

4. Life

Domain: The capability to be alive

Sub-domains:

- A. Avoid premature mortality through disease, neglect, injury or Suicide
- B. Be protected from being killed or murdered.

Final short list

Indicator 1: Life expectancy

Measure 1.1 (E,S,W): Period life expectancy at birth, and ages 20, 65 & 80

Indicator 2: Homicide

Measure 2.1 (E,S,W): Homicide rate

Measure 2.2 (E,W): Domestic homicide rate (with separate reporting of relationship of victim to principal suspect, including partner homicide)

Measure 2.3 (E,W): Homicides involving sharp instruments and shootings

Measure 2.4 (E,W): Racially motivated, religiously motivated and homophobic homicide

Indicator 3: Other specific-cause mortality rates

Measure 3.1 (E,S,W): Cardio-vascular disease mortality rate (age-standardized)

Measure 3.2 (E,S,W): Cancer mortality rate (age-standardized)

Measure 3.3 (E,S,W): Suicide rate

Measure 3.4 (E,S,W): Accident mortality rate

Indicator 4: Death rates from non-natural causes for people resident and / or detained in public and private institutions

Measure 4.1 (E,W): Deaths from non-natural causes during or following police custody

Measure 4.2 (E,S,W): Self-inflicted deaths in prisons

Measure 4.3 (E,W): Deaths from non-natural causes for people resident in health or social care establishments (under development)

Indicator 1: Life expectancy**Measure 1.1 (E,S,W): Period life expectancy at birth, and ages 20, 65 and 80**

Sources: General Register Office (England and Wales); General Register Office for Scotland; ONS Census Longitudinal Study

Sub-domain: A

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3/4	Disaggregation	
	- at GB level	Gender, age
	- within England	Gender, age, social class
	- within Scotland	Gender, age
	- within Wales	Gender, age
5	Aspect of inequality	Outcome
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

Life expectancy at birth and at later ages continues to be a central indicator for monitoring health inequalities. It is an expression of contemporary age-specific mortality rates.

Feedback from the first round of specialist consultation

Participants broadly endorsed the inclusion of life expectancy as an indicator for the life domain. In addition, they emphasised the importance of recommending that the Registrar General records ethnicity on death certificates, despite the complications of not knowing how the deceased would define his or her ethnicity for him or herself.

Some participants felt that the infant mortality rate could be included in the adult list because of the impact on adults and overall life expectancy. The measure should cover still-births; participants suggested that some trusts are recording more perinatal deaths as still-births to meet the target on infant mortality.

Participants argued that ethnicity categories would need to be relatively refined, for many purposes. For example, infant mortality differentials are significant for

Pakistani and Bangladeshi groups, whilst on other indicators these two groups are quite similar.

Feedback from the second round of specialist consultation

Participants in the second round of specialist consultation also endorsed the inclusion of life expectancy as an indicator. The Department of Health regard its inclusion as 'essential', and recommend period life expectancy. They note that it is an expression of contemporary mortality rates rather than a prediction of lifespan. In contrast, the Department of Work and Pensions find cohort life expectancy more informative for their purposes than period life expectancy. It was agreed that life expectancy at different ages is informative as well as life expectancy at birth.

DoH observed that infant mortality is a cross-government PSA target, and noted that it varied by many of the equality characteristics under consideration in the EMF. They would like to see it included in the short list for adults. They would welcome discussion with the Commission and GEO about how to take forward the calculation of mortality rates by ethnicity, following recent work by ONS on infant mortality, through data linkage or other means. Participants at the Welsh consultation event would like to see disability being recorded on death certificates, as well as ethnicity.

The health inequalities agenda in Scotland focuses on improving health outcomes in deprived areas to close the gap between deprived and other areas; mortality rates by area can be, and are, calculated. However, the level of deprivation in a given area may change over a period of years so is not necessarily a useful measure for tracking change over time. Area deprivation is not a proxy for social class of individuals. Disaggregation of mortality rates or life expectancy by socioeconomic group is possible for England and Wales using the ONS Census Longitudinal Study, but is not available in Scotland.

Feedback from one-to-one discussions and meetings

The Scottish Government expressed some concern about requesting the recording of life expectancy by ethnicity, especially in relation to the issue of non-self reporting and how this could be overcome.

They also requested the inclusion of life expectancy at age 65 rather than 50.

Decisions following consultation feedback

The preferred indicator has been specified more precisely: (a) as life expectancy at various birth, and ages 20, 65 and 80, and (b) as period life expectancy. While cohort life expectancy is useful for forecasting purposes – such as future pension

payments for example – the simpler methodology of period life expectancy is sufficient to illuminate inequalities in current mortality and is, therefore, appropriate for this indicator.

We recommend that recording of ethnicity on death certificates be reconsidered, despite concerns about accuracy. In the meantime, EHRC and GEO should take forward discussion with DoH and ONS about other possible ways of producing mortality rates by ethnicity (for example data linkages).

Infant mortality should be a high priority for inclusion as an indicator in the children's framework. Strong arguments have been put forward by consultation participants for its importance, which we fully endorse, including the fact that it has an enormous impact on parents and other adults. However, given the necessity of limiting the overall number of indicators and avoiding overlap, we are not recommending it be included in the adults' framework.

Further information - An additional source for Scotland: Scottish Longitudinal Study: <http://www.lscs.ac.uk/sls/> has also been highlighted.

Table 4.1 Measure 1.1 Period life expectancy by age, country and gender, 2005-07

	England				Wales				Scotland			
	Birth	20	50	80	Birth	20	50	80	Birth	20	50	80
Male	77.5	58.2	29.8	7.7	76.7	57.4	29.3	7.6	74.8	55.5	27.9	7.2
Female	81.7	62.3	33.3	9.2	81.1	61.6	32.7	9.0	79.7	60.3	31.5	8.6

Source: ONS (2008)

Table 4.2 Measure 1.1 (EW) Period life expectancy by age, social class and gender, 2002-05

	At birth	At age 65
Social Class - Men		
Professional	80.0	18.3
Managerial and technical/intermediate	79.4	18.0
Skilled non-manual	78.4	17.4
Skilled manual	76.5	16.3
Partly skilled	75.7	15.7
Unskilled	72.7	14.1
Social Class- Women		
Professional	85.1	22.0
Managerial and technical/intermediate	83.2	21.0
Skilled non-manual	82.4	19.9
Skilled manual	80.5	18.7
Partly skilled	79.9	17.7
Unskilled	78.1	17.6

Source: ONS (2007)

Indicator 2: Homicide

Measure 2.1 (E,S,W): Homicide rate

Measure 2.2 (E,W): Domestic homicide rate (with separate reporting of relationship of victim to principal suspect, including partner homicide)

Measure 2.3 (E,W):Homicides involving sharp instruments and shootings

Measure 2.4 (E,W): Racially motivated, religiously motivated and homophobic homicide

Sources: England and Wales: Home Office Homicide Index (Office will supply tables disaggregated by the equality characteristics recorded in the homicide data base – see Home Office Consultation response below)

Scotland: Scottish Government Statistical Bulletin / Justice Analytical Statistics

Sub-domain: B

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3	Disaggregation	
	- at GB level	
	- within England	Gender, age, ethnicity, sexual orientation, economic position
	- within Scotland	Gender, age
	- within Wales	Gender, age, ethnicity, sexual orientation, economic position collected ¹

¹The disaggregation characteristics indicated are based on the fields available from the Homicide Index database. The Home Office has indicated that Wales-only data can be provided for all measures of homicide. However, information provided by the Welsh Assembly Government (based on independent robustness rules, including the rule of a minimum of 30 cases for administrative sources) suggests; For 2.1, the need to combine years to disaggregate by gender, age, sexual orientation and social class, and numbers too small to disaggregate by ethnicity, even if combining years. This information also suggests that disaggregation is not possible for 2.2, 2.3 or 2.4. The availability of Wales-only data for these measures therefore requires further discussion and clarification at the next stage of the project.

5	Aspect of inequality	Outcome
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

Feedback from the first round of specialist consultation

Participants emphasised that although domestic violence is to be included in the physical security domain, domestic homicide should also explicitly appear in the life domain. Many participants argued that a domestic homicide indicator would be more suitable than an intimate partner homicide measure, because it would cover a broader range of the homicides that can arise in the domestic context (for example, homophobic killings, and killing of elderly people or disabled people).

Feedback from the physical security specialist consultation event reinforces these comments. The importance of a broad definition of domestic violence, covering homophobic violence, elder abuse, violent crimes against disabled people and violent crimes committed because of belief or lack of belief in a domestic setting, as well as partner violence more narrowly construed, was emphasised by many participants. The question of broad-based v gender-focused definitions of domestic violence is discussed in detail in Chapter 6 (which also sets out the various definitions of domestic violence submitted to the specialist consultation by stakeholders and subject experts).

Participants commented that excess winter deaths is not a suitable indicator because of variation caused by the temperature of the winter and new strains of flu.

Feedback from the second round of specialist consultation

The definition of domestic homicide differs between Scotland, England and Wales. There was further extensive discussion on whether the measure of domestic homicide should be defined broadly or should exclusively focus on partner violence. Participants in Scotland emphasized the importance of retaining a gender-focused specification in the Scottish context.

The Welsh Assembly Government (WAG) warned that flagging of domestic homicide could be inconsistent in police records and recommended that we use the policy statutory performance indicator definition (see below). WAG noted that Honour Homicide Offences are measured separately, and although this is not a published series, they would like to see it included in the short list for the EMF.

It was pointed out that the Homicide Index becomes reliable only with a lag of a couple of years, since the statistics are recoded once it becomes clear whether a case was suicide, accident, murder etc, depending on the outcome of various investigations and prosecutions. It was also suggested that including measures of homicides using knives and guns would be useful, to mirror the measures included in the Physical Security and Legal Security domains. WAG also suggested that we should consider including attempted murder, and death by dangerous driving.

Home Office consultation response

The Homicide Index data is disaggregated by age, gender and ethnicity. Data is made available for police operational purposes and information is also made available under strict conditions. The number of homicides per year is such that care has to be taken not to over-interpret information relating to small subsets of the population.

The high level of concern regarding issues around release of sensitive personal data is leading the Home Office to review requests for access to the data. Nevertheless, the Home Office has agreed in principle to provide defined indicator data by disaggregation characteristics in table form on special request. The Homicide Return form provided by the Home Office suggests that homicide statistics can be disaggregated by gender, age, ethnicity, sexual orientation and economic position and by the circumstances around the homicide (see Box below). The Home Office has also clarified that separate figures for Wales can be provided; and that there is currently no field for honour killings in the Home Office classification system (Home Office 2009).

Homicide statistics: Which disaggregation characteristics are currently available?

The homicide database has fields for age, gender, ethnicity, sexual orientation and economic position and for the circumstances around the homicide, including:

- Racially motivated
- Religiously motivated
- Homophobic
- Result of alleged 'homosexual panic'
- Sharp instruments and firearms
- Homicide linked to prior incidents of domestic violence against the suspect.

Existing indicators of domestic homicide: The Statutory Performance Indicators for Policing and Community Safety

The indicator of domestic homicide set out in the Statutory Performance Indicators for Policing and Community Safety 2008-9 (Home Office 2008b) covers **all partners and ex-partners**. The publication states that over 2008/09, further work will be undertaken (through analysis of the Homicide Index) to ensure that forces are consistently flagging domestic violence cases which cover broader family members (that is, honour killings) in a standardised way. Once this has been achieved, the publication suggests that the indicator will be broadened out to cover all domestic violence homicides (Home Office 2008b: 29).

Decisions following consultation

A separate domestic homicide rate, Measure 2.2, was introduced following the first round of consultation. The measure for this indicator was based on a broad definition of domestic homicide, covering all family members (including extended family members). We have re-specified the description of this Measure to reflect the importance of reporting the relationship of the victim to the principal suspect, with separate reporting of partner homicide. Honour killings have not been included as a separate category but will be reflected in the overall figures for domestic homicide. In follow-up meetings, the Scottish Government requested that we note that the recording of domestic homicide across Police Forces is not consistent.

Two separate measures: 2.3 covering homicides involving sharp instruments and shootings; and 2.4 covering racially motivated, religiously motivated and homophobic homicides, have been introduced. We anticipate that the data for these measures will be provided by the Home Office in table form on special request. The disaggregation equality characteristics will be in line with those recorded in the homicide data base (see 'Home Office consultation response' above).

Feedback from Welsh Assembly Government

Whilst the Home Office have indicated that the data detailed above can be disaggregated for within Wales analysis, WAG have also provided their own analysis of the availability of within Wales homicide data by characteristic, which presents a slightly different picture. See evaluation criteria table (footnote) for further details. . The Tables below provide a summary of the homicide and domestic homicide data available from existing published sources.

Table 4.3 Measure 2.1 (EW) Offences currently recorded as homicide 2007/8 (recorded crime statistics)*

	Number
16-29	240
30-49	297
50-69	114
70+	43
Male 16+	512
Female 16+	182

Source: Home Office (2008a: Table 1.07)

Notes: *As at 4 November 2008; figures are subject to revision as cases are dealt with by the police and the courts, or as further information becomes available.

Table 4.4 Measure 2.1 (EW) Ethnic appearance of currently recorded homicide victims, combined data for 2004/5 to 2006/7*

	Number
White	1610
Black	248
Asian	169
Other	75
Not known	139

Source: MoJ (2008: Table 3.5)

Notes: *Offences recorded as homicide as at 12 November 2007; figures are subject to revision as cases are dealt with by the police and the courts, or as further information becomes available.

Measure 2.2 (E,W): Domestic homicide (with separate reporting of relationship of victim to principal suspect, including separate reporting of partner homicide)

Table 4.5 Measure 2.2 (EW) Homicides currently recorded for all victims by relationship of victim to principal suspect, 2007-8 *

	Number
Partner/ex-partner:	
Male victims	34
Female victims	72
Other family (parent + other family):**	
Male victims	26
Female victims	26

Source Home Office (2008a: Table 1.05)

Notes: *As at 4 November 2008; figures are subject to revision as cases are dealt with by the police and the courts, or as further information becomes available.

**Figures for son / daughter are not currently included in this table since child victims are not covered by this Indicator. However, a more accurate solution would be to omit son and daughter victims who are children.

Table 4.6 Measure 2.2 (EW) Relationship of currently recorded homicide victims to principal suspect by ethnic appearance of victim combined data 2004/5 to 2006/7*,**

	Ethnic appearance of victim				
	White	Black	Asian	Other	Not known
Relationship of victim to principal suspect:					
Family	465	37	40	15	20
of which, spouse/lover	308	19	19	11	9

Source: MoJ (2008: Table 3.6)

Notes: *Figures may include child victims.

**Offences recorded as homicide as at 12 November 2007; figures are subject to revision as cases are dealt with by the police and the courts, or as further information becomes available.

Indicator 3: Other specific-cause mortality rates**Measure 3.1 (E,S,W): Cardio-vascular disease mortality rate (age standardized)****Measure 3.2 (E,S,W): Cancer mortality rate (age standardized)****Measure 3.3 (E,S,W): Suicide rate****Measure 3.4 (E,S,W): Accident mortality rate**

Sources: Registrar General Mortality Statistics (England and Wales); General Register Office for Scotland

Sub-domain: A

Evaluation against essential selection criteria:

1	Relevance	All equality characteristics
2	Legitimacy	Strong
3/4	Disaggregation	
	- at GB level	Gender, age
	- within England	Gender, age, social class
	- within Scotland	Gender, age
	- within Wales	Gender, age, social class (combined years may be necessary for 3.3)
5	Aspect of inequality	Outcome
6	Frequency	Annual
7	Individual level	Yes
8	Robustness	Good

Feedback from the first round of specialist consultation

Whilst some participants at the first specialist consultation event expressed the view that specific-cause mortality rates are not necessarily revealing from the equality and human rights perspective, others argued that specific-cause mortality rates associated with certain health conditions, as well as deaths through suicide and accident, should be included within the portfolio of indicators selected for the life domain.

The first three of these specific measures reflect existing priorities for the Department of Health. Details of the life expectancy and all-cause mortality indicators under PSA 18 (HM Government 2007:8-9) include references to established Department of Health targets focusing on:

- reducing the mortality rate by 2010 for cancer by at least 20 per cent in people under 75, with a reduction in the inequalities gap by at least 6 per cent;
- reducing the mortality rate by 2010 for heart disease, stroke and related diseases by at least 40 per cent in people under 75, with a reduction in the inequalities gap by at least 40 per cent.

In addition, the Department of Health *Suicide Prevention Strategy* sets out ways in which commissioners can reduce risk in key risk groups, for example, young men or people who have recently self-harmed, promoting mental well-being in the wider population, and reducing the availability of suicide methods.

Feedback from the second round of specialist consultation

It was suggested that the specific-cause mortality rates should be age-standardised, since there are differences in the age structures of equality groups (for example, ethnic groups). DoH welcomed inclusion of specific cause mortality rates, especially Cardio-vascular disease (CVD) and cancer, and suggested they should cover all ages rather than being restricted to a particular age group such as the under-75s. Participants at the consultation in Wales wanted to see mortality due to diabetes and to respiratory conditions added to the specific-cause mortality rates to be monitored.

The Fawcett Society also endorsed the importance of looking at specific-cause mortality rates, including accidents. DoH suggested that Measure 3.4 be specified as the accident mortality rate (rather than, as originally, the prevalence of deaths caused by accidents).

Decisions following consultation feedback

Measures 3.1 to 3.4 will be presented in raw form, in order to show age differentials in risks of different causes of mortality, and age-standardised form to reveal differences by other equality characteristics, independently of age.

Measure 3.4 has been re-specified as the accident mortality rate in line with DoH comments.

Indicator 4: Death rates through non-natural causes for people resident or detained in public or private institutions

Measure 4.1 (E,W): Deaths from non-natural causes during or following police custody

Source: IPCC (England and Wales)

Measure 4.2 (E,S,W): Self-inflicted deaths in prisons

Source: MoJ (England and Wales)

Scotland: SPS Apparent Suicide in Custody Database

Measure 4.3 (E,S,W): Deaths from non-natural causes for people resident or detained in health or social care establishments

Source: Under development (England, Wales and Scotland)

We consulted on the possible development of an indicator for the life domain covering the capability for longevity in a variety of institutions and establishments such as care homes for older people, mental health institutions and within prisons and police cells. This would be an overarching indicator bringing together multiple administrative data sources including data collected by bodies such as the Healthcare Commission, the Commission for Social Care Inspection, the Prisons Inspectorate, the Ministry of Justice, and Home Office data.

The original indicator tabled at the specialist consultation event focused on deaths from non-natural causes in places of detention within the police and criminal justice system. However, participants at the specialist consultation event on life argued strongly for a more broad-based indicator covering people resident or detained in a variety of public and private institutions. Participants argued that the concept of deaths from non-natural causes should cover suicide.

We asked for comments and feedback on taking the development of Indicator 4 forward as part of the web consultation.

Feedback from the first round of specialist consultation

The indicator should be broadened to include care homes /residential care if possible, and deaths in psychiatric institutions. Participants emphasized that the Commission for Social Care Inspection (CSCI) investigates all suspect deaths and would be a potential source of data. Participants suggested that the Independent Complaints Advisory Services for NHS complaints is another potential source of data for this measure. Participants also suggested that deaths and serious incidents within the residential care context and in places of detention are notifiable and are, therefore, logged as part of police records (although the relevant equality characteristics and the fact that the death has occurred in the residential context may not be recorded).

Participants highlighted the need for clarification of whether the measure focusing on non-natural deaths in places of detention within the police and criminal justice system covers non-natural deaths in asylum detention centres. It was pointed out that the Home Office produces a series focusing on deaths in police custody for England and Wales; and that the Independent Police Complaints Commission must investigate all deaths in custody, and is potentially a source of data.

Feedback from the second round of specialist consultation

Participants in the second round welcomed the broader specification of this measure, covering care homes and hospitals. Age Concern told us that deaths in care homes are often mis-reported and mis-recorded.

An organisation of transgender people observed that prisons and psychiatric hospitals were particularly stressful environments for trans people, because their gender identity is often not respected, especially if the person has not had surgery. Monitoring of suicides in such institutions should therefore include whether the person was trans.

DoH welcomed the proposal for an indicator to monitor deaths of people under the care of the NHS and local authority organisations. However, they cautioned against simplistic interpretation of higher death rates among people in hospitals and care homes than among the population as a whole as evidence of abuse or neglect. Given that most people in hospitals and care homes are frail, ill and very old, higher mortality rates may be expected.

The Welsh Assembly Government were not convinced that this was a key overall indicator for this domain. These events – especially deaths in police custody and prison – are hopefully exceptional and do not sustain generalised conclusions. They

noted that some data could be obtained from the Homicide Index but that it would be incomplete, as deaths from neglect that did not result in court proceedings would be unlikely to be recorded.

MoJ web consultation response

The MOJ web consultation response pointed out that it is important that any proposals recommended for measuring the equality PSA take into account data already available and MoJ to ensure that for Physical security NOMs data and any statistics collected for children and old people's homes are made available and included as a source for information.

The Human Rights Division is in the process of establishing the UK's National Preventive Mechanism (NPM) required by the Optional Protocol to the Convention against Torture (OPCAT). MoJ is the custodian of OPCAT's requirement for regular independent inspection of all places of detention. The protocol stipulates that the NPM can be composed of one or several bodies. The UK intends the domestic requirements of the Protocol to be fulfilled by the collective action of existing statutory inspection bodies, which are empowered to carry out unrestricted visits to places of detention (for example HM Inspectorate of Prisons, the Mental Health Act Commission and others). Similarly, the bodies who will be designated part of the NPM will carry on with their normal programmes of inspection but they will need to be aware that they are now operating within a new context - that is, to fulfil a UN treaty. Arrangements for a co-ordination role for the NPM are being considered, and how communications will flow back and forth to the UN. The flow of information between these bodies and the co-ordinator of the NPM, especially on the deaths from non-natural causes for people resident or detained in institutions such as prisons and police cells, could act as a source for Life and Health indicator.

Feedback from follow-up meetings and discussions

The Welsh Assembly Government noted that the proposed indicator looks far-ranging and needs to be clearer as to which 'private and public institutions' are being targeted - is it just custodial ones or could it include healthcare facilities? All deaths in social care settings are reported by the provider to CSSIW under the requirements of the Care Standards Act. CSSIW should be involved in the development of this indicator.

Scottish Government emphasized the importance of engaging with Scottish stakeholders, especially audit and inspection bodies.

Building on existing processes of indicator development: The Department of Health / Home Office Consultation on Safeguarding Adults

The DoH and the Home Office have recently taken the lead on the *Safeguarding Adults* consultation. The consultation document raises the need for indicators covering social and health care establishments. For further details of the consultation process and the likely outcomes, see Chapter 6 Indicator 3 (physical security for people resident in public and private institutions).

Decisions following consultation feedback

Three separate measures are now specified under this main Indicator. The first two - deaths during and following police custody, and self-inflicted deaths in prisons - are already available.

In line with better data regulation principles, rather than recommending an entirely new indicator development process under Measure 4.3, we recommend that the Commission and GEO work with the DoH and the Home Office, who are taking the lead on the Safeguarding Adults consultation, to develop an indicator of deaths from non-natural causes in social and healthcare establishments. The relevant Inspectorates and Audit bodies should also be involved in this work. Should the Safeguarding Adults consultation not result in the development of a relevant indicator, a new process of indicator development will be necessary.

We recommend that the Commission follow-up the MoJ web consultation responses detailed above to ensure that available data, including data on care homes and prisons, is fed into the EMF as it becomes available.

Table 4.7 Measure 4.1 (EW) Deaths in or following police custody

Total 07/08	21
Male	20
Female	1
18-20	1
21-30	3
31-40	6
41-50	7
51-60	2
61+	2
White	18
Asian or Asian British	0

Black or Black British	1
Mixed	1
Other	1
By type of incident:	
- Apparent suicide attempt in cell/transit	0
- Died in custody/on arrest (non suicide)	2
- Concern raised/taken ill in custody/on arrest	19
- Died following release (non suicide*)	0

Source: IPCC (2008)

Notes: *Suicides following release from police custody are counted separately

Table 4.8 Measure 4.2 (EW) Self-inflicted deaths in prison by gender and age

Gender	Male	Female	Total	Population	Rate/100k
1995	57	2	59	51084	115
1996	62	3	65	55256	118
1997	65	3	68	61467	111
1998	80	3	83	65727	126
1999	86	5	91	64529	141
2000	73	8	81	65194	124
2001	67	6	73	66403	110
2002	86	9	95	71218	133
2003	80	14	94	73657	128
2004	82	13	95	74488	128
2005	74	4	78	76190	102
2006	64	3	67	77962	86
2007	84	8	92	80689	114
2008	60	1	61	83240	73

Age band	Under 18s	18-20	21+	Total
1995	1	7	51	59
1996	1	11	53	65
1997	1	8	59	68
1998	3	11	69	83
1999	2	13	76	91
2000	3	13	65	81
2001	3	10	60	73
2002	2	12	81	95
2003	0	11	83	94
2004	0	6	89	95
2005	2	10	66	78
2006	0	2	65	67
2007	1	6	85	92
2008	0	4	57	61

Source: MoJ (2009)

Notes:

1. The numbers of self-inflicted deaths in prison custody can vary considerably. Rises and falls from one year to the next are not good indicators of underlying trends. The most reliable guide to trends is the three-year average annual rate which is currently about 91 per 100,000 of population (lower compared to 101 for the three years ending December 2007).
2. Prisoner 'self-inflicted deaths' include all deaths where it appears that a prisoner has acted specifically to take their own life. Approximately 80 per cent of these deaths receive a suicide or open verdict at inquest.
3. Revised Prison Service Order 2700 (Suicide Prevention and Self-Harm Management) was published in October 2007 and implementation was completed in April 2008. Building on several years of learning from the experience of prisoners, staff, investigators, inspectors and others, it incorporates developments such as the introduction of Assessment, Care in Custody and Teamwork (ACCT), improved cross-agency information flows, and integrated local Safer Custody Teams pursuing a continuous improvement plan in each prison. Also reflected are longstanding areas of safer custody work such as peer supporters (Listeners and Insiders) and work with outside organisations such as the Samaritans and Childline
4. ACCT (Assessment, Care in Custody and Teamwork) is the care planning system for prisoners at risk of suicide or self-harm, introduced across the prisons estate in partnership with the Department of Health during 2005-07. ACCT aims to improve the quality of care by introducing individual/flexible care-planning, supported by improved staff training in case management and in assessing and understanding at-risk prisoners.
5. The new Ministerial Council on Preventing Deaths in Custody will start its work in April 2009. It will comprise three tiers. The Ministerial Council will be chaired by Shahid Malik, Under Secretary of State for Justice. The Ministerial Council will be advised by the Independent Advisory Panel (IAP) which will be chaired by Lord Toby Harris. The final tier will be ad hoc working groups commissioned by the IAP and made up of experts and practitioners.
6. Learning from deaths in custody is a key part of the prisoner suicide prevention strategy. Since 1 April 2004, all deaths in prison custody have been investigated by the Prisons and Probation Ombudsman, Stephen Shaw. The Ombudsman's investigators and family liaison officers carry out independent investigations which also address any issues raised by the bereaved family.

Table 4.9 Measure 4.2 (EW) Self-inflicted deaths in prison by self-identified ethnicity (1), gender, age and cause of death, 2007/08

Male	78
Female	7
11-20(2)	7
21-30	28
31-40	27
41-50	17
50+	6
White	67
Mixed	0
Black or Black British	8
Asian or Asian British	9
Chinese or Other	1

Source: MoJ 2008, Table 11.2

Notes:

1. Ethnicity based on self-identification at point of imprisonment.
2. The youngest age of prisoners is 15. Children aged under 15 are held in Secure Children's Homes and Secure Training Centres.

The Prison Service definition of self-inflicted deaths is broader than the legal definition of suicide and includes all deaths where it appears that a prisoner has acted specifically to take their own life. This inclusive approach is used in part because inquest verdicts are often not available for some years after a death (some 20 per cent of these deaths will not receive a suicide or open verdict at inquest). Annual numbers may change slightly from time to time as inquest verdicts and other information become available. This will typically be no more than 1 or 2 in or out of the self-inflicted category in a given year. The figures presented here are a fair reflection of the number of self-inflicted deaths in custody but should not be taken as absolute.

The numbers in this table are subject to change as new information becomes available for example from inquests which often take place some years after the event. Annual numbers of self-inflicted deaths are subject to large random and cyclical swings. As a result rises or falls from one year to the next are not good indicators of underlying trends. Figures include prisoners released on temporary licences for medical reasons (ROTL-Medical) who subsequently died.

Recommendations

Looking at the portfolio of indicators being proposed for the Life domain, they cover the components of sub-domains A and B well, including death through disease, neglect, injury, suicide or being killed.

The measures recommended for this domain focus on hard outcomes, rather than using subjective measures or measures of process. This seems appropriate given the nature of the capability under consideration: life itself. Consultation participants were keen that we should also reflect issues of autonomy (choice, control and empowerment) for this domain – especially in relation to death. This will be taken forward in the parallel project which is developing autonomy indicators for the EMF.

The relevance, quality and geographical coverage of data available for this domain is good but the potential for disaggregation by equality characteristics other than age and gender is presently limited. Progress has been made by ONS in producing infant mortality statistics by ethnicity and this development should be built on across all three countries as a key priority, to extend the range of mortality statistics available by ethnicity. Possible ways forward include data linkage or recording ethnicity on death certificates (despite the difficulties inherent in non-self-reported coding of ethnicity).

The inclusion of Indicator 4 - death rates from non-natural causes for people resident or detained in institutions - ensures that, in line with the selection criteria outlined in Chapter 2, a particular human rights concern is captured and reflected in the Life domain. However, an important component of this Indicator, 4.3 covering social and healthcare establishments, remains under development.

Given the particular health concerns of Gypsies and Travellers highlighted by the Sheffield study (Department of Health, 2004; Parry *et al* 2007; Van Cleemput *et al* 2007), as well as the new ethnicity classifications associated with the next census, it is important that ethnicity codes include Gypsy/Traveller wherever possible, to permit more accurate life expectancy and mortality statistics for this community to be monitored.

We recommend:

- Recording of ethnicity on death certificates be reconsidered, despite concerns about accuracy. In the meantime, EHRC, GEO and the devolved administrations should take forward discussion with DoH and ONS about other possible ways of producing mortality rates by ethnicity (for example data linkages).

- Infant mortality should be a high priority for inclusion as an indicator in the children's framework. Strong arguments have been put forward by consultation participants for its importance, which we fully endorse, including the fact that it has an enormous impact on parents and other adults. However, given the necessity of limiting the overall number of indicators and avoiding overlap, we are not recommending it be included in the adult's framework.
- Life expectancy and specific-cause death rates can be disaggregated by social class in England and Wales, but not in Scotland. The Scottish Government may wish to consider instituting a census longitudinal study, similar to that derived from the England and Wales census, to provide a source for mortality statistics by social class.
- In line with better data regulation principles, rather than recommending an entirely new indicator development process under Measure 4.3, we recommend that EHRC, GEO and the devolved administrations work with the DoH and the Home Office, who are taking the lead on the Safeguarding Adults consultation, to develop an indicator of deaths from non-natural causes in social and healthcare establishments. The relevant Inspectorates and Audit bodies should also be involved in this work. Should the Safeguarding Adults consultation not result in the development of a relevant indicator, a new process of indicator development will be necessary. This work should be undertaken in conjunction with the development of an indicator of physical security for people in private and public institutions (see recommendations under the physical security domain).
- We recommend that EHRC follow-up the MoJ web consultation responses detailed above to ensure that available data, including data on care homes and prisons, is fed into the EMF as it becomes available.