Independent Advisory Panel on Deaths in Custody

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on Deaths in Custody

Statistical analysis of recorded deaths in custody between 2017 and 2021

April 2024

Chair's Foreword

It is a principal duty of the government to take active steps to safeguard the lives of people detained under the state's care.

As this report demonstrates, people in state custody are at a significantly elevated risk of death, both natural and unnatural, compared with the general population. Tragically – as countless reports and inquiries have demonstrated over the years – these deaths are all too often preventable. Greater transparency is key to understanding who is dying in closed institutions and why. This is why high-quality data on deaths is so important. This report covers deaths between 2017 and 2021 and follows on from our previous statistical analysis covering the period between 2016 and 2019. These analyses are vital to our understanding of deaths in complex landscapes where multifactorial risks are at play. Accurate and disaggregated data forms the basis of effective, evidence-based interventions to help better understand and reduce the rates of all deaths in custody and prevent deaths where possible.

Our analysis shows that prisons continue to have the highest number of deaths, with an average of 322 deaths per year between 2017 and 2021. However, when rates are considered, the mortality rate of individuals detained under the Mental Health Act is three times higher than prisons and the highest across all places of custody. Further, while numbers of deaths in police custody remain low, its rate of death is in fact comparable to those two settings, if the approximate length of time spent in detention is taken into account.

Men continue to have considerably higher rates of death, particularly in prisons and police custody, with almost two thirds of all deaths across the custodial landscape from natural causes. The majority of unnatural deaths across all settings – which includes suicides, accidents and homicides – occurs in those under the age of 40.

In line with findings from our previous report, the mortality rate of individuals detained under the Mental Health Act remains disproportionately higher than other places of detention. Yet, despite the frequency with which these deaths occur, a lack of timely and high-quality data limits learning to prevent further deaths in secure health settings. I welcome the recommendations arising out of the rapid review into mental health inpatient safety to improve data collection and publication commissioned by the Department of Health and Social Care. Urgent changes are needed to the way data is recorded, published, and shared to drive forward much-needed improvements to patient safety.

Further, there is a serious anomaly with how deaths under the Mental Health Act are investigated. Unlike deaths in prison, police custody, and immigration detention which are subject to independent scrutiny, deaths of patients detained in secure settings are investigated by the same trust responsible for their care. Two decades since the Joint Committee on Human Rights called for an independent investigative body,[2] there remains a troubling inconsistency with how the deaths of some of society's most vulnerable people are examined. An independent investigative body is needed to urgently address this gap and help us better understand why so many people are dying in mental health settings. This is an area of priority focus for the IAPDC as we look to make recommendations to government and senior health leaders over the coming year.

Each death in custody has far-reaching impact. When a death does occur, it should raise searching questions for public services and the government about their ability to keep people under their care safe. I urge the government and all those involved in the care of people in detention to heed the findings of this report. Finally, I want to give special thanks to Dr Amir Sariaslan and IAPDC member Professor Seena Fazel for their expert advice and the diligence with which they carried out this comprehensive analysis.

L. Emslie

Lynn Emslie

Chair of the Independent Advisory Panel on Deaths in Custody

[1] DHSC, 'Rapid review into data on mental health inpatient settings: final report and recommendations', June 2023, available here.

[2] UK Parliament, 'Joint Committee on Human Rights: Deaths in Custody', December 2004, available here.

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Executive Summary

1. Since 2011, as part of its role in advising Ministers and officials on the prevention of deaths in custody, the Independent Advisory Panel on Deaths in Custody (IAPDC) has provided independent statistical analyses of deaths in state custody. This data is vital to monitoring trends, highlighting vulnerable cohorts, and assessing the impact of preventative measures. As this new statistical report for 2017-2021 makes clear, prevention relies on the availability of high-quality evidence on death rates and risk factors. Prevention of deaths will also require improved assessment of suicide and premature mortality risks and better interventions. More work needs to be done to clarify these related aspects of the evidence base.

2. This statistical report provides a breakdown for all recorded deaths in custody in England and Wales from the start of 2017 to the end of 2021 in (i) prisons; (ii) detention under the Mental Health Act 1983 (MHA); (iii) Immigration Removal Centres (IRCs); and (iv) police custody. Importantly, this report presents and assesses deaths in custody through the calculation of population rates, enabling us to identify rates of death for each custody setting. While His Majesty's Prisons and Probation Service (HMPPS) publishes such rates for those held in prison custody, rates of death relating to the other custody settings are not publicly available elsewhere.

3. The findings of this report are stark. They include:

Rates of deaths remain far too high

- In comparison to the general community, significantly higher rates of deaths were observed in detention facilities. MHA detention continues to be associated with a very high rate of death, three times higher than prisons and higher than other custody areas. Further, although this is an approximation so caution must be applied, the rate is even higher – more than 10 times higher – if adjusted for the time actually spent in detention, which is estimated on average to be a month.

- Caution must be applied in looking at detention settings with far fewer deaths each year, such as police custody. But when adjusted for an estimated average time actually spent in custody, rates of death in that setting are more similar to those in prisons, which themselves remain far too high.

Data on deaths in mental health detention is still not good enough

- Data on deaths in MHA detention remains poor quality in terms of comprehensive and timeliness. As the IAPDC has found for a number of years, we cannot identify the proportion or rate of deaths by race or ethnicity due to the lack of available data.

- The same remains true for identifying rates of death for both men and women within MHA detention: it is currently not possible due to the poor data quality.

- It remains the case that a large number of deaths in MHA detention in each new year are reported as "awaiting classification". This is because those reporting the data wait for coroners' verdicts before determining whether a death was self-inflicted or 'non-natural'.

- However, this issue does not pose a problem for the other detention settings, such as prisons or police custody, with the relevant bodies using other, provisional methods for reporting apparent self-inflicted deaths before a coroners' verdict to ensure timely and potentially actionable data. This should be changed for data on deaths in MHA detention.

Gender, age and ethnicity

- Men have consistently higher rates of death across all custody settings, particularly prisons and police.
- The majority of deaths across all settings – on average 65% – are from natural causes (i.e. (caused by disease or natural process). Older people are more likely to die of natural causes, while younger people are more likely to die of non-natural causes (such as suicides or accidents). Further, while Covid-19 increased the absolute numbers of natural deaths, it does not appear to have affected rates across ages.
- The proportion of individuals with an ethnic minority background who have died in custody has risen from 12% between 2017 and 2019 to 16% between 2020 and 2021 among those with a known ethnic background (Table 8). We currently lack sufficient data to investigate their causes of death. Without further clarification about the ethnicity of the missing data in the years covered, it is uncertain whether this is a trend or represents better reporting of ethnicity in more recent years.

Methods and background

4. The analysis in this statistical report, contained in parts 1-5 and the Annex, was carried out by Dr Amir Sariaslan and IAPDC member Professor Seena Fazel (University of Oxford). Data was gathered from departments between 29 September 2023 and 15 January 2024. The numbers, especially for cause-specific mortality in between 2019 and 2021, are subject to change due to changes to the classification of deaths.
5. There have been few attempts to determine a method of calculating a population of interest for rates of death while detained in custody, as it is difficult to obtain information on the total number of people who are detained each year or at a particular moment in various settings. To calculate an estimated mortality rate, data on the population at risk was sourced from the relevant governmental departments and other relevant public bodies, as detailed in the Appendix.
6. Analysing death rates by comparing them with target populations allows for further interpretation than simply considering number of deaths, which in some cases remain statistically small, although even one death in custody is a death too many. Indeed, small numbers of deaths may nonetheless suggest a rate of deaths demanding serious attention.
7. There are some caveats that should be born in mind in reading this report. First, the analysis covers the years 2017 to 2021. It is therefore difficult to draw any long-term trends from the data. Caution should also be applied to drawing trends across these five years.
8. Further, caution may be needed in comparing some detention settings with others. For example, rates of death may be less easily compared between police custody and the other settings due to differences in durations of detention, with individuals being held in police custody for far shorter periods. The data also does not include deaths that take place following police contact but without arrest or detention under section 136 of the Mental Health Act. Information on these deaths may be necessary to further contextualise the findings.
9. In addition, where numbers of deaths within a detention setting are low, small absolute differences across each year may generate outsize, relative differences in rates, so caution may be needed in comparing rates within some detention settings across each year.

[3] Previous statistical analyses produced by the IAPDC, covering the period between 2000 and 2019, can be accessed here.

Part 1: Deaths by place of detention

10. Between 2017 and 2021, there were an average of 604 deaths per annum in detention, ranging from 538 deaths in 2018 to 700 in the pandemic year of 2020 (Table 1).

Table 1. Deaths in custody in England and Wales 2017-2021 expressed as counts and rates per 100,000 people.

	2017	2018	2019	2020	2021	Average 2017-2021
Community[4]						
Count	1462	1590	1581	1599	1732	1593
Rate	74	80	79	79	86	80
Prisons						
Count	295	325	300	318	371	322
Crude rate	344	390	362	396	472	393
Adjusted rate[5]	257	291	270	295	353	293
Mental Health Act (MHA)						
Count	247	195	240	363	270	263
Crude rate	1245	919	1165	1872	1369	1314
Adjusted rate (1 month on average)	14,941	11,033	13,985	22,462	16,431	15,770
Police						
Count	23	17	18	19	11	18
Crude rate	2	2	2	2	1	2
Adjusted rate (2 days on average)	452	338	363	402	226	356
Adjusted rate (1 day on average)	904	676	725	804	453	712
Immigration Removal Centres (IRCs)						
Count	4	1	1	0	1	1
Crude rate	15	4	4	0	4	5
Adjusted rate (2 months on average)	88	24	25	0	24	32
Adjusted rate (1 month on average)	59	16	16	0	16	21
Total (excluding community)	569	538	559	700	653	604

[4] Rates of deaths in custody are compared against an average all-cause mortality rate for 30-34 year olds in England and Wales between 2017 and 2021, obtained from the UK Office of National Statistics. We weighted the death counts and rates by using 95% of the male sample and 5% of the female sample to make it comparable to most custody settings. See Table 1 in the Appendix for further details.

[5] Adjusted for relative proportions of remand (by receptions) and sentenced prisoners (by census).

11. In comparison to the general community, significantly higher rates of deaths were observed in detention facilities. Between 2017 and 2021, prisons accounted for the majority of these deaths (53%, 1609 out of 3019 deaths), followed by psychiatric hospitals (44%, 1314 out of 3019 deaths).

Chart 1: Total number of deaths across places of detention: 2017-2021

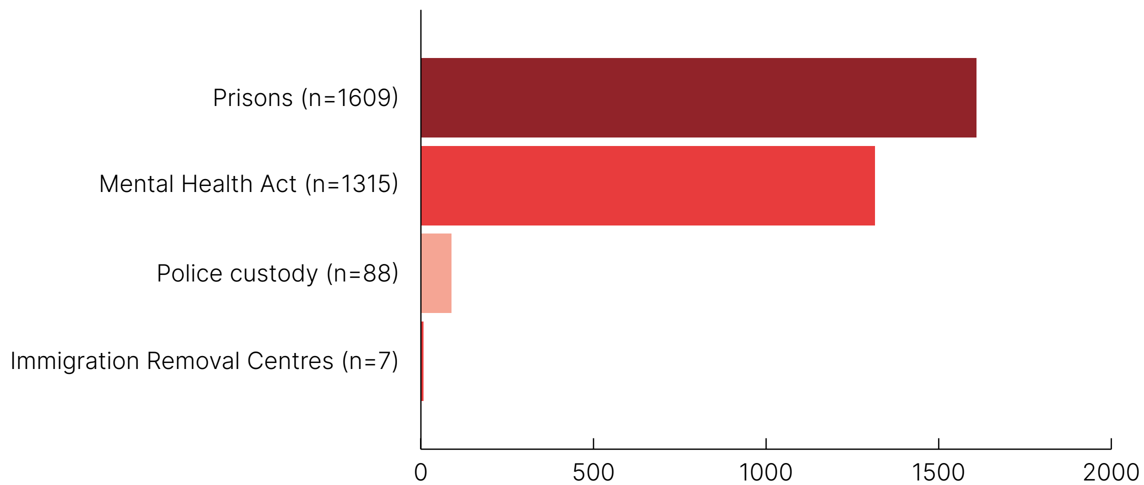
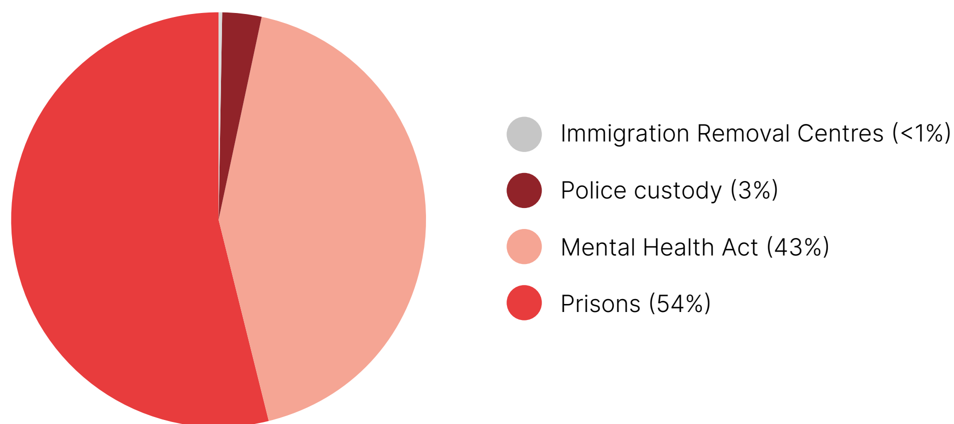


Chart 2: Average percentage of deaths across places of detention 2017-2021



12. People detained under the Mental Health Act had the highest crude rates of death, averaging 1314 deaths per 100,000 detainees and ranging between 919 to 1872 deaths per 100,000 detainees. These rates were about three times higher than those recorded in prisons, which averaged 393 deaths per 100,000 detainees and ranged between 344 and 472 deaths per 100,000 detainees.

13. By accounting for differences in time spent in custody, we calculated that the death rates of people detained under the Mental Health Act were considerably larger, averaging 15,770 deaths per 100,000 detainees and year, and ranging between 11,033 and 22,462 deaths per 100,000 detainees and year.

14. The absolute numbers of deaths in police custody and IRCs were considerably lower, and their rates should therefore be interpreted with caution. Accounting for time at risk similarly led to large increases in the adjusted rates, but these adjustments were heavily dependent on the specific assumptions made. Ideally what is needed to calculate an accurate rate is the actual number of person days in custody in any given year. This should be a priority for these services so that rates and trends over time can be studied more precisely.

Part 2: Deaths by sex

15. The majority of deaths in custody affected males, from an average of 64% among people detained under the Mental Health Act to 97% among people in prison.

Table 2. Deaths in custody in England and Wales 2016-2021 by sex

	Prisons		Mental Health Act (MHA)		Police		Immigration Removal Centres (IRCs)	
	No. (%)	Proportion in setting population	No. (%)	Proportion in setting population[6]	No. (%)	Proportion in setting population	No. (%)	Proportion in setting population
2017								
Male	287 (97%)	95%	161 (65%)	52%	21 (91%)	85%	4 (100%)	75%
Female	8 (3%)	5%	86 (35%)	48%	2 (9%)	15%	0 (0%)	25%
2018								
Male	314 (97%)	95%	120 (62%)	52%	15 (88%)	85%	1 (100%)	76%
Female	11 (3%)	5%	73 (38%)	48%	2 (12%)	15%	0 (0%)	24%
2019								
Male	292 (97%)	95%	146 (63%)	51%	17 (94%)	85%	1 (100%)	77%
Female	8(3%)	5%	87 (37%)	49%	1 (6%)	15%	0 (0%)	23%
2020								
Male	311 (98%)	96%	225 (63%)	51%	17 (89%)	85%	0 (0%)	85%
Female	7 (2%)	4%	130 (37%)	49%	2 (11%)	15%	0 (0%)	15%
2021								
Male	365 (98%)	96%	169 (65%)	52%	9 (82%)	85%	1 (100%)	89%
Female	6 (2%)	4%	93 (35%)	48%	2 (18%)	15%	0 (0%)	11%

[6] These were calculated based on data on repeated detentions, where sex was recorded. This data was used as a proxy to provide insights into the sex distribution of hospital detentions. This estimate of the sex balance encompasses all detentions, including community treatment orders and hospital detentions.

16. Males consistently had substantially elevated mortality rates compared to females in all custody settings. In police custody, their rates were 42% higher, and in prisons, the gap was even greater, with males dying at 83% higher rates than females.

17. Due to the absence of data on denominators, it was not possible to calculate rates for hospital detentions. Similarly, given that only males died in IRCs, it was not possible to compare their rates with females.

Table 3. Rates of death in custody in England and Wales 2016-2021 by sex

	Prisons		Police		Immigration Removal Centres (IRCs)	
	Male	Female	Male	Female	Male	Female
2017	351	201	3	1	17	0
2018	395	286	2	1	5	0
2019	369	211	2	1	5	0
2020	404	208	2	2	0	0
2021	484	188	1	2	4	0

Part 3: Deaths by cause

18. Between 2017 and 2021 the majority of deaths were due to natural causes (1956, 65% of all deaths in custody), followed by deaths due to external causes (829, 27% of all deaths) (Tables 4 and 5). Deaths due to external causes include deaths by suicide, along with other self-inflicted deaths where the intent may not have been to cause death, or where the intent was not clear.

Table 4. Deaths in custody in England and Wales 2016-2021 by cause of death and settings

Setting/Cause	Number of deaths				
	2017	2018	2019	2020	2021
Prison					
Natural	193	168	176	222	262
External	102	155	122	94	102
Awaiting classification	0	2	2	2	7
MHA					
Natural	189	136	143	268	165
External	48	34	32	33	50
Awaiting classification	10	25	65	62	55
Police					
Natural	6	4	9	7	5
External	13	14	8	12	6
Awaiting classification	0	0	3	3	1
IRC					
Natural	1	1	1	0	0
External	3	0	0	0	1
Awaiting classification	0	0	0	0	0

Table 5. Deaths in custody in England and Wales 2016-2021 by cause of death across all settings

Cause	Number of deaths				
	2017	2018	2019	2020	2021
Natural	389 (69%)	309 (57%)	329 (59%)	497 (71%)	432 (66%)
External	166 (29%)	203 (38%)	162 (29%)	139 (20%)	159 (24%)
Awaiting classification	10 (2%)	27 (5%)	70 (12%)	67 (9%)	63 (10%)

Part 4: Deaths by age

19. More natural deaths (Table 6) occur in older detainees, with an average of 65% occurring in the over 60s over the five years, and overt 83% occurring in the over 50s.

20. For deaths due to external causes, on average, 57% occur in those 40 and under, and 90% of deaths occurring in those under 60.

21. Although the absolute numbers of deaths increased during the pandemic year of 2020, the age distributions across both natural and external causes of death remained relatively constant over time.

Table 6. Deaths in custody in England and Wales 2016-2021 by age categories and cause of death

Cause/Age groups	Number of deaths (%)				
	2017	2018	2019	2020	2021
Natural Causes					
11-20	0 (0%)	0 (0%)	2 (1%)	1 (0%)	0 (0%)
21-30	6 (2%)	8 (3%)	9 (3%)	9 (2%)	4 (1%)
31-40	15 (4%)	9 (3%)	10 (3%)	24 (5%)	17 (4%)
41-50	33 (9%)	26 (9%)	25 (8%)	36 (7%)	39 (9%)
51-60	68 (18%)	58 (19%)	62 (19%)	71 (14%)	96 (22%)
61-70	85 (22%)	64 (21%)	67 (21%)	117 (24%)	85 (20%)
71-80	89 (23%)	75 (25%)	70 (22%)	123 (25%)	120 (28%)
>80	70 (18%)	50 (16%)	60 (19%)	108 (22%)	66 (15%)
Not stated	16 (4%)	14 (5%)	14 (4%)	1 (0%)	0 (0%)
External Causes					
11-20	1 (1%)	4 (2%)	10 (5%)	5 (3%)	12 (9%)
21-30	32 (19%)	35 (17%)	38 (19%)	36 (25%)	37 (27%)
31-40	62 (36%)	69 (34%)	58 (29%)	41 (28%)	46 (34%)
41-50	41 (24%)	46 (22%)	32 (16%)	33 (23%)	26 (19%)
51-60	25 (15%)	25 (12%)	24 (12%)	21 (14%)	12 (9%)
61-70	4 (2%)	15 (7%)	4 (2%)	8 (5%)	2 (1%)
71-80	1 (1%)	4 (2%)	1 (0%)	2 (1%)	1 (1%)
>80	0 (0%)	1 (0%)	1 (0%)	0 (0%)	0 (0%)
Not stated	4 (2%)	6 (3%)	33 (16%)	0 (0%)	0 (0e%)

Part 5: Deaths by ethnicity

22. The majority of deaths occur in people of white ethnicity across all settings, for both males and females (Table 7). The completeness of ethnicity data varied by setting.

23. There was a large amount of missing data on ethnicity in people detained in hospitals under the Mental Health Act, reaching 40% in 2019. This large proportion of missing data has the potential to obscure the underlying pattern of deaths by ethnicity, particularly if the data is not missing at random. In contrast, the data collected by prisons is more complete and therefore reliable. The numbers of deaths occurring in or following police custody or in IRCs are few, with largely complete ethnicity data.

24. The proportion of individuals with an ethnic minority background who have died in custody has risen from 12% between 2017 and 2019 to 16% between 2020 and 2021 among those with a known ethnic background (Table 8). We currently lack sufficient data to investigate their causes of death.

Table 7. Deaths in custody in England and Wales 2016-2021 by ethnicity and setting

	Prisons		Mental Health Act (MHA)		Police		Immigration Removal Centres (IRCs)
	No. (%)	Proportion in setting population	No. (%)	Proportion in setting population[7]	No. (%)	Proportion in setting population	No. (%)
2017							
White	268 (91%)	74%	100 (45%)	67%	14 (74%)	72%	2 (50%)
Ethnic minority	27 (9%)	26%	14 (6%)	22%	5 (26%)	21%	2 (50%)
Not stated	0 (0%)	0%	110 (49%)	11%	0 (0%)	7%	0 (0%)
2018							
White	283 (87%)	73%	133 (62%)	65%	15 (83%)	68%	0 (0%)
Ethnic minority	35 (11%)	27%	15 (7%)	24%	3 (17%)	20%	1 (100%)
Not stated	7 (2%)	0%	68 (31%)	11%	0 (0%)	12%	0 (0%)
2019							
White	262 (87%)	73%	106 (50%)	67%	16 (80%)	65%	0 (0%)
Ethnic minority	36 (12%)	27%	19 (9%)	24%	3 (15%)	20%	(100%)
Not stated	2 (1%)	0%	85 (40%)	9%	1 (5%)	15%	0 (0%)
2020							
White	277 (87%)	73%	254 (70%)	67%	17 (89%)	65%	0 (0%)
Ethnic minority	41 (13%)	27%	61 (17%)	24%	2 (11%)	20%	0 (0%)
Not stated	0 (0%)	0%	48 (13%)	9%	0 (0%)	15%	0 (0%)
2021							
White	325 (88%)	72%	192 (71%)	62%	10 (91%)	67%	1 (100%)
Ethnic minority	46 (12%)	28%	46 (17%)	24%	1 (9%)	19%	0 (0%)
Not stated	0 (0%)	0%	32 (12%)	13%	0 (0%)	15%	0 (0%)

[7] These were calculated based on data on repeated detentions, where ethnicity was recorded. This data was used as a proxy to provide insights into the ethnicity distribution of hospital detentions. This estimate of the sex balance encompasses all detentions, including community treatment orders and hospital detentions.

Table 8. Deaths in custody in England and Wales 2016-2021 by ethnicity across all settings

Ethnic background	Number of deaths				
	2017	**2018**	**2019**	**2020**	**2021**
White	384 (71%)	431 (77%)	384 (72%)	548 (78%)	528 (81%)
Ethnic minority	48 (9%)	54 (10%)	59 (10%)	104 (15%)	93 (14%)
Not stated	110 (20%)	75 (13%)	88 (17%)	48 (7%)	32 (5%)

Appendix

eTable 1. Deaths in community controls aged 30-34 years in England and Wales 2017-2021

	All individuals	Males	Females	Weighted
2017				
Count	2326	1495	831	1462
Rate	59	76	42	74
2018				
Count	2490	1628	862	1590
Rate	63	82	43	80
2019				
Count	2490	1618	872	1581
Rate	62	81	44	79
2020				
Count	2550	1635	915	1599
Rate	63	81	46	79
2021				
Count	2739	1772	967	1732
Rate	66	88	45	86

Notes: The weighted approach uses 95% of the male sample and 5% of the female sample to calculate counts and rates.

eTable 2. Self-inflicted deaths among people imprisoned for public protection in England and Wales 2017-2021

	2017	2018	2019	2020	2021	Average 2017-2021
Count	7	5	2	2	3	5
Rate	170	136	58	60	98	138

25. The average rate of self-inflicted death within the population imprisoned for public protection was 138 deaths per 100,000 people. The rates fluctuated throughout the period studied, ranging from a 58 to 170 deaths per 100,000 people. The rates were unadjusted due to the assumption of continuous incarceration for the individuals throughout the analysed annual periods.

References

Settings	Year(s)	References
Prisons	2017-21	National statistics: Deaths in prison custody 1978 to 2022 https://assets.publishing.service.gov.uk/media/63cec3d08fa8f53fe508fbf3/Deaths_in_prison_custody_1978_to_2022.xlsx National statistics: Safety in Custody - Deaths data tool (Q4, 2022): https://www.gov.uk/government/statistics/safety-in-custody-quarterly-update-to-december-2022 **For the distribution of race among prisoners, we used data from the following reports:** National statistics: Ethnicity and the Criminal Justice System, 2020 https://www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-statistics-2020/ethnicity-and-the-criminal-justice-system-2020 National statistics: Ethnicity and the Criminal Justice System, 2022 https://www.gov.uk/government/statistics/ethnicity-and-the-criminal-justice-system-2022/statistics-on-ethnicity-and-the-criminal-justice-system-2022-html
MHA	2017	CQC: Monitoring the Mental Health Act in 2017/18 https://assets.publishing.service.gov.uk/media/5c9269a0e5274a29a357008f/CQC_monitoring_the_mental_health_act.pdf NHS Digital: Mental Health Act Statistics, Annual Figures 2017-18 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2017-18-annual-figures
	2018	CQC: Monitoring the Mental Health Act in 2018/19 https://www.cqc.org.uk/sites/default/files/20200206_mhareport1819_report.pdf NHS Digital: Mental Health Act Statistics, Annual Figures 2018-19 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2018-19-annual-figures
	2019	CQC: Monitoring the Mental Health Act in 2019/20 https://www.cqc.org.uk/sites/default/files/20201127_mhareport1920_report.pdf NHS Digital: Mental Health Act Statistics, Annual Figures 2019-20 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2019-20-annual-figures
	2020	CQC: Monitoring the Mental Health Act in 2020/21 https://www.cqc.org.uk/sites/default/files/2023-06/20230629_mhareport202021_print.pdf NHS Digital: Mental Health Act Statistics, Annual Figures 2020-21 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2020-21-annual-figures
	2021	CQC: Monitoring the Mental Health Act in 2021/22 https://www.cqc.org.uk/sites/default/files/2022-12/20221201_mhareport2122_print.pdf NHS Digital: Mental Health Act Statistics, Annual Figures 2021-22 https://digital.nhs.uk/data-and-information/publications/statistical/mental-health-act-statistics-annual-figures/2021-22-annual-figures

References

Settings	Year(s)	References
MHA	2017-2021	The CQC reports did not include the gender and age breakdown of deaths under to the Mental Health Act. We were provided with this data by CQC via e-mail. Data on ethnicity was similarly not available for the years 2017-2019, and we used figures presented in Botchway and Fazel (2021; *The Journal of Forensic Psychiatry & Psychology*; https://www.tandfonline.com/doi/full/10.1080/14789949.2021.1991979).
Police	2017-2021	IOPC: Deaths during or following police contact: Statistics for England and Wales Time series tables 2004/05 to 2021/22 https://www.policeconduct.gov.uk/sites/default/files/documents/Time_series_tables_2021_22.pdf National statistics: Police powers and procedures, stop and search and arrests, 2022/23 https://www.gov.uk/government/statistics/stop-and-search-and-arrests-year-ending-march-2023/police-powers-and-procedures-stop-and-search-and-arrests-england-and-wales-year-ending-31-march-2023
IRC	2017-2021	Home Office: Immigration System Statistics, year ending March 2023 https://assets.publishing.service.gov.uk/media/64635b77a09dfc000c3c182d/detention-summary-mar-2023-tables.ods
Community controls	2017-2021	We obtained the mortality statistics for community controls aged 30-34 years in England and Wales throughout the studied period by using Nomis, a database service provided by the Office for National Statistics. The data were retrieved on 29 September 2023.

About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody (MCDC) formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care, and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody
- Independent Advisory Panel on Deaths in Custody (IAPDC)
- Practitioner and Stakeholder Group

The remit of the IAPDC (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises, and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, an advisory non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials, and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Lynn Emslie chairs the IAPDC. The other members are:

- Raj Desai, barrister, Matrix Chambers
- Professor Seena Fazel, professor of Forensic Psychiatry, University of Oxford
- Dr Jake Hard, Associate Clinical Director for the South West Prisons, Oxleas NHS Foundation Trust
- Pauline McCabe OBE, international criminal justice advisor and former Prisoner Ombudsman for Northern Ireland

Further information on the IAPDC can be found on its website: **https://www.iapondeathsincustody.org.**

For more information on this paper – or on the IAPDC more generally – please contact **MinisterialCouncilonDeathsinCustody@justice.gov.uk.**

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Statistical analysis of recorded deaths in custody between 2017 and 2021

April 2024