this country have personal experience of educational disadvantage, low-quality housing, mental illness, violent policing, unemployment, poor health and homelessness.[30] Those that are incarcerated are at the furthest end of the spectrum of marginalisation.

Racialised groups tend to be greatly overrepresented in prison. For example, official statistics show that Black and minority ethnic people account for 28% of the prison population, but only 13% of the general population,[31] with certain racialised groups more greatly overrepresented in prisons compared to others.[d] The overrepresentation of racialised groups is even more marked in youth custody, where Black, Asian and Other, and Mixed young people collectively account for 53% of the population, with Black young people alone comprising 29% of the population.[32]

Reports from HM Inspectorate of Prisons (HMI Prisons) have consistently evidenced that BME and racial minority men report worse experiences and outcomes compared to White men across a wide range of indicators covering prison life, including restraint, segregation and victimisation.[33] In previous annual reports,[34] HMI Prisons have also compared the outcomes between Traveller and non-Travellers, with more Travellers reporting having been bullied or victimised by both staff and other prisoners, and being restrained, in comparison to their non-Traveller counterparts.

[d] According to the UK Prison Population Statistics 2021, Black or Black British people comprise 13% of the prison population but just 3% of the general population; Asian or Asian British people comprise 8% of the prison population yet 7% of the general population; and Muslim people make up 18% of the prison population but just 4% of the general population. Gypsy, Roma and Traveller people represent 5% of men according to HMI Prisons' annual report prisoner survey in 2019/2020, and 6% of women in prison according to the Traveller Movement's 2021 report, but only 0.1% of the general population according to the 2011 census. Currently, there is no data on the percentage of people of White Irish ethnicity or people of Eastern European nationality in the prison population, so it is not possible to calculate if their presence in prison is disproportionate to that in the general population.

The 2021/2022 annual report by HMI Prisons also evidences that racial minority women reported being more likely than White women to have been bullied or victimised by both other prisoners and staff. In comparison to White women, fewer BME women reported being treated well by segregation staff and more BME women reported being restrained. Relating more generally to data, the HMI Prisons 2021/2022 annual report said:[35]

> "Equality monitoring data were a concern in virtually all our inspections. National data were often out of date and local data were not always gathered. Even when available, data were not analysed fully every time or used effectively to address disproportionate treatment.

Though this information is useful, there is scant interrogation of the reasons behind this concerning evidence. More broadly, research by HMI Prisons on the experiences of racialised groups in prison is very limited. Though they have compared the outcomes between Traveller and non-Traveller prisoners in previous prisoner surveys, research by HMI Prisons typically refers to BME people collectively, which obscures the experiences of specific racialised groups. Where research into specific racialised groups has been conducted, such as in thematic reports, much of it has now become outdated.

Nevertheless, NGOs, academics and journalists, amongst others, have sought to address this deficit by conducting their own research into racialised groups in prison. The research has shown that racialised groups generally experience worse treatment, poorer outcomes and specific issues in prison. We summarise this research below.

Research has previously evidenced worse outcomes for Black people in prison. For example, a joint report[36] by the University of Greenwich and the Runnymede Trust in 2017 for the Independent Advisory Panel on Deaths in Custody showed that 40% of Black people compared to 21% of White prisoners in the previous six months had reported negative outcomes measured by use of segregation and force, complaints, incentives and earned privileges, and general treatment. With regards

to gender, the Institute of Race Relations[37] have noted how Black men in custody "acting erratically or even asking for help" are stereotyped as bad and mad, which often leads to them being subjected to violence. Meanwhile, Women in Prison[38] have said that Black women reported being stereotyped as "loud and aggressive", with their mental health issues more likely to be classed as anger management. INQUEST's casework over decades has borne out the racial stereotyping of Black people in custody and the intersection between race and gender.[39]

The Traveller Movement have also noted that Traveller people in prison have a much higher incidence of mental ill health, physical health problems, disability and illiteracy, and are greater affected by family separation and the impact of being imprisoned compared to other prisoners.[40] Furthermore, research by HMI Prisons has shown that Gypsy, Romany and Traveller people report higher levels of victimisation, restraint and segregation compared to other prisoners.[41]

With regards to White Irish people, despite the overwhelming lack of research on their experiences, existing evidence points to anti-Irish discrimination in prison. In 2003, an internal Prison Service review prompted by the self-inflicted deaths of seven Irish prisoners found that Irish prisoners at HMP Brixton were subject to racist and inappropriate abuse by prison staff.[42] Additionally, in 2007 the Irish Department of Foreign Affairs noted[43] that there had been "a number of allegations of racial prejudice against Irish prisoners on the part of the prison staff in Britain".

Though there is no research into the specific experiences of those of Eastern European nationality/background in prison, broader research into the experiences of foreign nationals has highlighted limited family contact, immigration-related issues and language barriers as key matters of concern which can have a detrimental impact on mental health.[44] Similarly, there is extremely limited to no research on the experiences of Asian and mixed-race people and Middle Eastern and mixed-race people in prison. Given the severity of the issues affecting racialised groups in prison, the lack of research is unacceptable. We now turn to our own evidence-based research, which begins to fill in the gaps in this area.

The data

The existing data

Publicly available data concerning the deaths of racialised people in prison is extremely limited. To illustrate, the main official resource on deaths in prisons, the Ministry of Justice's quarterly publication *Safety in Custody Statistics: England and Wales*,[45] has published data on a small number of occasions on self-harm/self-inflicted deaths by broad ethnicity categories. These have included Asian, Black, Mixed, Other and White; as well as broader categories such as BAME and 'other ethnic groups'. Elsewhere, the government has published data on self-inflicted deaths in prison, which has also used broad ethnicity categories (Asian, Black, Mixed, Other, and White).[46] The government has also failed to provide data disaggregated by ethnicity on all types of death (natural causes, self-inflicted, other non-natural, awaiting further information and homicide) in prison.

The data we present

The paucity of official data on the ethnicity of those who die in prison renders any detailed analysis almost impossible. This led INQUEST to file Freedom of Information requests to the Ministry of Justice to obtain data concerning the ethnicity of those who 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.

It is important to note that the latter part of the seven-year period covered in our data analysis coincides with the COVID-19 pandemic. Thus, it is necessary to bear in mind the influence of COVID-19 on deaths in prison. For instance, between March 2020 and February 2021, the COVID-19-related death rate was 3.3 times higher among people in prison than that of people of the same age and sex outside prison.[47] Research points to the higher risk of transmission and outbreaks in prison, and the increased risk of underlying health problems, as reasons for the discrepancy.[48] It is not possible to comment on how COVID-19 affected the death rate between different ethnic/racialised groups in prison, as the only ethnicity breakdown of COVID-19 deaths in prison is PPO data,[49] which uses broad ethnicity categories and is limited in terms of timeframes. However, research has shown that in the general population, almost all ethnic groups have a higher risk of dying of COVID-19 in comparison to the White British majority of a comparable age.[50]

The grouping of racialised groups

The Ministry of Justice provided us with the ethnicity of those who died in prison. We grouped these distinct ethnicities into 'racialised groups', as consistently as possible with the way in which we have done so throughout this report. Exceptions include the addition of a 'Mixed Other people' group and a 'White Irish of Eastern European nationality' group, to accommodate for a White Irish person of Romanian nationality. The ethnicities included in each racialised group throughout the data sections are as follows.

Asian and mixed-race people: Asian Bangladeshi, Asian Indian, Asian Pakistani, Asian Other, Mixed White/Asian, Chinese or Other and Asian Chinese

Black and mixed-race people: Black African, Black Caribbean, Black Other, Mixed White/Black African and Mixed White/Black Caribbean

Middle Eastern and mixed-race people: Other Arab

Mixed Other people: Mixed Other

People of Eastern European nationality: White, White Other, or Other of Eastern European nationality. Eastern European nationalities include the Czech Republic, Hungary, Kosovo, Lithuania, Poland, Romania, Slovakia, Slovenia and Ukraine

White Gypsy or Irish Traveller people: White Gypsy or Irish Traveller

White Irish people: White Irish

White Irish people of Eastern European nationality: White Irish of Romanian nationality

We include the deaths of 'White people' in some graphs for comparative purposes. Ethnicities included in the 'White people' group are outlined below.

White people: White, White British, or White Other not of Eastern European nationality. This is because we consider White, White British or White Other people of Eastern European nationality as racialised people.

Definitions of death categories according to the Ministry of Justice

Natural causes: Natural cause deaths include any death of a person as a result of a naturally occurring disease process.

Self-inflicted: Self-inflicted deaths are any death of a person who has apparently taken his or her own life irrespective of intent. This not only includes suicides but also accidental deaths as a result of the person's own actions. This classification is used because it is not always known whether a person intended to commit suicide.

Other non-natural: Accidents arising from external causes, accidental overdose/ poisoning and deaths where taking a drug contributed to a death but not in fatal amounts.

Awaiting further information: This category includes any death for which there is insufficient information to make a judgement about the cause. The information awaited may refer to post-mortem or toxicology reports, Prison and Probation Ombudsman (PPO) reports or the coroner's inquest. INQUEST received the FOI data at different stages. Therefore, deaths classified as awaiting further information were classified as such as of the date we received the data. Since then, the death may have been reclassified under another category.

Homicide: Homicides include any death of a person at the hands of another. This includes murder and manslaughter cases. As with self-inflicted deaths, the classification system does not make any judgement about intent with regards to homicide.

Note of caution concerning the data analysis

Firstly, correlation does not imply causation. Secondly, so-called 'natural causes' deaths as defined by the Ministry of Justice are the leading cause of mortality in prisons and are commonly attributed to the ageing prison population. However, INQUEST's casework and monitoring show that many of these so-called 'natural' deaths are anything but, and often reflect serious lapses in healthcare; therefore, applying the term 'natural' can be misleading and obscure the relevant issues in care. Finally, due to rounding up, percentages do not always total 100%.

Data analysis

Our data analysis covers the seven-year period between 1 January 2015 and 31 December 2021. During this period, 2220 people died in prison.

- Of the 2220 people that died, 97% (2149) were men and 3% (71) were women.
- Of the 2220 people that died, 16% (354) were racialised people.
- The 15 deaths of racialised women made up 21% of all deaths of women in prison whilst the 339 deaths of racialised men made up 16% of all deaths of men in prison.

It is important to note that though the deaths of racialised people are not disproportionate to the prison population, this could potentially be attributed to in part by the differences in the average ages of racialised groups. For example, in 2020, the "ethnicity of prisoners varied across age groups, with a higher proportion of younger prisoners [being] from minority ethnic groups (53% of under 18 year olds). In contrast, 85% of prisoners aged 50 or over were White".[51] We reiterate that though the deaths of racialised people are not disproportionate, they are among some of the most contentious, violent and neglectful.

All deaths

We have conducted an analysis of all the deaths that occurred between 1 January 2015 and 31 December 2021. The pie chart in figure 1 is a percentage breakdown of all the deaths in prison that occurred during the seven-year period. This chart shows that natural causes deaths and self-inflicted deaths comprised the majority of all deaths. More than a quarter of people who died in prison took their own lives.

Meanwhile, the line graph in figure 2 depicts the number of deaths in each death category, as well as the total number of deaths, per year. Significantly, it highlights that 371 people died in prison in 2021, which is the highest death toll in prisons in England and Wales ever recorded. It exceeded the previous high of 354 deaths in 2016.[52] The longer-term data shows that, even without accounting for COVID-19-related deaths, 2021 and the previous five years have seen the highest-ever numbers and rates of deaths in prison.[53]

Figure 1

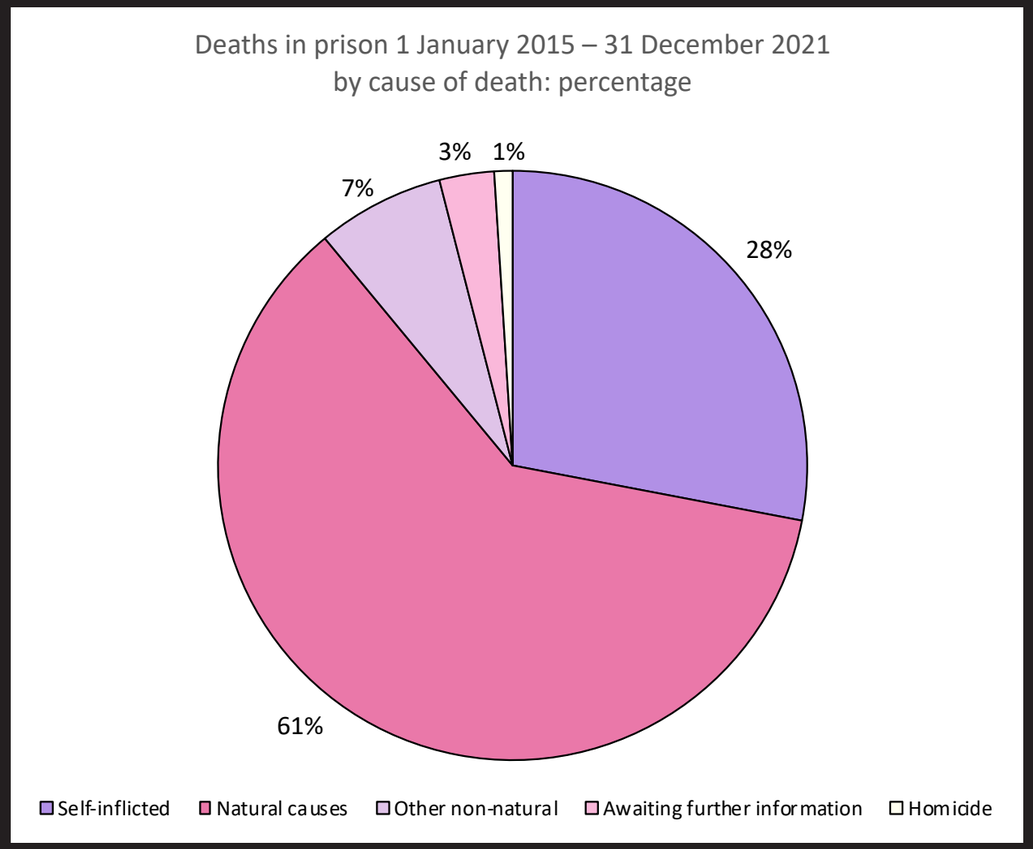
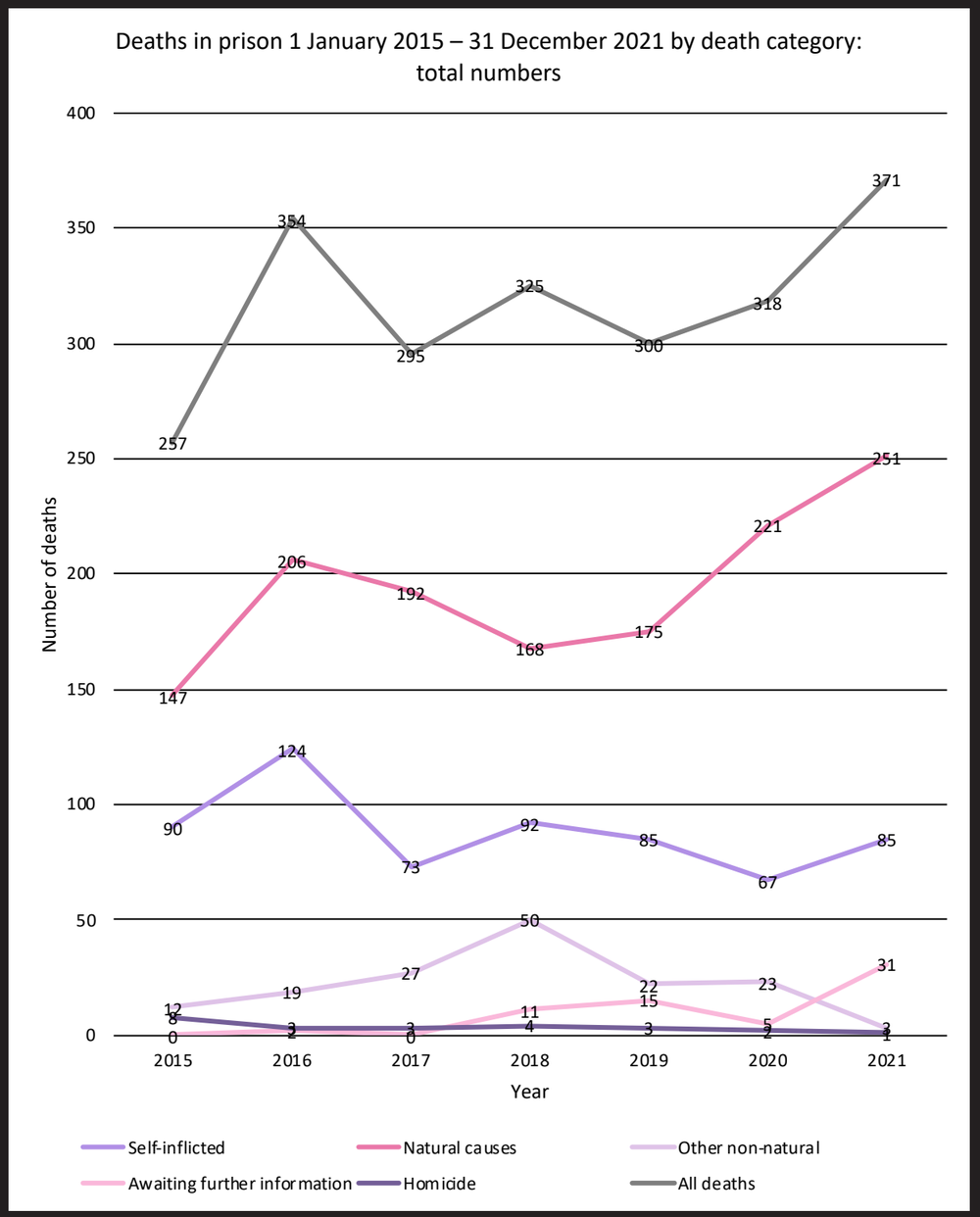


Figure 2



Deaths of racialised people

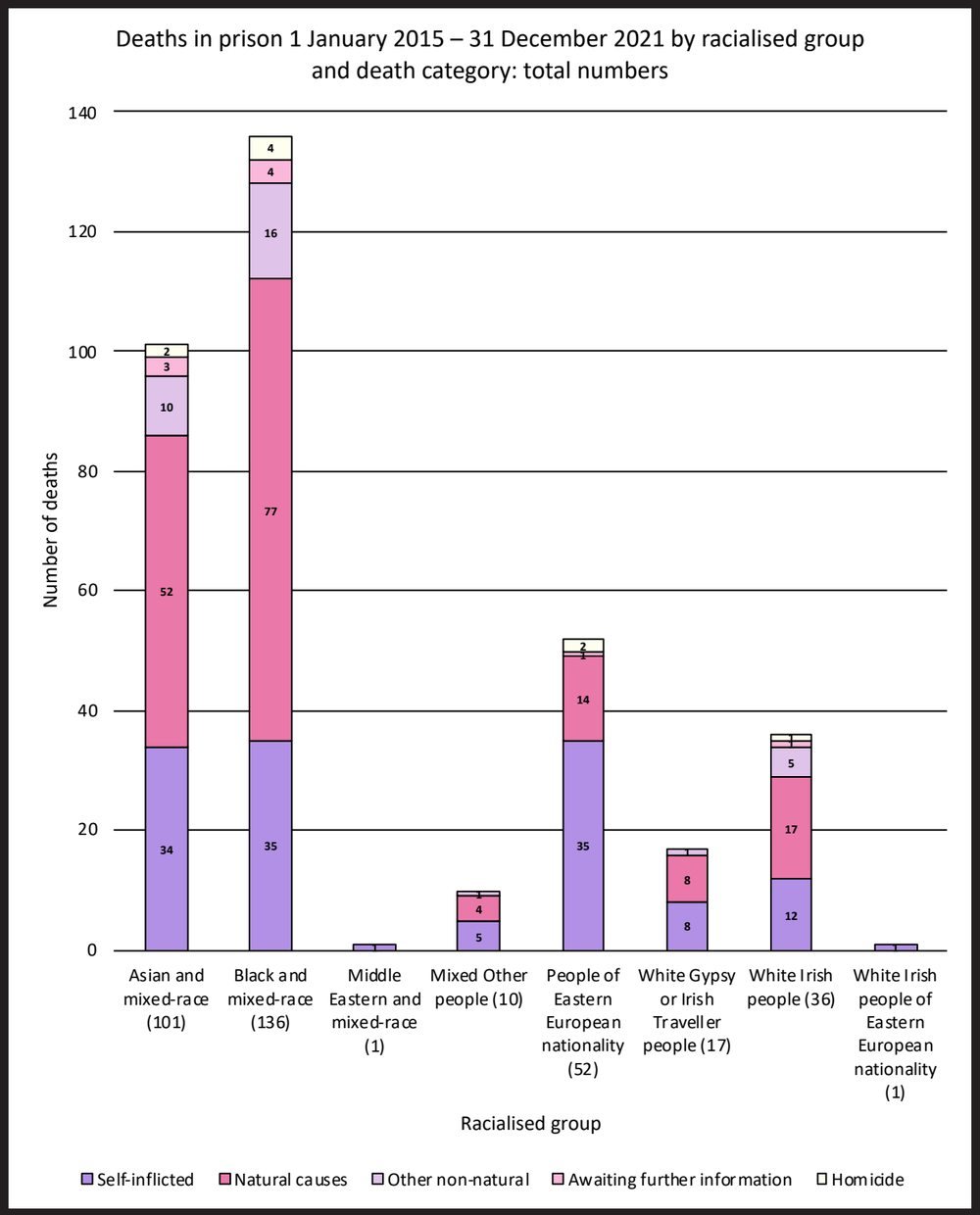
We present graphs on the deaths of racialised people below. In figure 3, we present data on the numbers of deaths of racialised people by death category, and in figure 4 we represent those same deaths by percentage. This allows us to identify what percentage of the deaths were natural causes or self-inflicted, for example, and to compare the percentages across racialised groups as well as to the White group.

In figure 5, we represent the deaths of racialised women, as the deaths of women in prison have been a long-standing area of thematic concern at INQUEST. We have conducted other research in this area.[54]

In figure 6, we show the deaths of those of non-British nationality by nationality, which enables us to identify which nationalities experience the highest number of deaths in prison and to see how the deaths of people of differing nationalities are classified.

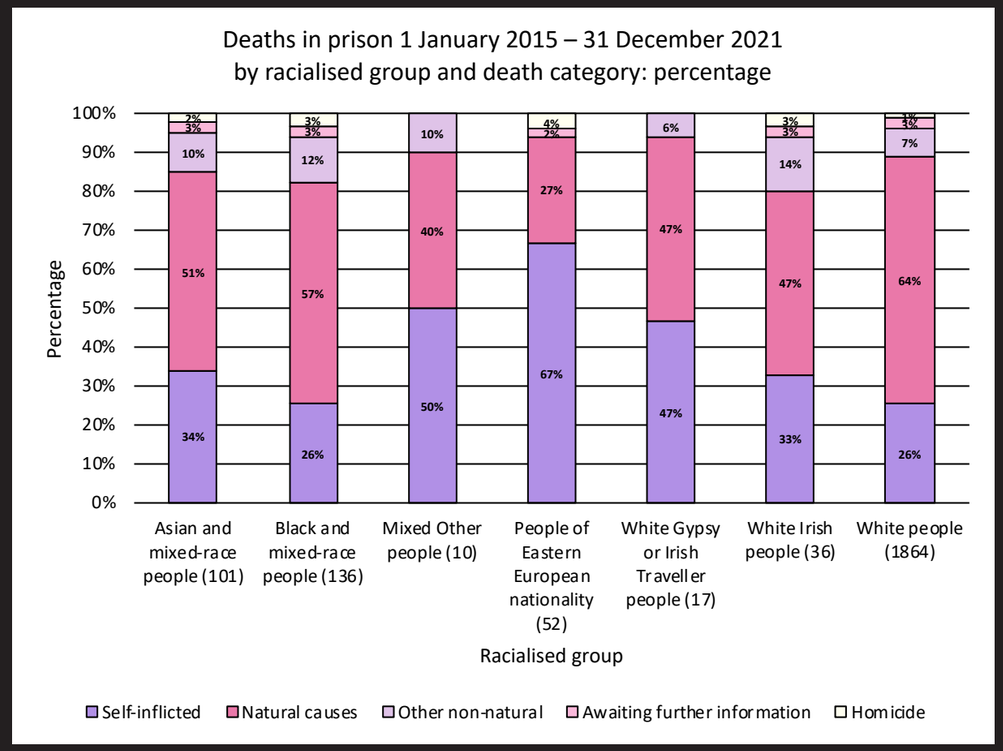
In figure 7, we present data on the average ages at time of death per year of each racialised group and the White group. In figure 8, we present the average age at the time of death over the seven-year period, which helps us to compare the average age at the time of death between racialised groups and the White group.

Figure 3[e]



[e] This 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.

Figure 4[f]

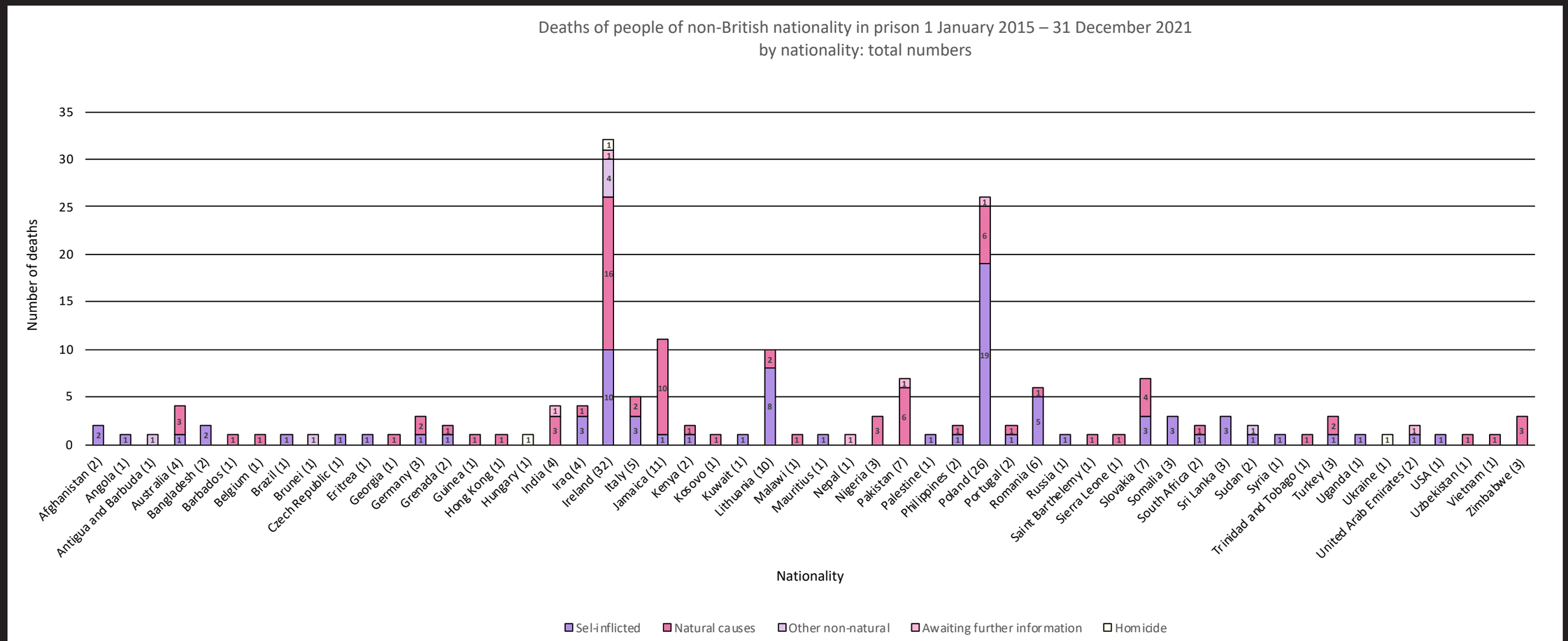


[f] We have not included the one self-inflicted death of a Middle Eastern and mixed-race person and the self-inflicted death of a White Irish person of Eastern European nationality in this graph, as we felt it was misleading.

Figure 5[g]

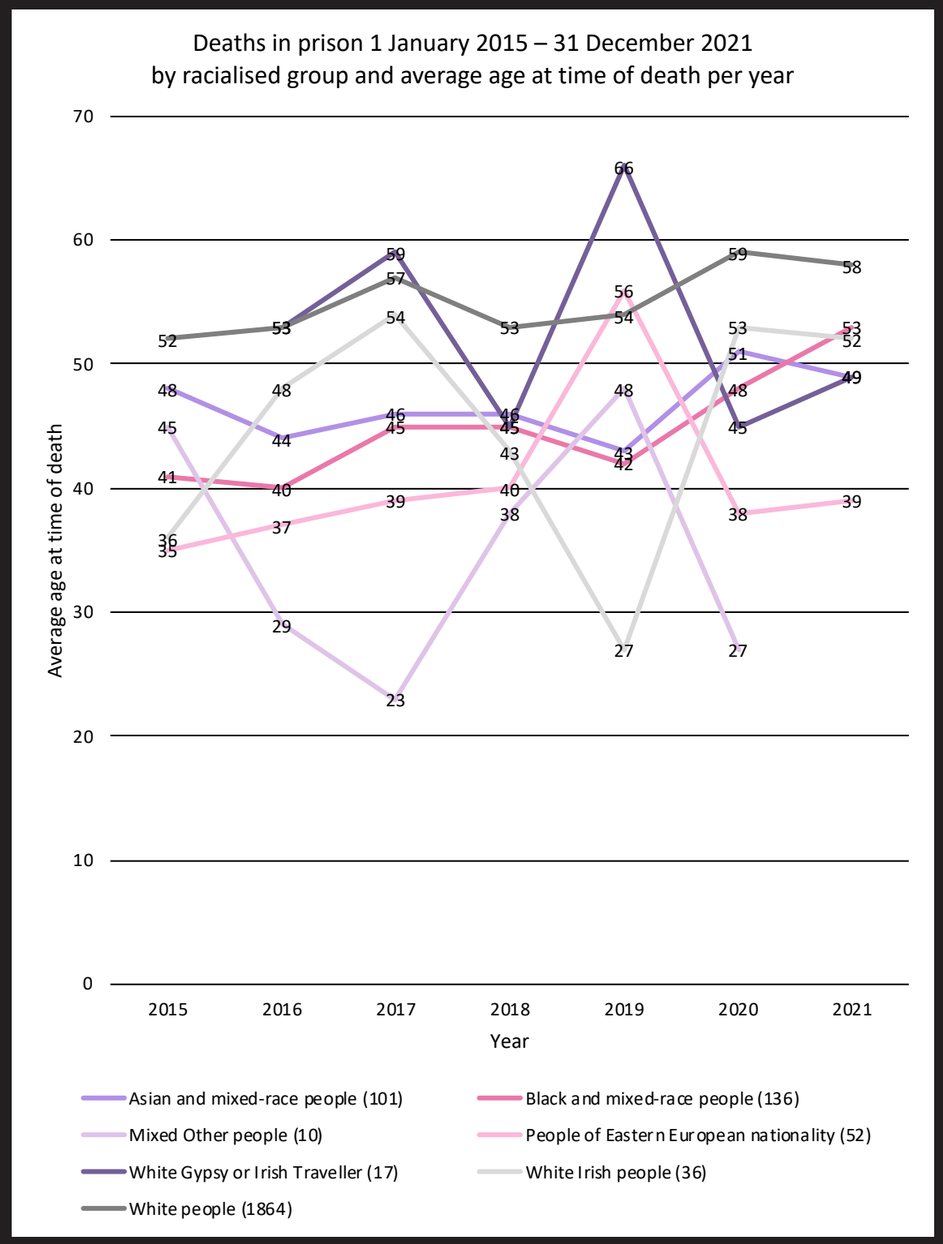
[g] In order to highlight the deaths of racialised women, this graph does not include the 56 deaths of White women. The 56 deaths of White women are broken down as follows: 22 self-inflicted; 23 natural causes; 4 other non-natural; and 1 awaiting further information.

Figure 6[h]



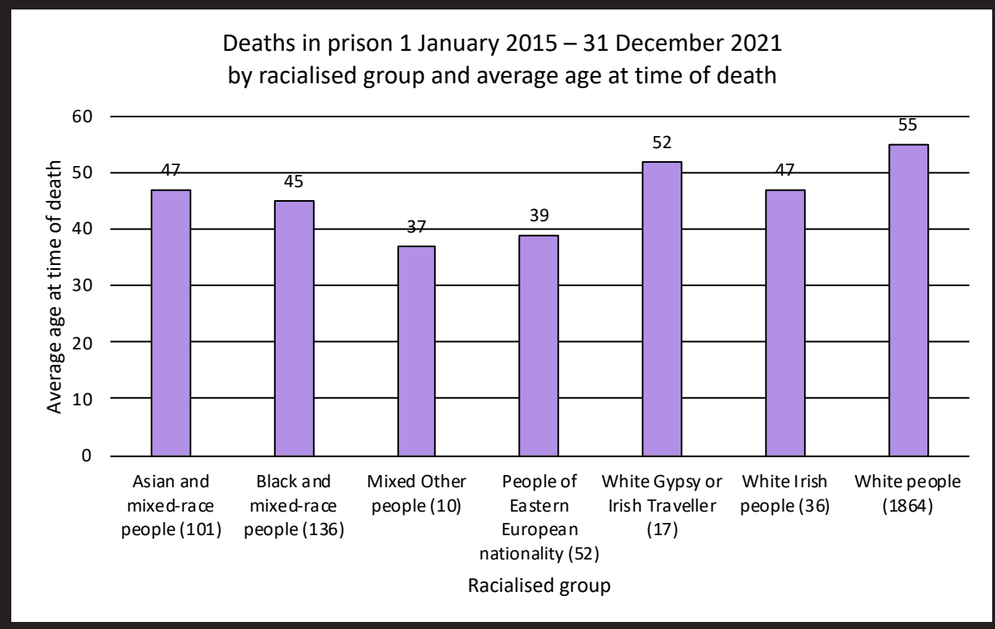
[h] This graph does not present the 2038 deaths of those of British nationality in order to highlight the deaths of those not of British nationality. The 2038 deaths of those of British nationality are broken down as follows: 533 self-inflicted; 1278 natural causes; 149 other non-natural; 57 awaiting further information; and 21 homicide. Furthermore, it does not present the deaths of two people who died natural causes deaths whose nationalities were listed as not stated/unknown.

Figure 7[i]



[i] This graph does not present the average age at the time of death of the one person of a Middle Eastern and mixed-race person (they were 40 years old when they died) nor the one death of a White Irish person of Eastern European nationality (they were 33 years old when they died), as we felt this was misleading.

Figure 8[j]



[j] This graph does not present the average age at the time of death of the one person of a Middle Eastern and mixed-race person (they were 40 years old when they died) nor the one death of a White Irish person of Eastern European nationality (they were 33 years old when they died), as we felt this was misleading.

What the data on racialised groups shows

- Among racialised groups, the highest number of deaths occurred amongst Black and mixed-race people and Asian and mixed-race people respectively.
- The deaths of Black and mixed-race women made up almost half of all the deaths of racialised women in prison.
- Self-inflicted deaths as a percentage of total deaths were highest amongst people of Eastern European nationality, Mixed Other people, and White Gypsy or Irish Traveller people respectively. Self-inflicted deaths as a percentage of all deaths were lowest amongst Black and mixed-race people and White people.
- The highest percentage of natural causes deaths occurred amongst White people.
- The percentage of other non-natural deaths was highest amongst White Irish people, followed by Black and mixed-race people.
- The percentage of homicides was highest amongst people of Eastern European nationality, and second highest amongst Black and mixed-race people and White Irish people.
- The highest number of deaths amongst people of non-British nationality occurred amongst those of Irish, Polish, Jamaican and Lithuanian nationality respectively.
- 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.

The human stories behind the statistics

Official statistics can provide useful quantitative information on the trends and patterns of deaths in prison, but they can obscure the human stories behind them. INQUEST has provided long-standing support to bereaved families to help ensure they can meaningfully participate in post-death investigations. Our support, alongside the hard work and campaigning of many families, has greatly influenced the level of scrutiny on the individual deaths and shone a spotlight on the systemic issues that occur behind the closed walls of prisons. Family participation, through their legal representation at inquests, has been crucial in uncovering the systemic failures of prisons and healthcare providers, which are repeated with depressing regularity.

We feature the stories of 22 racialised individuals who died in prison below, which evidence the human cost of failures in our prison, health and criminal justice systems. We present the deaths by racialised group and chronologically with regards to the date of death. We have anonymised five deaths in which the families did not respond to our request for consent to include their name. For all five of these deaths, the information included is already in the public domain.

Asian and mixed-race people

Jonathan Palmer[55]
Prison: HMP Wandsworth
Date of death: 19 November 2015
Month inquest concluded: May 2017
Inquest conclusion: Narrative

Jonathan Palmer was a 30 year old Asian man. On 3 June 2015, he was remanded to HMP Wandsworth. In prison, Jonathan had chronic back pain, and was prescribed medication for anxiety and depression as well as heroin replacement medication. He also began a diazepam detoxification programme.

The prison failed to obtain Jonathan's community GP records, which would have included his history of suicidal thoughts and the diagnosis

of a major depressive illness. Consequently, the prison knew little of his previous medical history.

Jonathan's family and prison staff became concerned about his behaviour and paranoid thoughts. Accordingly, mental health professionals assessed Jonathan seven times. These assessments, including two by a psychiatrist, concluded that Jonathan did not have a psychotic illness. Instead, they considered that Jonathan's psychotic symptoms might have been the effect of the new psychoactive substance known as 'spice'. However, the post-mortem tests indicated that Jonathan had not used spice or other illicit drugs in the three months prior to his death.

On 12 August 2015, the night manager began suicide and self-harm monitoring procedures (known as ACCT) because he was concerned about Jonathan's low mood. The next day, a case review concluded that he was not at risk, and ACCT procedures were terminated.

Jonathan continued to behave erratically, including lighting fires in his cell, but mental health staff still considered he did not have a psychotic illness. Jonathan's two brothers, who shared a cell with him for part of the time, were convinced that he was developing a psychotic illness in addition to his pre-existing psychiatric conditions. Jonathan's wife spoke to the prison's safer custody department several times about her concerns about his mental health, including four days before his death, but no one logged these calls or took any action.

On 19 November, an officer found Jonathan hanging and he later died at 2.58pm.

The inquest jury returned a narrative conclusion and found that on the balance of probability, a significant contribution to the decision to take his own life was the pressure of his impending trial, whilst his depression and chronic back pain possibly contributed to the decision.

Ketheeswaren Kunarathnam (known as Kumar)[56]
Prison: HMP Wormwood Scrubs
Date of death: 23 February 2018
Month inquest concluded: December 2021
Inquest conclusion: Suicide and narrative

Kumar was a 45 year old Sri Lankan national and immigration detainee who was detained in prison under immigration powers following the completion of his 28-day prison sentence.

Whilst detained, Kumar made a bail application stating that he feared being tortured and killed if he were to be deported to Sri Lanka. Despite a Home Office representative recognising that this could serve as the basis for an asylum application, immigration officers did not follow this up. Kumar's request for an alternative to prison (Kumar was eligible to be transferred to an immigration removal centre) was also not followed up.

On 6 November 2017, Kumar seriously self-harmed to the extent that the incident was described as "near death". After the incident, he required urgent hospital treatment. On 16 November 2017, a senior prison officer wrote to the Home Office stating that "Mr Kunarathnam has clearly stated he will kill himself if deported back to Sri Lanka [...] he is also likely to attempt another serious act of self-harm if he is to remain in jail."

Nevertheless, the Home Office maintained his detention and failed to attend any reviews considering Kumar's risk of self-harm after December 2017. Around 15 January 2018, Kumar started to refuse food, but he was not referred to mental health support until February. His physical condition deteriorated, and health care did not carry out the required checks while he was on hunger strike and lost 10% of his body weight. On 21 February 2018, the mental health team deemed Kumar to be at high risk of suicide.

Two days later on 23 February, five months after the completion of his sentence but still imprisoned, Kumar was found hanging and died. The inquest concluded Kumar died by suicide and that his mental health was not appropriately reviewed. The inquest found there were "shortcomings from all organisations" involved in Kumar's care. After the inquest, Kumar's partner, Sarah Jayanetti, said:

> I am still very sad about Kumar not being with me. It has been upsetting to hear about all the things that went wrong.

Tariq Dalton[57]
Prison: HMP High Down
Date of death: 19 November 2018
Month inquest concluded: April 2021
Inquest conclusion: Narrative

Tariq was as 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 access 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 returned a narrative conclusion and 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.

Tariq's sister, Sonya Dalton, said:

> 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.

Mohammed Irfaan Afzal
Prison: HMP Leeds
Date of death: 4 August 2019
Month inquest concluded: June 2022
Inquest conclusion: Narrative

Mohammed was a 22 year old man of Pakistani background. He was remanded to HMP Leeds in June 2019.

Mohammed arrived at prison at a healthy weight. However, over the course of the next 48 days, he lost three stone (19 kilograms) – almost one third of his body weight. On the day before he died, prison staff found a large quantity of uneaten food in Mohammed's cell.

Prison staff raised concerns about Mohammed during his time at the prison, describing him as bewildered and child-like. While prison staff

considered that he may have had a learning disability or mental ill health, Mohammed was never seen by the learning disability nurse nor received a full mental health assessment.

Two days before he died, Mohammed was found slumped on a chair. A nurse assessed that he did not need to go to hospital, but the inquest heard that staff did not examine his chest nor his ability to walk unaided. The PPO found Mohammed was not assessed as fully as he should have been. The next day Mohammed was found unresponsive in his cell. He died later that day.

Prison staff failed to contact Mohammed's family at any stage, even though his family called the prison numerous times. Mohammed's family even wrote to the prison governor with their up-to-date telephone details.

The inquest jury delivered a narrative conclusion and found that there were failures relating to the lack of recording interactions with Mohammed and following up on healthcare referrals.

Mohammed's sister, Yaasmeen Afzal, said:

> Our whole family is disgusted and outraged at the way he was treated. The amount of systemic failings is appalling. He was essentially left to starve and die alone.

Black and mixed-race people

Anonymous A
Year of death: 2015
Year inquest concluded: 2016
Inquest conclusion: Neglect

A was a 29 year old Black man. He had a history of stomach complaints which he made clear at a previous prison, though staff at his current establishment denied that he had ever explicitly told them about any stomach pains. The PPO report states that on one occasion, A "aggressively resisted officers, who had to restrain him". It also says that on another occasion, one prison officer noted that A was very aggressive with extremely high levels of strength, whilst another described his strength as "phenomenal".

One day in 2015, a psychiatrist referred A to a secure psychiatric hospital for treatment. The day after he was referred, A was found with blood in his cell. At the inquest, a member of healthcare admitted that at that point, A should have been taken to a general hospital. Instead, he was found dead in his cell the following morning, having died from a burst duodenal ulcer.

The inquest jury returned a highly critical narrative conclusion and found that A's duodenal ulcer should have been diagnosed and treated. They concluded that systemic failings amounting to neglect by prison staff and NHS Trust healthcare staff significantly contributed to his death.

Anonymous B
Year of death: 2015
Year inquest concluded: 2017
Inquest conclusion: Narrative

B was a 42 year old mixed-race man of White and Black African background. B died in 2015 after a sustained violent assault by his cellmate. The inquest delivered a narrative conclusion and found that a catalogue of failures contributed to his death, including the failure to thoroughly investigate evidence that his cellmate had been in possession of a large blade and the failure to review the cellmate's cell-sharing risk.

Sarah Reed[58]
Prison: HMP Holloway
Date of death: 11 January 2016
Month inquest concluded: July 2017
Inquest conclusion: Narrative

Sarah was a 32 year old mixed-race Black woman. Throughout her life, Sarah struggled with mental ill health: she had never recovered from the death of her baby daughter in 2003 and her mental ill health worsened after a police officer assaulted her in a brutal attack in 2012.

Sarah was remanded to prison for an alleged offence which took place whilst she was a sectioned inpatient at a mental health unit. She was in prison for the sole purpose of obtaining two psychiatric reports to establish whether she was fit to plead, the finalisation of which had been delayed. In prison, Sarah's mental health deteriorated. After being taken off anti-psychotic medication due to concerns about her heart, Sarah did not sleep, hallucinated and chanted. The inquest heard that alternative cardiac-safe anti-psychotic medication was available at the time.

Prison staff treated Sarah's extremely distressed behaviour and the deterioration in her mental health as a discipline issue: the prison put her on a basic regime and denied her visits from family and lawyers in contravention of her rights. She was deemed such a risk to staff that she was on a 'four man unlock', where four prison officers must be present before opening her cell door.

On 11 January 2016, Sarah was found dead, lying in bed with a ligature around her neck. The inquest delivered a narrative conclusion and found that unacceptable delays in psychiatric assessment, inadequate treatment for her high levels of distress and the failure of prison psychiatrists to manage Sarah's medication contributed to her death. Marilyn, Sarah's mother said:[59]

> I personally don't believe that prison is the place for anyone with mental health issues. I would like, if anything comes from what happened to my daughter, that it would save the life of another [person], who shouldn't be in a prison.

Natasha Chin[60]
Prison: HMP Bronzefield
Date of death: 19 July 2016
Month inquest concluded: November 2018
Inquest conclusion: Neglect

Natasha was a 39 year old Black woman. Natasha had a history of alcohol and drug dependencies, depression and poor physical health. On 18 July 2016, she was recalled to prison and taken to HMP Bronzefield. Upon arrival, Natasha told prison staff that she felt unwell. Consequently, she was placed on the prison's specialist drug and alcohol wing and prescribed medication.

The next morning, Natasha's condition deteriorated and she started to vomit profusely. She did not collect her essential prescribed medication and healthcare staff did not follow up to ensure that Natasha had received it. Furthermore, the healthcare staff did not respond to a prison officer's requests to attend her cell and monitor her vomiting.

By the evening, Natasha had been vomiting for at least nine hours. At 6.30pm, she was taken to collect her evening medication, after which she was locked in her cell for the night. At 7.08pm, Natasha rang her cell bell, but the cell bell system was faulty, so no prison staff responded.

At 9.42 pm, a healthcare assistant looked into Natasha's cell and thought she was asleep. At 10.42pm, Natasha was found unresponsive in her cell. Less than 36 hours after entering the prison, Natasha died at 11.21pm.

The inquest jury delivered a critical narrative conclusion and found

that Natasha's death was caused "by a systemic failure through poor governance which led to a lack of basic care" and that the death was "contributed to by neglect". Following the inquest, Natasha's sister, Marsha Chin, said:

> As a family we have been shocked to learn of the inadequacies of the care provided to her and the fact that prison staff and management could have prevented her untimely death.

Annabella Landsberg[61]
Prison: HMP Peterborough
Date of death: 6 September 2017
Month inquest concluded: April 2019
Inquest conclusion: Narrative

Annabella was a 45 year old mixed-race White and Black African woman born in Zimbabwe and living in the UK. Annabella had HIV, type 2 diabetes and a brain injury as a result of tuberculosis.

After a few months in other women's prisons, in May 2017 Annabella was transferred to HMP Peterborough. Prison staff described Annabella's behaviour as challenging and consequently she was often placed in the segregation unit. The PPO investigation[62] 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 to herself, others or the good order of the establishment".

On the evening of 2 September 2017, prison officers restrained Annabella (the incident was not filmed as the officer removed her body-worn camera) and from this point on she was observed to be unresponsive, lying on the floor of the segregation unit for the next 21 hours. The PPO investigation[63] into Annabella's death says that HMI Prisons had noted that the use of force at HMP Bronzefield was not always justified.

During this period, discipline and healthcare staff considered that she was faking illness. The expert evidence at the inquest confirmed the severity of Annabella's illness and expressed the view that by midnight she had become irreversibly ill with a low chance of survival. Therefore, the delay in the provision of medical assistance inevitably impacted on her chance of survival.

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 still 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 at 4.56pm, Annabella was pronounced dead.

The inquest jury delivered a narrative conclusion and found "failings on the part of the prison, healthcare staff, GPs and custody officers [that] contributed to the death". Following the inquest, Annabella's sister, Sandra Landsberg, said:

> 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'.

Jamal Hussein[64]
Prison: HMP Manchester
Date of death: 13 September 2016
Month inquest concluded: October 2019
Inquest conclusion: Misadventure

Jamal was a 32 year old Black Muslim man with a history of mental ill health. He had previously been detained under the Mental Health Act. The inquest heard evidence that a series of threats had been directed at Jamal and that he had suffered bruising on his face after being assaulted. He told family members he feared for his life.

Subsequently, Jamal's family conveyed their concerns to his solicitor, the prison and his social worker. The inquest heard that a total of three intelligence reports were submitted in relation to Jamal potentially being at risk or being bullied, but only one report was analysed prior to his death.

Jamal was found with a ligature in his cell and died in hospital 11 days later on 13 September 2016. The inquest jury determined that Jamal died as a result of misadventure. Jamal's family said:

> As a family we still miss him dearly and we still grieve for his loss.

Anthony Solomon[65]
Prison: HMP Nottingham
Date of death: 27 September 2017
Month inquest concluded: September 2019
Inquest conclusion: Narrative

Anthony was a 38 year old Black man. On 27 September 2017, Anthony took 'mamba', a synthetic cannaboid drug which was widespread in the prison in September 2017. He is said to have looked unwell instantly. Anthony's cellmate told the inquest that Anthony dropped to his knees and appeared to be vomiting and incontinent. His cellmate immediately rang the emergency cell bell, but despite a requirement that cell bells be answered within five minutes, staff took 40 minutes to attend. Anthony died that day. The inquest jury delivered a narrative conclusion and found that the delay in answering the emergency cell bell "denied Anthony the opportunity to receive the timely medical attention he deserved". They also highlighted the prevalence of drugs in Nottingham prison at the time of his death. Anthony's partner, Leanne Blakely, said:

> I am aghast at what we have heard about the level of drugs in Nottingham at the time, and the response times on cell bell emergencies. Staff knew what was going on with Anthony.

Tyrone Givans[66]
Prison: HMP Pentonville
Date of death: 26 February 2018
Month inquest concluded: January 2019
Inquest conclusion: Narrative

Tyrone was a 32 year old profoundly deaf Black man with a history of alcohol misuse, depression, self-harm and anxiety. On 6 February 2018, Tyrone was remanded into police custody without his hearing aids. The Person Escort Record noted Tyrone had said that he would self-harm if taken to prison – but it did not record that he had also expressed suicidal thoughts.

On 7 February, Tyrone was transferred to HMP Pentonville where an officer and a nurse noted he was deaf and was without his hearing aids. However, they made no effort to obtain these nor to accommodate Tyrone's disability.

On 19 February, Tyrone told his aunt that he did not like being located on his current detoxification wing and that he felt vulnerable without his hearing aids. Tyrone's aunt asked the prison officers to look after him. Two days later, Tyrone told his mother that he wanted to move wings as his mattress had been slashed and he did not feel safe. His mother reported this to a member of staff. In response, a wing supervising officer said Tyrone had not said he felt unsafe or that he wanted to move wings, only cells.

At around 6.00pm on 26 February, an officer found Tyrone hanged in his cell and he died later that day. Tyrone had neither moved cells or wings before he died.

The inquest jury delivered a narrative conclusion, stating that collectively that a number of factors including the insufficient management of his alcoholism, substance abuse and profound deafness by the prison and healthcare services "resulted in Tyrone Givans' needs not being met and contributed to his death". After the inquest, his mother, Angela Augustin, said:[67]

> To know that none of these needs were met because of the failings of the prison system – my son could have been alive today.

Eshea Nile Dillon (known as Nile)[68]
Prison: HMP Stocken
Date of death: 24 March 2018
Month inquest concluded: October 2021
Inquest conclusion: Open

Nile was a 22 year old Black man with severe asthma and a lung capacity of 55%. Accordingly, Nile was prescribed medication to be administered regularly through a nebuliser or inhaler. There is evidence that Nile and his brother, who was in the cell below Nile's and who also had asthma, sometimes shared inhalers.

On 24 March 2018, Nile had severe asthma symptoms and called for help as he was locked in his cell and struggling to breathe. Prison officers did not enter for eight minutes, by which stage Nile had lost consciousness. There was a delay in alerting others to the medical emergency and calling an ambulance. Nile was pronounced dead later that day.

The inquest jury delivered an open conclusion and found that prison staff missed the opportunity to call 'code blue' – a radio alert that immediately calls an ambulance – as soon as it was observed that Nile was struggling to breathe. The coroner also highlighted other failures, such as a prison officer's lack of knowledge about their ability to enter a cell without fellow officers if they thought there was an immediate risk to life.

Winston Augustine[69]
Prison: HMP Wormwood Scrubs
Date of death: 30 August 2018
Month inquest concluded: May 2021
Inquest conclusion: Narrative

Winston was a 43 year old mixed-race man of White British and Black Caribbean background on remand. Winston had multiple vulnerabilities: he had pre-diabetes as well as a history of depression, drug use and cancer. Although Winston was not being monitored under suicide and self-harm procedures known as Assessment, Care in Custody and Teamwork (ACCT), the PPO report into his death states that his presenting risk factors for suicide and self-harm should have been considered further.

On 28 August 2018, after being restrained for an alleged offence, Winston was transferred to the segregation unit without prior assessment. During Winston's 48 hours in the segregation unit before he died, his cell door was not unlocked so he did not receive any food nor exercise, was not able to shower or make a phone call, and only received one low dose of prescribed pain-relief medication.

The prison had prescribed Winston with daily pain-relief medication for chronic pain caused by kidney stones. On 29 August, a prison doctor conducting a GP and medication round was told by prison officers that Winston was too aggressive to be seen. Later that day, a nurse dispensed a single low dose of pain-relief medication by pushing it under his cell door, which she described as "inhumane" at the inquest. On 30 August, prison officers told a nurse conducting a medication round that Winston was non-compliant and therefore could not be seen.

The inquest heard evidence that on the day of his death, Winston was not checked for almost four hours between 11:12am and 15:08pm. Two prison officers conducting welfare checks at 3.08pm and 3.53pm observed no movement from Winston's cell but did not take any action.

On 30 August 2018 at 4.47pm, Winston was found hanging in his cell and pronounced dead. At the time of his death, Winston was in a state of ketoacidosis suggestive of starvation. Furthermore, pathologists said that Winston had probably died at least four hours before he was found.

The coroner stated that it was a matter of "greatest concern" and a

"violation of Winston's dignity" that in an English prison he did not receive food for as long as he did. The inquest jury delivered a narrative conclusion and found that the failure to provide food and medication were contributing factors in Winston's death. On behalf of Winston's family, his cousin, Diane Martin, said:

> We have concerns about how a prison is run. Policies should have been in place and carried out correctly.

Caden Stewart[70]
Prison: HMP & YOI Cookham Wood
Date of death: 27 June 2019
Month inquest concluded: August 2021
Inquest conclusion: Natural causes

Caden was a 16 year old mixed-race boy of White and Black Caribbean background. On 26 June 2019, Caden complained of a headache and chest pains, and appeared to be in pain and discomfort after playing football and attending the gym. The inquest saw CCTV footage which showed a physical education instructor (PEI) reading a magazine and not attending to Caden, despite Caden clearly being in line of sight and in pain. The PEIs did not contact healthcare to say that Caden had become unwell in the gym.

Caden was taken back to his cell where he later rang his emergency cell bell and asked to see healthcare staff as he felt unwell. The prison officer who attended his cell stated that he passed this message to healthcare staff, but the nurses deny receiving it and they did not attend.

Caden was found unresponsive in his cell over four hours after asking for medical help. He was taken to hospital where he received a CT scan which showed that he had suffered a brain haemorrhage. He was then transferred by ambulance to King's College Hospital and taken for urgent surgery. He was formally pronounced dead in hospital on 27 June 2019.

The inquest heard evidence from a consultant doctor who thought that if Caden had received appropriate hospital treatment at the hospital sooner, it was more likely than not that he would have survived. The inquest jury found that Caden died of natural causes, but outlined the prison's multiple failings. His family said:

> Caden was asking for help from the people who were meant to be looking after him. It breaks our hearts that we were not there to help him that day, and that the people who were trusted to look after him failed him and failed us.

Thokozani Shiri (known as Thoko)
Prison: HMP & YOI Chelmsford
Date of death: 14 April 2019
Month inquest concluded: June 2022
Inquest conclusion: Neglect

Thoko was a 21 year old Black man from Essex who had a long-standing HIV diagnosis. He was imprisoned at HMP & YOI Chelmsford at the time of his death.

Staff were aware that Thoko had HIV. However, healthcare staff at the prison failed to provide him with life-saving antiretroviral medication during two separate periods of imprisonment at Chelmsford. The inquest into his death heard how healthcare staff at the prison also failed to arrange appointments for Thoko at the local specialist HIV clinic, which represented a missed opportunity to monitor and treat his HIV. The PPO described the healthcare Thoko received as "unacceptably poor".

There were also critical delays in providing Thoko with emergency care. A week before he died, he told a prison officer "I can't breathe…I need to go to hospital". However, an ambulance was not called until five days later because a 'code blue' was not triggered. The inquest heard from a

senior prison governor who appeared not to understand the 'code blue' policy correctly.

Furthermore, there were significant delays in allowing Thoko's mother, Beauty, to see him before his condition deteriorated. Thoko was already in an induced coma, as he remained until his death, when his mother was finally able to see him. Whilst in an induced coma, the prison restrained him inhumanely with handcuffs. He died on 14 April 2019.

The inquest jury found that systemic failures in the healthcare Thoko was provided which amounted to neglect. Following the inquest, his family said:

> Thoko was denied very basic care that would have enabled him to live his life despite his long-term condition [...] We are saddened as we know that people with his condition do not have a reduced life expectancy and that, with basic management, his condition was not fatal.

Middle Eastern and mixed-race people

Anonymous C
Year of death: 2015
Year inquest concluded: 2017
Inquest conclusion: Unlawful killing

C was a 66 year old Egyptian man on remand. C had a cellmate who was deemed suitable for cell sharing, despite being imprisoned for committing a violent and unprovoked assault on an unarmed man.

Over the following months, the cellmate was repeatedly referred to the mental health in-reach team over concerns about his behaviour and was disciplined as a result of fighting with a cellmate and smashing his cell. At one point, psychiatrists recommended that the cellmate be sent to hospital to assess his mental health, but this did not occur.

A few months later, the cellmate attacked C with their shared television set and C died from severe head injuries. The jury at the inquest concluded that he was unlawfully killed. They found that a report by a consultant psychiatrist on the cellmate, which contained useful information about his mental state, should have been read by the mental health in-reach team prior to their assessment of him, but that this did not contribute to C's death.

Thomas James Nicol (known as Tommy)[71]
Prison: HMP The Mount
Date of death: 25 September 2015
Month inquest concluded: November 2018
Inquest conclusion: Suicide

Tommy was a 37 year old mixed-race man of White and Middle Eastern background. In November 2009, Tommy received an IPP sentence with a minimum term of four years; but at the time of his death, he had served six years with no immediate hope of being released.

In June 2015, the Parole Board's review of Tommy's sentence recommended that he complete a course of therapy before release. Tommy expressed frustration about not being able to do the required therapy course ahead of the review, with his next Parole Board review not due until February 2017. In another setback, he was moved to HMP The Mount, where the recommended course was not available.

After the review, Tommy's mental health deteriorated until the time of his death and he seriously self-harmed and set fire to his cell. The prison subsequently began ACCT procedures. A nurse who inadequately assessed Tommy agreed it would be safe to hold him in segregation, where he began displaying symptoms of psychosis.

Tommy received no mental health support in the four days he spent in segregation, despite spending over 24 hours in an unfurnished cell. Two

days later, the mental health in-reach team leader went to see Tommy twice in the segregation unit, but segregation staff said that his risk was too high for her to observe or speak to him through the cell door.

On 21 September, Tommy was found hanging in his segregation cell and he died four days later in hospital.

The inquest jury concluded that Tommy died by suicide. His family were disappointed that no critical findings were made regarding Tommy's care and the evidence given about the impact of the IPP sentence, despite the wealth of evidence to the contrary. His sister, Donna Mooney, said:

> Tommy became more and more desperate, but nobody would listen to him. The prison authorities didn't even carry out a mental health assessment despite his very high risk of self-harm and suicide.

Osman Ali Hassan (known as Ossie)[72]
Prison: HMP Wandsworth
Date of death: 10 October 2018
Month inquest concluded: March 2020
Inquest conclusion: Narrative

Ossie was a 45 year old Turkish man. On 25 September 2017, Ossie was remanded to HMP Wandsworth and was later sentenced to prison.

Ossie had been diagnosed with high blood pressure before entering prison. Throughout his time at HMP Wandsworth, the healthcare team recorded several blood pressure readings, the majority of which showed Ossie's blood pressure to be consistently high. Ossie reported chest pain on 11 October 2017 and abdominal and back pain on 11 March 2018. He was seen by emergency response nurses on both occasions. In July 2018, he complained of dizzy spells and blurred vision.

During a blood pressure check the day before he died, Ossie told a nurse he often had dizzy spells, headaches and tension in his neck. As a result, the nurse added him to the list for an appointment with an advanced nurse practitioner and for blood pressure monitoring. At 11.20pm the same day, he collapsed whilst talking to other prisoners on the prison landing. On 10 October at 12.43am, Ossie died.

The inquest delivered a narrative conclusion and found that "there was a failure to adequately manage his hypertension in prison, which made more than a minimal contribution to his death". His sister, Abide Kumyalili, said:

> I feel that Ossie was let down by the care he received at HMP Wandsworth. His hypertension was allowed to get out of control, but no one seemed to do anything about it.

People of Eastern European nationality

Anonymous D
Year of death: 2015
Year inquest concluded: 2017
Inquest conclusion: Accident

D was a 19 year old Slovakian-born teenager on remand. One day in 2015, he twice tied ligatures around his neck and the duty manager began ACCT procedures. However, a supervising officer acting alone without a mental healthcare representative cancelled the ACCT monitoring the following day. A week later, D was sentenced.

Exactly two weeks after that, D was served with a Home Office notice stating that he was liable to be deported to Slovakia after his sentence. That night, officers saw D in an unnaturally high position in his cell, but there was a delay of some minutes before they opened his cell. D was found hanged and he died in hospital on 25 December 2015. The

inquest jury concluded that D died by accident.

Anonymous E
Year of death: 2016
Year inquest concluded: 2018
Inquest conclusion: Accident

E was an 18 year old teenager and Lithuanian national. E was imprisoned on 8 August 2016 pending extradition to Lithuania under a European Arrest Warrant for minor theft.

He found it difficult to communicate in English. After recurrently being interviewed without a professional interpreter – except on one occasion – he was repeatedly assessed as not suffering from significant mental health problems. E had been found with a ligature around his neck on five previous occasions. This included one occasion when a nurse, who found him with a noose around his neck and saying that he wanted to die, declared him fit to be segregated for a disciplinary hearing.

One day, E rang his cell bell at 1.00pm. Staff did not respond until 37 minutes later and found him hanging in his cell. He died in hospital a few days later. The inquest jury concluded that E died by accident and found that prison staff did not carry out timely checks and that there was a delay in responding to the emergency cell bell which contributed to his death.

Michal Netyks[73]
Prison: HMP Altcourse
Date of death: 7 December 2017
Month inquest concluded: December 2018
Inquest conclusion: Suicide

Michal 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 headfirst from a first-floor landing, and consequently died due to a head injury that day. The inquest jury concluded that Michal's death was the result of suicide, which was in part contributed to by the immigration deportation process. His parents, Rósa and Ryszard Netyks, said:

> 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.

Analysis

We analysed the 22 deaths featured above and identified seven critical issues in the deaths of racialised people in prison. They include the inappropriate use of segregation, racial stereotyping, the hostile environment, the neglect of physical health, the neglect of mental health, the failure to respond to warning signs, and bullying and victimisation.

Action to address the persistent failures of prison and healthcare services to rectify dangerous practice is long overdue. The same failures are repeated with depressing regularity. There is no effective oversight of the action taken in response to critical inquest conclusions and recommendations.

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.

The segregation of prisoners with mental health issues highlighted the inadequacy or absence of assessment of a person's suitability for segregation prior to and during segregation. For example, E was on ACCT and Winston Augustine had risk factors for self-harm and suicide. While prison policy states they should have only been segregated in exceptional circumstances, both were segregated following an inappropriate assessment and no assessment respectively. It is telling that the PPO's independent investigation[74] into the death of Annabella Landsberg states that the decision to segregate her may not have been "proportionate to the risk she posed to herself, others or the good order of the establishment". A and Tommy Nicol both exhibited mental ill health in segregation. A was not re-assessed at all for his suitability in segregation and Tommy Nicol was not re-assessed as promptly as he should have been. Meanwhile, despite Tommy Nicol displaying symptoms of psychosis in segregation, his mental health was not assessed and he did not receive any mental health support.

Furthermore, some prisoners were subject to inhumane and negligent treatment during their time in segregation. To illustrate this, during the 48 hours Winston Augustine was segregated, his human rights were violated as he was deprived of food, medication, exercise, phone calls and showers. While Annabella Landsberg was segregated, she was restrained after which she was observed to be unresponsive on the floor of her cell for 21 hours, unaided.

Racial stereotyping

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

Winston Augustine, Sarah Reed, A and Tommy Nicol were repeatedly described as "aggressive", in addition to high-risk or "non-compliant" in certain cases. In the case of A, the prison went as far to make comments that clearly demonstrate racial stereotyping, noting his "phenomenal" and "extremely high levels" of strength.

The racial stereotyping of prisoners as aggressive denied their vulnerability and was used to justify inhumane and disciplinary treatment. For example, it appears that racial stereotyping twice prevented the prison from delivering Winston Augustine with prescribed pain-relief medication. It also seems that racial stereotyping denied Tommy Nicol being mentally assessed or receiving mental health support when he was exhibiting symptoms of psychosis in segregation. Following one of many instances in which prison staff described A as aggressive, prison staff restrained him. When Sarah Reed, who was repeatedly described as aggressive, displayed symptoms of psychosis after being taken off anti-psychotic medication, prison staff treated her distress and mental ill health as a matter of discipline. They consequently prohibited visits from her family and solicitor.

A clear-cut and troubling example of the prison estate's culture of disbelief, characterised by a refusal to accept signs of vulnerability or distress as sincere, relates to Annabella Landsberg, who healthcare staff considered to be 'faking it' whilst she lay unresponsive on the floor of her segregation cell for a total of 21 hours after being restrained. As Deborah Coles has previously stated, "the distress of black women is too often disbelieved and viewed as a discipline and control problem, rather than requiring care and support".[75]

Hostile environment

The Home Office's inherently discriminatory hostile environment policy encourages the continued detention and deportation of foreign nationals. UK deportation law clearly states that "the deportation of foreign criminals is in the public interest", irrespective of the offence or their connection to the UK.[76] Since 2007, foreign nationals who receive a 12-month custodial sentence are automatically deported.[77] Foreign nationals who have served their sentence, but who remain in prison under immigration powers awaiting deportation, are known as immigration detainees. Being detained in prison is generally a worse experience than being detained in a detention centre because in prison, immigration detainees have less access to information, translated materials, the internet, legal advice and support.[78]

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. Indeed, all four of the deaths of immigration detainees and foreign nationals were self-inflicted deaths, with three of those prisoners of Eastern European nationality.

D and Michal Netyks took their lives hours after being notified that on completion of their sentence they were to become immigration detainees liable for deportation. Michal Netyks was notified of his new immigration detainee status at the worst possible time – on the day of his release – and was not assessed for his risk of self-harm or suicide prior to being told. This is despite prison guidance clearly stating that the serving of immigration detention or deportation papers can raise the risk of self-harm and suicide.

E's pending extradition to Lithuania and immigration detainee Kumar Kunarathnam's possible continued detention/deportation resulted in the steep decline in their mental health, with the latter self-harming and going on hunger strike. They both took their own lives.

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. This is exacerbated by the inadequacy of healthcare in prison[79] more generally, and failures in communication between hospitals, community GPs, prison healthcare staff and prison staff. The prison system's neglect of physical health was most marked amongst Asian and mixed-race and Black and mixed-race prisoners.

The cases underscore the prison system's neglect of prisoners' pre-existing physical health conditions as an area of concern. For example, prison staff knew Thoko Shiri had HIV but failed to give him life-saving medication, arrange vital appointments with a local clinic and facilitate emergency care in a timely manner. In the case of Tyrone Givans, prison staff noted he was deaf and without hearing aids on arrival but made no effort to obtain these. HMP Wandsworth failed to adequately manage Ossie Ali Hassan's high blood pressure, despite it being an issue that was consistently raised, and Winston Augustine was not provided with the correct dosage of prescribed pain-relief medication.

Prison staff's disregard of prisoners' rapidly deteriorating physical health is illustrated by several cases. For example, Mohammed Irfaan Afzal was able to lose almost one third of his body weight over 48 days

in HMP Leeds. When Tariq Dalton complained of internal bleeding and when A was found with blood, both went unseen by healthcare staff and died shortly afterwards. Some cases show instances whereby alerts made by prisoners and staff were responded to with delays or not at all. For example, Caden Stewart, who rang his emergency cell bell to see healthcare staff, and Natasha Chin, who a prison officer requested that healthcare staff attend to, both also went unseen by healthcare staff and died soon after. When Nile Dillon called for help by pressing his emergency cell bell over breathing issues, prison staff only entered eight minutes later, and there was a delay in alerting other staff members and calling an ambulance. A lack of understanding of how to trigger emergency response via a 'code blue' alert to call out an ambulance was a feature of both Nile Dillon and Thoko Shiri's cases.

In instances where healthcare staff did attend, they were of little to no help. When Annabella Landsberg was lying unresponsive on the floor of the segregation cell for a total of 21 hours, healthcare staff repeatedly chose not to aid her and instead subjected her to dehumanising treatment. In the case of Kumar Kunarathnam, healthcare staff failed to carry out the required checks after he had lost 10% of his body weight on hunger strike. Similarly, the nurse's assessment of Mohammed Irfaan Afzal the day before he died was inadequate.

Another key issue related to the physical healthcare received in the above cases is poor communication with, and treatment of, bereaved families. In the case of Mohammed Irfaan Afzal, his family were not kept updated on his worsening condition despite trying to contact the prison. Further, there were critical delays in allowing Thoko Shiri's mother to see her son in hospital, where he was inhumanely restrained in handcuffs whilst in a coma.

Neglect of mental health

The neglect of prisoners' mental ill health was a defining feature of many of the prison deaths included in this report. 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 and Black and mixed-race and Asian and mixed-race people.

The inadequacy of mental health assessments emerged as a key issue, especially prior to and during placement in segregation. [See segregation section above for more information on this].

The inadequacy of mental health assessments also surfaced as an issue. To illustrate, Winston Augustine and D both had risk factors for self-harm and suicide, yet the former was not considered for placement on ACCT and the latter was taken off it. Furthermore, E's mental health was repeatedly assessed without an interpreter and numerous mental health assessments of Jonathan Palmer failed to identify symptoms of a mental health condition, which was compounded by the prison's failure to obtain community GP records and to act on his family's repeated concerns. In the case of Mohammed Irfaan Afzal, he was never seen for a full mental health assessment or by a learning disability nurse.

The poor management of prisoners' mental health transpired as an additional issue, with Sarah Reed being taken off anti-psychotic medication due to concerns about her heart, despite the availability of alternative cardiac-safe medication. Additionally, Kumar Kunarathnam was not referred to mental health support for at least two weeks after he started to refuse food.

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.

Emergency cell bells are installed in cells for prisoners to call for immediate help in an emergency and prison staff are supposed to answer within five minutes. In cases where the physical health of prisoners was gravely at risk, emergency cell bells were often answered to after significant delays: eight minutes in the case of Nile Dillon, 37 minutes in the case of E and 40 minutes in the case of Anthony Solomon. In other cases, emergency cell bells were not responded to at all, as with Natasha Chin and Caden Stewart. In the case of Anthony Solomon, the inquest jury concluded that the delay in answering "denied Anthony the opportunity to receive the timely medical attention he deserved", whilst the inquest jury in the case of E concluded that the delay contributed to his death. In all five of the cases, when individuals were eventually attended to, they died shortly afterwards.

Other cases demonstrate prison staff failing to act after observing signs that the prisoner's wellbeing might be in danger. This includes the case of Winston Augustine, in which prison staff repeatedly observed no movement from his cell but took no action. In the case of C, prison staff failed to act on warning signs about his cellmate, who was deemed suitable for cell sharing despite being imprisoned for committing a violent and unprovoked assault on an unarmed man. Furthermore, the cellmate was repeatedly referred to the mental health in-reach team over concerns about his behaviour, and despite psychiatrists recommending that he be sent to hospital to assess his mental health, this did not occur.

Bullying and victimisation

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

For example, Jamal Hussein was subjected to threats, pressured to hold contraband and physically assaulted; Tyrone Givans had his mattress slashed; and B was killed by his cellmate in a brutal physical attack. While bullying in prison is an obvious concern in and of itself, the cases are especially troubling because of the prison's repeated failures to act on Jamal Hussein's and his family's repeated allegations of bullying, as well as three of the prison's own reports which detailed him potentially being bullied. The prison also failed to act on the concerns of Tyrone Givans' family regarding his vulnerability in prison, whilst the inquest into the death of B highlighted the prison's failure to review his cellmate's cell-sharing risk and evidence that he had been in possession of a large blade.

Post-death investigations and scrutiny

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/ethnicity of the prisoner, or the potential role of racism or discrimination in the death, were addressed in post-death investigations. We conducted a review of the PPO investigations (termed fatal incident reports), records of inquests and any Prevention of Future Death (PFD) reports associated with the deaths of the 22 racialised people featured in this report.

With regards to the PPO, although four investigations cited the nationalities of prisoners of Eastern European backgrounds and one of Sri-Lankan background, the investigations did not address the race/ethnicity of any prisoner. One investigation report into the homicide of a mixed-race Black prisoner made a general reference to an HMI Prisons inspection that noted that "black and minority ethnic prisoners were among those more likely to say they felt unsafe". Similarly, another investigation report into the death of a Black man made a broad statement that the prison's substance misuse strategy "recognises the specific needs of particular groups, including those from ethnic minorities".

Our analysis concluded that none of the investigation reports directly addressed the potential role of racism or discrimination in the death. As PPO investigation reports typically occur before the inquest, the lack of exploration of racism or discrimination in the deaths of racialised people in these reports directly affects the scope and remit of the inquest and the evidence to be called by the coroner.

Moreover, our review concluded that none of the record of inquests examined, nor did the PFD reports address, the race/ethnicity of the prisoner or the potential role of racism or discrimination in the death. However, one record of inquest touching the death of a prisoner of Eastern European background cited their nationality. The PFD into the same death also cited their nationality and referenced specific issues affecting foreign national prisoners and the "unfairness" of Home Office actions towards the prisoner preceding their death. Another record of inquest and PFD into a death of a Sri Lankan national noted that the prisoner had been tortured in Sri Lanka and had been granted indefinite leave to remain as a refugee in the UK.

In conclusion, there was a near absence of consideration of whether racism or discrimination played a role in the deaths of racialised prisoners in PPO investigation reports, records of inquests and PFD reports. This does not mean that it was not a factor in their deaths, but that there was no examination of its potential impact. Given the evidence of racialised people's experiences and institutional racism in prison as documented throughout this report, as well as HMI Prisons' own survey data which has consistently shown worse outcomes for BME and racial minority prisoners in many areas, 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.

More broadly, we found the PPO's monitoring of race/ethnicity and racism to be inadequate. Apart from limited data on the ethnicity of prisoners who died COVID-19-related deaths[80] and those who died self-inflicted deaths in 2014,[81] we have been unable to find any data or analysis relating to race/ethnicity and deaths in prison. In addition, we considered the PPO's first Race Action Plan, published in October 2021,[82] to be underwhelming. It is almost entirely focused on workforce and internal issues, whilst its objectives to "address effectively racism and discrimination in our casework" and to "consider the Lammy Review […] in the context of its intersection and potential impact on the PPO's work", are vague and do not specify concrete steps to achieve said objectives.

In essence, the PPO's current and proposed strategy does not give us confidence that the deaths of prisoners will be analysed quantitatively or qualitatively by race/ethnicity, nor that the potential role of racism or discrimination will be investigated in individual death investigations. The consideration of the potential role of racism and discrimination in the deaths of racialised people in prison should be an integral and proactive part of the PPO's work.

Conclusion

Through the evidence gathered, this report highlights that the deaths of racialised people in prisons in England and Wales are among some of the most contentious, violent and neglectful. In so doing, this report reinforces INQUEST's long-held assertion that the deaths of racialised people in prison are distinct from the deaths of others in prison as they involve specific issues. Vital questions about whether the potential role of racism and discrimination informed the treatment of racialised people who died in prison should be carefully considered in post-death investigations to help prevent future contentious deaths of racialised people.

That racialised people continue to die in contentious circumstances in prison, as outlined through this report, reflects the persistence of institutional racism in the prison estate and the criminal justice system. It also exposes the failure of successive governments to acknowledge and address the issue, and to fulfil their duty of care to prisoners. Institutional racism in the prison estate, or any institution, does not occur in isolation. Rather, it is part and parcel of structural racism in broader society. Considering that racism is so deeply entrenched in wider British society outside prison – exemplified by worse outcomes for racialised groups in almost all areas of life[83] – how can we expect racism to not be embedded within the structures of the prison estate? In this way, the contentious deaths of racialised people must be understood as symptomatic of a society in which structural racism is deeply embedded. To truly confront institutional racism in the prison estate, we must engage in transformative social change.

Current and previous governments have relied on prison expansion and harsher sentencing rules to address criminal justice issues. But imprisonment has offered little by way of a solution to the complex issues around crime. It has failed and continues to fail to reform, rehabilitate or deter.[84] Evidence shows this policy has had little or no long-term effect on public safety or reconviction rates.[85] Prisons, by their very nature, are dehumanising institutions which create and intensify vulnerability. The high numbers of deaths, and the contentious, violent and neglectful nature of many of these deaths, reflect the inherent issues associated with the prison estate. The deaths of racialised people featured in this report clearly demonstrate this.

We can no longer continue to pretend that imprisonment, and the criminal justice more broadly, are a solution to crime. In fact, imprisonment and the criminal justice system exacerbate harm and violence. To break this vicious cycle, we must ensure that change happens. Thus, we must immediately halt prison building and decrease investment into prisons and the criminal justice system, institutions which disproportionately impact racialised people.

Instead, we must redirect resources from the criminal justice system to welfare, health, housing, education and social care. Holistic investment in society would address the root causes of crime and violence in our society, thus reducing it.

Recommendations

Treatment of racialised people in prison

- Racialised people in prison cannot continue to die in contentious, violent and neglectful circumstances as outlined in this report. The specific issues in the deaths of racialised people evidenced in this report must be addressed by the Ministry of Justice, the Department of Health and Social Care, and government. These issues include racial stereotyping, the inappropriate use of segregation, the hostile environment, the neglect of physical health and mental health, the failure to respond to warning signs, and bullying and victimisation. 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 deaths in prison

- It is extremely concerning that the only publicly available data on the ethnicity of those who die in prison relates solely to self-inflicted deaths, and that the ethnicity categories are very broad. 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). This should already be in the public domain. The publication of this data is crucial in order to understand and analyse the patterns and trends in the deaths of racialised people in prison. Therefore, we call on the Ministry of Justice to ensure that Safety in Custody publications publish data disaggregated by ethnicity on all types of death in prison.

- At present, the ethnicity categories used by the Ministry of Justice in their ethnicity analyses exclude certain racialised groups that we have included in this report, such as White Irish people, White Gypsy or Irish Traveller people, and people of Eastern European nationality. This is a serious omission. Throughout this report we have highlighted how each of these groups is a particularly vulnerable group in prison, with a high percentage of White Gypsy or Irish Traveller people and people of Eastern European nationality taking their own lives. Therefore, we believe that 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 (Asian, Black, Mixed, Other, White) in any ethnicity analysis.

- The Ministry of Justice's data on the ethnicity of prisoners is incomplete and insufficient. For example, the Ethnicity and the Criminal Justice System bulletin is only published every other year. To provide full transparency on the deaths of racialised people in prison, and to identify the patterns and trends, INQUEST believes the Ethnicity and Criminal Justice System statistics should be published annually.

Post-death investigations and scrutiny of deaths in prison

- It is unacceptable that INQUEST found no meaningful consideration of the race/ethnicity of the deceased nor of the potential role of racism or discrimination in any of the PPO investigations, coroner's inquests or prevention of future death reports we examined. Therefore, the PPO and the coroner's service should ensure that they meaningfully consider the race/ethnicity of those who die in prison as well as the potential role of racism or discrimination in their death. This should be an integral and proactive part of their work in order to identify, and learn from, systemic issues in the deaths of racialised people in prison and should inform monitoring and inspectorate bodies such as HMI Prisons, the Independent Monitoring Boards and the Care Quality Commission.

- HMI Prisons do not investigate their own survey data, which clearly shows that racial minority women report worse outcomes in many areas and that BME and racial minority

men prisoners consistently experience worse outcomes in almost every aspect of prison life. We recommend HMI Prisons conduct a new thematic inspection looking at the overall experiences in prison of the racialised groups included in this report. Further, HMI Prisons should include a standalone analysis of the survey data on prisoners of all ethnic minorities in each of their annual reports.

Establish a 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. It should provide a role for bereaved families and community groups to voice concerns and provide a mandate for its work.

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. To end the heightened criminalisation, intensified policing, disproportionate incarceration 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. This holistic approach would help address the root causes of crime and violence in our society, and thus would reduce it.

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Appendix

The naming and grouping of racialised groups

We acknowledge that by grouping distinct ethnicities into racialised groups, we conceal the ethnic diversity within groups. However, this report is concerned with racialised groups rather than ethnic groups, which explains the groupings we have chosen. Further, we have decided to group mixed-race Black people with Black people; mixed-race Asian people with Asian people; and mixed-race Middle Eastern people with Middle Eastern people, owing to the way in which mixed-race Black, Asian and Middle people are typically racialised as Black, Asian and Middle Eastern respectively, both within the criminal justice system and wider society.

It is important for us to explain the naming and grouping of certain racialised groups. With regards to Gypsy, Roma and Traveller people, currently only the White Gypsy or Irish Traveller ethnicity is recorded in prison, hence why we have named the group 'White Gypsy or Irish Traveller people'. Moreover, at present the only way to identify people of Eastern European background is through observing the nationalities of prisoners. For this reason, we have named the racialised group 'People of Eastern European nationality'. We recognise that the boundaries of Eastern Europe "are subject to overlap and fluctuation depending on the context in which they are used".[86] For the purposes of this report, we include the countries as stated by the United Nations Statistics Division in the category of 'People of Eastern European nationality', as well as those bordered by the Baltic and Barents Seas[87] in addition to Kosovo. We understand that the people of these countries may not identify as Eastern European.

We recognise that the term Middle Eastern is a contested term and the Middle East is a contested geopolitical region. We also acknowledge that there are differences of opinion concerning the countries that are included within this region. For the purposes of this report, we have included 18 countries in our definition of the Middle East as specified by the World Atlas.[88] We understand that people from these countries may not identify as Middle Eastern. Nevertheless, despite these complications, we felt that the term currently best reflects the different groups of people within it.

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