Deaths in State Custody

An examination of the cases 2000 to 2014

Independent Advisory Panel on
DEATHS IN CUSTODY

www.iapdeathsincustody.independent.gov.uk

December 2015

Contents

Acknowledgements

The Independent Advisory Panel gratefully acknowledges the analytical support provided by Dr Tammi Walker at Manchester Metropolitan University in the production of this report, and the assistance of those who have provided data and whose advice has been invaluable.

Foreword

I would like to begin this foreword by paying tribute to the leadership shown by the inaugural Chair of the Independent Advisory Panel Lord Toby Harris. Under his leadership, the visibility of this vital area of concern across state settings has increased markedly culminating in the publication of the Harris Review earlier this year. Deborah Coles, Philip Leach and Richard Shepherd have each been active and passionate contributors too and the existing panel and wider sector owes them a debt of gratitude for their sterling work in this challenging area.

It is probably axiomatic to observe that there will, inexorably, be challenges in trying to compare data across settings. Each sector will have their own nomenclature and context. However, broad comparisons may be made, and this is the purpose of this annual statistical summary, which serves to inform our understanding of such deaths. That said, this year because of a significant (and retrospective) change in definitions used in the data by the Care Quality Commission this will have had a significant impact and readers need to be aware of this. But, of course, there are significant benefits to tracking changes in the data. Notwithstanding any definitional changes, there are clear overall benefits to year on year comparisons. Such data may be used to inform both management and clinical decision-making.

Important though these statistics are, going forward it may be helpful to better understand appropriate international comparisons. This will be fraught with some of the methodological challenges experienced in the United Kingdom, but just because it may be difficult does not mean that it should not be done. For illustrative purposes if we take comparisons between Self-Inflicted Deaths in prisons, too often comparisons are made simply within the general population on rates of suicide in England and Wales. Comparisons with other, e.g. European, prison systems' rates of suicide may well be more meaningful. On a methodological point, the prison population is not a random sample of the general population therefore assertions made about the rates being say, five times higher in prisons, make very limited sense.

I hope that readers find this annual report useful, albeit with the caveats mentioned above.

Professor Graham Towl

Professor of Forensic Psychology and Pro Vice Chancellor and Deputy Warden at Durham University UK.
Formerly Chief Psychologist at the Ministry of Justice, UK.

Executive Summary

This report provides an analysis of all recorded deaths that occurred in Prisons, in or following Police Custody, Secure Training Centres/Secure Children's Homes, Immigration Removal Centres, Approved Premises and deaths of those detained under the Mental Health Act (MHA) in hospital in England and Wales from 2000 to 2014. A descriptive analysis was undertaken and split into the following sections: prevalence of deaths in state custody, deaths by custodial setting in 2014 and Self-Inflicted Deaths from 2000-2014.

Results of the data show that there were 8,129 deaths recorded for the 15 years from 2000 to 2014. Of these deaths, 73% were men (Number=5918) and 27% (N= 2211) were women. This represents 21% fewer total deaths in 2014 (N=479) compared to 2000 (N=607). The majority of the 8129 deaths in the 15 years (59%) were patients detained under the Mental Health Act (N=4801) and the second highest were within Prison settings at 34% (N=2728) of all deaths. Overall, the numbers of deaths amongst detained patients appears to be decreasing year on year whilst the Prison sector has had a continued increase from 2006 onwards.

Over the last 15 years, the White ethnic grouping has had the highest number of deaths; patients detained under the MHA have had the highest number of natural cause-related deaths whilst the highest number of recorded deaths caused by others (including homicide) has been in Prisons.

In 2014, there were 479 recorded deaths in state custody which is a decrease of 15% from 2013. The largest cause of recorded death was related to natural cause (67%, N=323) followed by Self-Inflicted Deaths (23%, N=111). White males accounted for the majority of deaths. Age was only recorded for 194 of those who died in state custody in 2014 and the largest age band was those age 61 and over, who were patients detained under the MHA (N=121) and recorded death for the nearly all (N=120) was from natural causes.

From 2000-2014 there were 1921 self-inflicted deaths across all settings, 1572 (82%) were men and 349 (18%) were women. This is a 27% decrease from in 2014 compared to 2000. The Prison setting has the highest proportion of self-inflicted deaths for 2000-2014, however in relation to the total number of deaths in Prison this appears to be decreasing as a proportion of overall deaths from 55% (N=81) in 2000 to 35% (N=84) in 2014.

The report also highlights some data limitations. Firstly, comparison of restraint-related deaths was difficult to compare between the different custodial settings because of the varying definitions that exist for these deaths across the sectors. Secondly, the Care Quality Commission and Health Inspectorate Wales undertook a data cleansing exercise on the data for the years 2010-2013. As a result of this exercise, and in larger measure due to the removal of the numbers and details of patients who died while subject to Community Treatment Orders and Guardianship, the tables on deaths of detained patients contain a smaller number of records than those previously reported. Thirdly, caution should be taken when interpreting the reported figures due to the statistically small numbers and the fact that recorded deaths across the custodial sectors involved have been drawn from administrative IT systems, which with any large scale recoding system are, of course, subject to potential errors with data entry and processing.

Introduction

1. Currently, the Independent Advisory Panel (IAP) on Deaths in Custody forms the second tier of the three-tier Ministerial Council on Deaths in Custody, acting 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 that occur in Prisons, in or following Police Custody, Secure Training Centres/Secure Children's Homes, Immigration Removal Centres, Approved Premises and deaths of those detained under the Mental Health Act in hospital.

2. The Panel published its first statistical analysis in October 2011 and since then the Panel has made a commitment to publish an annual update of the recorded deaths in state custody.

3. This report provides a breakdown of all recorded deaths in custody in England and Wales from 2000 to 2014 in the following custodial sectors:

    - Prisons and Young Offender Institutions[1]
    - Police[2]
    - Immigration Removal Centres
    - Approved Premises[3]
    - Secure Children's Homes[4]
    - Secure Training Centres[5]
    - Deaths of patients detained under the Mental Health Act in hospital

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

[2] These figures include deaths of persons who have been arrested or otherwise detained by the police. It includes deaths that occur while a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle. These figures do not include fatal shootings, road traffic accidentsm involving police vehicles and 'other' deaths following police contact, which are not custody related.

[3]Approved Premises are premises approved under Section 13 of the Offender Management Act (2007). They are managed either by the National 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.

[4] SCHs are for the youngest offenders (aged between 10 and 14) and those who may have been in care or have mental health problems. Local councils run them.

[5] STCs hold young people up to the age of 17 and are run by private companies.

Statistics – data collection

Data Sources

4. The data used in this report was provided to the Secretariat of the IAP on Deaths in Custody in England and Wales by the different custodial settings and it is produced with the permission of the following sectors and organisations:

    - Independent Police Complaints Commission (IPCC) –data on deaths in or following police custody has been provided by the IPCC since 2004.

    - Care Quality Commission (CQC) and the Healthcare Inspectorate Wales (HIW) - data of those patients detained under the Mental Health Act (MHA).

    - Youth Justice Board –data on all young people (under the age of 17) in a Secure Training Centre (STC) or Secure Children's Home (SCH).

    - UK Immigration –data from the Immigration Removal Centres (IRC)

    - National Offender Management Service (NOMS) - data on adults in prison, Young Offender Institutions and residents in Approved Premises.

5. Some of the reported figures have changed from the 2013 Deaths in Custody statistical release as previous deaths, where the cause of death was unknown, may have been classified after this date.

6. A data cleansing exercise has resulted in the CQC data being amended for the years 2010-2013. As a result of this exercise, and in larger measure due to the removal of the numbers and details of patients who died while subject to Community Treatment Orders and Guardianship, the tables on deaths of detained patients contain a smaller number of records than those previously reported.[6]

7. Caution should be taken when interpreting the reported figures due to the statistically small numbers and also recorded deaths across the custodial sectors involved have been drawn from administrative IT systems, which with any large scale recoding system are subject to possible errors with data entry and processing.

[6] http://iapdeathsincustody.independent.gov.uk/wp-content/uploads/2015/02/Statistical-analysis-of-recorded-deaths-2000-to-2013.pdf

Prevalence of Deaths in State Custody

This section will start with definitions of deaths in state custody and then will move onto the prevalence of deaths during the period of 2000 to 2014showing how custodial settings break down deaths. Different demographic groups will be compared with cause of death.

Definitions of deaths

When interpreting the data for causes of deaths caution should be taken as some custodial sectors have different methods of classifications.

- Restraint related deaths definitions vary widely between the custodial sectors. For the Care Quality Commission (which collates data on patients detained under the MHA) a restraint related death is defined as a death in which restraint was used in the previous seven days, although this may not necessarily be related to the cause of death. For police custody, restraint is defined as ‘restraint-related’, being mentioned in the post mortem report. In all other sectors, a restraint-related death is defined as one in which restraint is a primary cause of death.

- For natural cause of death this could include deaths where death was inevitable; where the care and treatment of the person could have been better and those that could be viewed as preventable and avoidable.

Summary of Deaths in State Custody 2000-2014

Table 1 summarises the number of recorded deaths in state custody between 1 January 2000 and the 31 December 2014. Some of the figures in the table will have changed from the 2013 Deaths in Custody statistical release as previous deaths where the cause of death was unknown, may have since been classified.

Table 1: All deaths in state custody between 2000-2014

	00	01	02	03	04	05	06	07	08	09	10	11	12	13	14	Total
Police[7]	30	28	32	34	39	28	26	23	18	16	19	19	10	15	18	**355**
Approved Premises	24	22	21	12	20	17	10	17	15	9	12	17	9	10	7	**222**
Immigration Removal Centres	1	0	0	2	4	2	1	0	0	0	2	4	1	2	2	**21**
Prisons (inc YOI)[8]	146	142	164	183	208	174	153	185	165	169	197	192	192	215	243	**2728**
STC/SCH	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	**2**
Patients detained under the MHA[9]	406	346	307	331	310	337	363	325	326	312	* 323	* 283	* 341	* 282	209	**4801**
Total	607	538	524	562	583	558	553	550	524	506	553	515	553	524	479	**8129**

*The Care Quality Commission and Health Inspectorate Wales have amended these figures through a data cleansing exercise.

In total there were 8,129 deaths recorded for the 15 years from 2000 to 2014. Of these deaths, 73% were men (N=5918) and 27% (N=2211) were women.

In 2000, a total of 607 deaths were recorded in state custody compared with 479 in 2014. This is 21% fewer deaths in 2014 compared to 2000. There was an8% decrease in total deaths in state custody from 2013 to 2014.

The majority of the 8129 deaths in the 15 years (59%) were patients detained under the Mental Health Act (N=4801) and the second highest were within prison settings at 34% (N=2728) of all deaths. These figures are equivalent to 2013.

[7] Deaths in or following police custody as defined in Category A of the PACE Act (1984).
[8] 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.
[9] Patients detained under the Mental Health Act.

Deaths in Four Custodial Settings: 2000-2014

Key Points
Patients detained under the Mental Health Act have the highest number of deaths; however, these appear to be decreasing overall. The Prison sector has had a continued increase from 2006 onwards.

Figure 1 shows average number of deaths in state custody for four custodial sectors: 2000 to 2014.

On average patients detained under the Mental Health Act have the highest number of deaths; however, these appear to be decreasing overall. The Prison sector has had a continued overall increase in deaths, from 2006 onwards. Deaths were numerically smallest in Police Custody and Approved Premises sectors. Immigration Removal Centre's and STC/SCH Young People deaths were not included due to the combined total for both being 23 deaths for the 15-year period.

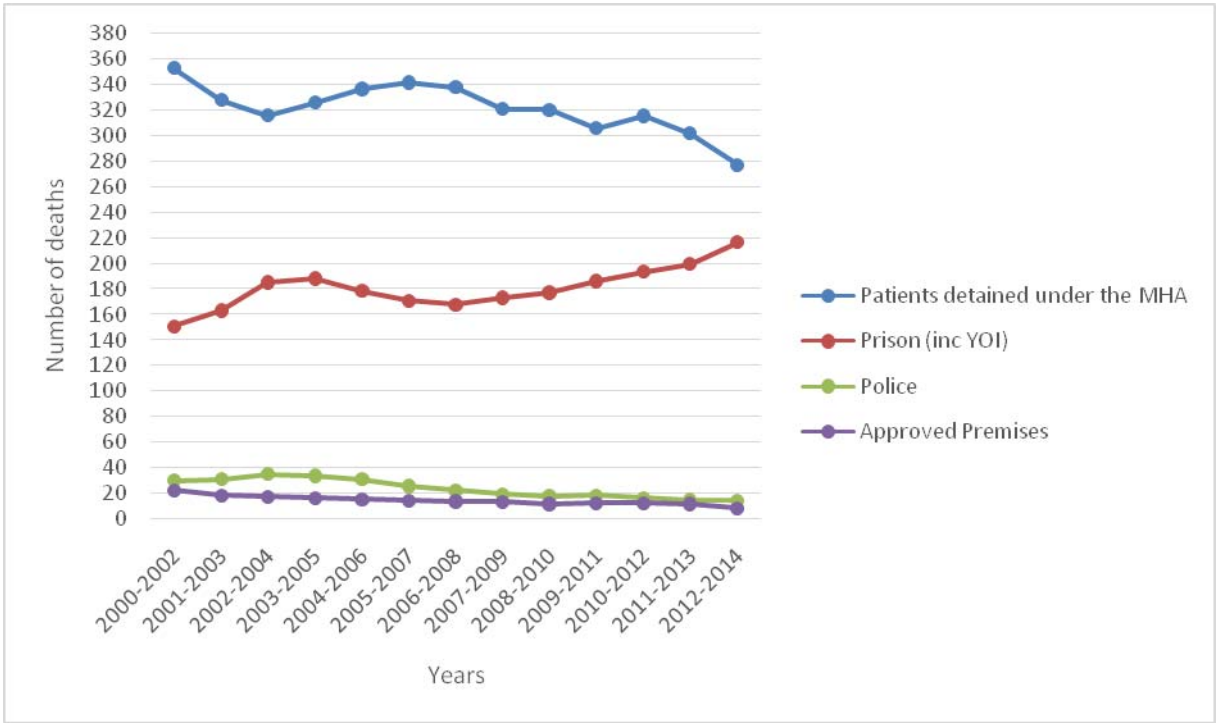

Figure 1: Average number of deaths in state custody for four custodial sectors: 2000 to 2014

It was desirable to examine the rate of deaths in custody so that these can be compared with the rates of similar types of death in the general population. In order to calculate rates, information about the population in each setting would need to be available. This information was not available for the custodial sectors.

Deaths by All Ethnic Groupings for Prison and YOI settings: 2000-2014

Key Point
Individuals from the White ethnic grouping have the highest number of deaths and this has risen consistently since 2008.

Figure 2 shows all deaths by ethnic grouping for the Prison and YOI custodial sectors from 2000-2014.

The White ethnic grouping has the highest number of deaths and it has risen since 2008 consistently, apart from 2011 when it decreased slightly.

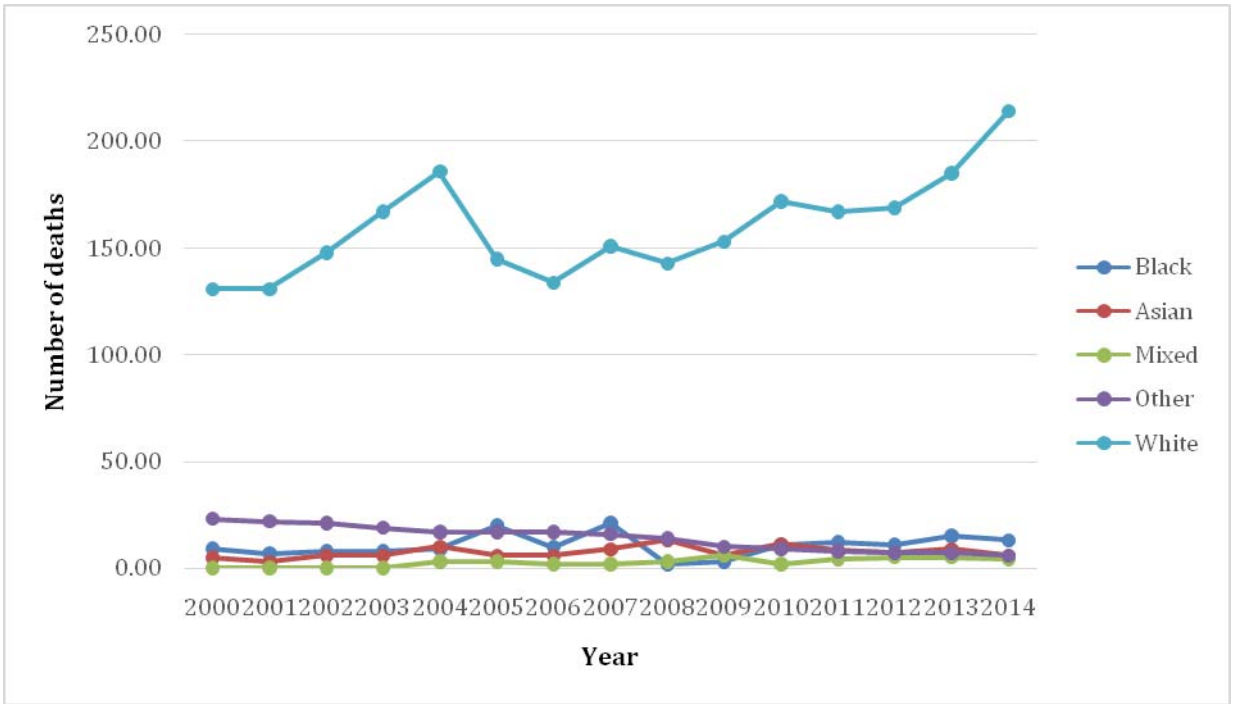

Figure 2: All deaths by ethnic groups within Prison and YOI settings: 2000-2014

Deaths among BME Groupings for Prison and YOI settings: 2000-2014

Key Point
Deaths in the Black ethnic group have fluctuated the most since 2000 and have had the largest number of deaths in 2007 with 21 deaths.

Figure 3 shows the average number of deaths among Black, Asian and Mixed Ethnic groups within the Prison and YOI custodial sectors from 2000-2014.

For all groups there was a decrease in deaths from 2013 to 2014. Deaths in the Black ethnic group have fluctuated the most since 2000 and have had the largest number of deaths in 2007 with 21 deaths. The Asian ethnic group has fluctuated over the last fifteen years and the highest point for deaths in this ethnic group was in 2008 with 14. Caution needs to be taken here due to the statistically small figures. Also it is worth being mindful of possible within group differences in global categories such as 'mixed' for ethnicity.

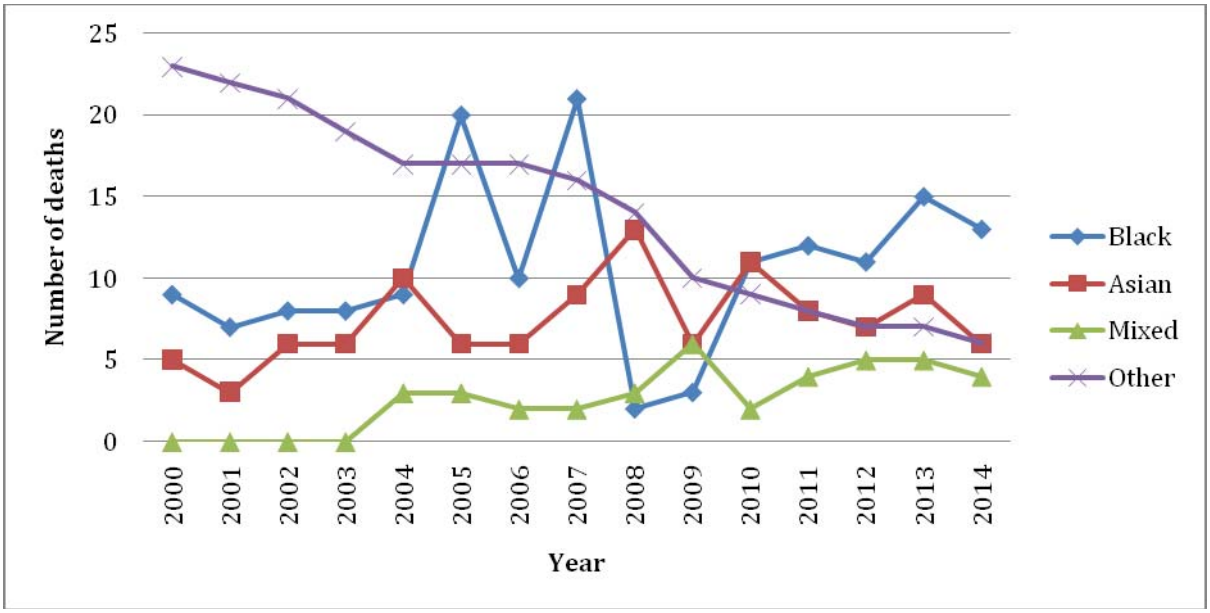

Figure 3: Average number of deaths among Black, Asian and Mixed Ethnic groups within Prison and YOI settings: 2000-2014

Deaths of Patients Detained Under the Mental Health Act: 2000-2014

Key Point
A reduction in deaths from 406 in 2000 to 209 in 2014 among patients detained under the MHA.

Figure 4 shows the number of deaths of patients detained under the MHA between 2000 and 2014.

There has been a reduction in deaths from 406 to 209 (48%), of deaths among patients detained under the MHA from 2000 to 2014. It must be noted that a data cleansing exercise was undertaken by the CQC that resulted in the data being amended for the years 2010-2013. As a result of this exercise, and substantively due to the removal of the numbers and details of patients who died while subject to Community Treatment Orders and Guardianship, the information on deaths of detained patients contain a smaller number of records than those previously reported.

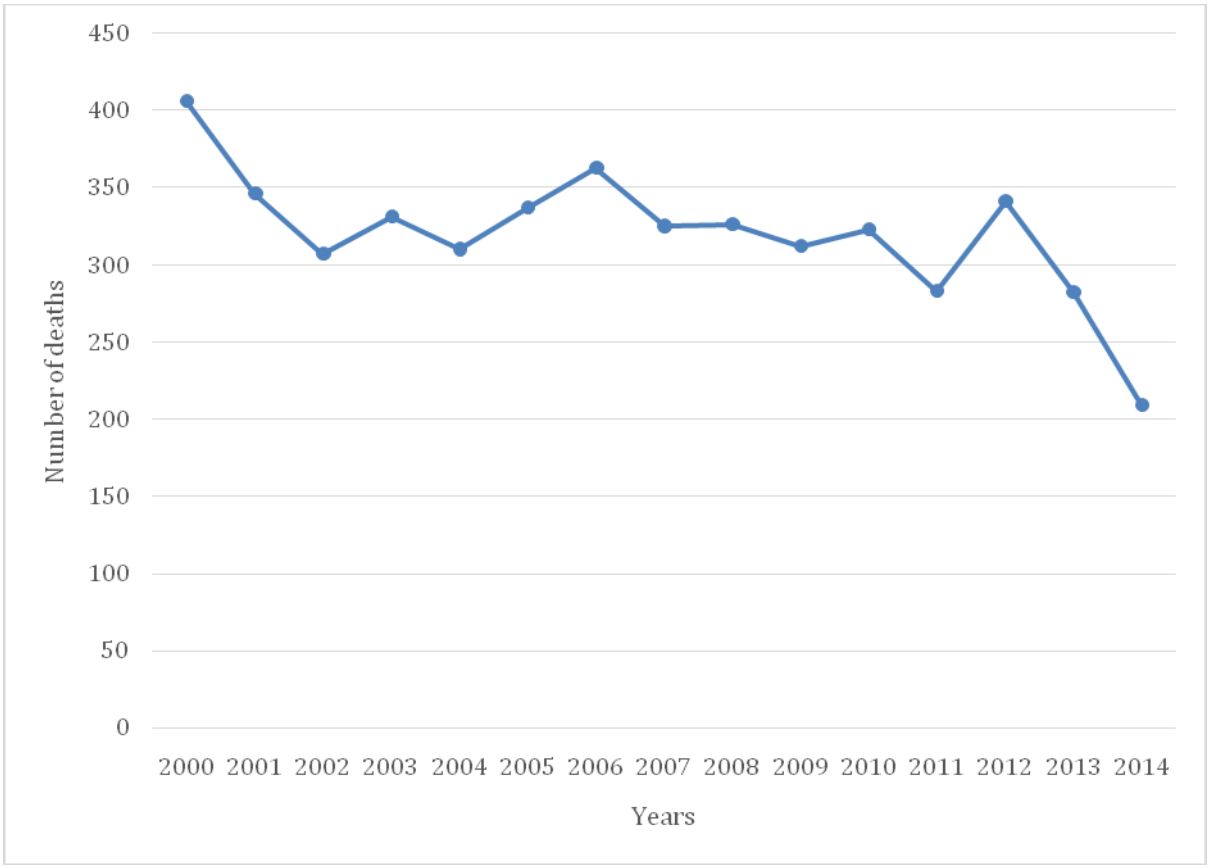

Figure 4: Number of deaths of patients detained under the MH Act:2000-2014

Natural Cause-Related Deaths for Four Custodial Sectors: 2000-2014

Key Point
The highest number of natural cause-related deaths was amongst the patients detained under the MHA.

Figure 5 shows the number of natural cause-related deaths across four sectors (MHA, prisons, police and approved premises) from 2000 to 2014.

The highest number of natural cause-related deaths was amongst the patients detained under the MHA compared to those in approved premises, police custody and prison. Natural cause-related deaths appear to have continued to increase since 2012 in the prison sector and since 2000 they have more than doubled between 2000 and 2014 (from 61 deaths to 141 deaths respectively).

Youth Custody and Immigration Removal Centres' data has not been used due to the low figures for each of these sectors.

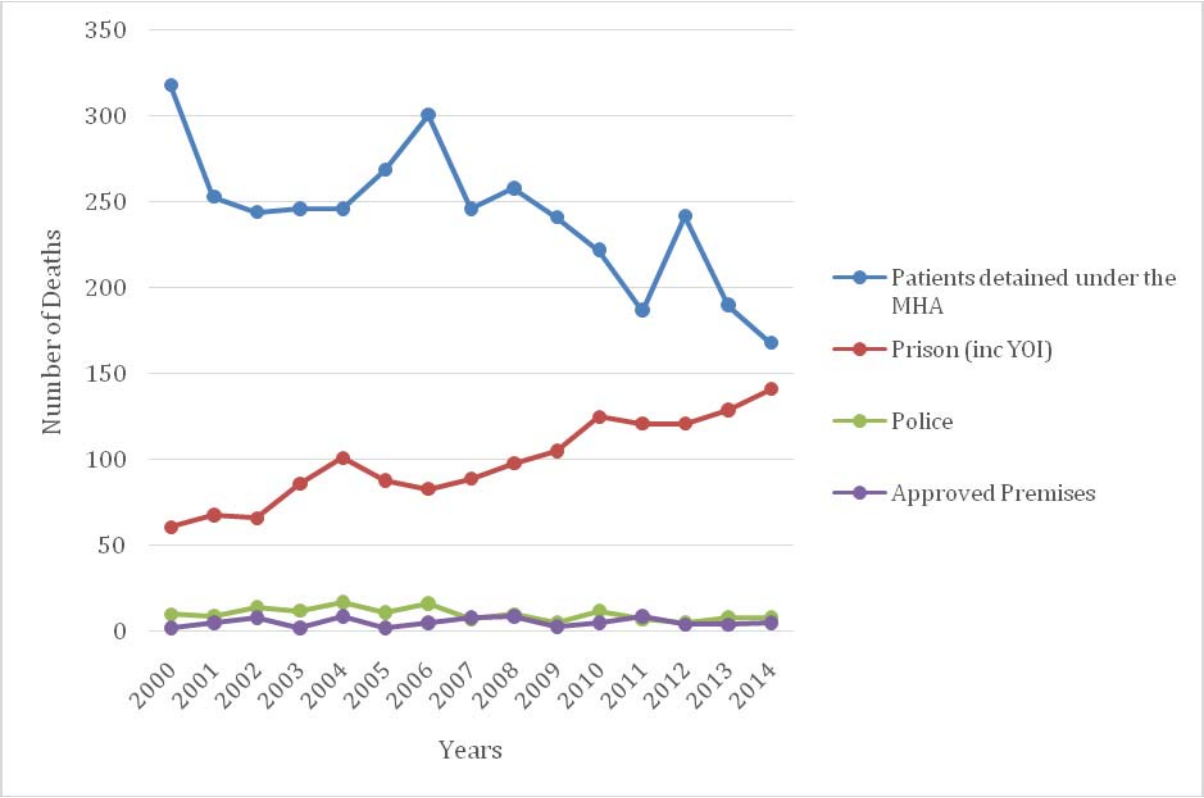

Figure 5: Natural cause-related deaths in four custodial sectors: 2000-2014

Restraint-Related Deaths for Five Custodial Sectors: 2000-2014

Key Point
The highest number of restraint-related deaths was amongst the patients detained under the MHA.

Figure 6 shows the distribution of restraint-related deaths in five custodial sectors between 2000-2014 (Approved Premises do not collect this information).

In total there were 100 restraint-related deaths across the five sectors between 2000 and 2014, with patients detained under the MHA accounting for nearly half of all deaths 46% (N=46) in this period. In this same setting, there was a 75% increase in restraint related deaths in 2011 and 2012 from 8 to 14 respectively. As ever, caution needs to be taken here due to the statistically small figures and differences in criteria used in different settings.

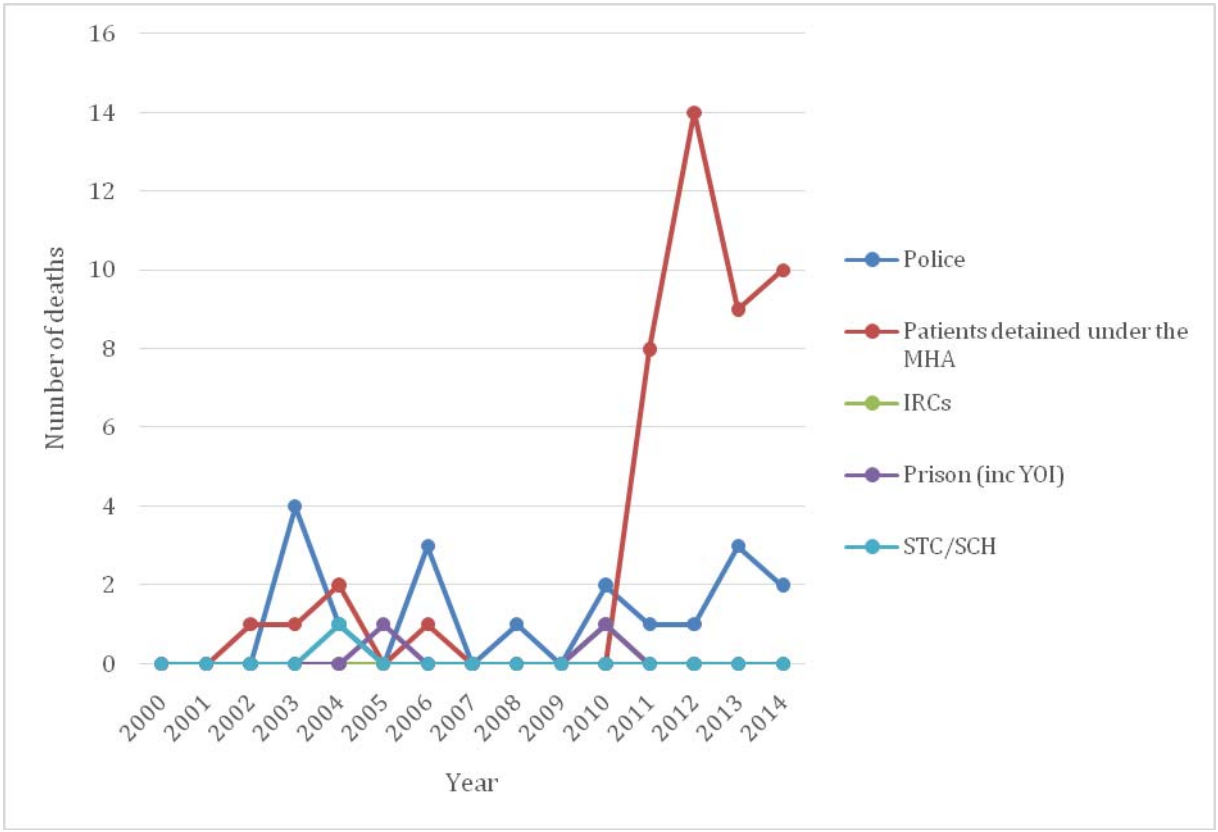

Figure 6: Restraint related deaths in five custodial sectors: 2000-2014

Death Caused by Others (including Homicide): 2000-2014

Key Point
The highest number of recorded deaths caused by others (including homicide) was in the prison setting.

From 1 January 2000 and 31 December 2014, there were 28 recorded deaths caused by others (including homicide) across the custodial settings.

Figure 7 shows that of these28deaths, 23(82%) were in prison settings, 3 were patients detained under the MHA and two in Approved Premises. With regard to gender, all but one of deaths across the five custodial settings were of men (96%, N=27). In 2014, there were 3deaths in prison. All three deaths were males and of White ethnic grouping. No information was available of the victim's ages.

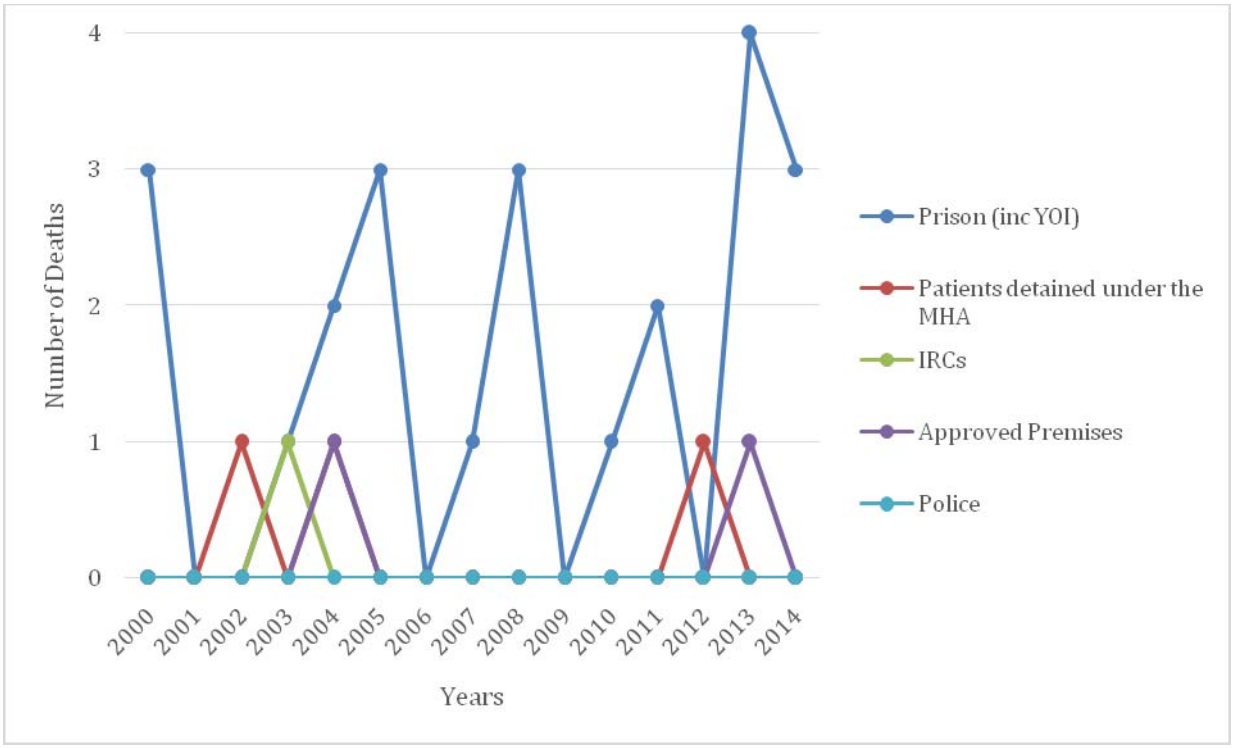

Figure 7: Deaths caused by others (including homicide) across five custodial settings: 2000-2014

Deaths by Custodial Setting 2014

In 2014, there were 479 recorded deaths in state custody. Table 2 shows the figures across the different custodial sectors for England and Wales for 2013 and 2014. The largest numbers of deaths were in the Prison sector with an increase of deaths (13%) to 243 deaths.

Table 2: Deaths in State Custody by Settings: 2013 and 2014

Custodial Setting	2013	2014	Percentage changes
Prison	215	243	+13%
Police	15	18	+20%
Patients detained under the MHA*	324	209**	-35%
IRCs	2	2	0%
Approved Premises	10	7***	-30%
STC/SCH	0	0	0%
Total	566	479	-15%

*The Care Quality Commission and Health Inspectorate Wales have amended these figures through a data cleansing exercise.
** Does not count the total deaths that occurred away from premises/off site (N=23) or deaths within 7 days of the use of restraint (N=10).
***This total does not include 2 deaths that were not yet classified - pending outcome of the PPO report.

A breakdown of the deaths in state custody[10] in 2014 by cause of death shows that:

- 67% (N=323) were natural cause of deaths, although 168 of these deaths (52%) were patients detained under the Mental Health Act;
- 23% (N=111) were Self-Inflicted Deaths;
- 3% (N=13) were categorised as 'cause of death unknown' and 9 of these were patients detained under the Mental Health Act;
- 1% (N=7) were 'Other non-natural (mainly Accidental Deaths and overdoses);
- 2 were classified as 'Restraint Related';
- 3 deaths were caused by others (including Homicide)
- 1% (N=6) of deaths were classified as 'Other Accidental';
- 14 deaths from the Prison data were 'Awaiting Further Information' and was a temporary category.

[10]The total percentage does not add up to 100% due to rounding.

From 2013 to 2014 there has been a decrease of 15%. Deaths of patients detained under the MHA has decreased by 35%, from 324 in 2013 to 209 in 2014 although caution should be adhered to here as the CQC and HIW have amended these figures through a data cleansing exercise. The total also does not count the total deaths that occurred away from premises/off site (N=23) or deaths within 7 days of the use of restraint (N=10).

There were two deaths in the Immigration Removal Centres in 2014. One male and one female, one was classified as Asian ethnicity and one Black ethnicity. One death was classified as a Self-Inflicted Death and the other death was deemed to be by natural causes.

There were no deaths in Secure Children's Homes and Secure Training Centres in 2014.

Deaths in State Custody by Gender: 2014

Key Points
Men account for the majority of deaths in state custody. However, in Prisons the female numbers doubled from 6 in 2013 to 13 in 2014, but10 of these were classified as 'natural causes'.

Table 3 illustrates the deaths in state custody by gender 2014.

Of the 479 deaths in state custody in 2014, 79% (380) were men and 21% (99) were women. Across the sectors deaths by gender varies, however the great majority of deaths are males in most settings. However, in Prisons the female numbers doubled from 6 in 2013 to 13 in 2014 but10 of these were classified as 'natural causes'. Further, in mental health settings, of the 209 deaths 61% were males and 39% were females. Caution needs to be taken with interpretations here due to the differing baseline gender mixes of the population in individual settings and statistically low numbers in some of the categories.

Table 3: Deaths in state custody by gender: 2014

	Percentage of males and females	**Total Numbers**
Prison		
Male	95	230
Female	5	13
Police		
Male	83	15
Female	17	3
Patients detained under the MHA*		
Male	61	127
Female	39	82
IRCs		
Male	50	1
Female	50	1
Approved Premises		
Male	100	7
Female	0	0
STC/SCH		
Male	0	0
Female	0	0
Total (N)		**479**

Ethnicity and Deaths in State Custody: 2014

Key Point
The White ethnic grouping account for the majority of deaths in state custody.

Table 4 shows the number of White and Black Minority Ethnic (BME) deaths across the individual custodial sectors in 2014.

In total, of the 479 deaths in England and Wales in 2014[11]:

- 413 (86%) were classified as White
- 22 (4%) were classified as Black
- 13 (2%) were classified as Asian
- 9 (1%) were classified as 'Other' (i.e. none of the ethnic categories above)
- 16 (3%) were cases where ethnicity was either not stated or not known
- 1 person was classified as Chinese
- 5 (1) were classified as Mixed ethnicity.

Table 4: Ethnicity breakdown of recorded deaths across all custodial settings: 2014

	Prison (inc YOI)	**Police**	**Patients Detained under the MHA**	**Approved Premises**	**STC/ SCH**	**IRCs**	**Total**
White	214	16	177	6	0	0	413
Black	13	1	6	1	0	1	22
Asian	6	1	5	0	0	1	13
Mixed	4	0	1	0	0	0	5
Chinese	0	0	1	0	0	0	1
Other*	5	0	4	0	0	0	9
Not Known*	1	0	15	0	0	0	16
Total (N)	**243**	**18**	**209**	**7**	**0**	**2**	**479**

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

[11]The total percentage does not add up to 100% due to rounding.

The highest number of deaths within BME groups was amongst those classified as ‘Black’. In comparison with ethnic distribution and deaths between 2014 and 2013 across all sectors there was limited variation. The majority of deaths in custody in 2014 were White (86%) and this has increased slightly from 2013 (81%).

Deaths in State Custody by Age: 2014

Key Points
Deaths in the custodial settings of the Police, Approved Premises, Patient's detained under the MHA in the 61 and over age band had the highest proportion of deaths (N=121). Deaths by patients detained under the MHA in this age band died from natural causes apart from 1.

Table 5shows the age distribution of those who died in state custody in England and Wales in 2014. The age distribution can only be shown for natural causes of deaths and self-inflicted deaths across four custodial sectors, Police, Approved Premises, Patient's detained under the MHA and IRCs. Data for Prisons was omitted as age distribution in relation to these types of deaths were not provided for 2014 and STC/SCH has no deaths in 2014.

Age was recorded for 194 of those who died in state custody in 2014. The largest aged band was those age 61 and over and were patients detained under the MHA (N=121). Of the 121 deaths in this age band and group 120 were from natural causes and 1 was a self-inflicted death. There were two deaths under 20 years of age by patients detained under the MHA, both were self-inflicted deaths and the 11-17 year old was female and the 18-20 year old was male.

Table 5: Age breakdown of recorded for self-inflicted deaths for Police, Patients detained under the MHA, Approved Premises and IRCs: 2014[12]

Age	Police	Patients Detained under the MHA	Approved Premises	IRCs	Total
11-17		1			1
18-20		1			1
21-30	3	6	1	1	11
31-40	3	13		1	17
41-50	2	13	2		17
51-60	1	23			24
61 and over		121	2		123
Totals	9	178	5	2	**194**

[12] For natural cause deaths and self-inflicted deaths only.

Individual Custodial Sectors

This section focuses on the two custodial sectors where the majority of the 479 deaths in custody in England and Wales occurred in 2014, Prisons (N= 243) and Patients detained under the MHA (N=209).

Prisons

In 2014 there were 243 deaths recorded in England and Wales by individuals in prison. Of these deaths, 230 (95%) were of males and 13 of females (5%). This is equivalent to the percentage of men and women detained in prison, 95.4% and 4.6% respectively. The largest recorded ethnicity grouping of deaths were individuals classified as White 214 (88%) followed by the Black ethnic group at 13 (5%).

A breakdown of the deaths in 2014 by cause of death shows that:

- 58% (N=141) were natural cause of deaths;
- 34% (N=84) were recorded as Self-Inflicted Deaths by males (N=81, 96%) and hanging was the main method used (N=78, 93%);
- 3 deaths were caused by others (including Homicide) and all victims were male and classified as White ethnic grouping;
- 1 death was due to ‘Other non-natural’ (mainly Accidental Deaths and overdoses);
- 14 deaths were classified as ‘Deaths awaiting further information’, which appears to have been a temporary category, and all deaths under this classification were male.

Patients detained under the MH Act: 2014

Recorded deaths in England and Wales by patients who were detained under the MH Act were 209 in 2014. Of these deaths, 127 (61%) were of males and 82 of females (39%). The largest recorded ethnicity grouping of deaths were individuals classified as White 177 (85%) followed by ‘Not known’ where ethnicity was not recorded (N=15, 7%).

A breakdown of the deaths in 2014 by cause of death shows that:

- 80% (N=168) were natural cause of deaths;
- 12% (N=25) were Self-Inflicted Deaths by males (N=15, 60%) and hanging was the main method used (N=9, 36%);
- 2 deaths were due to ‘Other non-natural (mainly Accidental deaths and overdoses);

- 5 (2%) were deaths classified as ‘Other – Accidental’;
- 9 (4%) were deaths classified as ‘Other - Cause unknown’

It must be noted that the total for 2014 (N=209) does not include deaths that occurred away from premises/off site (N=23) or deaths within 7 days of the use of restraint (N=10). The CQC and HIW have also removed the numbers and details of patients who died while subject to Community Treatment Orders and Guardianship.

Self-inflicted Deaths by Custodial Setting and Gender: 2000-2014

Key Point
From 2000-2014 there were 1921 self-inflicted deaths, 1572 (82%) were men and 349 (18%) were women.

From January 1 2000 to 31 December 2014 there were 1921 self-inflicted deaths in state custody. Of these deaths, 1572 (82%) were men and 349 (18%) were women. These figures are equivalent to 2013.

Table 6 shows that of the 111 self-inflicted deaths in state custody in 2014, the majority were in prison (N=84, 76%) followed by patients detained under the MHA (N=25, 23%).

In 2000, a total of 152 self-inflicted deaths were recorded compared with 111 in 2014. This represents 27% fewer self-inflicted deaths in 2014 compared to 2000, although this percentage has fluctuated in the years over this period.

Table 6: Self-inflicted deaths by custodial setting and broken down by gender 2000-2014

All Self-inflicted deaths	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014	Total
Police	4	2	5	2	8	2	1	3	2	1	0	3	2	0	1	36
Male	4	2	5	1	7	1	1	3	2	1	0	3	2	0	0	32
Female	0	0	0	1	1	1	0	0	0	0	0	0	0	0	1	4
Approved Premises	8	3	3	4	1	7	2	5	4	2	1	5	2	2	0	49
Male	8	3	3	4	1	7	2	4	4	2	1	5	2	2	0	48
Female	0	0	0	0	0	0	0	1	0	0	0	0	0	0	0	1
Immigration	1	0	0	1	3	2	1	0	0	0	0	1	0	0	1	10
Male	1	0	0	1	3	2	1	0	0	0	0	1	0	0	1	10
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Prison	81	73	95	95	96	78	66	92	61	61	58	57	60	75	84	1132
Male	73	67	86	81	83	74	63	84	60	58	57	55	59	73	81	1054
Female	8	6	9	14	13	4	3	8	1	3	1	2	1	2	3	78
MHA	58	60	35	50	42	49	49	51	40	36	54	51	52	41	25	693
Male	36	35	21	30	21	30	31	34	25	29	32	32	29	27	15	427
Female	22	25	14	20	21	19	18	17	15	7	22	19	23	14	10	266
YJB	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Male	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	1
Female	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
Total	152	138	138	152	151	138	119	151	107	100	113	117	116	118	111	1921

Self-inflicted Deaths by Custodial Setting: 2000-2014

Key Point
The number of self-inflicted deaths in all settings has decreased from levels in 2007 (but there has been an increase again since 2010).

Figure 8 illustrates that whilst the average number of self-inflicted deaths in all settings has decreased since 2007 (an average of 151 self-inflicted deaths in 2007), these have increased steadily since 2010.

In 2014, the rolling 3 year Self-Inflicted Deaths had reached 115 deaths, an increase from an average of 107 self-inflicted deaths in 2010.

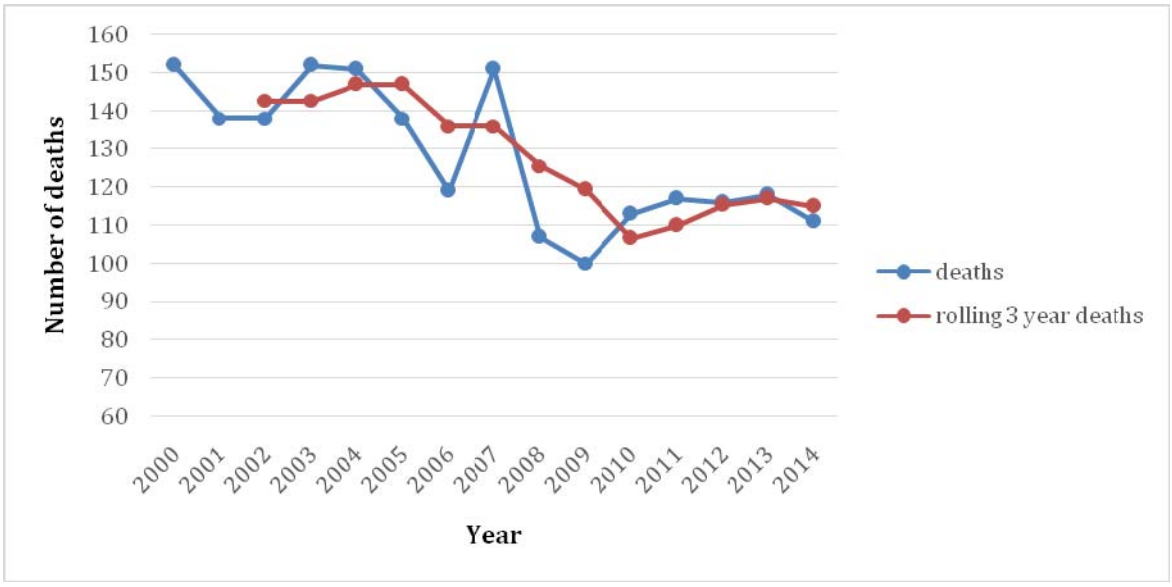

Figure 8: Average self-inflicted deaths across all custodial sectors: 2000-2014

Self-Inflicted Deaths for Four Custodial Settings: 2000-2014

Key Point
The highest proportion of self-inflicted deaths for 2000-2014 was in the Prison setting.

Figure 9 shows that the highest proportion of self-inflicted deaths was in Prison followed by patients detained under the MHA. The average numbers of deaths of patients detained under the MHA remained relatively stable over the period 2000 to 2014. Self-inflicted deaths in the police and Approved Premises remain comparatively low.

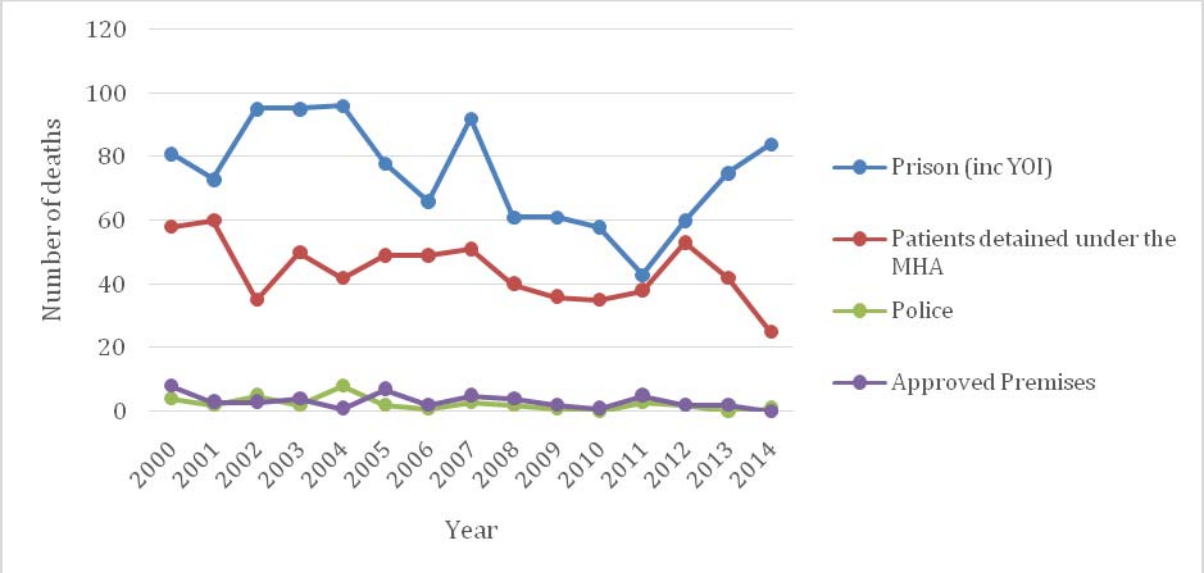

Figure 9: Deaths of self-inflicted deaths for the Police, Prison, patients detained under the MHA and Approved Premises: 2000-2014

Self-Inflicted Deaths for the Prison Setting: 2000-2014

Key Point
From 2000 to 2014, the percentage of self-inflicted deaths in comparison to all deaths in Prison (inc YOI) has decreased by 20%.

Table 7 shows the self-inflicted deaths in prison year on year compared with total deaths in prison with percentages they represent of all deaths in prison, Since 2000 the percentage that self-inflicted deaths account for in relation to the total number of deaths in prison has decreased from 55% (N=81) to 35% (N=84) in 2014.

Table 7: Self-inflicted deaths in prison compared to all deaths in prison: 2000-2014

	Total Self-Inflicted Deaths in Prison (inc YOI)	**Total Deaths in Prison (inc YOI)**	**Percentage of Self-Inflicted Deaths in relation to all deaths in Prison (inc YOI)**
2000	81	146	55%
2001	73	142	51%
2002	95	164	58%
2003	95	183	52%
2004	96	208	46%
2005	78	174	44%
2006	66	153	43%
2007	92	185	49%
2008	61	165	37%
2009	61	169	36%
2010	58	197	29%
2011	57	192	30%
2012	60	192	31%
2013	75	215	35%
2014	84	243	35%
Total	**1132**	**2728**	**41%**

Method of Self-Inflicted Death: 2014

Key Point
Hanging was the most frequent method used and the largest proportion was in the Prison setting.

Table 8 shows that the most common method of self-inflicted death across all settings in 2014 was hanging, which accounted for 79% of all self-inflicted deaths (88) with the largest proportion being in the Prison setting. Of the 25 self-inflicted deaths whilst detained under the MHA, 9 died from hanging, 6 from jumping /falling (including railways), three from overdose/poisoning, three from self-strangulation and the remaining four other methods or unknown.

Table 8: The main methods of self-inflicted deaths across all custodial settings: 2014

Method **Custodial Setting**	**Hanging**	**Self-strangulation**	**Suffocation**	**Drug Alcohol OD/ Poisoning***	**Cutting**	**Other Jumping/ Falling**	**Other/ Unknown**
Prison	78	0	4	1	1	0	0
Police	0	0	1	0	0	0	0
Patients detained under the MHA	9	3	0	3	0	6	4
IRCs	1	0	0	0	0	0	0
Approved Premises	0	0	0	0	0	0	0
STC/SCH	0	0	0	0	0	0	0
Total	**88**	**3**	**5**	**4**	**1**	**6**	**4**

*This includes self-inflicted deaths by poisoning, overdosing and drug and alcohol overdosing.

Self-Inflicted Death by Gender in Prison: 2000-2014

Key Point
The rate of self-inflicted deaths for both males and females has remained constant over the last 15 years.

Figure 10 shows the rate of self-inflicted deaths in prison for males and females separately. In 2000 there were 73 self-inflicted deaths among males in prison compared to 81 in 2014 while for females in prison in 2000 there was eight compared to three in 2014. The rate for both males and females has remained relatively constant over the last 15 years,

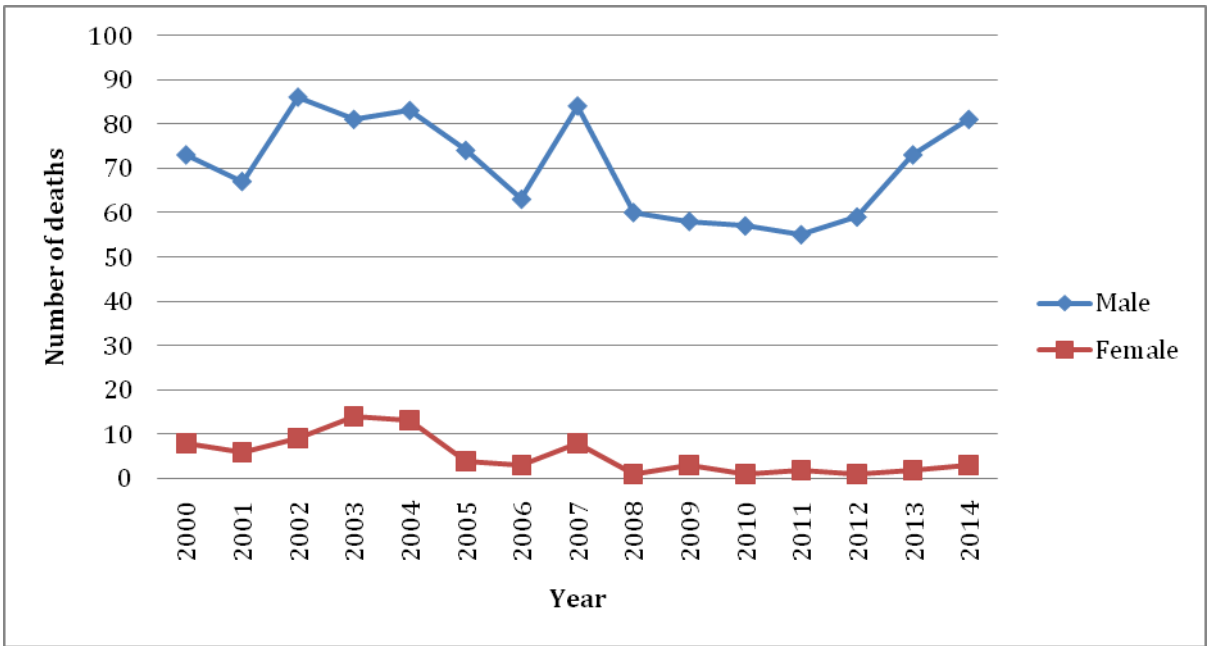

Figure 10: Number of Self-Inflicted Deaths by gender in prison: 2000-2014

Self-Inflicted Death by Age Group (where age was known) in State Custody: 2014

Key Point
The highest proportion of self-inflicted deaths occurred amongst 21-30 year olds (29%) across the Police, Patient's detained under the MHA and IRCs in 2014.

Figure 11 shows the percentage of self-inflicted deaths by age band across three custodial sectors Police, Patient's detained under the MHA and IRCs. Data was not available from Prisons and Approved Premises and STC/SCH had no self-inflicted deaths in 2014.

There were 111 self-inflicted deaths across state custody in 2014. However, in the Police, Patient's detained under the MHA and IRCs custodial settings, the highest proportion of self-inflicted deaths (29%) occurred amongst 21-30 year olds, followed by 28% amongst the 31-40 year olds, 19% amongst the 41-50 year olds and 8% among the 51-60 year olds. For the 11-20 age bands there were 8% self-inflicted deaths. However, there was not data available on populations in these settings to calculate rates.

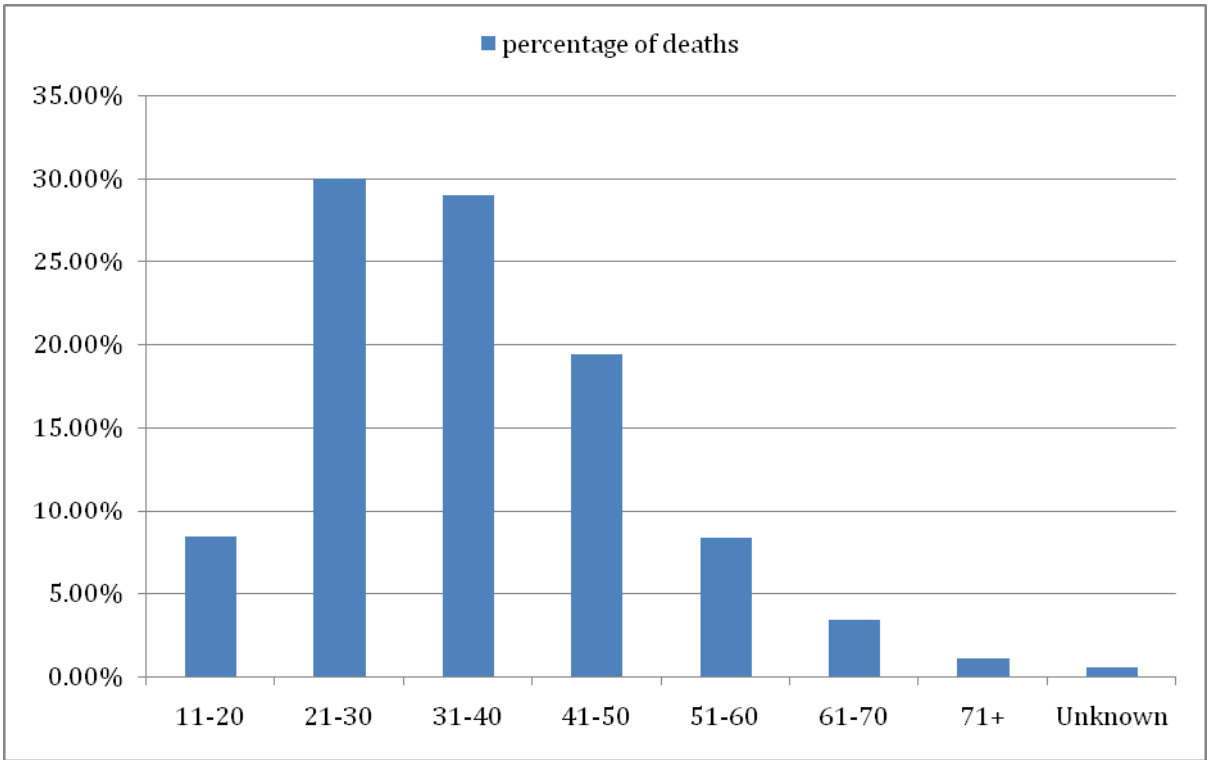

Figure 11: Percentage of Self-Inflicted Deaths by age group for three custodial settings: 2014

Conclusions

There were 8,129 deaths recorded for the 15 years from 2000 to 2014. This represents 21% fewer total deaths in 2014 (N=479) compared to 2000 (N=607). The majority of the 8129 deaths in the 15 years (59%) were patients detained under the Mental Health Act (N=4801) and the second highest were within prison settings at 34% (N=2728) of all deaths. On these figures, the overall numbers of deaths amongst detained patients appear to be dropping in contrast to those in prisons, which appear to be on an overall increase.

Patients detained under the Mental Health Act have the highest number of deaths, however, these appear to be decreasing year on year. The Prison sector has had a continued increase from 2006 onwards. Over the last 15 years the White ethnic grouping has had the highest number of deaths and it has risen since 2008 consistently, apart from 2011 when it appears to have decreased slightly. Deaths in the Black ethnic group have fluctuated the most since 2000 and have had the largest number of deaths in 2007 with 21 deaths. Deaths in the Black ethnic group have had the biggest increase from 2 in 2008 to 15 in 2013. However, for all ethnic groups there has been a decrease in deaths from 2013 to 2014.

Restraint-related deaths have been difficult to compare between the different custodial settings because of the varying definitions that exist for these deaths across the sectors. For instance the Care Quality Commission (which collates data on patients detained under the MHA) a restraint related death is defined as a death in which restraint was used in the previous seven days, although this may not necessarily be related to the cause of death. For police custody, restraint is defined as ‘restraint-related’, being mentioned in the post mortem report. In all other sectors, a restraint-related death is defined as one in which restraint is a primary cause of death. As ever, we therefore need to be cautious when interpreting these deaths between settings.

In 2014 there were 243 deaths recorded in England and Wales of individuals in Prison. Of these deaths, 230 (95%) were of males and 13 of females (5%). The female numbers of recorded deaths has increased from 6 in 2013 to 13 in 2014 in this setting, however 10 of these were classified as ‘natural causes’. The largest recorded ethnicity grouping of deaths were individuals classified as White 214 (88%) followed by the Black ethnic group at 13 (5%).

From 2000 to 2014 there were 28 recorded deaths caused by others (including homicide) across the custodial settings. Of these the majority (N=23, 82%) were in prison settings and

were caused by men (96%, N=27). In 2014, there were 3 such deaths in prison. All three deaths were males and of White ethnic grouping.

The recorded deaths in Police custody were 18 in 2014, which is an increase of three deaths since 2013. Of the recorded deaths in 2014, 15 were male and 3 were female. The majority was of White ethnic origin (N=16) and the other two were of Asian and Black origin. Since 2000 there have been 355 deaths recorded in Police custody.

Immigration Removal Centres in 2014 had 2 deaths; one male of Asian ethnicity and one female of Black ethnicity. There was no increase of death from the previous year. Overall, since 2000 there have been 21 deaths recorded in Immigration Removal Centres

There were 7 deaths in Approved Premises in 2014. All were male; six of White ethnicity; one of Black ethnicity. There was a decrease of three deaths from the previous year. Overall there have been 222 deaths recorded in Approved Premises since 2000.

Secure Children's Homes and Secure Training Centres had no recorded deaths in 2014 and this has been the case since 2004.

Age distribution data was only available for the recorded deaths of individuals who had had natural case related and self-inflicted deaths in the Police, Approved Premises, Patient's detained under the MHA and IRCs It was found that patient's detained under the MHA in the 61 and over age band (N=121) had the largest proportion of deaths and this was for deaths caused by natural causes.

From 2000-2014 there were 1921 self-inflicted deaths, 1572 (82%) were men and 349 (18%) were women. The number of self-inflicted deaths in all settings has decreased from 2007 levels but there has been a steady increase in numbers again 2010. In 2014, there were 111 recorded self-inflicted deaths in state custody and the majority was in prison (N=84, 76%) followed by patients detained under the MHA (N=25, 23%). However, it must be noted that from 2000 to 2014, the percentage of self-inflicted deaths in comparison to all deaths in Prison (inc YOI) has decreased by 20%.

With regard to age the highest proportion occurred amongst 21-30 year olds (29%) in the Police, Patient's detained under the MHA and IRCs custodial settings. Hanging was the most frequent method used. Overall, the rates of self-inflicted deaths for both males and females have fluctuated over the last 15 years.