

Statistical Release 2013

Foreword by Lord Toby Harris

Welcome to the fourth statistical report by the Independent Advisory Panel (IAP) into deaths in custody, which covers the period between 2000 and 2013.

The purpose of the Panel is to give advice to Ministers to help reduce future deaths in custody. Over time these annual updates enable the Panel to draw on a larger pool of data and to develop its analysis and comparison between custodial settings and to inform our future priorities. This year's publication was prepared by the University of Greenwich and Dr Zubaida Haque, with advice from Professor Graham Towl.

In June we held a roundtable meeting with all the organisations which provide the data used for this report. It was a productive discussion about the different approaches to classification of deaths in a range of custodial settings and the reasons why it would not be informative to produce rates of deaths for some settings, such as police custody, given the small numbers involved. We have, however, produced three year average figures and rates by 100,000 where population data is available. This has helped us to draw sound conclusions about how deaths in custody have changed over time and the use of rates by 100,000 will enable us to make comparisons to deaths in the community in due course.

The Panel has previously noted with concern the number of deaths of those detained in hospital under the Mental Health Act, which rose to 341 in 2012. In our previous report, I explained that we would be enquiring into the reasons for this increase. The CQC has been examining data from 2012 but has not found a root cause for the large increase in natural cause deaths notified to them. They are continuing to investigate the notifications submitted to understand whether there are errors in the data. However, it is worth noting that the number of deaths of detained patients in 2013 was 282, which shows a reduction to levels similar to those in the years preceding 2012.

There is a thematic analysis of self-inflicted deaths in this year's report. It shows that whilst the average number of self-inflicted deaths in all settings has decreased since 2005, there has been a steady increase again since 2010. When broken down by custodial setting, the increase in self-inflicted deaths in prison did not occur until 2012. The number of self-inflicted deaths of detained patients has remained at similar levels throughout the period covered in this report (2000-2013). In terms of gender, figures for self-inflicted deaths in prison show that the rate has reduced for female prisoners but has remained relatively stable for male prisoners.

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Introduction

1. The Independent Advisory Panel (IAP) on Deaths in Custody forms the second tier of the three tier Ministerial Council on Deaths in Custody, and it acts as the primary source of independent advice to ministers and service leaders through the Ministerial Board on measures to reduce the number and rate of deaths in custody. This covers all deaths which occur in prisons, in or following police custody, secure training centres/secure children's homes, immigration removal centres, in Approved Premises and deaths of those detained under the Mental Health Act in hospital.
2. In the Panel's first statistical analysis, published in October 2011, the panel made a commitment to publish an annual update of the recorded deaths in state custody.
3. The report provides a breakdown of all recorded deaths in the following custodial sectors:
 - Prisons and Young Offender Institutions¹
 - Police²
 - Immigration Removal Centres
 - Approved Premises³
 - Secure Children's Homes⁴
 - Secure Training Centres⁵
 - This report also contains data on the deaths of patients who have died in hospitals whilst detained under the Mental Health Act.

Statistical Methodology

Data Sources

4. The data used in this report was provided to the Secretariat of the IAP on Deaths in Custody by the different custodial sectors, and is produced with the permission of the following organisations:
 - National Offender Management Service (NOMS) – for data on adult estates, YOIs and residents of Approved Premises.

¹These figures include all prisoners within public and private sector prisons, but exclude deaths in NOMS run Immigration Removal Centres. YOIs are run by both the HM Prison Service and the private sector and can accommodate 15-21 year olds, although the estate is split between establishments that take 15-17 year olds and 18-21 year olds.

² These figures include deaths of persons who have been arrested or otherwise detained by the police. It includes deaths that occur while a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle. These figures do not include fatal shootings, road traffic accidents involving police vehicles and 'other' deaths following police contact, which are not custody related. See: http://www.ipcc.gov.uk/en/Pages/reports_polcustody.aspx

³Approved Premises (formerly known as Probation & Bail Hostels) are premises approved under Section 13 of the Offender Management Act 2007. They are managed either by the Probation Service or independent organisations and offer residential provision to selected offenders and some bailees in order to provide enhanced levels of protection to the public and reduce the likelihood of further offending.

⁴SCHs are generally used to accommodate young offenders aged 10-14 years old, girls up to the age of 16, and 15-16 year old boys who are assessed as 'high risk'.

⁵STCs are purpose built centres for young offenders up to the age of 17. They are run by private operators under contract, and operate to a detailed set of operational requirements.

- Independent Police Complaints Commission (IPCC) – for data on deaths in police custody which has been provided by the IPCC since 2004.
 - UK Immigration – for data from the Immigration Removal Centres.
 - Care Quality Commission (CQC) and the Healthcare Inspectorate Wales (HIW) – for data on those detained under the Mental Health Act (MHA).
 - Youth Justice Board – for data on all young people (under the age of 17) in a Secure Training Centre (STC) or Secure Children’s Home (SCH).
5. Some of the figures in the tables will have changed from the 2012 Deaths in Custody⁶ statistical release as previous deaths, where the cause of death was unknown, may have been classified since. A data cleansing exercise has resulted in the CQC data being amended for the years 2010, 2011 and 2012.
6. Caution should be taken when interpreting the figures for causes of deaths, as some of the custodial sectors (namely police and CQC) have different methods of classification for restraint related deaths and ‘Other non-natural’ deaths. For the CQC a restraint related death is defined as a death in which restraint was used in the previous seven days, but this may not necessarily be actually related to the cause of death. For police custody, restraint is defined as ‘restraint-related, being mentioned in post mortem reports.
7. All of the recorded deaths across the custodial sectors have been drawn from administrative IT systems, which with any large scale recording system are subject to possible errors with data entry and processing.

⁶<http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2014/05/IAP-Statistical-analysis-of-recorded-deaths-2000-to-2012-Publication.pdf>

Deaths in State Custody

This section focuses on deaths in state custody in England and Wales during the period of 2000 to 2013 and provides details on the following areas: all deaths, including average number of deaths in state custody; average number of deaths across different custodial sectors; rate of deaths per 100,000 by gender; average number of deaths in prison amongst those of BME groups.

Summary of Deaths in State Custody 2000-2013

Table 1 summarises the number of recorded deaths in state custody between 1 January 2000 and the 31 December 2013. Some of the figures in the table will have changed from the 2012 Deaths in Custody statistical release as previous deaths where the cause of death was unknown, may have since been classified.

Table 1: All deaths in state custody between 2000-2013

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
Prison ¹	146	142	164	183	208	174	153	185	165	169	197	192	192	215	2485
Police ²	30	28	32	34	39	28	26	23	18	16	19	19	10	15	337
Patients detained under the MHA ³	406	346	307	331	310	337	363	325	326	312	298	289	341	282	4573
Approved Premises	24	22	21	12	20	17	10	17	15	9	12	17	9	9	214
STC/SCH Young People	0	0	0	0	2	0	0	0	0	0	0	0	0	0	2
Immigration Detention ⁴	1	0	0	2	4	2	1	0	0	0	2	4	1	2	19
Total deaths in State Custody for England and Wales	607	538	524	562	583	558	553	550	524	506	528	521	553	523	7630

*These figures are confirmed numbers from previous years; * These figures have been amended by the Care Quality Commission

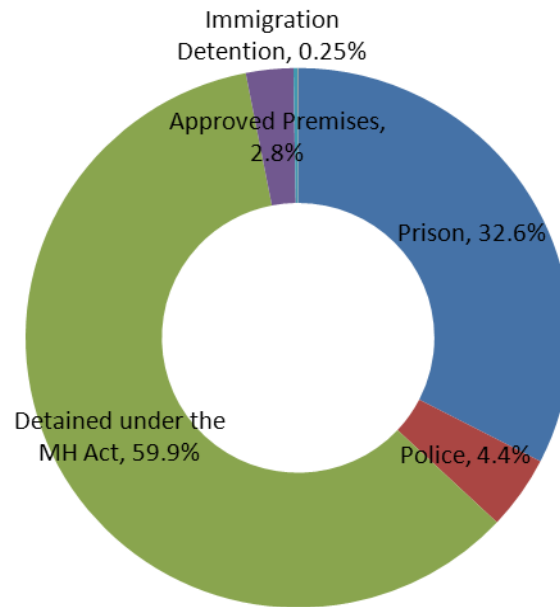
1. Includes deaths of individuals 18 and over in custody, or released on licence for medical reasons. Also includes deaths of 15-17 year olds held in YOIs (1 death 15-17 year old 2011, 2 in 2012 and none in 2013).
2. Deaths in or following police custody as defined in Category A of the PACE Act 1984.
3. Patients detained under the Mental Health Act.
4. These figures include any deaths that occurred in the three Prison Service run Immigration Removal Centres at Haslar, Dover and Lindholme (as at December 2013). We are not aware of any deaths in those settings in recent years but it is possible that there has been double counting earlier in the period 2000-2013.

In total there were 7,630 deaths recorded for the 14 years from 2000 to 2013. This is an average of 545 deaths per year. Of these deaths, 72% were men (n=5,516) and 28% (n=2,114) were women.

In 2000, a total of 607 deaths were recorded in state custody compared to 523 in 2013. This represents 14% fewer deaths in 2013 compared to 2000, although this percentage has fluctuated in the years in between this period. There was a 5% decrease in deaths in state custody from 2012 to 2013.

Figure 1 shows that majority of the 7,630 deaths in the last 14 years (60%) were patients detained under the Mental Health Act and 33% of all deaths were within prison settings.

Figure 1: Deaths in state custody by settings: 2000-2013 (England and Wales)⁷



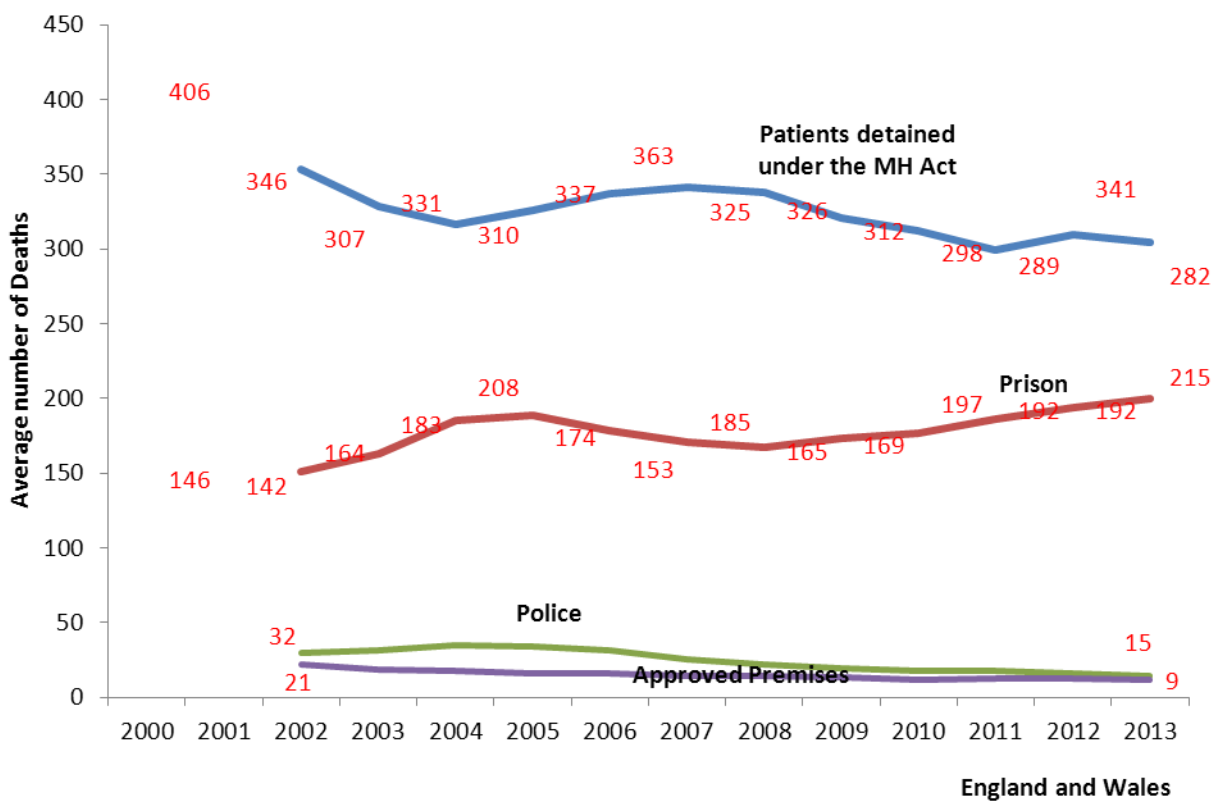
*Percentage figures may not add up to 100 due to rounding and prisons data includes deaths in YOIs of under 18 year olds.

⁷ The chart excludes deaths in STC/SCH as the total number of deaths between 2000 and 2012 was 0.03% (two deaths).

Figure 2 shows the average number of deaths across four sectors between 2000 and 2013 (based on rolling averages of every three years).

On average, there were a higher number of deaths of patients detained under the MHA (around 300 or more) compared to those in prison (averages of between 151 deaths in 2000 to 200 in 2013). There were a small number of deaths in police custody and Approved Premises. Whilst there has been a general decrease in the average number of deaths of patients detained under the MHA, in police settings and Approved Premises, there has been an increase in the average number of deaths in prisons (from an average of 151 between 2000-2002 to 200 deaths between 2011 to 2013). The three yearly average number of deaths in police and Approved Premises has decreased by about a half from 2000 to 2013.

Figure 2: Three yearly rolling average number of deaths in state custody by custodial sector: 2000 to 2013



*Red numbers in chart denote annual number of deaths

It is desirable to examine the rate of deaths in custody so that these can be compared with the rates of similar types of death in the general population. In order to calculate rates, information about the population in each setting must be available. This information was only available for prisons. Figure 3 shows the rate of deaths in prison per hundred thousand by males and females separately. For example, in 2000, there were 136 males who died in prison, and a population of 61,252 males in prison; this meant that there were 222 deaths in prison per 100,000 males. This rate has remained fairly constant over the past 14 years, although there has been a rise in the rate of deaths for males in prison between 2012 and 2013, from 228 to 260. The rate of death for females in prison (per 100,000 females in prison) in 2000 was higher than for males (299 deaths compared to 222). In 2013 this figure has reduced by almost a half to 154 female deaths per 100,000 females in prison, and is now lower than male deaths.

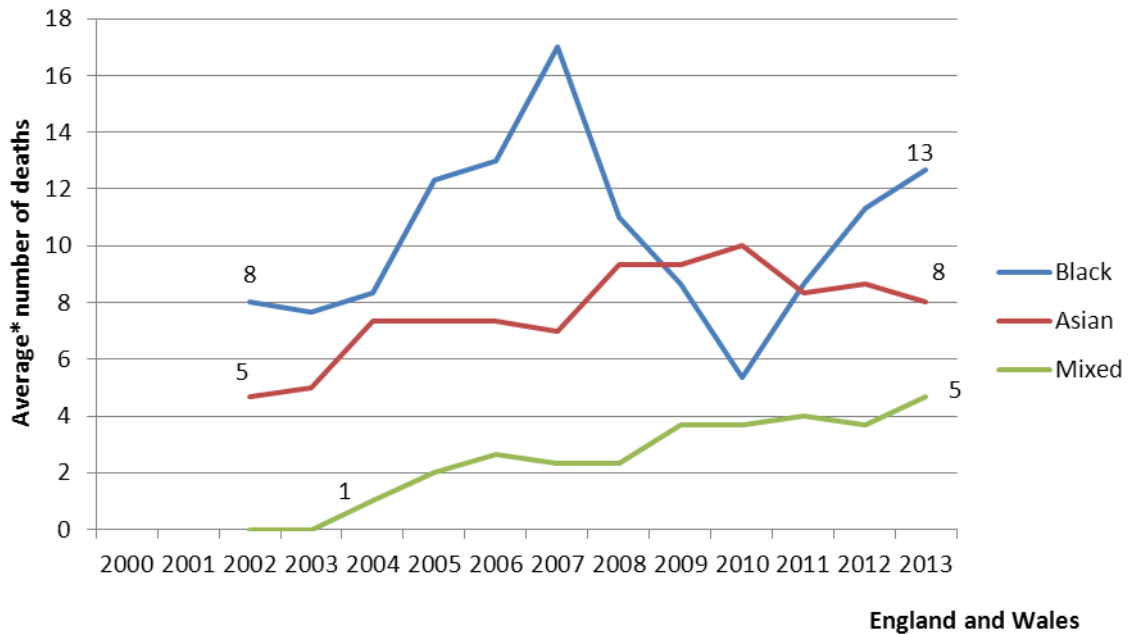
Figure 3: Rate of deaths (per 100,000) by gender in prison: 2000-2013



*Numbers in brackets denote number of deaths

Figure 4 shows that, overall, there was a slight increase in deaths for the Black, Asian and Mixed ethnic groups in prison from 2000 to 2013, although it is notable that there is a bigger increase in the average number of deaths amongst Black groups since 2010. However, these are numerically small figures and need caution in their interpretation.

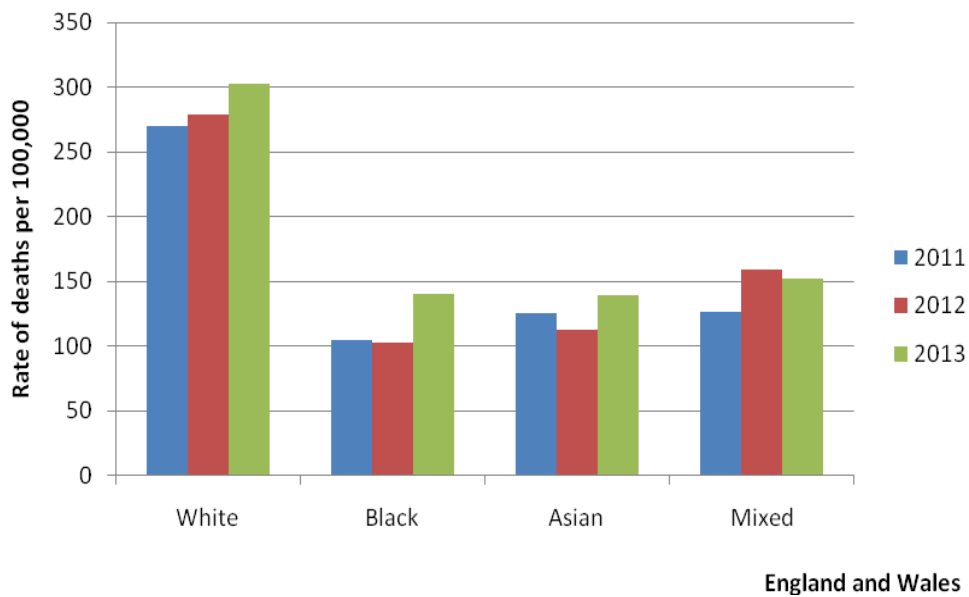
Figure 4: Average number of deaths among BME groups within Prison and YOI settings: 2000-2013



*Rolling three yearly average

Figure 5 shows the rate of deaths per 100,000 for different ethnic groups in prison over three years. Overall, white groups had the highest rate of deaths in prison; in 2011, the rate was 269 deaths in prison per 100,000 white prisoners and this increased to 302 deaths by 2013. This was more than double the rate of deaths for BME (Black, Asian and Mixed) prisoners. Amongst BME groups, those from the Mixed ethnic group had the highest rate of deaths per 100,000 and this has increased from 126 deaths per 100,000 mixed ethnic group prisoners in 2011 to 152 deaths per 100,000 in 2013. Asian groups had an average rate of 125 deaths per 100,000 between 2011 and 2013). There was an increase in the rate of deaths for the Black group between 2012 and 2013.

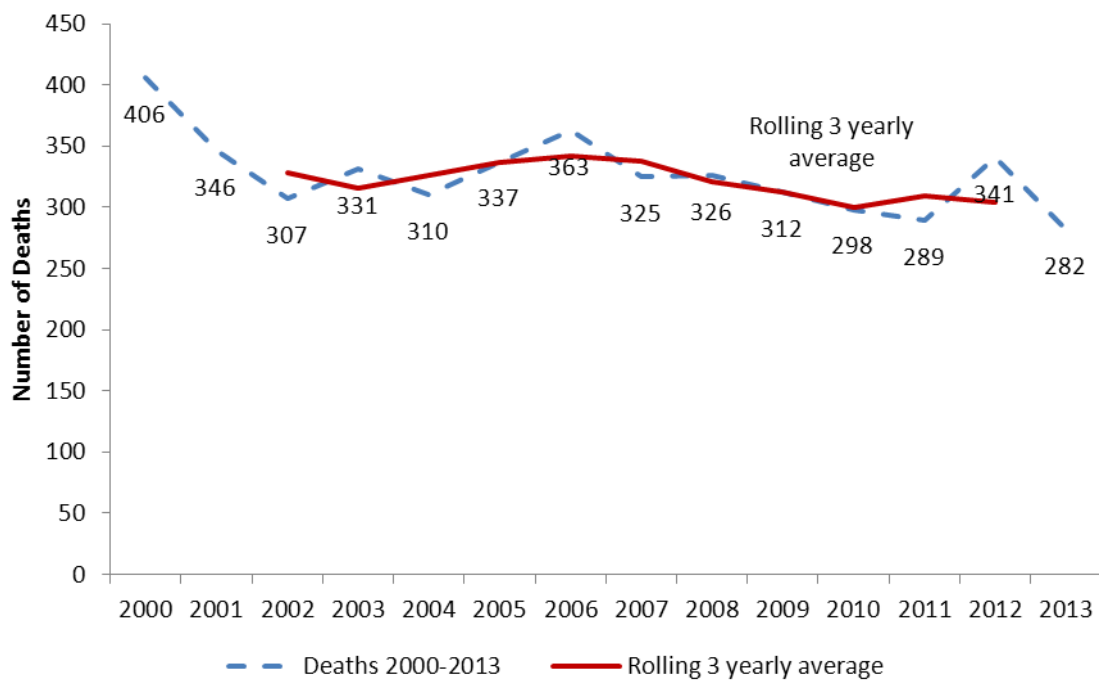
Figure 5: Rate of deaths per 100,000 in prison by ethnic group: 2011, 2012 and 2013



Deaths of Patients Detained Under the Mental Health Act

Figure 6 shows the number of deaths of patients detained under the MHA between 2000 and 2013, as well as average number of deaths (rolling averages for every three years) between 2000 and 2013. Overall there has been a reduction in deaths, from 406 to 282 (31%), of patients detained under the MHA from 2000 to 2013. The contrast between the actual number of deaths and the average number of deaths over the period of 2000 to 2013 suggests that 2012 may have been an anomalous year with 341 deaths - an increase of 18% from the previous year.

Figure 6: Number of deaths of patients detained under the MH Act: 2000-2013

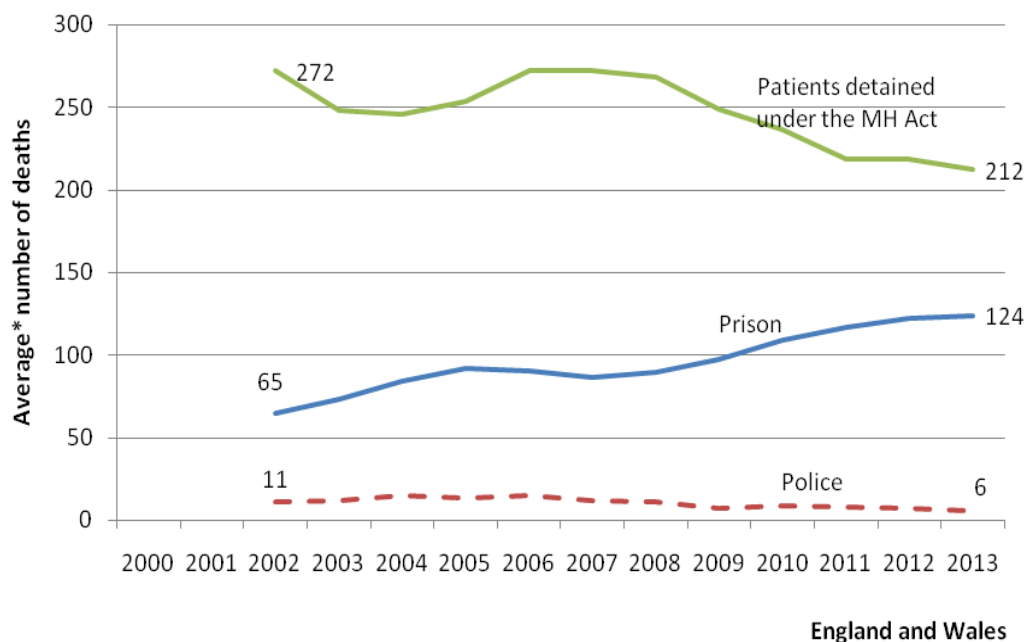


England and Wales

Natural Cause Deaths

Figure 7 shows the average⁸ number of natural cause-related deaths across three sectors (prisons, MHA, police) from 2000 to 2013. Natural cause deaths could include deaths where death was inevitable; where the care and treatment of the detainee could have been better and those that could be viewed as preventable or avoidable. Overall, there was on average, a higher number of natural-cause related deaths amongst patients detained under the MHA (rolling average of over 200 deaths every three years) compared to those in prison or police custody. However, the average number of natural-cause related deaths of those who died in prison has almost doubled between 2000 and 2013 (from 65 deaths to 124 deaths).

Figure 7: Average number of natural cause-related deaths across three custodial sectors: 2000 to 2013



*Rolling average, every three years

⁸ Rolling averages, every three years.

Restraint-related deaths

Table 2 shows the distribution of restraint related deaths recorded in state custody between 2000 and 2013 (across all custodial sectors). In total, there have been 65 restraint-related deaths across all custodial sectors between 2000 and 2013, with the majority of restraint-related deaths associated with patients detained under the MHA (78% of all restraint-related deaths between 2000 and 2013). However, the definitions of 'restraint related deaths' varies widely between the custodial sectors. For the Care Quality Commission (which collates data on patients detained under the MHA) a restraint related death is defined as a death in which restraint was used in the previous seven days, although this may not necessarily be related to the cause of death. For police custody, restraint is defined as 'restraint-related', being mentioned in the post mortem report. In all other sectors, a restraint-related death is defined as a primary cause of death

Table 2: Restraint-related deaths across all custodial sectors: 2000-2013

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
Prison	0	0	0	0	0	1	0	0	0	0	1	0	0	0	2
Police	0	0	0	4	1	0	3	0	1	0	2	1	0	1	13
Patients detained under the MH Act	0	0	1	1	2	0	1	0	0	0	12	8	14	9	48
Approved Premises	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
STC/SCH Young People	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Immigration Detention 4	0	0	0	0	0	0	0	0	0	0	1	0	0	0	1
Total	0	0	1	5	4	1	4	0	1	0	16	9	14	10	65

England and Wales

Death Caused by Others (including Homicide)

Table 3 shows that between 1 January 2000 and 31 December 2013, there were 26 homicides recorded in state custody. Of the 26 homicide related deaths in state custody, 20 (77%) were in prison settings, four were patients detained under the MHA, one in Approved Premises and one in an Immigration Removal Centre. The majority of homicide-related deaths (across the custodial settings) were men (92%, n=24). In 2013, there were four homicides in prison. All four deaths were males; three of the four were aged between 21-30 years; one was aged between 71-80 years. Two of the homicide victims were White males and two were Asian males.

Table 3: Number of deaths caused by others (including homicide) across custodial settings: 2000-2013

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	Total
Prison	3	0	0	1	2	3	0	1	3	0	1	2	0	4	20
Police	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Patients detained under the MH Act	0	0	1	0	1	0	0	0	0	0	1*	0	1*	0	4
Approved Premises	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
STC/SCH Young People	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Immigration Detention	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Total	3	0	1	2	4	3	0	1	3	0	2	2	1	4	26

*These figures have been amended from previous versions by a CQC data cleansing exercise.

Deaths in State Custody by Setting: 2013

There were 523 recorded deaths in state custody in 2013. Table 4 shows the figures across the different custodial sectors in England and Wales for 2012 and 2013.

Table 4: Deaths in State Custody by Settings: 2012 and 2013

Custodial Settings	2012	2013
Prison	192	215
Police	10	15
Patients detained under the MH Act	341*	282
Approved Premises	9	9
STC/SCH Young People	0	0
Immigration Detention	1	2
Total deaths in State Custody for England and Wales	553	523

* This figure has been amended from previous years due to a data cleansing exercise by the CQC

A breakdown of the deaths in state custody⁹ in 2013 by cause of death shows that:

- 63% (N=331) were natural cause deaths although 190 of these deaths (57%) were patients detained under the Mental Health Act;
- 23% (N=119) were self-inflicted deaths;
- 9% (N=46) were categorised as 'cause of death unknown'. Of the 46 deaths, 42 were patients detained under the Mental Health Act¹⁰;
- 2% (N=10) were 'Other non-natural deaths'¹¹ including ODs;
- 1.1% (N=6) of deaths were 'awaiting further information' before classification;
- 1.1% (N=6) of deaths were classified as 'Other Accidental';
- 4 were classified as 'Homicide';
- 1 was classified as 'Restraint Related' although this excludes the 'restraint-related deaths from the CQC (9 deaths) as these cases are recorded as having more than one contributory factor.

There was a 12% increase of deaths in prison from 2012 to 2013. There was a 17% decrease in deaths of patients detained under the MHA, from 341 in 2012 to 282 in 2013, although it is expected that 2012 was an anomalous year. The number of deaths of patients detained under the MHA in 2013 is similar to the number of deaths in this setting in 2010 and 2011 where there were 298 and 289 deaths respectively.

There were two deaths in Immigration Removal Centres in 2013. Both were males, one was White ethnicity and one Asian. Both died from natural causes.¹²

⁹ The total percentages do not add up to 100% due to rounding.

¹⁰ 'Cause of death unknown' includes those deaths 'awaiting further information' in CQC data.

¹¹ 'Other non-natural deaths' includes iatrogenic, Unsure suicide/accident in CQC data.

Gender

Of the 523 deaths in state custody in 2013, 78% (410) were men and 22% (113) were women (see Table 5). The proportion of deaths by gender varies between the sectors, with the great majority of deaths (97% and over) being males in most settings. The exception is in mental health settings, where of the 282 deaths 62% were males and 38% were females. This needs to be understood in terms of the gender mix of the population at individual settings.

Table 5: Deaths in state custody by gender: 2013

	Percentage of males and females	Total Numbers
Prison		
Male	97	209
Female	3	6
Police		
Male	100	15
Female	0	0
Patients detained under the MH Act		
Male	62	175
Female	38	107
Approved Premises		
Male	100	9
Female	0	0
STC/SCH Young People		
Male	0	0
Female	0	0
Immigration Detention		
Male	100	2
Female	0	0
Total (N)		523

¹² Natural cause deaths could include deaths where death was inevitable; where the care and treatment of the detainee could have been better and those that could be viewed as preventable or avoidable (Source: IAP Deaths in Custody Statistical Analysis Report: November 2012)

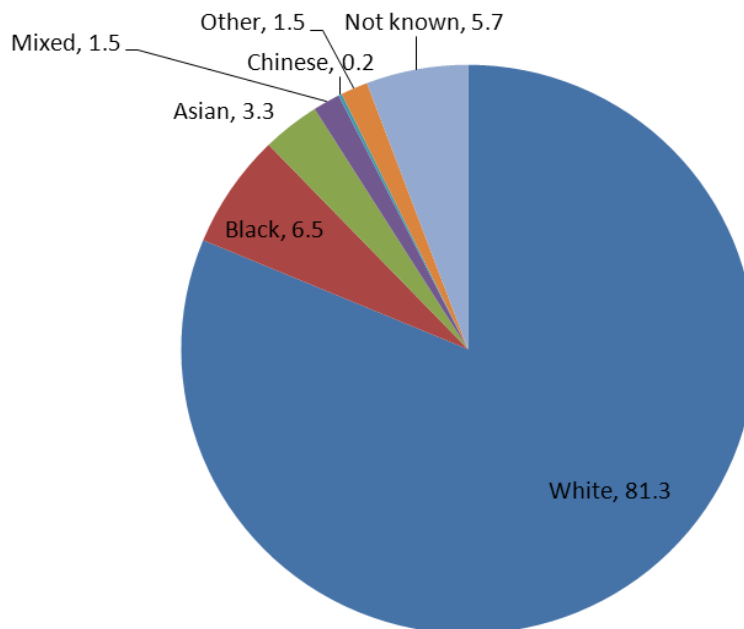
Ethnicity

Figure 8 shows the proportion of White and Black and Minority Ethnic (BME) deaths across the different custodial sectors in 2013.

In total, of the 523 of those who died in state custody in England and Wales in 2013:

- 425 (81%) were classified as White
- 34 (7%) were classified as Black
- 17 (3%) were classified as Asian
- 8 (2%) were classified as 'Other' (i.e. none of the ethnic categories above)
- 30 (6%) were cases where ethnicity was either not stated or not known
- 8 (2%) were classified as Mixed ethnicity
- 1 person was classified as Chinese

Figure 8: Ethnicity breakdown (percentage) of all recorded deaths in state custody: 2013¹³



The ethnic distribution of those who died across all sectors in 2013 was compared to those who died in 2012. The proportion of those who died within each ethnic group showed limited variation between 2012 and 2013. The majority of those who died in custody in 2013 were White (81%), although this has decreased slightly from in 2012 (83%).

¹³Other is an ethnicity that does not fall under any of the given categories. "Not known" is where ethnicity was not recorded.

Table 6 shows the breakdown of deaths by ethnicity across the custodial sectors in 2013. There was considerable variation in the number of deaths between each ethnic group across the custodial sectors. The highest percentage of deaths was amongst the white group (81% of all deaths across all the custodial sectors in 2013), and the lowest proportion of deaths was amongst the Chinese group (one death in 2013). Overall, 13% of deaths were those of BME groups. The highest number of deaths within BME groups was amongst those classified as 'Black'.

Table 6: Ethnicity breakdown of recorded deaths across all custodial settings: 2013

	Prison	Police	Patients detained under the MHA	Approved Premises ¹	STC/SCH Young People	Immigration Detention	Total
White	185	14	216	9	0	1	425
Black	15	0	19	0	0	0	34
Asian	9	0	7	0	0	1	17
Mixed	5	1	2	0	0	0	8
Chinese	0	0	1	0	0	0	1
Other*	1	0	7	0	0	0	8
Not known*	0	0	30	0	0	0	30
Total	215	15	282	9	0	2	523

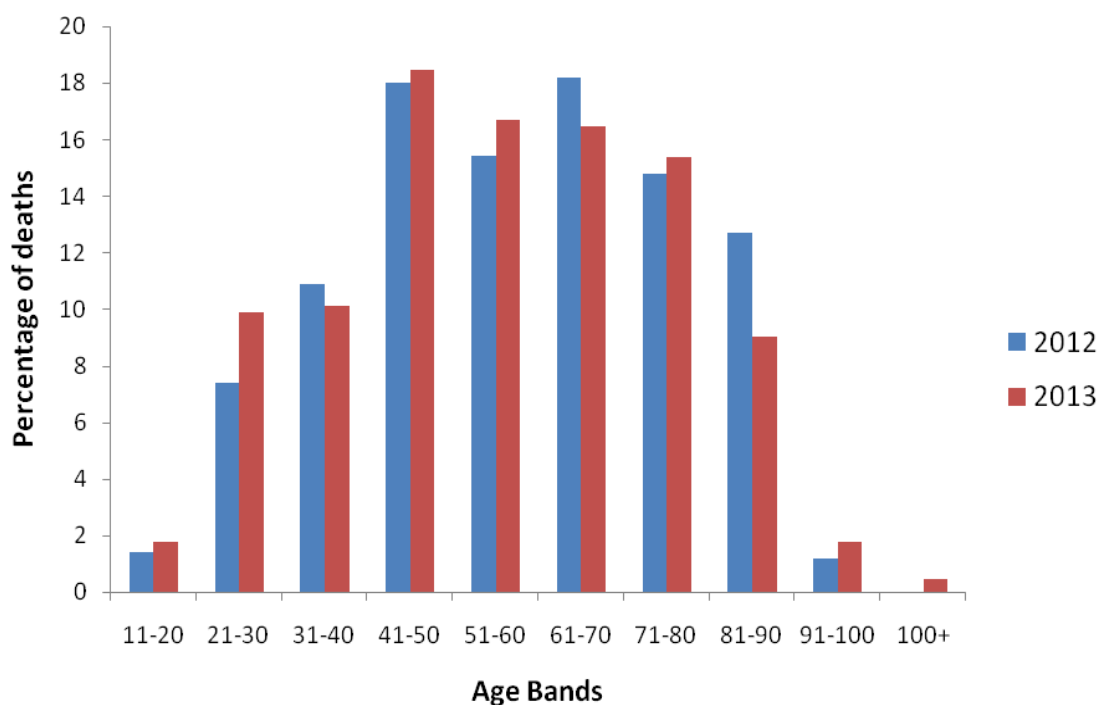
*Other is an ethnicity that does not fall under any of the given categories. "Not known" is where ethnicity was not recorded.

Age

Figure 9 shows the age distribution of those who died in state custody in England and Wales in 2013. The age distribution can only be shown for natural cause deaths, self-inflicted deaths, homicides and restraint-related deaths across all the custodial sectors (excluding restraint-related deaths for patients detained under the MH Act because restraint-related in this category includes other causes of death).

Age was recorded for 455 of those who died in state custody in 2013. There were two deaths for those over 100 in 2013. There were no deaths of young people under 17 years in 2013 in the sectors where this information was available¹⁴ (in 2012 there were 2 deaths in Prison and YOI settings amongst the 15-17 year group).¹⁵ There was a slight increase in the percentage of deaths amongst the younger age groups from 2012 to 2013, from 1.4% to 1.8% for the 18-20 year old group and 7.4% to 9.9% for the 21-30 age band. In 2013 the highest proportion of natural cause, self-inflicted, homicide and restraint-related deaths occurred within the 41-50 age group.

Figure 9: Percentage of deaths by age across all custodial sectors in 2012 and 2013¹⁶



England and Wales

¹⁴ CQC data only provides an 11 – 20 age classification for young people.

¹⁵ There have been a total of 16 deaths of 11 – 17 year olds in the sectors where this is recorded between 2000 and 2013. Of these, 14 occurred in prison (all self-inflicted and males between age 15-17) and 2 in STC/SCH (both in 2004; one restraint-related; one self-inflicted).

¹⁶For natural cause deaths, self-inflicted deaths, restraint-related and homicide only.

Of the 455 deaths in custody where age was recorded and known:

- 2% (8) of those who died were between 11-20; of this group, five of the deaths were between 18-20 in prison; 3 were patients detained under the Mental Health Act and were between 11-20.
- 10% (45) between 21-30
- 10% (46) between 31-40
- 19% (84) between 41-50
- 17% (76) between 51-60
- 16% (75) between 61-70
- 15% (70) between 71-80
- 9% (41) between 81-90
- 2% (8) between 91-100
- 2 where the person was 100+

Self-inflicted Deaths

Between 1 January 2000 and 31 December 2013, there were 1,812 self-inflicted deaths in state custody. Of the 1,812 self-inflicted deaths, 1,477 (82%) were male, and 335 (18%) were female. Overall, the number of self-inflicted deaths has decreased from 152 deaths in 2000 to 119 deaths in 2013 – a reduction of 22%.

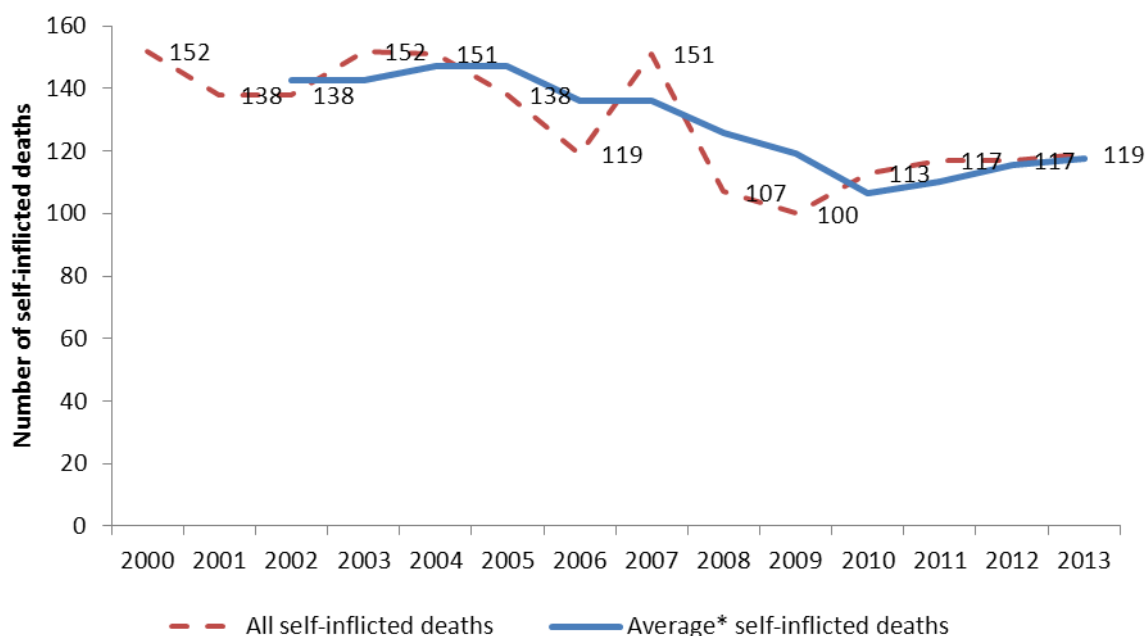
Table 7: Self-inflicted deaths by custodial setting and broken down by gender 2000-2013

All Self Inflicted Deaths	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	TOTALS
Prison (inc YOI)	81	73	95	95	96	78	66	92	61	61	58	57	60	75	1048
Males	73	67	86	81	83	74	63	84	60	58	57	55	59	73	973
Females	8	6	9	14	13	4	3	8	1	3	1	2	1	2	75
Police	4	2	5	2	8	3	2	3	2	1	0	3	2	0	35
Males	4	2	5	1	7	2	2	3	2	1	0	3	2	0	34
Females	0	0	0	1	1	1	0	0	0	0	0	0	0	0	3
Deaths of patients detained under MHA	58	60	35	50	42	49	49	51	40	36	54	51	53	42	670
Males	36	35	21	30	21	30	31	34	25	29	32	32	30	28	414
Females	22	25	14	20	21	19	18	17	15	7	22	19	23	14	256
Approved Premises	8	3	3	4	1	7	2	5	4	2	1	5	2	2	49
Males	8	3	3	4	1	7	2	4	4	2	1	5	2	2	48
Females	0	0	0	0	0	0	0	1	0	0	0	0	0	0	1
IRCs	1	0	0	1	3	2	1	0	0	0	0	1	0	0	9
Males	1	0	0	1	3	2	1	0	0	0	0	1	0	0	9
Females	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
STC / SCH	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Males	0	0	0	0	1	0	0	0	0	0	0	0	0	0	1
Females	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	152	138	138	152	151	139	120	151	107	100	113	117	117	119	1812

Table 7 shows that of the 119 self-inflicted deaths in state custody in 2013, almost two-thirds were in prison (63%, n=75) followed by over one-third (35%, n=42) who were patients detained under the MHA.

Figure 10 shows that whilst the average¹⁷ number of self-inflicted deaths in all settings has decreased since 2005 (an average of 147 self-inflicted deaths in 2005), these have increased steadily since 2010. In 2013, the average number of self-inflicted deaths had reached 118 deaths, an increase from an average of 107 self-inflicted deaths in 2010.

Figure 10: Rolling three yearly average self-inflicted deaths across all custodial sectors: 2000-2013



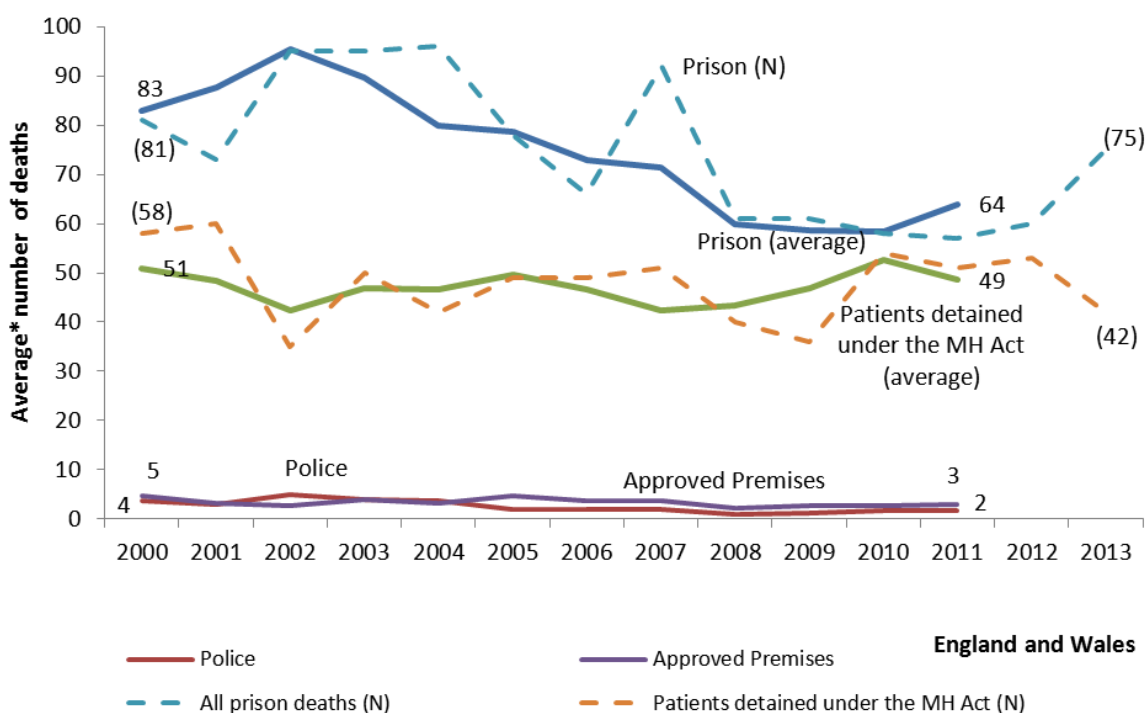
England and Wales

¹⁷ Rolling average, every three years

Figure 11 shows the rolling three yearly average self-inflicted deaths from 2000 to 2013 across four settings (prison, MHA, police, Approved Premises).

The second highest proportion of self-inflicted deaths was among patients detained under the MHA. Figure 11 shows that the average number of self-inflicted deaths of patients detained under the MHA has remained relatively stable over the period 2000 to 2013 at an average of about 48 self-inflicted deaths a year. In contrast to prison settings, however, there has been a reduction (21%) in the number of self-inflicted deaths of patients detained under the MHA – from 53 self-inflicted deaths in 2012 to 42 self-inflicted deaths in 2013.

Figure 11: Rolling three yearly average and number of self-inflicted deaths between 2002 and 2013

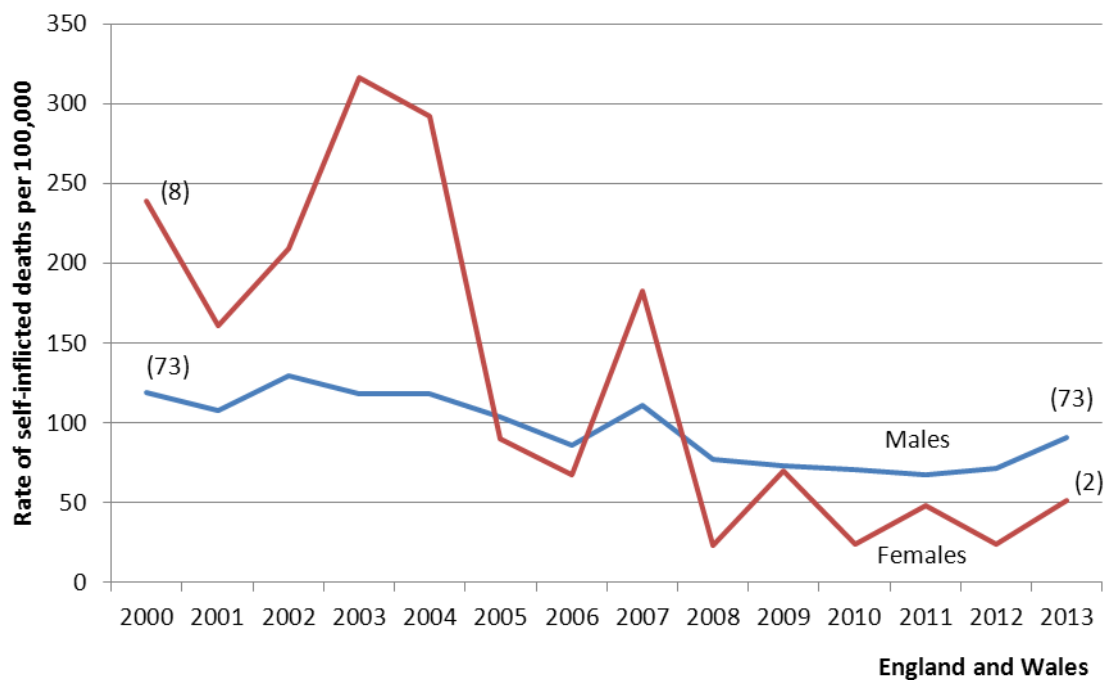


*Rolling three yearly average

Figure 11 also shows that the average number of self-inflicted deaths in police and Approved Premises remain numerically very low (below five).

Figure 12 shows the rate of self-inflicted deaths in prison per hundred thousand for males and females separately. For example, in 2000, there were eight self-inflicted deaths among females in prison, and a population of 3,350 females in prison. This is equivalent to 239 self-inflicted deaths per 100,000 females in prison in 2000. In contrast, there were 73 self-inflicted deaths among males in prison in 2000, and a population of 61,252 males in prison, equal to 119 self-inflicted deaths in prison per 100,000 males. Therefore the rate of self-inflicted deaths amongst females in prison in 2000 (239) was about twice the rate of self-inflicted deaths amongst males (119). Figure 12 shows that this rate has dropped for females, but remained more constant for males over the past 14 years. The rates of self-inflicted deaths in 2013 were 51 females per 100,000 females in prison, and 91 males per 100,000 males.

Figure 12: Rate of self-inflicted deaths (per 100,000) by gender in prison: 2000-2013

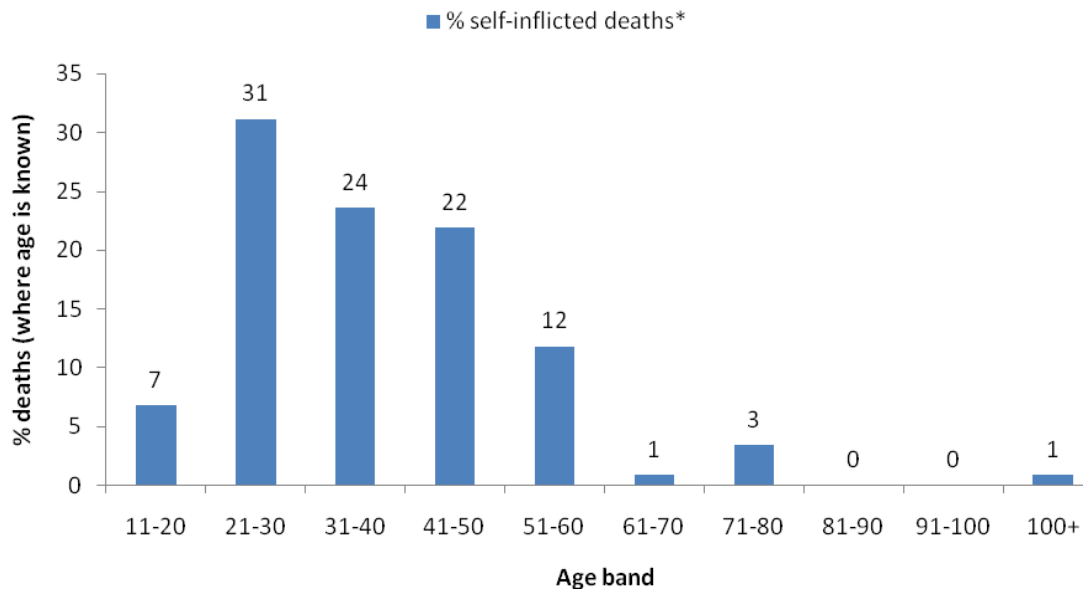


*Numbers in brackets denote actual number of deaths

The most common method of self-inflicted death across all settings in 2013 was hanging, which accounted for 69% of all self-inflicted deaths (82). Of the 42 self-inflicted deaths whilst detained under the MHA, 17 died from hanging, 12 died from jumping/falling (including railways), three from overdose/poisoning, one from suffocation and the remaining four from other methods.

Figure 13 shows the percentage of self-inflicted deaths by age band¹⁸ across all custodial sectors in 2013. There were 119 self-inflicted deaths across state custody in 2013. Of these, the highest proportion of self-inflicted deaths (31%) occurred amongst 21-30 year olds, followed by 24% amongst the 31-40 year olds, 22% amongst the 41-50 year olds and 12% among the 51-60 year olds. For the 11-20 age band there were no self-inflicted deaths amongst 11-17 year olds. A total of 7% (n=8) of the self-inflicted deaths occurred amongst 18-20 year olds.

Figure 13: Percentage of self-inflicted deaths by age group (where age was known) in state custody: 2013



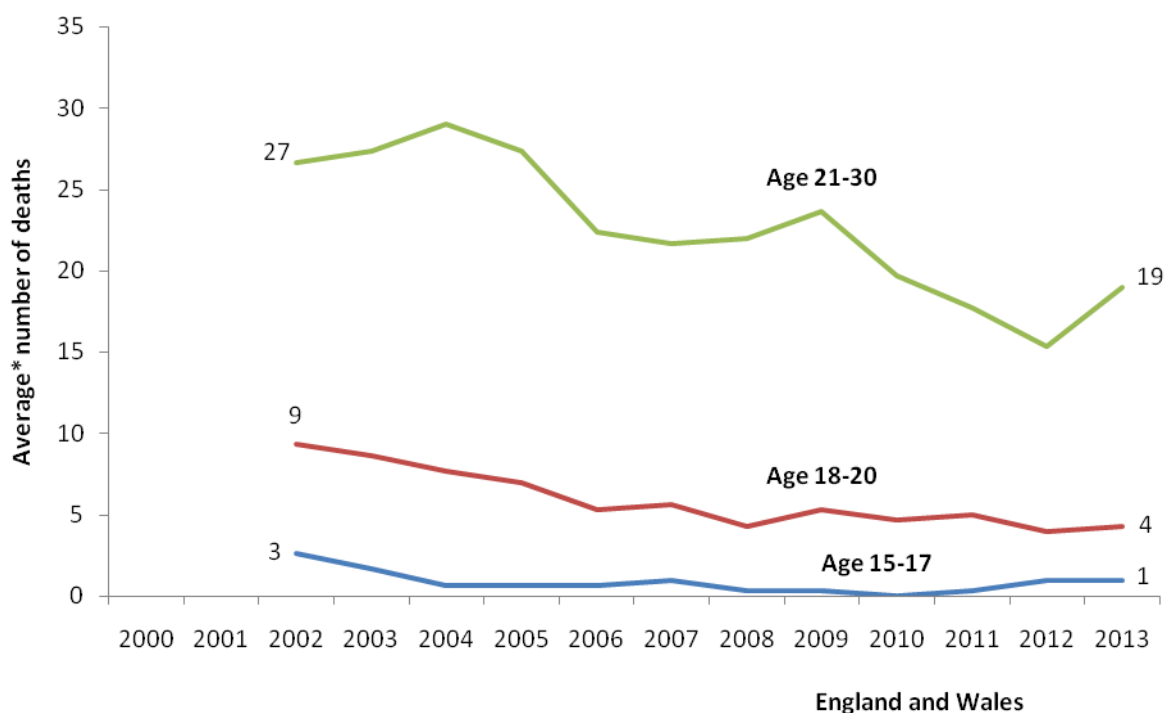
England and Wales

¹⁸ Where age was recorded and only for natural cause deaths, self-inflicted deaths, restraint-related and homicide deaths.

Figure 14 shows the average number of self-inflicted deaths for young males in prisons and YOI custodial settings between 2000 and 2013. The age bands have been disaggregated into 3 groups: 15-17; 18-20 and 21-30. Figures younger than age 15 are not recorded for prisons and YOI settings. The self-inflicted deaths of young females in prisons have not been included.

The chart shows that across the three age bands, the highest three yearly average¹⁹ of self-inflicted deaths for males has been amongst the 21-30 year age group (an average of 19 deaths in 2013), and the lowest average number of self-inflicted deaths for males has been amongst the 15-17 year group (an average of one death by 2013). Overall, the average number of self-inflicted deaths amongst males for all three age groups has been decreasing since 2000, although there has been a notable increase in self-inflicted deaths for the 21-30 year group. Between 2012 and 2013, the number of self-inflicted deaths for males amongst the 21-30 year group has doubled from 13 to 26 deaths. Caution is required when interpreting numerically low numbers within specific age groups.

Figure 14: Average number of self-inflicted deaths for young males in prisons and YOI settings between 2000 and 2013



*Rolling 3 yearly average

¹⁹ Rolling average, every three years

Ethnicity and Self-inflicted Deaths

Table 8 shows the number of all deaths in custody in 2013 ('all deaths 2013'), as well as the number of self-inflicted deaths recorded for each ethnic group in custody for 2013 ('number of self-inflicted deaths'). The last column on the right shows the percentage of self-inflicted deaths (as a proportion of all deaths) for each ethnic group across all custodial sectors in 2013. For example, of the 425 white individuals who died in custody, 84 (or 20%) were classified as self-inflicted deaths. Looking at the percentage of self-inflicted deaths for each ethnic group, Table 8 shows that 47% (n=8) of the recorded deaths of Asian people in custody were self-inflicted, followed by the 38% (n=3) of self-inflicted deaths for Mixed and Other ethnic groups in custody. Over a quarter (n=10) of the recorded deaths of black groups in custody was also self-inflicted. There was one death among the Chinese ethnic group in 2013, and this was self-inflicted. The lowest proportion of self-inflicted deaths (20%) occurred amongst the white groups in state custody. Some caution needs to be taken when interpreting these figures as the number of deaths amongst BME groups is small (which inflates the percentages).

Table 8: Self-inflicted deaths compared to total number of deaths by ethnic group: 2013

Ethnic group	All deaths 2013 by ethnic group	Number of self-inflicted deaths by ethnic group	% of deaths that were self-inflicted by ethnic group
White	425	84	20
Black	34	10	29
Asian	17	8	47
Mixed	8	3	38
Chinese	1	1	100
Other	8	3	38
Not known	30	10	33
Total	523	119	

England and Wales

Conclusions

This report shows that there were 523 recorded deaths in state custody in 2013. This represents 14% fewer deaths in 2013 compared to 2000, and a 5% decrease in deaths in state custody from 2012. The majority (63%) of the recorded deaths in state custody in 2013 were natural-cause deaths (which include deaths where death was inevitable; where the care and treatment of the detainee could have been better and those that could be viewed as preventable or avoidable). A total of 190 of the 523 recorded deaths were patients detained under the Mental Health Act.

Between 2000-2013, the highest annual number of deaths has been amongst patients detained under the MH Act. This is partly explained by the high number of natural-cause related deaths amongst this group. The number of deaths amongst patients detained under the MH Act has fluctuated over the period 2000-2013, although there has been a general decrease in deaths amongst this group since 2009 (with the exception of 2012, when there were 341 deaths amongst patients detained under the MH Act).

There has been an increase in the number of recorded deaths in prison since 2002 (from an average²⁰ of 151 deaths between 2000-2002 to an average of 200 deaths between 2011 and 2013). Some of this can be explained by an increase in natural-cause deaths in prison. There was also a 12% increase in recorded deaths in prison between 2012 and 2013 – due predominantly to an increase in self-inflicted deaths which rose from 60 to 75.

In contrast to males, the rate of deaths for females in prison has declined (with some fluctuation) since 2000. In 2000, the rate of deaths among females was 299 female deaths per 100,000 females (N=10); by 2013 it had reduced to 154 female deaths per 100,000 females in prison (N=6). The rate of deaths among males has remained more steady, and, on average, higher than females. The rate of deaths for males in prison between 2012 and 2013 increased from 228 male deaths per 100,000 males in 2012 (N=188) to 260 male deaths per 100,000 males in 2013 (N=209).

The number of recorded deaths among Black and Ethnic Minority (BME) groups is small in comparison to Whites (there was a total of 68 recorded deaths amongst BME groups in 2013).

Comparing restraint-related deaths between different custodial sectors has been difficult because of the varying definitions of restraint-related deaths across the sectors. For instance, for the Care Quality Commission (which collates data on patients detained under the MHA) defined restraint related as a death in which restraint was used in the seven days prior to death, although this may not necessarily be related to the cause of death. For police custody, it is defined as 'restraint-related if restraint was mentioned in the post mortem report. Therefore we need to be cautious when interpreting restraint-related deaths between settings.

There were two deaths in Immigration Removal Centres in 2013. Both were males; one White ethnicity; one Asian. There was an increase of one death from the previous year. Overall there have been 19 deaths recorded in Immigration Removal Centres since 2000.

Age is recorded for natural-cause related deaths, self-inflicted deaths, restraint-related deaths and homicides only. In 2013, this added up to 455 deaths where age was recorded.

Between 2000 and 2013, there have been a total of 16 recorded deaths of 11-17 year olds – all of which were males and self-inflicted. However, there were no deaths amongst this group in 2013.

²⁰ Rolling average, every three years

Of the 119 self-inflicted deaths in state custody in 2013, almost two thirds were in prison and just over one third were patients detained under the MH Act.

Self-inflicted deaths in state custody had been decreasing since 2002 (from a three yearly average of 143 deaths in 2002 to a three yearly average of 118 self-inflicted deaths in 2013), although there has been an increase again since 2010. In particular, there has been an increase of self-inflicted deaths in prison from 2012 to 2013 (from 60 to 75). Self-inflicted deaths of detained patients under the MH Act decreased from 2012 to 2013 (from 53 to 42).

The majority of self-inflicted deaths in prison are amongst males (73 of 75 self-inflicted deaths in prison were males in 2013). The most common method of self-inflicted deaths across all settings was hanging (69% of all self-inflicted deaths).

Almost a third of all the self-inflicted deaths in state custody in 2013 occurred among the 21-30 year group. The number of male self-inflicted deaths amongst this age group in prison doubled from 13 self-inflicted deaths in 2012 to 26 self-inflicted deaths in 2013. There were no self-inflicted deaths of 11-17 year olds in 2013.

Although the numbers of self-inflicted deaths among BME groups (25 deaths) in state custody is relatively small in comparison to those of white origin (84 self-inflicted deaths), it is worth noting the higher proportions of self-inflicted deaths among some of the BME groups. In particular, eight out of the 17 recorded deaths of Asian detainees in state custody were self-inflicted, ten out of the 34 recorded deaths of Black people in custody were self-inflicted and 84 of 425 recorded deaths of White detainees were self-inflicted.