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 2011

November 2012

Advising the Ministerial Board sponsored by:

Contents

List of figures and tables

Foreword from the Chair of the IAP

In October 2011, we published our first comprehensive statistical summary of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2010. In the report, we made a commitment to develop the publication in future and this year, we have been assisted by the Care Quality Commission (CQC) to identify how this could be taken forward in future. I would like to take this opportunity to thank the CQC for their positive contribution.

This report has been structured to provide a focus on deaths in custody data for 2011, whilst looking at recent trends between 2009 and 2011 and the wider context of deaths in state custody between 2000 and 2011.

This report does not include data on deaths that have occurred in 2012, although we take account of unconfirmed figures provided by custodial settings to inform development of our work programme. We acknowledge there have been a number of deaths that have attracted public interest in 2012 but this report is confined to analysis of confirmed and validated statistics.

If you would like to discuss any of the issues contained within this report in greater detail, please feel free to contact the **Secretariat** who will be able to pass your comments to the Panel.

Thank you

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 deaths which occur in prisons, the secure youth estate, 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.

2. In the Panel's first statistical analysis, published in October 2011, 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 year[1]. The IAP made a commitment to publish an annual update and to build on the depth of analysis in the report. This year we have worked with the CQC Intelligence Team who attempted to analyse, from the available data, whether there is evidence of disproportionality of deaths in all custodial settings by type of death (natural/non-natural) and by gender.

3. Due to the lack of detail provided in population breakdowns for some sectors it was only possible for CQC to standardise the data by gender. Following consultation with CQC and a range of stakeholders, the Panel has decided not to include that analysis because it is missing standardisation by age and ethnicity and could, therefore, present an inaccurate picture. The process of analysis and discussion has led to some delay in publishing this report but we are in a position to specify more clearly what is required from the sectors to fully standardise the data in future. The analysis in this report draws on comparison of raw values.

4. Although it will not be possible to draw conclusions by comparing two years of data – the annual updates will enable the Panel to develop its analysis, cover additional variables and to compare rates between custodial sectors in the longer term.

[1] Available to download here: http://iapdeathsincustody.independent.gov.uk/news/iap-publish-statistical-analysis-of-all-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.

5. The report provides a breakdown of all recorded deaths in the following custodial sectors:
    - Prisons and Young Offender Institutions (YOIs)[2]
    - Police[3]
    - Immigration Removal Centres
    - Approved Premises[4]
    - Young Offender Institutions (YOIs)
    - Secure Children's Homes (SCHs)[5]
    - Secure Training Centres (STCs)[6]
    - Whilst not specifically a custodial sector, the report also contains data on the deaths of patients who died in hospitals whilst detained under the Mental Health Act (MHA).

6. The data used in this report was collated by the Secretariat to the Panel and is produced with permission from the following organisations:

    - National Offender Management Service (NOMS)[7]
    - Independent Police Complaints Commission (IPCC)[8]
    - UK Border Agency (UKBA)[9]
    - Care Quality Commission (CQC) and Healthcare Inspectorate Wales (HIW)[10]
    - Youth Justice Board (YJB)[11]

[2] 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.
[3] 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
[4] 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.
[6] 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.
[7] For prisoners in the adult estate, YOIs and residents of Approved Premises.
[8] Between 2000 and 2004, the Home Office collated statistics on deaths in police custody. The IPCC took over responsibility for data collection in 2004.
[9] These include the three HM Prison Service run Immigration Removal Centres at Dover, Haslar and Lindholme.
[10] As of 1 April 2009, the Mental Health Act Commission's functions were split between the CQC and HIW.
[11] The figures provided by the YJB include all young people in an STC or SCH.

Statistical Methodology

Data Sources[12]

7. The IAP is reliant on data sources provided by a range of organisations. The CQC were initially commissioned to provide an analysis of all recorded deaths in state custody to identify any equality issues from the available data by looking at any disproportionality of deaths in all custodial settings by type of death (e.g. self inflicted/restraint related) and the protected characteristics (where the data allows – that is, race, age and gender).

8. However, it was not possible to produce an analysis comparing rates by ethnicity and age because the demographic breakdowns for population figures in each sector are produced in variable formats. This prevented standardisation of the data by ethnicity and age with the population of England and Wales[13].

Inclusion Criteria

9. The terms of reference for the Ministerial Council on Deaths in Custody include all types of death in state custody (prison, approved premises, police, immigration and those detained under the Mental Health Act - MHA). The IAP also considers deaths which occur in the secure youth estate as part of its work.

Exclusion Criteria

10. The Panel have not included data for residents in Bail Accommodation Support Services (BASS)[14]; those subject to probation supervision on either post release licence, or community supervision (both suspended sentence orders and community orders) and those detained in military custody[15] as they fall outside of

[12] The data contained within this report was provided to the Secretariat by the custodial sectors. They were drawn from administrative IT systems, which, as with any large scale recording system, are subject to possible errors with data entry and processing and can be subject to change over time.
[13] Furthermore, there are variations between how sectors record their population data (for example, the Home Office record total throughput in police custody, whilst NOMS record average custodial population in prisons). Additionally, periods of detention vary significantly. Detainees can be in police custody for a matter of hours and are very rarely in police custody for more than 24 hours, whereas most people in the general population are in England and Wales for a year and can die at any point within that period.
[14] The BASS commenced in June 2007 and provides a service for those who would otherwise be held in prison. The service is specifically for defendants who can be bailed and offenders who can be released on Home Detention Curfew or who are subject to a community order as an alternative to custody. For data relating to BASS and probation supervision, please refer to the Ministry of Justice *Offender Management Caseload Statistics* publication by clicking http://www.justice.gov.uk/statistics/prisons-and-probation/safety-in-custody, which provides statistics relating to offenders who under probation supervision.
[15] For data on deaths in the UK military, please refer to the website of the Defence Analytical Service and Advice (by clicking http://www.dasa.mod.uk/applications/newWeb/www/index.php?page=48&pubType=1&thiscontent=300&PublishTime=09:30:00&date=2011-03-31&disText=2010&from=listing&topDate=2011-03-31).

the terms of reference[16]. Patients on Community Treatment Orders are also not included in the analysis.

Data Analysis

11. This report contains data, where available, on the following[17]:

- Natural cause deaths broken down by age, gender and ethnicity;
- Self-inflicted deaths broken down by age, method, gender and ethnicity;
- Homicides broken down by age, gender and ethnicity;
- Restraint deaths broken down by age, gender and ethnicity[18];
- Other causes of death broken down by gender and;
- Data on the average annual populations and/or throughput in each sector in order to provide some context to the number of deaths[19].

[16] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2010/01/IAP-Terms-of-Reference.pdf
[17] A full demographic breakdown of these deaths is included in **Appendices 1-6**.
[18] These are cases where restraint by custodial staff was identified as either a contributory or direct cause of death or happened in the seven days preceding the death.
[19] These should be viewed with caution, given the differing population sizes in custodial establishments and as such they should not be used as a comparator of death rates between custodial sectors.

Deaths in State Custody

12. This section provides details on the following: (i) deaths in state custody in 2011 (ii) recent trends between 1 January 2009 and 31 December 2011; (iii) the context of deaths in state custody between 1 January 2000 and 31 December 2011 (iv) restraint related deaths; (v) natural cause deaths in all settings; (vi) self-inflicted deaths in all settings and (vii) deaths caused by others in all settings (including homicide).

13. This report does not include data on deaths that have occurred in 2012, although the Panel does take account of unconfirmed figures provided by custodial settings to inform development of its work programme. We acknowledge there have been a number of deaths that have attracted public interest in 2012 but this report is confined to analysis of confirmed and validated statistics.

(i) Deaths in state custody: 2011[20]

14. The following breakdowns can be provided for 2011:

- There were 515 recorded deaths in state custody:
    - N=322 (63%) were natural causes;
    - N=104 (20%) were self-inflicted deaths;
    - N=58 (11%) were cause of death 'unknown'. 55 of these deaths were of patients detained under the Mental Health Act, which accounts for 19% of the 273 recorded deaths in this setting[21];
    - N=12 (2%) in which prisons were awaiting further information before classification;
    - N=11 (2%) were other non-natural deaths;
    - N=4 (0.8%) were Other[22];
    - N=2 (0.4%) were homicides (both in prison) and;
    - N=2 (0.4%) were Other – Accidental

[20] A full breakdown of these figures are available in **Appendices 1-6**
[21] In 2009 there were 23 deaths of patients detained under the MHA where the cause of death was unknown, 36 in 2010 and 55 in 2011. This includes those categorised CQC as 'Method unclear / other', 'Not known / unascertained' or 'Awaiting information'. The figures in this category are subject to change as further information is received and deaths are re-classified.
[22] The cause of death in these cases has been recorded by a pathologist in a post-mortem or at inquest as excited delirium related, and are all related to deaths in or following police custody.

Ethnicity[23]

15. The proportion of individuals from Black and Minority Ethnic (BME) groups who have died in custody varies slightly between sectors, a breakdown of which can be found in **Annex A.** This shows that for prisons, 87% of those who died were White, 6% were Black and 4% were Asian. 83% of detained patients who died were White, 5 % were Black and 4% were Asian. Figures for deaths in or following police custody show that 84% (n=16) of those who died were White, 11 % (n=2) were Black and 5% (n=1) were of mixed ethnicity.

- In total, N=432 (83%) of the 515 detainees who died in state custody in 2011 were classified as White;
- N=28 (6%) were classified as Black,
- N=22 (4%) were classified as Asian;
- N=19 (4%) of cases, the ethnicity was either not stated or known[24]
- N=8 (2%) were of Mixed Ethnicity;
- N=4 (1%) were classified as Other and;
- N=2 (0.4%) were classified as Chinese.

Gender

- In 2011, N=385 (76%) of the deceased were men and N=120 (24%) were women. Gender proportions vary throughout the custody sectors. For example, the gender split of patients who died whilst detained under the MHA shows that out of the 283 deaths, N=166 (59%) were men and N=117 (41%) were women. In prisons and YOIs, out of 192 deaths in 2011, N=187 (97%) were men and N=5 (3%) were women.

Age (only for self-inflicted deaths, natural causes, restraint related deaths and homicides)

- N=9 (2%) of the 515 detainees were aged between 11-20;
- N=39 (8%) were aged between 21-30;

[23] It is not possible to determine whether there is any disproportionality as the Panel do not have access to a full data set by ethnicity on custodial populations.
[24] 18 of these cases were of patients detained under the Mental Health Act. CQC are revisiting these files to ascertain the ethnicity of the patient. These figures will be updated for the next IAP analysis in 2012. In the remaining case, the resident in the Approved Premises did not provide their ethnic identity.

- N=51 (10%) were aged between 31-40;
- N=70 (14%) were aged between 41-50;
- N=60 (12%) were aged between 51-60;
- N=83 (16%) were aged between 61-70;
- N=25 (5%) were aged between 71-80;
- N=36 (7%) were aged between 81-90;
- N=7 (1%) were aged between 91-100;
- N=6 (1%) the age was not known / not stated.

Custodial settings

- There were four deaths in Immigration Removal Centres (IRCs) in 2011 (three natural causes and one self inflicted death), the highest number of deaths in IRCs since 2004, when there were also four.
- There were 17 deaths in Approved Premises all of which were male residents.
- Nine of the 17 deaths in Approved Premises were recorded as natural causes, four of which were offenders aged between 31-40 (there were also five self-inflicted deaths, one other non-natural death and two Other-Accidental deaths). This was the highest number of natural cause deaths in this setting since 2008 (in 2009, there were three natural cause deaths, rising to five in 2010).

(ii) Recent trends in deaths in state custody: 2009 to 2011

16. In order to analyse more recent trends in deaths in custody, we have looked at data for the three-year period, between 2009 and 2011. There were 506 deaths in 2009 and 515 in 2011:

- Looking at specific settings, there was an increase in prison deaths from 2009 to 2010 (169 (61 self-inflicted) and 197 (58 self-inflicted) deaths respectively), followed by a slight decrease to 192 (57 self-inflicted) in 2011. Deaths of detained patients have reduced each year from 312 in 2009, 303 in 2010 to 283 in 2011. The number of deaths in Approved Premises increased between 2009 and 2010 from nine to 12, respectively, and to 17 in 2011[25].

[25] The Panel acknowledge that numbers are not statistically significant, given the relatively low numbers. The Panel also acknowledge some of the difficulties for staff in Approved Premises to prevent deaths outside of the premises.

- Deaths in police custody increased between 2009 and 2010 from 16 to 19 in 2010 and remained at 19 in 2011.
- UKBA recorded two deaths of immigration detainees in 2010, which were the first recorded deaths since 2006. In 2011, there were four deaths.

(iii) Context – Summary of Deaths in State Custody 2000-2011[26]

Table 1. (below) summarises the number of recorded deaths in state custody between 1 January 2000 and the 31 December 2011[27].

	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	Total
Prison[1]	146	142	164	182	207	174	153	185	165	169	197	192	**2076**
Police[2]	30	29	32	34	39	28	26	23	18	16	19	19	**313**
In-Patient Mental Health Setting (detained patients)	406	346	307	331	310	337	363	325	326	312	303	283	**3949**
Approved Premises	24	22	21	12	20	17	10	17	15	9	12	17	**196**
STC / SCH[3]	0	0	0	0	2	0	0	0	0	0	0	0	**2**
Immigration detention[4]	1	0	0	2	4	2	1	0	0	0	2	4	**16**
Total Deaths in State Custody for England and Wales	**607**	**539**	**524**	**561**	**582**	**558**	**553**	**550**	**524**	**506**	**533**	**515**	**6552**

1. Includes deaths of individuals 18 and over in custody or released on licence for medical reasons. These also include deaths of 15 - 17 year olds held in YOIs. These figures exclude two deaths that occurred in Haslar Immigration Removal Centre, which is run by HM Prison Service in 2003 and 2004. These are included in the immigration detention figures.

2. Deaths in or following police custody as defined in category A of the PACE Act 1984.

3. These figures include deaths of young people in Secure Training Centres (STCs) and Secure Children's Homes (SCHs)

4. These figures include the three prison service run IRCs at Haslar, Dover and Lindholme.

- In total, there were 6,552 deaths recorded for the 12 years from 2000 to 2011. This is an average of 546 deaths per year[28]. Of these deaths, n=4,724 (72%) were men and n=1,828 (28%) were women[29].
- A total of 607 deaths were reported in 2000 compared to 515 in 2011 (which represents 15% fewer deaths in 2011 compared to 2000 although there have been fluctuations between years in that period).
- Deaths of those detained under the MHA and those in prison custody, account for n=6,025 (92%) of all deaths in state custody at n=3,949 (60%) and n=2,076 (32%) respectively.
- N=4,326 (66%) of all deaths were recorded as natural causes. Of these, n=3,031 (70%) of deaths were of patients detained under the MHA and n=1,091 (17%) were of prisoners[30].

[26] Some percentages may add up to more or less than 100% due to rounding.
[27] These figures have been revised from the previous IAP statistical analysis in 2011 to account for data supplied by the HIW for detained patients under the MHA in Wales.
[28] In 2010, one prison natural cause death was reported late to NOMS, which accounts for the additional death in 2010's figures.
[29] For data on gender, please see **Appendices 1-6**.
[30] A breakdown of these deaths can be found in **Appendices 1 and 3**.

- N=611 (9%) of the 6,552 deaths were of individuals from Black and Minority Ethnic (BME) groups, with n=333 (5%) classified as Black, n=203 (3%) as Asian, n=55 (1%) as Mixed Ethnicity and n=13 (0.2%) as Chinese. N=5,661 (86%) were classified as White. Ethnicity was either not known, or not stated in n=200 (3%) of cases[31]. N=80 (1%) were classified as 'Other'.[32]

(iv) Restraint related deaths[33]

- There were nine deaths in 2011 where restraint by custodial staff was identified as either a contributory or direct cause of death or happened in the seven days preceding the death[34].
- Eight of these were of patients detained under the MHA, four of which were male and four were female. Two of the eight patients who died were aged 21 -30; two were aged 41-50; two were aged 61-70; one was aged 71-80 and one was aged 81-90[35]. Seven of the eight patients were classified as White and one was classified as Asian.
- The Panel recognise 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, given the number of deaths where restraint has been flagged, the Panel will explore this further with CQC, in the context of its work on common principles on the use of physical restraint, to understand whether there are significant issues and risks that need to be addressed to manage risks to detained patients.
- The other restraint death occurred in police custody, where the use of restraint has been recorded as a factor in the cause of death in the post mortem.

[31] 67 were residents of Approved Premises. Up to and including 2002, NOMS did not record data on the ethnicity of Approved Premises residents. There are 16 deaths in or following police custody where the ethnicity of the detainee is not recorded. These cases predated the IPCC, who are in the process of requesting this information from the relevant police forces. Furthermore, the death in or following police custody in 2006 was subject to a local police investigation and was not investigated by the IPCC. They have written to the force to ascertain the ethnicity of the individual. The CQC are revisiting these files to ascertain the ethnicities of 117 patients who died whilst detained under the MHA. These figures will be updated for the updated analysis in 2013.
[32] For data on ethnicity, please see **Appendices 1-6** and pie charts at **Annex A**.
[33] The definition of restraint varies between custodial sectors and can range from restrictive practices, for example, placing a hand on a shoulder to guide an individual to the use of physical hold restraint techniques.
[34] One of these cases involved restraint by UKBA escort staff. At the time of this report's publication, there is an ongoing investigation into the official cause of death.
[35] The CQC classification is that restraint was used on the patient in the seven days preceding their death.

- Between 1 January 2000 and 31 December 2011, restraint by custodial staff was identified as either a contributory or direct cause of death or happened in the seven days preceding the death[36] in 28 (0.4%) of deaths. Of these:
    - N=23 (82%) were men and n=5 (18%) were women;
    - N=18 (72%) were classified as detainees who were White; n=5 (18%) were classified as Black; n=3 (11%) were classified as Asian; one individual was classified as Mixed Ethnicity and in one case, the ethnicity was not recorded.
    - One of the 28 detainees was aged 15 at the time of their death; n=5 (18 %) were aged 21-30; n=11 (39%) were aged 31-40; n=3 (11%) were aged 41-50; n=3 (11%) were aged 51-60 and n=5 (21%) were aged over 61[37].

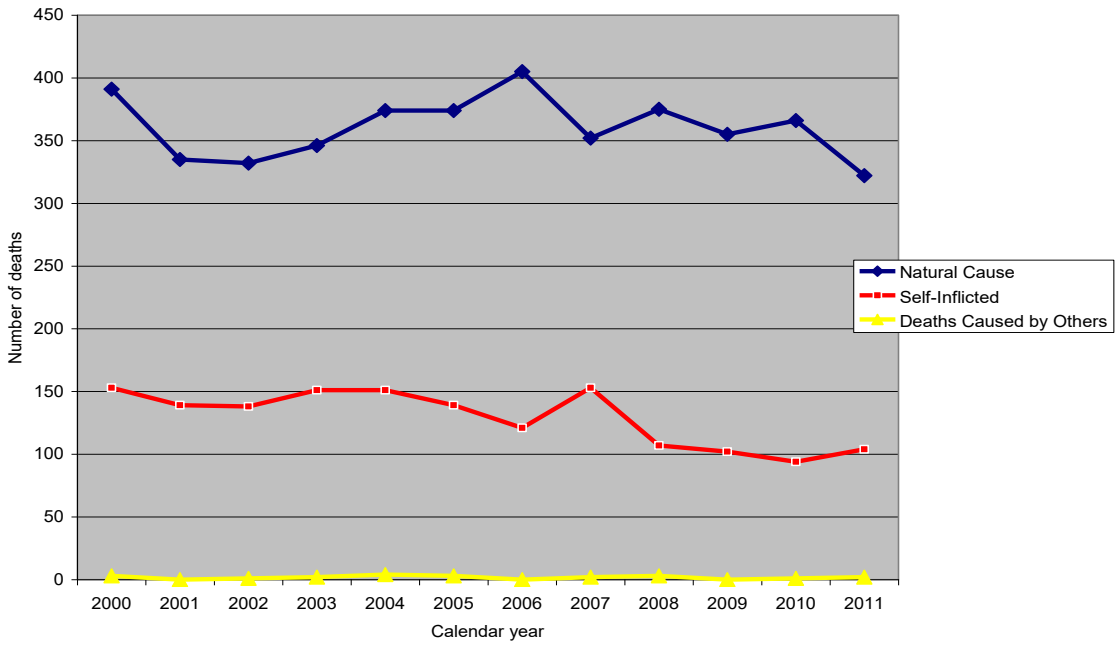
[36] The age, gender and ethnicity of restraint deaths are available in **Appendices 1-6**. For further information about the Panel's work on restraint, please visit the IAP website here: http://iapdeathsincustody.independent.gov.uk/work-of-the-iap/working-groups/use-of-restraint

[37] Further details of these deaths can be found in **Appendices 1-6**

Deaths in state custody by cause of death

17. The Panel has worked with the custodial sectors to compile the figures and tables in the report, which provide an overview of the number of deaths in state custody between 1 January 2000 to 31 December 2011 broken down by cause of death (natural cause, self-inflicted and homicide) and gender. The full ethnicity and age breakdown, where this information was available, is included in the appendices to this paper.

Figure 1: Trend lines for natural cause, self-inflicted and deaths caused by others in all state custody: 2000-2011.



(v) Natural cause deaths

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. These deaths are of concern to the Panel, given that many of them result in critical comment from investigative bodies about the treatment received by the individual and potential preventability of the death.

Figure 2: Number of natural cause deaths by custodial sector: 2000-2011[38].

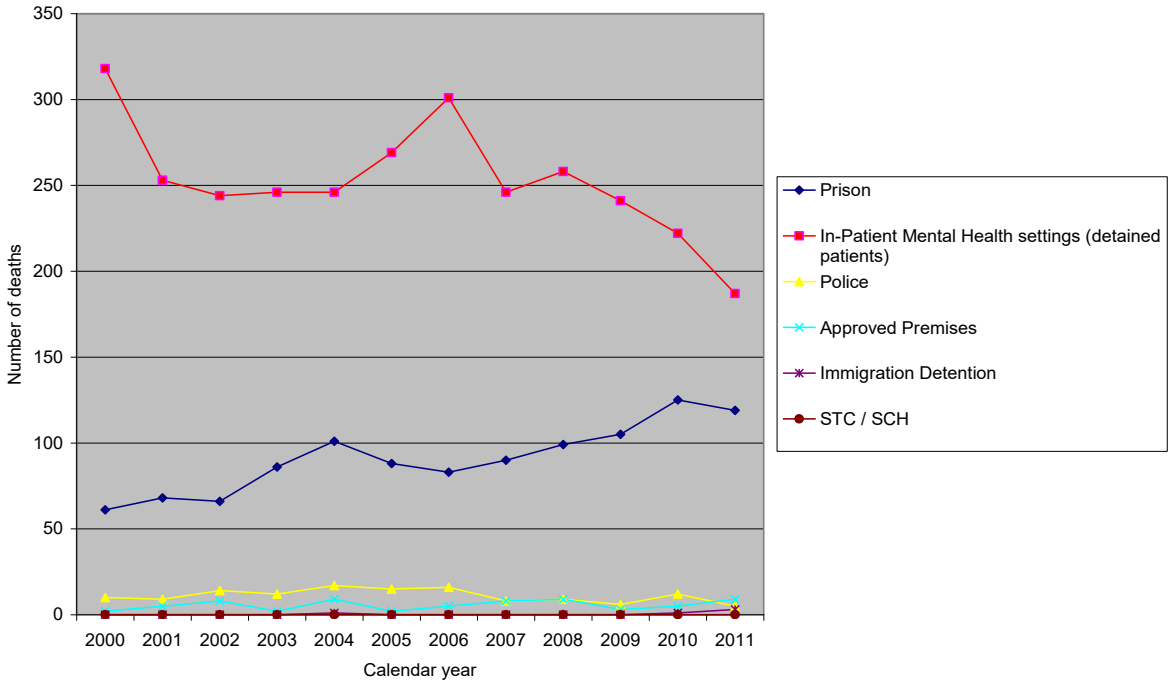


Table 2. (overleaf)**:** Number of natural cause deaths, broken down by gender, by custodial sector: 2000 – 2011.

[38] In 2010, NOMS introduced a new category of 'unclassified' deaths. In 2012, this term was changed to 'awaiting further information'. Upon receipt of data from NOMS in July 2012, there were currently 12 such deaths in the prison estate in 2011. Once these have been classified, the overall death in custody figures for natural cause deaths, self inflicted deaths and homicide deaths will change slightly as these prison deaths are classified.

All Natural Causes Deaths	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	TOTALS
Prison	**61**	**68**	**66**	**86**	**101**	**88**	**83**	**90**	**99**	**105**	**125**	**119**	**1091**
Males	59	66	63	85	94	86	80	90	96	102	122	116	**1059**
Females	2	2	3	1	7	2	3	0	3	3	3	3	**32**
Police	**10**	**9**	**14**	**12**	**17**	**15**	**16**	**8**	**9**	**6**	**12**	**5**	**133**
Males	10	9	14	10	16	13	13	8	8	5	10	4	**120**
Females	0	0	0	2	1	2	3	0	1	1	2	1	**13**
In-Patient Mental Health settings (detained patients)	**318**	**253**	**244**	**246**	**246**	**269**	**301**	**246**	**258**	**241**	**222**	**187**	**3031**
Males	163	132	129	133	141	150	164	126	149	133	137	108	**1665**
Females	155	121	115	113	105	119	137	120	109	108	85	79	**1366**
Approved Premises	**2**	**5**	**8**	**2**	**9**	**2**	**5**	**8**	**9**	**3**	**5**	**9**	**67**
Males	2	5	8	2	9	2	5	8	9	2	5	9	**66**
Females	0	0	0	0	0	0	0	0	0	1	0	0	**1**
Immigration Removal Centres	**0**	**0**	**0**	**0**	**1**	**0**	**0**	**0**	**0**	**0**	**1**	**3**	**5**
Males	0	0	0	0	1	0	0	0	0	0	1	3	**5**
Females	0	0	0	0	0	0	0	0	0	0	0	0	**0**
STC / SCH	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**	**0**
Males	0	0	0	0	0	0	0	0	0	0	0	0	**0**
Females	0	0	0	0	0	0	0	0	0	0	0	0	**0**
TOTALS	**391**	**335**	**332**	**346**	**374**	**374**	**405**	**352**	**375**	**355**	**365**	**323**	**4327**

Analysis of statistics for natural cause deaths[39]

- In 2011, there were 323 deaths recorded as natural causes. N=119 (38%) were in prisons and YOIs and n=187 (57%) were of patients detained under the MHA. The trend lines on **figure 2** show that natural cause deaths have been falling amongst detained patients but rising for prisoners since 2008.
- In 2009, the number of natural cause deaths across all settings was 340, which rose to 351 in 2010, before falling to 323 in 2011[40]:

    - There were six natural cause deaths recorded in police custody in 2009, rising to 12 in 2010, before falling to five in 2011 – which is the lowest number of natural cause deaths in police custody in this report's timeframe[41];
    - Natural cause deaths have increased in Approved Premises with three in 2009, five in 2010 and nine in 2011;
    - Although we are dealing with very small numbers, there has also been a steady increase in natural cause deaths in immigration removal centres, with none recorded in 2009, one in 2010 and three in 2011.
    - Natural cause deaths in prisons and of patients detained under the MHA are discussed in greater detail in paragraphs **21-27**.

[39] This data does not cover other non-natural deaths, for example drug overdoses. Please see **Appendices 1-6** for details of these deaths.
[40] There are currently 54 deaths in 2011 where the cause of death is unknown. It is likely that these figures may change once a cause of deaths has been identified.
[41] These figures may change following inquests into these deaths.

Ethnicity and natural cause deaths: 2000-2011[42]

19. N=323 (7%) of the 4,327 detainees to have died from natural causes were classified as individuals from BME groups, with n=3,849 (89%) classified as White. In n=108 (2%) of cases, the ethnicity was not stated and n=48 (1%) individuals were classified as Other These figures are broken down further by custodial setting:

    - **Prisons and YOIs:** Of the 1,091 natural cause deaths, 973 prisoners were classified as White, 59 were classified as Black, 41 were Asian, 14 were Mixed and four were classified as Other.
    - **Police custody:** Of the 133 natural cause deaths, 114 detainees were classified as White, three were classified as Black, four were classified as Asian, three were classified as Mixed, one was classified as Chinese/Other and in eight of the cases, no ethnicity was stated[43].
    - **Deaths of patients detained under the MHA:** Of the 3,031 natural cause deaths, 2,710 patients were classified as White, 114 were classified as Black, 62 were classified as Asian, 13 were classified as Mixed, five were Chinese, 44 were classified as Other and in 84 cases, the ethnicity was not stated[44].
    - **Approved Premises:** Of the 67 natural cause deaths, 50 offenders were classified as White, one was classified as Asian and in 16 cases ethnicity was not stated[45].
    - **Immigration Removal Centres:** Of the five natural cause deaths, two detainees were classified as Asian, two were classified as Black and one was classified as White.
    - **STCs and SCHs:** There were no recorded natural cause deaths in this setting between 1 January 2000 and 31 December 2011.

20. As illustrated in **figure 2** between 1 January and 31 December 2011, there has been a steady decline in the number of natural cause deaths of patients detained

[42] Please refer to **Appendices 1-6** for this data in full.
[43] There were eight detainees who died in or following police custody whose ethnicity was not recorded. These cases predate the IPCC who are in the process of requesting this information from the relevant police forces. Furthermore, the death in or following police custody in 2006 was subject to a local police investigation and was not investigated by the IPCC. They have written to the force to ascertain the ethnicity of the individual.
[44] The CQC are revisiting the case files to ascertain the patient's ethnicity. These figures will be updated for the updated analysis in 2012
[45] Up to and including 2002, NOMS did not record data on the ethnicity of Approved Premises residents. The 16 natural cause deaths where the ethnicity was not recorded all occurred up to and including 2002.

under the MHA, whilst there has been a steady increase in the number of natural cause deaths in prison.

Natural cause deaths - prison

21. There were 119 natural cause deaths in prison in 2011, compared to 61 in 2000[46]. **Figure 2** shows that the number of natural cause deaths in prison has increased most years between 2000 and 2011. More recently, in 2009 there were 105 natural cause deaths, which rose to 125 in 2010 before falling to 119 in 2011.

22. The IAP acknowledges that the prison population has increased significantly in the reporting period from an average of 64,602 prisoners in 2000, to 85,951 in 2011, a rise of 31%. However, **Figure 3** shows natural cause deaths in the context of the rising prison population – which demonstrates that the rate of natural cause deaths has increased. In 2000, there were 0.94 natural cause deaths per 1000 prisoners, this rose to 1.35 in 2004 and fell again to 1.06 in 2006. In 2011 this figure had risen to 1.38 natural cause deaths per 1000 prisoners.

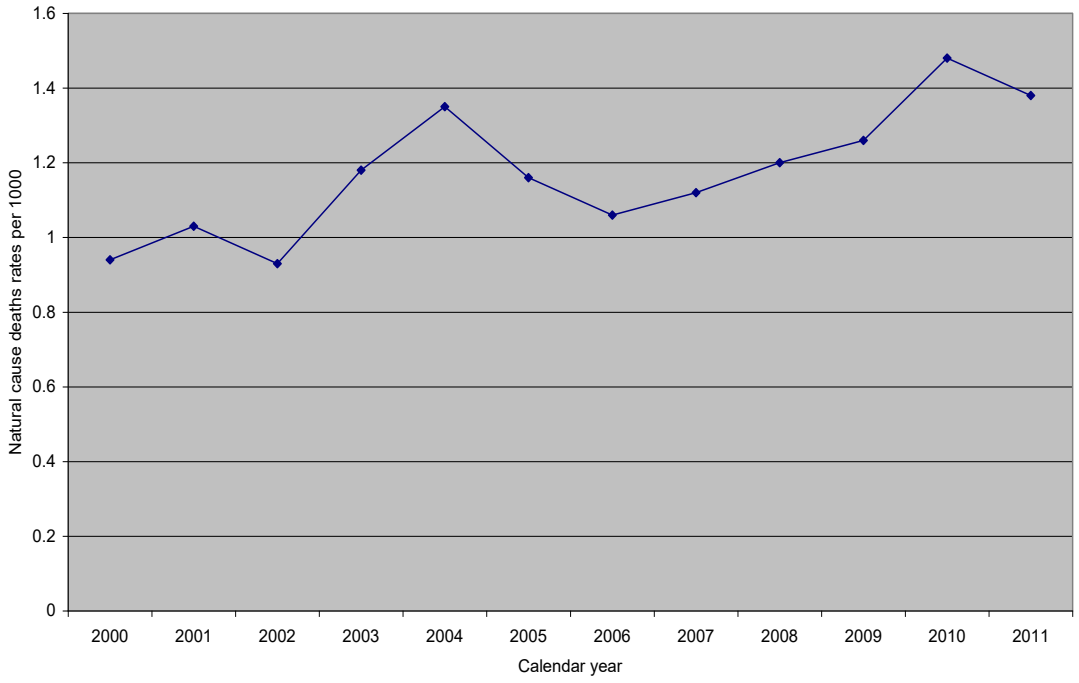
23. In March 2012, the Prisons and Probation Ombudsman published a report based on investigations into natural cause deaths in prisons between 2007 and 2010[47]. The report highlights that the number of natural cause deaths has increased in recent years, an increase that may continue given the nature of the prison population as people over 60 were now the fastest growing age group in the prison estate.

24. The report also acknowledges that deaths from natural causes in prison custody do not only reflect age, but also the range of serious or long-standing physical conditions that are often found amongst the prison population. The report recommends that additional work on the potential impact of an ageing population on prisons and their healthcare providers would be of benefit. The IAP would

[46] In 2010, NOMS introduced a new category of 'unclassified' deaths. The analysis does not seek to make comparisons of natural cause death rates from 2009 to 2011. It provides a commentary on the data provided by NOMS.
[47] Accessible by clicking here: http://www.ppo.gov.uk/docs/learning_from_ppo_investigations-natural_cause_deaths_in_prison_custody.pdf

welcome this work and continues to monitor how changes to NHS commissioning of healthcare in custodial settings impacts on the quality of provision.

Figure 3: Natural Cause Deaths in Prisons per 1000 prisoners

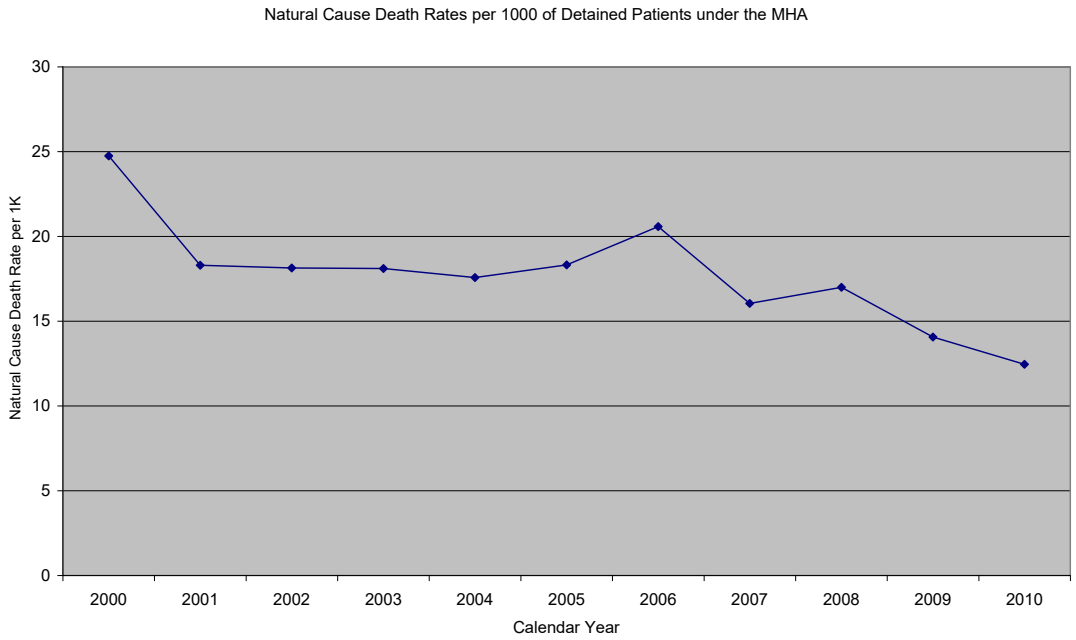


Natural cause deaths - patients detained under the Mental Health Act (MHA)

25. Between 2000 and 2011, 70% (n=3,031) of natural causes deaths across all custodial sectors were of individuals detained under the MHA. When looking at these figures in the context of the population of detained patients, the rate is higher than for prisoners. However, the number of natural cause deaths fell from 241 in 2009 to 222 in 2010, and then to 187 in 2011[48]. **Figure 4** (overleaf) shows that the population of detained patients increased from an average of 12,855 in 2000 to an average of 16,662 in 2010[49]. In 2000, there were 24.73 natural cause deaths of detained patients per 1000 patients, compared to 12.54 natural cause deaths in 2010.

[48] This reduction should be viewed with some caution. In 2009, there were 23 deaths where the cause of death was unknown, 36 in 2010 and 55 in 2011. It is likely that natural cause death figures for detained patients may increase once reclassified.
[49] Data on average populations is included in **Appendix 3**. Population figures for 2011 are currently being verified by CQC for their 2012/13 annual report.

Figure 4: Natural cause deaths of patients detained under the MHA per 1000 patients: 2000 - 2010[50]



26. Whilst this reduction is welcomed by the IAP, the Panel think that continued efforts to screen and treat physical health problems of detained patients will be vital. The Panel has been pursuing recommendations made to the Ministerial Board in March 2011 aimed at updating the analysis of natural cause deaths and to improve the physical health of detained patients. CQC have been working with the Health and Social Care Information Centre to develop a method of re-analysing natural cause deaths of detained patients, which the Panel hopes to receive in 2013. This will help the Panel to examine reasons for the high numbers of deaths from myocardial infarction and pulmonary embolism. The Mental Health Minimum Data Set is now also providing a richer source of data on natural cause deaths.

27. In addition, the mandate to the NHS Commissioning Board contains a specific focus on improving the physical health of mental health patients[51]. There is also increased activity by the relevant professional bodies to raise the profile of this issue, which is also supported by the Mental Health Implementation Framework which sets out what organisations can do to implement the six high-level objectives of the mental health strategy, No Health without Mental Health.[52] The

[50] Data on average populations is included in **Appendix 3**. Population figures for 2011 are currently being verified by CQC for their 2012/13 annual report.
[51] Available to download here: http://www.dh.gov.uk/health/2012/11/nhs-mandate/
[52] Available to download here: http://www.dh.gov.uk/health/2012/07/mentalhealthframework/

Panel welcomes these developments and will continue to monitor trends in natural cause deaths to ensure the changes are having an impact.

(vi) Self-inflicted deaths

Figure 5: Number of self-inflicted deaths by custodial sector 2000-2011

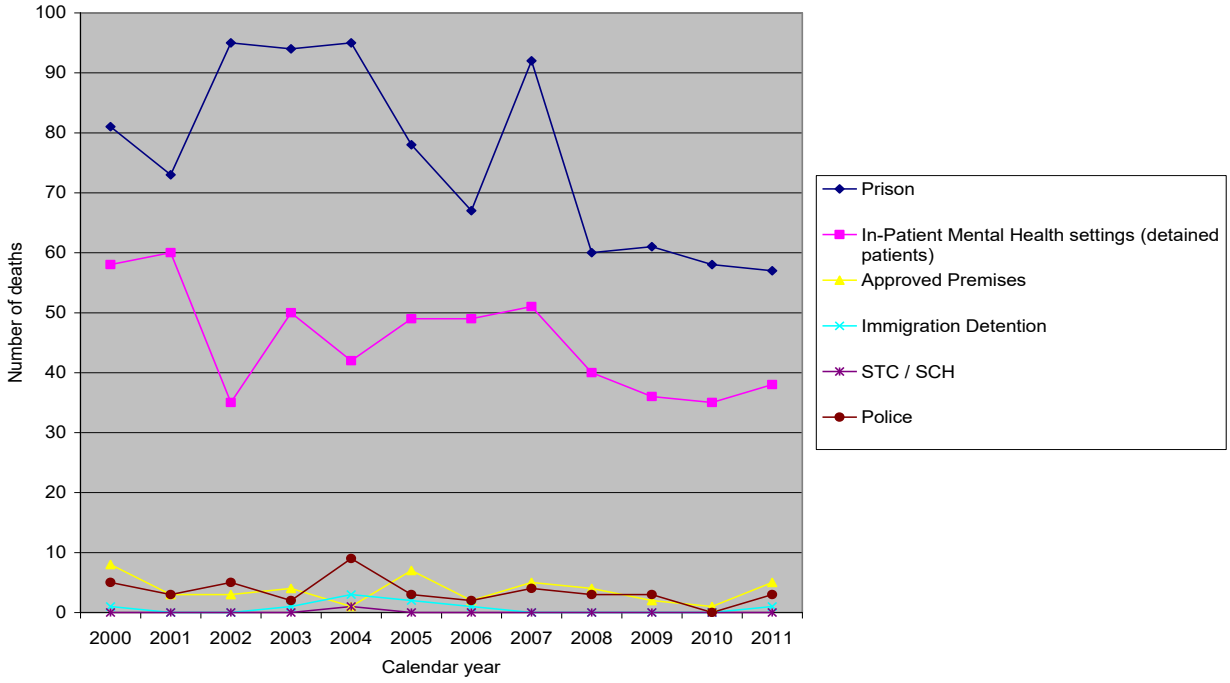


Table 3: Number of self-inflicted deaths, broken down by gender, by custodial sector 2000–2011

All Self Inflicted Deaths	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	TOTALS
Prison	81	73	95	94	95	78	67	92	60	61	58	57	911
Males	73	67	86	80	82	74	64	84	59	58	57	55	839
Females	8	6	9	14	13	4	3	8	1	3	1	2	72
Police	5	3	5	2	9	3	2	4	3	3	0	3	42
Males	5	3	5	1	8	2	2	4	3	3	0	3	39
Females	0	0	0	1	1	1	0	0	0	0	0	0	3
In-Patient Mental Health settings (detained patients)	58	60	35	50	42	49	49	51	40	36	35	38	543
Males	36	35	21	30	21	30	31	34	25	29	18	23	333
Females	22	25	14	20	21	19	18	17	15	7	17	15	210
Approved Premises	8	3	3	4	1	7	2	5	4	2	1	5	45
Males	8	3	3	4	1	7	2	4	4	2	1	5	44
Females	0	0	0	0	0	0	0	1	0	0	0	0	1
Immigration Removal Centres	1	0	0	1	3	2	1	0	0	0	0	1	9
Males	1	0	0	1	3	2	1	0	0	0	0	1	9
Females	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	1
Males	0	0	0	0	1	0	0	0	0	0	0	0	1
Females	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	153	139	138	151	151	139	121	152	107	102	94	104	1551

Analysis of statistics for self-inflicted deaths[53]

- In 2011, there were 104 self-inflicted deaths recorded in custody. In 2009, there were 102 and in 2010, there were 94.
- In prisons, there were 57 self-inflicted deaths recorded in 2011 – including that of a 17 year old male. There were 38 self-inflicted deaths of patients detained under the MHA. These numbers are broadly similar for the previous two years in each sector.
- Between 1 January 2000 and 31 December 2011, there were 1,551 self-inflicted deaths in state custody. There were 153 self-inflicted deaths in 2000 compared to 104 in 2011 (32% less than 2000 although there have been fluctuations between years in that period).
- Of the 1,551 self-inflicted deaths, 543 were of patients detained under the MHA. Of these, n=333 (61%) were male and n=210 (39%) were female.
- The most common method of self-inflicted death across all settings was hanging, which accounted for n=1,091 deaths (70%)[54].
- In n=295 (55%) self-inflicted deaths of detained patients, the ages ranged between 21-40[55]. In prisons, n=582 (64%) of self-inflicted deaths were of prisoners between the ages of 21-40).

28. In 2009 there were 36 self-inflicted deaths of detained patients; there were 35 in 2010 and 38 in 2011. There were seven self inflicted deaths of women in 2009, 17 deaths of women in 2010 and 15 in 2011[56]. The Panel wishes to explore the reasons behind the higher number of self-inflicted deaths amongst women detained under the MHA in 2010 and 2011 compared to 2009.

Ethnicity and self-inflicted deaths: 2000-2011

29. N=189 (12%) of the 1,551 detainees who died from self-inflicted deaths were classified as individuals from BME groups, with n=1,309 (84%) classified as White. In n=32 (2%) cases, the ethnicity was not stated and n=22 (1%) detainees were classified as Other. These figures are broken down further by custodial setting. These figures are broken down by custodial setting:

[53] There are currently 54 deaths in 2011 where the cause of death is unknown. It is likely that these figures may change once a cause of deaths has been identified.
[54] Methods of self-inflicted deaths are included in **Appendices 1-6.**
[55] For a breakdown on ages, please see **Appendix 3**.
[56] These figures should be viewed with some caution. In 2009, there were 23 deaths where the cause of death was unknown, 36 in 2010 and 55 in 2011. It is likely that self-inflicted death figures for detained patients may increase once reclassified.

- **Prisons and YOIs:** Of the 911 self-inflicted deaths, 789 were classified as White, 58 were classified as Black, 44 were Asian, 10 were Mixed, one was Chinese and nine were classified as Other.
- **Police custody:** Of the 42 self-inflicted deaths, 34 were classified as White, two were classified as Black, two were classified as Asian, two were classified as Mixed and in two cases, no ethnicity was stated[57].
- **Deaths of patients detained under the MHA:** Of the 537 self-inflicted deaths, 451 were classified as White, 35 were classified as Black, 22 were classified as Asian, seven were classified as Mixed, one was Chinese, 12 were classified as Other and in 16 cases, the ethnicity was not stated[58].
- **Approved Premises:** Of the 45 self-inflicted deaths, 27 were classified as White, three were classified as Black, one was classified as Asian and in 14 cases the ethnicity was not stated[59].
- **Immigration Removal Centres:** Of the nine self-inflicted deaths, seven were classified as White, one was classified as Chinese and one was classified as Other.
- **STCs and SCHs:** There was one recorded self-inflicted death in the time period, of a White boy, aged 14 in 2004.

[57] There were two detainees who died in or following police custody whose ethnicity was not recorded. These cases predate the IPCC who are in the process of requesting this information from the relevant police forces.
[58] The CQC are revisiting the case files to ascertain the patient's ethnicity. These figures will be updated for the updated analysis in 2012
[59] Up to and including 2002, NOMS did not record data on the ethnicity of Approved Premises residents. The 14 self-inflicted deaths where the ethnicity was not recorded all occurred up to and including 2002.

(vii) Deaths caused by others (including homicide)

Figure 6: Number of deaths caused by others (including homicide) by custodial sector 2000 - 2011

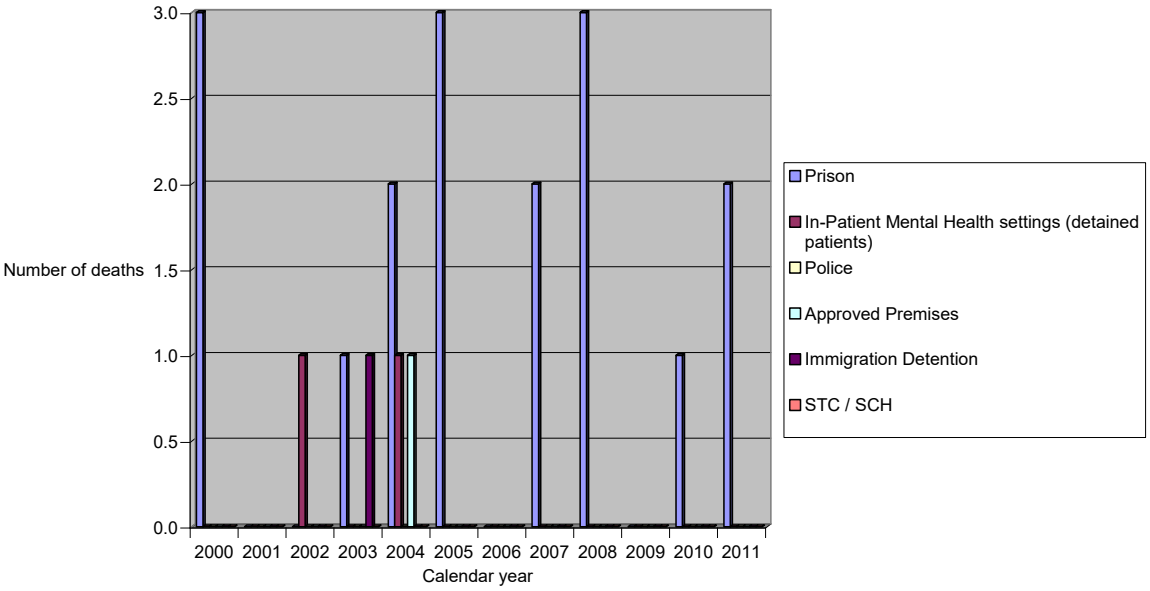


Table 4: Number of deaths caused by others (including homicide), broken down by gender, by custodial sector

All Deaths Caused by Others (including Homicide)	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	TOTALS
Prison	3	0	0	1	2	3	0	2	3	0	1	2	17
Males	3	0	0	1	2	3	0	2	3	0	1	2	17
Females	0	0	0	0	0	0	0	0	0	0	0	0	0
Police	0	0	0	0	0	0	0	0	0	0	0	0	0
Males	0	0	0	0	0	0	0	0	0	0	0	0	0
Females	0	0	0	0	0	0	0	0	0	0	0	0	0
In-Patient Mental Health settings (detained patients)	0	0	1	0	1	0	0	0	0	0	0	0	2
Males	0	0	0	0	1	0	0	0	0	0	0	0	1
Females	0	0	1	0	0	0	0	0	0	0	0	0	1
Approved Premises	0	0	0	0	1	0	0	0	0	0	0	0	1
Males	0	0	0	0	1	0	0	0	0	0	0	0	1
Females	0	0	0	0	0	0	0	0	0	0	0	0	0
Immigration Removal Centres	0	0	0	1	0	0	0	0	0	0	0	0	1
Males	0	0	0	0	0	0	0	0	0	0	0	0	0
Females	0	0	0	1	0	0	0	0	0	0	0	0	1
STC / SCH	0	0	0	0	0	0	0	0	0	0	0	0	0
Males	0	0	0	0	0	0	0	0	0	0	0	0	0
Females	0	0	0	0	0	0	0	0	0	0	0	0	0
TOTALS	3	0	1	2	4	3	0	2	3	0	1	2	21

- There were 21 homicides recorded between 1 January 2000 and 31 December 2011. Of these, 17 of homicides were in prison custody.

Conclusions and next steps

Natural cause deaths

30. This report has shown that the number of recorded deaths in state custody has fallen from 533 in 2010 to 515 in 2011. Natural cause deaths still represent the highest proportion of all deaths in custody, with n=322 (63%) recorded in 2011. Controlling for changes in custodial populations shows that the rate of deaths per 1000 prisoners has increased between 2006 and 2011, with a peak rate of 1.48 natural cause deaths per 1000 prisoners in 2010. The rates of natural cause deaths for detained patients has reduced in this period from 20.58 natural cause deaths per 1000 detained patients in 2006 to 12.45 deaths per 1000 detained patients in 2010 (figures for 2011 are still being verified).

31. Natural cause deaths remain the largest proportion of all deaths in state custody and there appears to be a continued rise in natural cause deaths in prisons. The Panel is particularly keen to support the suggestion by PPO that additional work should be undertaken to understand the potential impact of an ageing population on prisons and the implications for healthcare providers. The IAP will also continue to monitor how changes to NHS commissioning of healthcare in custodial settings impacts on the quality of provision.

Restraint related deaths

32. There were nine deaths in 2011, where restraint by custodial staff was identified as either a contributory or direct cause of death or happened in the seven days preceding the death, which is the highest recorded for this report's timeframe. Eight of these deaths were of patients detained under the MHA. The Panel recognise 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, given the number of deaths where restraint has been flagged, the Panel will explore this further with CQC, in the context of its work on common principles on the use of physical restraint and their work with Department of Health to develop improved training and delivery on restrictive practice. This will help the Panel to understand whether there are significant issues and risks that need to be addressed to manage risks to detained patients.

Natural cause deaths of detained patients

33. The Panel continues to explore the high number of natural cause deaths in this population and is working with the Health and Social Care Information Centre and CQC to re-analyse data to understand the reasons for the high number of deaths due to myocardial infarction and pulmonary embolism.

Self-inflicted deaths

34. The Panel wishes to explore the reasons behind the higher number of self-inflicted deaths amongst women detained under the MHA in 2010 and 2011 compared to 2009.

Data collection and methodology

35. Despite efforts by CQC to standardise data by gender it has not been possible to produce firm comparisons between custodial sectors and with the general population without full standardisation including age and ethnicity. In consultation with the custodial sectors, the IAP will be requesting population data to enable standardisation for next year's report. This will require some work with co-sponsors to ensure that population data can be provided in consistent formats by NOMS for prisons and approved premises; with UKBA for immigration removal centres and the Home Office and ACPO to access useful police custody population data. This will enable the Panel to develop its analysis of equality issues to identify any disproportionality by type of death and protected characteristics (i.e. by race, age and gender).

36. The IAP will provide an update to this publication in October 2013 to cover figures for 2012.

Annex A

Additional figures to show ethnicity breakdown of deaths in custody 2011

Figure 7. Ethnicity breakdown of all recorded deaths in state custody for 2011

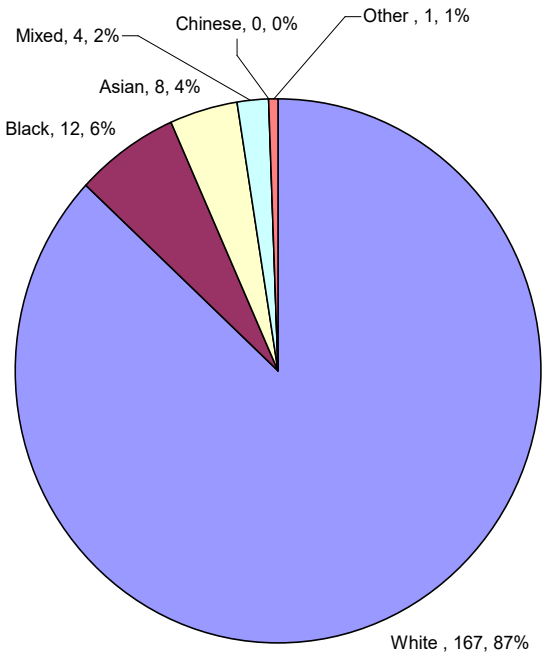


Figure 8. Ethnicity breakdown of all recorded deaths in police custody for 2011

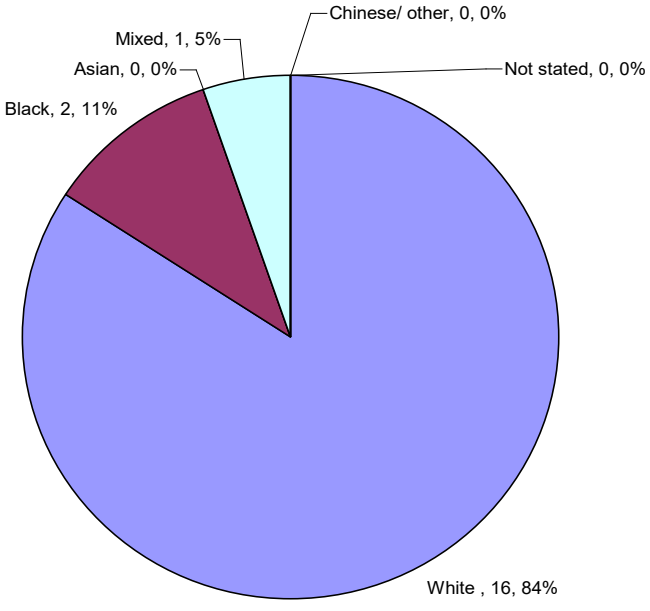


Figure 9. Ethnicity breakdown of all recorded deaths in prison and YOI custody for 2011

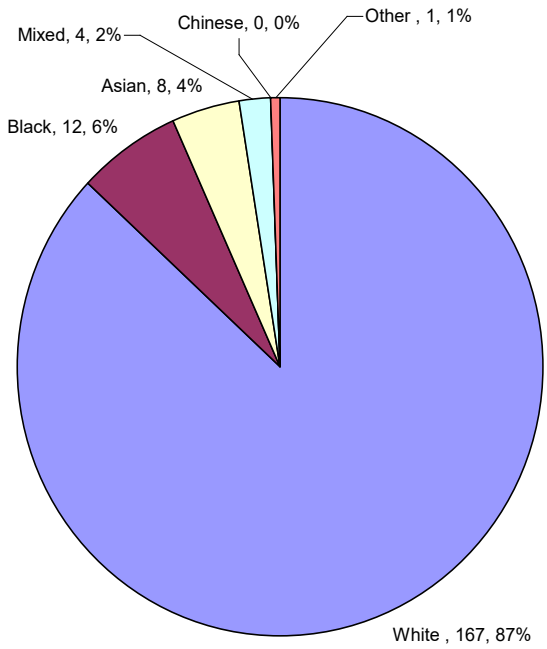


Figure 10. Ethnicity breakdown of all recorded deaths of patients detained under the Mental Health Act for 2011

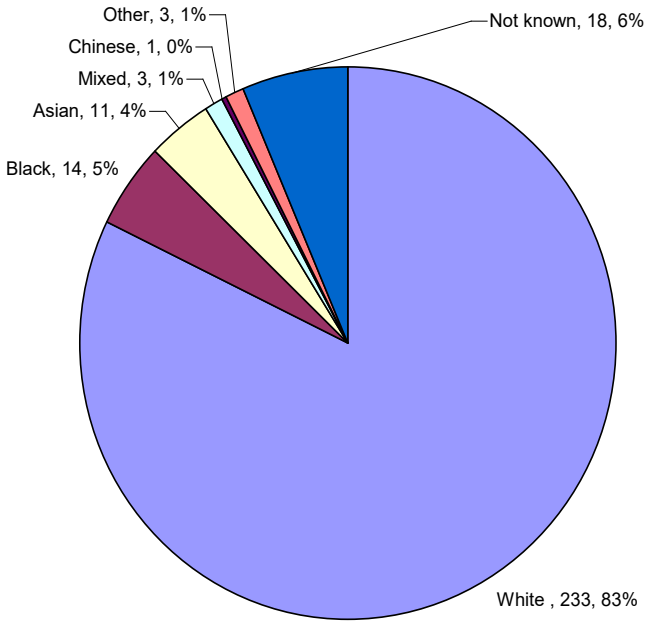


Figure 11. Ethnicity breakdown of all recorded deaths of detainees immigration removal centres for 2011

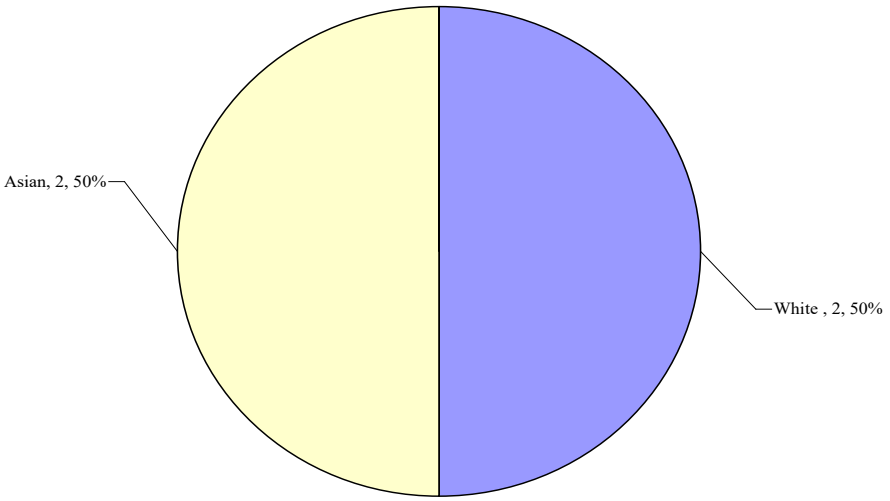


Figure 12. Ethnicity breakdown of all recorded deaths of residents in Approved Premises in 2011