Independent Advisory Panel on Deaths in Custody

Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2012

May 2014

Foreword by Lord Toby Harris

Welcome to the third statistical report by the Independent Advisory Panel (IAP) into deaths in custody and covers the period between 2000 and 2012.

The purpose of the Panel is to give advice to Ministers to help reduce future deaths in custody; over time these annual updates will enable the Panel to draw on a larger pool of data and to develop its analysis and comparison between custodial sectors which will help to inform potential future work for the Panel. For instance, our previous report highlighted a discrepancy between the number of recorded restraint related deaths in custody, and those "known" to practitioners anecdotally. This has indirectly led to discussions with ACPO on the collation and reporting of use of force figures.

This report is late for a variety of reasons, but I am pleased to note that work has already begun in pulling together the statistics for the year ending 2013 and this will be published in a few months' time.

There continue to be problems gathering population data on those in custody across all the sectors both in terms of overall population and breakdown by characteristic. Lack of this information makes it harder to analysis the figures for deaths in custody and in particular to draw any comprehensive conclusions or provide context to the number of deaths. The Panel will continue to work with the custodial sectors to develop this area of work.

The Panel have noted with concern the number of deaths of those detained in hospital under the Mental Health Act which have risen from 283 in the previous year to 344 in 2012. Every avoidable or preventable death is one death too many, and any increase is disturbing. We will be examining the reasons for this increase and will in any event continue to monitor the statistics for any themes that may emerge in this area or any other.

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Notes on the data

This report covers deaths in state custody recorded by the various custodial sectors in 2012. These figures were reported to the IAP, but beyond examining consistency in the reported figures within each sector (e.g., ensuring that the number reported as dying in custody remained the same when the figures were broken down by age and by gender), the IAP does not quality assure this data. In addition, when the deaths in custody were reported for 2012 some custodial sectors included revised figures for previous years. This might be because the outcome of an investigation allowed for a death in custody to be properly classified, for example, from a death awaiting further classification to self-inflicted. This potential for change should be kept in mind when comparing previous statistical releases to the current release.

The ability to analyse the relationships between deaths in custody and important background characteristics (e.g., race, gender, age) was limited by the data available. For example, because of the very small number of deaths from 2000 – 2012, data from Secure Children's Homes and Secure Training Centres was provided by the specific age of those children who have died. All other organisations provided age in categories, and the youngest category (with the exception of male young offenders) was 11-20. This prevents an examination by age across the sectors.

This statistical release shows the number of individuals who were recorded as having died in custody in 2012 (the absolute figures) and in some instances it was possible to locate additional information to allow for more in-depth analysis (the relative figures). For example, according to prison figures in 2000 there were 3,350 females in prison and 10 deaths in custody (3.0 deaths per 1000 females), and in 2012 there were 4,148 females in prison and 4 deaths in custody (0.96 per 1000 females). For males, the equivalent figures for 2000 were 61,252 males in prison with 136 deaths (2.2 per 1000 males) and in 2012, 82,464 with 188 deaths in prison (2.3 per 1000 males). This would suggest that the likelihood of females dying in prison has reduced from 2000 to 2012, but remained stable for males.

It is very important to cautiously interpret any comparisons of deaths in custody across the custodial sectors. This is because the sectors vary in the number of individuals flowing in and out of the system, the length of time individuals are detained and the types of people who are detained.

Number of individuals

The above analyses comparing the likelihood of males and females dying in prison was based on population figures provided by the National Offender Management Service (NOMS) to the IAP and is a still picture of those who were in prison on a given date in that year. Because this is a static picture, however, it may not accurately represent all individuals who could die in custody. That is, the actual number of individuals who spent time in prison in the year 2012, and therefore who could have died in prison, was actually higher than 86,612. This suggests that an individual's risk of death in custody in prison is actually lower than that it was possible to report, and also, if there were any differences between males and females in movement into and out of prison, then the comparison between the rate of death in custody for males and females in prison might vary from what it was possible to report.

While it is obviously a challenge to establish the number of individuals moving in and out of a closed environment (e.g., prison, young offender's institution, approved premises, immigration removal centres, SCH, STC), it is even more challenging to determine who is 'at risk' for a death in police custody because there is no available population data for those who have been detained in police custody or by the police under the Mental Health Act.

Length of time Individuals are detained

The longer that an individual spends in custody, the longer they are 'at risk' of dying in custody, and this needs to be factored in to any cross sector comparison of death in custody. For example, while the number of individuals dying in police custody in 2012 was low (9) compared to those in prison custody (192), on average individuals are in police custody for a very small fraction of the time that they are in prison.

Types of people detained

This statistical release does not provide a clear picture of key factors that might put an individual at a greater or lesser risk of a death in custody. It was only possible to obtain very basic information (gender, age band, and ethnicity) from some of the custodial sectors. Even if comparable information for all individuals was available, any associations identified between deaths in custody and these basic demographic features could be concealing more important (but unmeasured) factors such as mental or physical health. Comparisons of basic demographic characteristics might be able to help identify those who might be most 'at risk', but these factors do not provide critical information about how to reduce this risk.

Much more high quality data collection is needed to develop an evidence base on deaths in custody. Perhaps because these are statistically rare events, research has tended to focus either on exploring issues surrounding individual cases or on broad overviews rather than developing a systematic way of collecting information that could be used to explore factors associated with deaths in custody. As important for preventing future deaths in custody as exploring data around actual deaths, would be exploring data about near-misses. Development of these sorts of data collection mechanisms could allow for a much more evidence-based approach to preventing deaths in custody.

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. The report showed there were 5,998 recorded deaths in state custody between 1 January 2000 and 31 December 2010, which was an average of 545 deaths per year¹. The 2011 statistical release on deaths in custody² revealed the latest figure to be 6,552 deaths from 2000 to 2011, thus bringing the average to 546 deaths per year. The most recent addition of the 2012 figures on deaths in custody brings the total number of recorded deaths in state custody to 7,122 deaths recorded for the 13 years from 2000 to 2012. This is an average of 548 deaths per year.
- 3. The report provides a breakdown of all recorded deaths in the following custodial sectors:
- Prisons and Young Offender Institutions (YOIs)³ •
- Police⁴ •
- **Immigration Removal Centres**
- Approved Premises⁵ •
- Secure Children's Homes (SCHs)⁶ •
- Secure Training Centres (STCs)⁷ •
- Whilst not a custodial sector, this report also contains data on the deaths of patients who have died in hospitals whilst detained under the Mental Health Act.

¹ Available to download here: <u>http://iapdeathsincustody.independent.gov.uk/news/iap-publish-statistical-analysis-of-all-</u> recorded-deaths-2000-2010/. The report did not include data on deaths of patients detained under the Mental Health Act in Wales. The IAP has incorporated this data from the Healthcare Inspectorate Wales in all figures, charts and tables in this report.

² Independent Advisory Panel on Deaths in Custody (2012) Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2011. ³ These figures include all prisoners within public and private sector prisons, but exclude deaths in HM Prison Service 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. ⁴ 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

Approved 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.

⁵ SCHs 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 with high risk factors. ⁷ STCs are purpose built centres for young offenders up to the age of 17. They are run by private operators under contracts,

which set out detailed operational requirements.

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.
 - Independent Police Complaints Commission (IPCC) for data on deaths in or following 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
 - 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 2011 Deaths in Custody statistical release as previous deaths where the cause of death was unknown, have been classified since.
- 6. 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.
- 7. CQC have acknowledged difficulties with production data for 2012, particularly as the total number of deaths recorded reduced (by seven cases) in the period this report was being written. This occurred after a data cleansing exercise to support production of the CQC Annual Report into the use of the Mental Health Act in 2012/13. They noted that some information had been recorded incorrectly on their database. Although the new data has been analysed for production of the Panel's statistical analysis, it has not been possible to disaggregate the new figures to the level of detail provided last year for every section. However, as there were only seven fewer cases, the overall results of the analyses are unlikely to have changed significantly.

Deaths in State Custody

8. This section provides details on the following areas: (i) deaths in state custody in 2012 (ii) the context of deaths in state custody between 1 January 2000 and 31 December 2012 (iii) recent trends between 1 January 2010 and 31 December 2012 (vi) natural cause deaths in all settings (v) self-inflicted deaths in all settings, (vi) deaths caused by homicide in all settings and (vii) restraint related deaths.

9. This report does not include data on deaths that occurred in 2013, as many of these figures had not been confirmed. The Panel intends to produce a report on 2013 figures later this year.

Deaths in State Custody: 2012

10. There were 549 recorded deaths in state custody in 2012. Table 1 shows the distribution of these deaths across the different custodial sectors.

Table 1: Deaths in State Custody by Settings: 2012

Custodial Settings	2012
Prison	192
Police	10
In-patient Mental Health Setting (detained patient)	337
Approved Premises	9
STC/SCH Young People	0
Immigration Detention	1
Total deaths in State Custody for England and Wales	549

11. There was an increase of deaths in inpatient mental health settings (from 283 in 2011 to 337 in 2012), the highest number of deaths in this setting since 2006. Of the 337 deaths in mental health settings, 71% were from natural causes.⁸

12. There was 1 death in immigration detention (Immigration Removal Centres), a black male between the ages of 41-50 (awaiting determination of cause).

13. A breakdown of the 549 deaths in state custody in 2012 by cause of death⁹ shows that:

- 67% (368) were natural causes 65% (239) of which were deaths of patients detained under the Mental Health Act;
- 21% (115) were self-inflicted deaths
- 7.3%% (40) were 'cause of death unknown', 37 of the 40 were patients detained under the Mental Health Act;
- 1.8% (10) of deaths were 'awaiting further information' before classification
- 1.8% (10) were 'Other non-natural deaths' including ODs
- 0.9% (5) were classified as 'Other Accidental'
- 0.2% (1) was death caused by another person

⁸ 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)

⁹ The cause of death figures below exclude 'restraint-related deaths' as the only restraint-related deaths in 2013 were amongst those detained under the Mental Health Act where the definition of restraint-related deaths is where restraint was used in the seven days preceding the death.

Gender

14. Of the 549 deaths in state custody in 2012, 73% (399) were men and 27% (150) were women. However, table 2 shows the gender proportions varied between the sectors, with the majority of deaths (90% and over) being males in police, prison and approved premises. But for those who died whilst detained under the Mental Health Act (337 deaths), 57% were males and 43% were females.

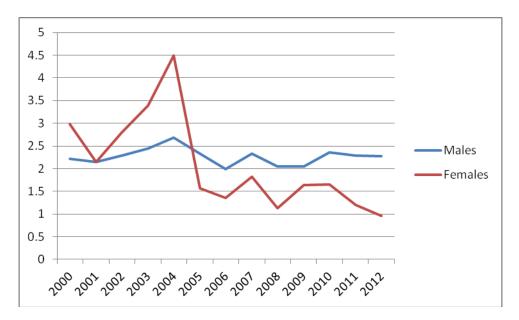
Table 2: Deaths in state custody by gender: 2012

	Percentage								
	of males and	Numbers							
_ ·	females								
Prison									
Male	98	188							
Female	2	4							
Police									
Male	90	9							
Female	10	1							
In-patient Mental Health Setting (detained									
patient)		102							
Male	57	193							
Female	43	144							
Approved Premises	5								
Male	89	8							
Female	11	1							
STC/SCH Young Pee	ople								
Male	0	0							
Female	0	0							
Immigration Deten	tion								
Male	100	1							
Female	0	0							
Total (N)		549							

15. The gender split between custodial sectors was not substantially different from 2011.

Gender and deaths in prison

Figure 1: Deaths in prison per 1000 by gender



Source: Data provided to the IAP from NOMS.

16. Figure 1 shows the rate of deaths in prison per 1000 by males and females separately. For example, in 2000 there were 136 males who died in prison and there were 61,252 males in prison (2.2 deaths in prison per 1000 males). It can be seen that the rate for males has stayed fairly constant, but the rate for females appears to have fluctuated. However, the apparent fluctuation in the rate of females dying in prison per 1000 females in prison is influenced by the low numbers of females dying in prison. The highest number was 20 (2004) and the lowest was 4 (2012).

Ethnicity

17. The proportion of Black and Minority Ethnic (BME) groups who have died across the different custodial sectors is highlighted below. Figure 2 shows that amongst the 549 deaths in state custody in 2012, the majority of those who died were White (84%), 6.4% Black, 3.3% Asian and 1.3% Mixed Race.

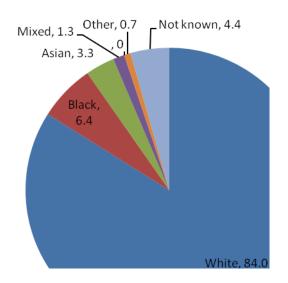


Figure 2: Ethnicity breakdown (percentage) of all recorded deaths in state custody: 2012¹⁰

18. In total, of the 549 of those who died in state custody in 2012:

- 461 (84%) were classified as White
- 35 (6.4%) were classified as Black
- 18 (3.3%) were classified as Asian
- 4 (0.7%) were classified as 'Other' (i.e. none of the ethnic categories above)
- 24 (4.4%) were cases where ethnicity was either not stated or not known
- 7 (1.3%) were classified as Mixed ethnicity

19. A more detailed look at the ethnicity breakdown of those dying in custody across the different custodial sectors shows considerable variation (see Annex A Table 3), although there are a very small number of deaths in some custodial sectors.

20. Table 4 highlights the distribution of deaths by ethnic group between prison and those detained under the Mental Health Act.

¹⁰ Other is for ethnicity that does not fall under any of the given categories. "Unknown" is where ethnicity was not recorded.

Table 4: Ethnicity breakdown (percentage) of recorded deaths in prison and in-patient mental health settings: 2012

	Prison (%)	Detained patient % (Mental Health setting)
White	88.0	81.9
Black	5.7	6.2
Asian	3.6	3.3
Mixed	2.6	0.3
Chinese	0.0	0.0
Other*	0.0	1.2
Not known*	0.0	7.1
Total (N)	192	337

* Other is for ethnicity that does not fall under any of the given categories. "Unknown" is where ethnicity was not recorded.

21. A higher proportion of the Black (6.2%), Not Known (7.1%) and 'Other' group (1.2%) died in mental health settings compared to prison (5.7% and 0% respectively). In contrast, a lower proportion of the White group died in mental health settings (81.9%) compared to deaths amongst the white group in prison settings (88%).

Ethnicity and deaths in prison

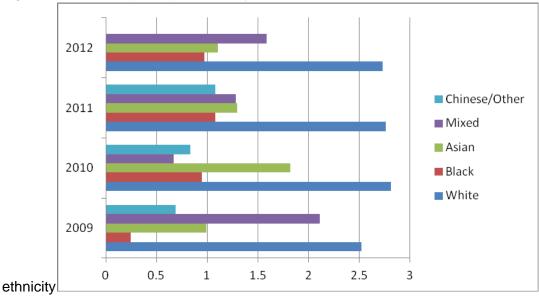


Figure 3: Deaths in prison per 1000 by

Source: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/269399/Race-and-cjs-2012.pdf.

22. Figure 3 shows the rate of deaths in custody per 1000 individuals of that ethnicity in prison from 2009 - 12. For example, in 2009 153 individuals of White ethnicity died in prison and there were 60,718 individuals of White ethnicity in prison, a rate of 2.5 deaths per 1000. The results show that those of White ethnicity had the highest rate of deaths in prison for all years where data was available. There appeared to have been an increase in the rate of death in prison of those of Black ethnicity from 2009 (0.25 per 1000 Black individuals) to

2012 (0.98 per 1000 Black individuals), but this change should be interpreted with caution because of the very small numbers (3 Black individuals dying in prison in 2009 compared to 11 in 2012).

23. When the rate of death in prison of those of White ethnicity was compared to those of all non-White individuals¹¹, the results suggested that those of White ethnicity were statistically significantly more likely to have died in all years¹². Looking at the odds ratios¹³ of these comparisons, those of White ethnicity were between 2.4 (2010 and 2011) to 3.5 (2009) times more likely to die in prison compared to those of non-White ethnicity.

Age

24. The age distribution of those dying in custody could only be calculated for natural cause deaths, self-inflicted deaths, homicides and restraint-related deaths.

25. Age band was known and recorded for 488 of those who died in state custody in 2012 (see Figure 4). It is notable that there were a higher number of deaths amongst the 71-80 and 81-90 age group (72 and 62 deaths, respectively) compared to the previous year (25 deaths for the 71-80 age band and 36 deaths for the 81-90 band). There were fewer deaths amongst the 11-20 group (7 in total) compared to 2011 (9 deaths), although it is worth noting that there were 2 deaths amongst the 15-17 age group in prison and YOI settings in 2012.

¹¹ It was not possible to compare those of White ethnicity to other specific ethnicities because of small numbers. ¹² This was based on the results of four chi squared tests. For 2009, chi squared = 26.4, p<.0001; For 2010, chi

squared = 18.6, p<.0001; For 2011, chi squared = 17.1, p<.0001; For 2012, chi squared = 19.5, p<.0001. ¹³ The odds ratio is another way of evaluating a relationship in a 2X2 table. The odds ratio is centred around 1 (no relationship), and as a rule of thumb an odds ratio of 2, or a doubling of the risk, is considered important.

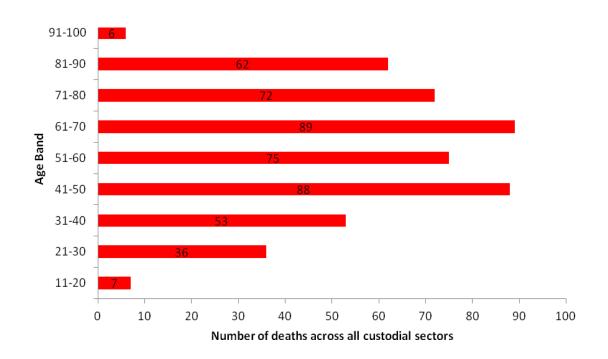


Figure 4: Total number of deaths where age is known across all custodial sectors: 2012¹⁴

26. Of the 488 deaths in custody where age was known and recorded:

- 1.4% of those who died were between 11-20
- 7.4% between 21-30
- 10.9% between 31-40
- 18% between 41-50
- 15.4% between 51-60
- 18.2% between 61-70
- 14.8% between 71-80
- 12.7% between 81-90
- 1.2% between 91-100

Summary of Deaths in State Custody 2000-2012

27. Table 5 summarises the number of recorded deaths in state custody between 1 January 2000 and the 31 December 2012. Some of the figures in the table will have changed from the 2011 Deaths in Custody statistical release as previous deaths where the cause of death was unknown, have since been classified.

¹⁴ Only for natural cause deaths, self-inflicted deaths, restraint-related and homicide deaths. All restraint-related deaths noted here were amongst detained patients within Mental Health settings; it is important to note that the CQC classify restraint-related differently to other custodial sectors.

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	Total
Prison 1	146	142	164	183*	208*	174	153	185	165	169	197	192	192	2270
Police 2	30	28	32	34	39	28	26	23	18	16	19	19	10	322
In-patient Mental Health Setting (detained patient)	406	346	307	331	310	337	363	325	326	312	323	283	337	4306
Approved Premises	24	22	21	12	20	17	10	17	15	9	12	17	9	205
STC/SCH Young People 3	0	0	0	0	2	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	17
Total deaths in State Custody for England and Wales	607	538	524	562	583	558	553	550	524	506	553	515	549	7122

Table 5: All deaths in state custody between 2000-2012

*Some deaths take several months to be classified. These figures are confirmed numbers i.e. deaths that have been subsequently classified from previous years

- 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. Statistics published on 24 April 2014 include 1 additional death in 2005, 2008 and 2010. But these have been excluded as all analysis had been completed prior to this date.
- 2. Deaths in or following police custody as defined by IPCC in their annual statistical publication (http://www.ipcc.gov.uk/page/deaths-during-or-following-police-contact)
- 3. Deaths of young people in Secure Training Centres (STCs) and Secure Children's Homes (SCHs).
- 4. These figures include the three prison service run Immigration Removal Centres at Haslar, Dover and Lindholme.

28. In total there were 7,122 deaths recorded for the 13 years from 2000 to 2012. This is an average of 548 deaths per year. Of these deaths, 72% were men (5,123) and 28% (1,999) were women.

29. In 2000, a total of 607 deaths were recorded in state custody compared to 549 in 2012. This represents 9.5% fewer deaths in 2012 compared to 2000, although this percentage has fluctuated in the years in between this period. Moreover, there has been a 6.6% increase in deaths in state custody since 2011.

30. Figure 5 shows that majority (92.4%) of the 7,122 deaths in the last 13 years occurred either within mental health settings or prison settings.

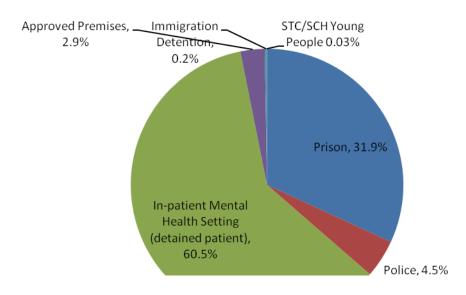


Figure 5: Deaths in state custody by settings: 2000-2012¹⁵

31. Figure 6 shows the number of deaths of those detained under the Mental Health Act between 2000 and 2012. Overall there has been a 17% reduction of deaths (from 406 to 337) of detained patients from 2000 to 2012. However, there was a 19% increase in deaths (from 283 to 337) of detained patients between 2011 and 2012.

 $^{^{15}}$ The chart excludes STC/SCH as the total deaths between 2000-2012 was 0.03% (2 deaths) which was too small to be shown in the chart.

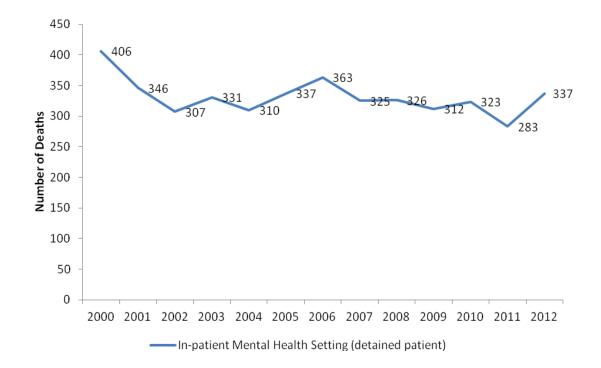
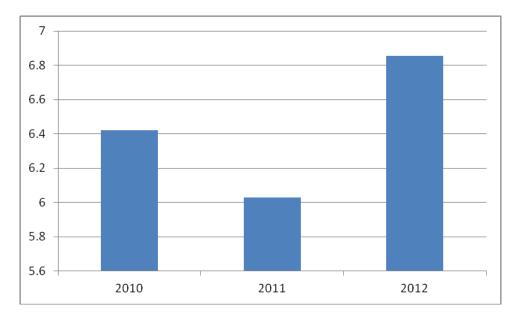


Figure 6: Number of deaths in in-patient mental health settings: 2000-2012

Deaths in custody of those detained under the Mental Health Act

Figure 7: Rate of deaths in custody of those detained under the mental health act per 1000 detained patients



Sources: <u>http://wales.gov.uk/statistics-and-research/patients-mental-health-hospitals-units/?tab=previous&lang=en</u>; <u>http://www.hscic.gov.uk/catalogue/PUB12503/inp-det-m-h-a-1983-sup-com-eng-12-13-tab.xlsx</u>

32. Figure 7 shows the rate of deaths in custody of those detained under the Mental Health Act per 1000 detained. For example, in 2010 303 individuals died while detained under the mental health act in England and Wales and 47,169 were recorded as being detained. This

is a rate of 6.4 per 1000 detained. There was an increase from 6.0 per 1000 detained in 2011 to 6.9 per 1000 detained in 2012, but this difference was not statistically significant. ¹⁶

Deaths in state custody by cause of death

33. This section provides an overview of the number of deaths across the different custodial sectors between 1 January 2000 to 31 December 2012, broken down by cause of death¹⁷ (natural cause, self-inflicted and homicide), gender and ethnicity.

34. Table 6 shows the number of deaths in state custody by cause of death in 2012. There were 368 deaths recorded as natural cause deaths¹⁸ in 2012 which constituted the majority of deaths (67%). Self-inflicted deaths were the second highest cause of deaths in 2012 (21% of all deaths). Notably 40 deaths (7.3%) were recorded as 'cause unknown.'

	Natural Causes	Self- inflicted	Non- natural mainly acc. and ODs	Cause Unknown	Homicide	Other Accidental	Deaths awaiting further info*	Total
Prison	121	60	2	0	0	0	9	192
Police1	4	2	1	2	0	1		10
In-patient Mental Health Setting (detained patient)	239	51	5	37	1	4		337
Approved Premises	4	2	2	1	0	0		9
STC/SCH Young People	0	0	0	0	0	0		0
Immigration Detention	0	0	0	0	0	0	1	1
Total	368	115	10	40	1	5	10	549
Percentage	67	21	1.8	7.3	0.2	0.9	1.8	100

Table 6: Deaths in state custody by cause of death: 2012

location and the other self-inflicted act that lead to the death took place prior to arrest *This column denotes 'deaths awaiting further information' and is a temporary category created by NOMS in 2012. Once these deaths have been classified, the overall deaths in custody figures for the other columns (e.g. natural cause, self-inflicted etc.) will change slightly.

35. The majority of natural cause deaths (N=239 or 65%) took place in in-patient mental health settings, followed by prison and YOIs (33%). Conversely, the majority of self-inflicted deaths took place in prison or YOIs (52%, n=60), followed by in-patient mental health settings (44%, n=51).

36. Figure 8 shows the deaths in state custody by the four main causes of death between 2011 and 2012. There was an increase in the number of deaths from natural causes (from 326 in 2011 to 368 in 2012) and self-inflicted deaths (an increase from 104 in 2011 to 115 in 2012). Conversely, there was a decrease in 'non-natural' deaths (i.e. mainly accidental or

¹⁶ Chi squared test = 3.32, n.s.

¹⁷ Restraint-related deaths has been excluded as the 15 restraint-related deaths were detained patients under the MH Act and the Care Quality Commission classifies restraint as restraint that was used on the patient in the 7 days preceding their death. This is problematic because it does not exclude other causes of death subsequent to restraint.

¹⁸ As a category, natural cause deaths include cases 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.

overdose) from 18 in 2011 to 10 in 2012 and deaths where the cause was unknown (from 56 in 2011 to 40 in 2012).

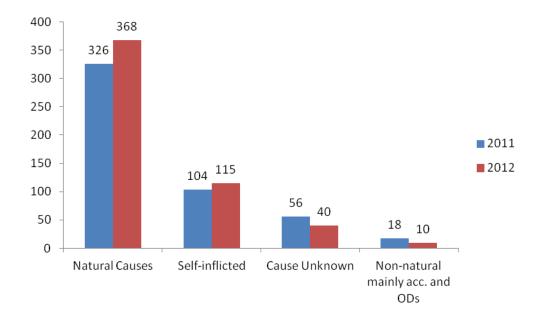


Figure 8: Number of deaths in state custody by cause of death: 2011 and 2012

37. Figure 9 shows the number of natural cause deaths across 3 custodial sectors over the last 13 years. It can be seen that the natural cause deaths in or following police custody have not changed dramatically from 2000 to 2012, although there were only 4 natural cause deaths in or following police custody in 2012 compared to 10 natural cause deaths in 2000. In contrast there has been a doubling (from 61 to 121) of natural cause deaths in Prison and YOI custody from 2000 to 2012. The number of natural cause deaths has fluctuated considerably amongst detained patients since 2000, with a significant increase from 2011 to 2012 (187 in 2011 to 239 in 2012).

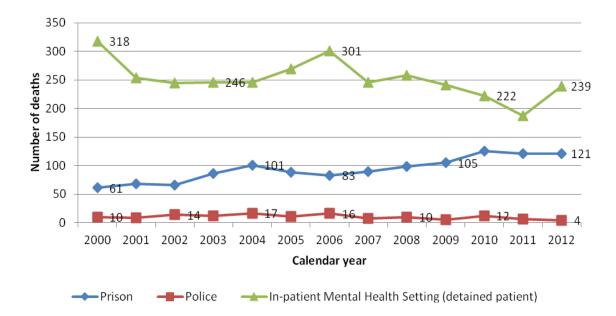


Figure 9: Number of natural cause deaths across prison, police and in-patient mental health settings: 2000-2012

38. Table 7 in Annex A shows there were no natural cause deaths in immigration removal centres¹⁹ or Secure Children's Homes/Secure Training Centres in 2012. For SCHs and STCs this was no change from 2011.

39. Natural cause deaths have also decreased in Approved Premises from nine in 2011 to four in 2012.

40. The prison population has increased significantly from 64,602 in 2000 to 83,909 in 2012, a rise of 30% since 2000. In the context of this rising prison population the rate of natural cause deaths has increased since 2000. In 2000, there were 0.94 natural cause deaths per 1000 prisoners²⁰; this rose to 1.35 in 2004 and then fell again to 1.06 in 2006. By 2012 the rate of natural cause deaths has risen to 1.44 natural cause deaths per 1000 prisoners. People over 60 are now the fastest growing age group in the prison estate, and the earlier chart on total deaths by age across all custodial sectors and Figure 4 shows that there was an increasing number of deaths amongst the over 70 age group. The increasing rate of natural cause deaths may also be a reflection of serious and long term physical conditions that are often found amongst the prison population.²¹

Ethnicity and natural cause deaths

41. Table 8 shows the 368 natural cause deaths in 2012 broken down by ethnicity across the custodial settings. Of the 368 natural cause deaths, 9.5% (n=35) were classified as BME groups (Black, Asian, Mixed and Chinese), and 85.1% were classified as White (n=313). In 2 cases, the ethnicity was classified as 'Other', and for 18 natural cause deaths the ethnicity was not stated or unknown.

¹⁹ In 2011 there were 3 natural cause deaths in Immigration Removal Centres.

²⁰ There were 61 natural cause deaths in Prison settings in 2000.

²¹ Prisons and Probation Ombudsman (2012) Learning from PPO investigations: natural cause deaths in prison custody 2007-2010. England and Wales

Natural causes	Prison	Police	In- patient mental health setting	Approved Premises	STCs/SCHs	Immigration Detention	Total
White	110	4	196	3	0	0	313
Black	7	0	16	1	0	0	24
Asian	4	0	7	0	0	0	11
Mixed	0	0	0	0	0	0	0
Chinese	0	0	0	0	0	0	0
Other*	0	0	2	0	0	0	2
*Not	0	0	18	0	0	0	18
stated/unknown							
Total	121	4	239	4	0	0	368

Table 8: Natural cause deaths by ethnicity across all custodial sectors

* Other is for ethnicity that does not fall under any of the given categories. "Not stated/unknown" is where ethnicity was not recorded.

42. Of the 313 natural cause deaths amongst the White group, over three-fifths (63%) died in mental health settings. Similarly, amongst the BME group (35 natural cause deaths), 66% died in mental health settings.

Self-inflicted deaths

43. In 2012, there were 115 self-inflicted deaths recorded in state custody (see Table 6). Over half of these deaths were in prison (52% n=60) with mental health settings being the next most prevalent (44% n=51). The number of self-inflicted deaths was broadly similar for the previous 3 years in prison settings (58, 57 and 60 self-inflicted deaths respectively), but has been increasing steadily since 2010 in mental health settings. In 2010, the number of self-inflicted deaths in mental health settings was 35 deaths; in 2011 it was 38 deaths; by 2012 it was 51 deaths, an increase of 46% between 2011 and 2012.

44. The most common method of self-inflicted deaths across all settings in 2012 was hanging, which accounted for 75 deaths (65% of all self-inflicted deaths). Some of the other methods of self-inflicted deaths in prison specifically were: self-strangulation, suffocation, drug/alcohol overdose and cutting, although these figures were very low. However, within mental health settings, there were 7 self-inflicted deaths (out of 39) from self-strangulation and 7 deaths from jumping/falling.

45. Of the 115 self-inflicted deaths recorded in state custody, 92 were men (80%) and 23 (20%) were women. However, as Table 9 shows, the gender split was not evenly distributed across the custodial sectors. Across prison, police and approved premises, almost all the self-inflicted deaths were men; however, in mental health settings, the self-inflicted deaths of detained patients were more evenly distributed between men and women (29 and 22 self-inflicted deaths, respectively). It is also important to note that there has been a rise in self-inflicted deaths amongst women between 2011 and 2012; in 2011, there were 15 self-inflicted deaths amongst women; this figure has risen to 22 in 2012.

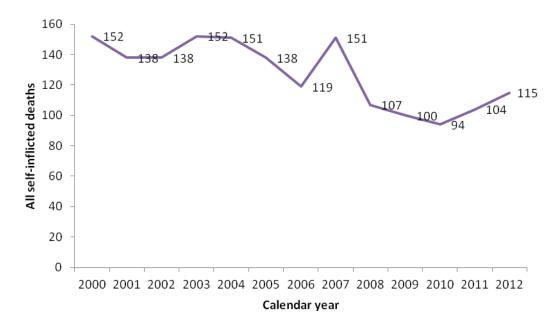
Table 9: All self-inflicted deaths by gender: 2012

	All	Male	Female
Prison	60	59	1
Police ²²	2	2	0
In-patient Mental Health Settings	51	29	22
(detained patient)			
Approved Premises	2	2	0
STC/SCH Young People	0	0	0
Immigration Detention	0	0	0
Total (N)	115	92	23
Percentage		80%	20%

46. Between 1 January 2000 and 31 December 2012, there were 1,659 self-inflicted deaths in state custody. Of the 1,659 self-inflicted deaths, 594 (36%) were of patients detained under the Mental Health Act. Over the same period, 59% (n=973) of self-inflicted deaths were in Prison and YOI settings.

47. Figure 10 shows that there were 152 self-inflicted deaths in 2000; by 2012 this had reduced to 115 self-inflicted deaths across all custodial sectors, a reduction of 24% in self-inflicted deaths since 2000. The number of self-inflicted deaths fluctuated between 2000 and 2007, decreased substantially after 2007, but has steadily increased since 2010.

Figure 10: Self-inflicted deaths in custody



Ethnicity and self-inflicted deaths

²² The 2 self-inflicted deaths under 'police custody' did not occur while being held in a police custody suite/cell; one occurred at the arrest location and the other self-inflicted act that lead to the death took place prior to arrest

49. Table 10 shows the self-inflicted deaths in 2012 broken down by ethnicity across the custodial settings. Of the 115 self-inflicted deaths in 2012, 16 (14%) were classified as individuals from BME groups, and 81% (n=93) were classified as White. In eight cases the individuals were classified as 'Other' ethnic group, and in 4 cases the ethnicity was not known or recorded.

Self-inflicted	Prison	Police	In- patient mental health setting	Approved Premises	STCs/SCHs	Immigration Detention	Total
White	48	2	41	2	0	0	93
Black	4	0	2	0	0	0	6
Asian	3	0	1	0	0	0	4
Mixed	5	0	1	0	0	0	6
Chinese	0	0	0	0	0	0	0
Other*	0	0	2	0	0	0	2
*Not Stated or unknown	0	0	4	0	0	0	4
Total	60	2	51	2	0	0	115

Table 10: Self-inflicted deaths by ethnicity across the custodial settings: 2012

*Other is for ethnicity that does not fall under any of the given categories. "Not stated/unknown" is where ethnicity was not recorded.

50. Of the 16 individuals from BME groups who died from self-inflicted deaths, 12 (75%) died in prison settings and 4 dies while in in-patient mental health settings from self-inflicted deaths.

Death caused by others (including homicide)

Table 11 shows that between 1 January 2000 and 31 December 2012, there were 21 deaths caused by others (including homicide) recorded in state custody.

Table 11: Number of deaths caused by others (including homicide) across custodial settings: 2000-2012

All deaths caused	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
by others													
Prison	3	0	0	1	2	3	0	1	3	0	1	2	0
Police	0	0	0	0	0	0	0	0	0	0	0	0	0
In-patient Mental	0	0	1	0	1	0	0	0	0	0	0	0	1
Health Setting													
(detained patient)													
Approved Premises	0	0	0	0	1	0	0	0	0	0	0	0	0
STC/SCH Young	0	0	0	0	0	0	0	0	0	0	0	0	0
People													
Immigration	0	0	0	1	0	0	0	0	0	0	0	0	0
Detention													
Totals	3	0	1	2	4	3	0	1	3	0	1	2	1

51. Of the 21 deaths caused by others in state custody between 2000-2012, 16 (76%) were in prison and the majority of these deaths (across the custodial settings) were men (90%, n=19).

Restraint related deaths

52. Restraint related deaths are defined (by prison and YOIs, police, approved premises, STC/SCH and immigration detention) as deaths where restraint by custodial staff was identified as either a contributory or direct cause of death. There were no restraint related deaths in 2012 in any of these custodial settings. However, for those detained under the Mental Health Act, the definition of a restraint-related death is that where restraint was used in the seven days preceding the death. This definition means that a restraint-related death does not necessarily mean that restraint was the primary cause of (or even related to) the actual cause of death.

53. Figure 11 shows the distribution of restraint related deaths recorded in state custody between 2000 and 2012. Between 1 January 2000 and 31 December 2012, restraint by custodial staff was identified as a <u>contributory or direct cause</u> in 16 deaths and a cause that happened within the 7 days preceding death in 28 deaths. Of the total of 44 restraint related deaths, 70% (n=31) were men. In 2012, there were 15 restraint related deaths (all detained patients under the MH Act) – an increase of 7 restraint related deaths of detained patients from 2011.

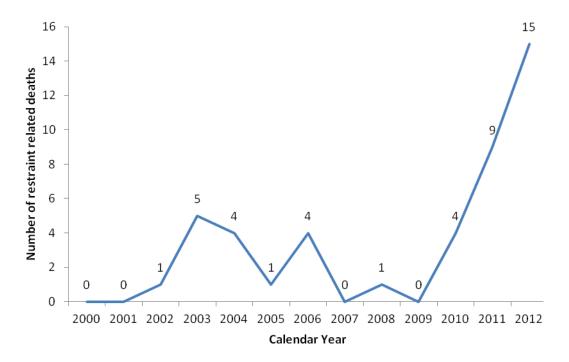


Figure 11: All restraint related deaths in state custody: 2000-2012

Restraint related death and ethnicity

54. There were 15 restraint related deaths (all detained patients within mental health settings) in 2012, and the majority of these deaths (14 out of 15) were people classified as of White ethnic origin.

55. Between 2000 and 2012, 12 restraint related deaths (where restraint was either a contributory or direct cause of death) took place within police settings. Table 12 shows that of the 12 restraint related deaths in police settings between 1 January 2000 and 31 December 2012, 9 of the people were classified as White, and 3 were classified as Black.

Police	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	All
White	0	0	0	3	1	0	2	0	0	0	2	1	0	9
Black	0	0	0	1	0	0	1	0	1	0	0	0	0	3
Asian	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Mixed	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Chinese	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Not stated	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	0	0	0	4	1	0	3	0	1	0	2	1	0	12

Table 12: Restraint related deaths in police custody by ethnicity: 2000-2012

56. In the same 13 year period (2000 to 2012), there were 28 restraint related deaths within mental health settings.

Conclusions and next steps

57. This report has shown that the number of recorded deaths in state custody rose from 515 in 2011 to 556 in 2012. Natural cause deaths still represent the highest proportion of all deaths in custody, 67% (n= 322) of all recorded in 2012, compared to 63% (n= 368) in 2011. The number of natural cause deaths remained stable in prisons (121 in both 2011 and 2012), but following a dip in 2011 (n=187) the number of natural cause deaths of detained patients has risen to n = 239 deaths in 2012. The Panel is keen to pursue a re-analysis of data on deaths of detained patients - which was first suggested by CQC and the Health and Social Care Information Centre in 2012 – to improve our understanding of the reasons for such high numbers of natural cause deaths and to focus efforts on areas where the Panel's attention can make a difference in future.

58. The lack of consistency between organisations as to how they record deaths in custody as well as the underpinning population data continue to make it difficult to produce a meaningful analysis comparing the situation across custodial settings. We now have consistent information on deaths disaggregated by gender, age and ethnicity. However, the Panel will be working with organisations this year to ensure we have access to data on populations broken down by protected characteristics, such as gender, age and ethnicity. This is needed in order to analyse whether there might be any dis-proportionality, for example, in terms of gender or black and minority ethnic detainees.

59. The Panel reported there were nine deaths in 2011 where restraint was identified as either a contributory or direct cause of death or happened in the seven days preceding the death. This rose to 15 in 2012, which was the highest number recorded for this report's timeframe. All of these cases relate to patients detained under the Mental Health Act. As in previous years, the Panel recognises the broad definition used by CQC of restraint used in the seven days before death and that there were no indications that restraint had caused the death. Nevertheless, the Panel will explore this further with CQC to understand whether there are significant issues and risks that need to be addressed to manage risks to detained patients.

60. The IAP will provide an update to this publication in October 2014 to cover figures for 2013.

Annex A

	Prison	Police	In- patient Mental Health Setting (detained patient)	Approved premises1	STC/SCH Young People	Immigration Detention	Total
White	169	9	276	7	0	0	461
Black	11	0	21	2	0	1	35
Asian	7	0	11	0	0	0	18
Mixed	5	1	1	0	0	0	7
Chinese	0	0	0	0	0	0	0
Other*	0	0	4	0	0	0	4
Not							
known*	0	0	24	0	0	0	24
Total	192	10	337	9	0	1	549

Table 3: Ethnicity breakdown (numbers) across all custodial sectors: 2012

*Other is for ethnicity that does not fall under any of the given categories. "Unknown" is where people do not want to declare.

1 Up to and including the year 2002, NOMS did not record data on the ethnicity of Approved Premises residents

Table 7: Number of natural cause deaths, broken down by gender across custodial sectors: 2000-2012

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Prison	61	68	66	86	101	88	83	89	98	105	125	121	121
Male	59	66	63	85	94	86	80	89	95	101	122	118	118
Female	2	2	3	1	7	2	3	0	3	4	3	3	3
Police	10	9	14	12	17	11	16	7	10	5	12	6	4
Male	10	9	14	10	16	10	13	7	9	5	10	5	4
Female	0	0	0	2	1	1	3	0	1	0	2	1	0
Mental	318	253	244	246	246	269	301	246	258	241	222	187	239
Health Setting													
Male	163	132	129	133	141	150	164	126	149	133	137	108	140
Female	155	121	115	113	105	119	137	120	109	108	85	79	99
Approved Premises	2	5	8	2	9	2	5	8	9	3	5	9	4
Male	2	5	8	2	9	2	5	8	9	2	5	9	3
Female	0	0	0	0	0	0	0	0	0	1	0	0	1

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
STC/SCH Young People	0	0	0	0	0	0	0	0	0	0	0	0	0
Male	0	0	0	0	0	0	0	0	0	0	0	0	0
Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Immigrati on Detentio n	0	0	0	0	1	0	0	0	0	0	1	3	0
Male	0	0	0	0	1	0	0	0	0	0	1	3	0
Female	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	391	335	332	346	374	370	405	350	375	354	365	326	368