

# Chapter 6: Life

## Summary

A girl born at the start of the twentieth century had an average life expectancy of less than 50 years.<sup>1</sup> By contrast, the Office for National Statistics predicts that girls born in 2008 will live, on average, for more than 90 years. This remarkable increase is a testament to medical breakthroughs, changes in the British economy, and improvements in diet and housing that have revolutionised life over the past century.

Despite this progress, there remain significant differences between the life expectancies of different groups in modern Britain. In some cases, we do not know whether these differences are a result of innate genetic predispositions. In other cases, the evidence suggests that the differences in life expectancy tell a story about the cumulative impact of inequalities experienced by different groups. Meanwhile, more specific data about particular causes of early death suggest a failure on the part of the state to safeguard the lives of people from different groups equally.

Men's life expectancy is lower than women's, though the gap is narrowing very gradually over time.

Some studies suggest some differences in life expectancy rates between different ethnic groups. There is some evidence that some ethnic minority groups are more likely to die early from certain causes. Black people are more likely to be homicide victims than are members of other ethnic groups. A disproportionate number of people who die following contact with the police are also Black. Infant mortality is higher than average among Black Caribbean and Pakistani groups, although, by contrast, it is lower than average among Bangladeshi groups.

Some groups may be particularly susceptible to certain types of risks to life. Infants and young adults are the most likely of any age group to be the victims of murder or homicide. There is some evidence to suggest that lesbian, gay and bisexual (LGB) and transgender people may be more likely than average to attempt suicide or to commit acts of self-harm. People with mental health conditions are more likely than those without to die during or following police custody.

There are differences in life expectancy between different parts of Britain. Life expectancy in Scotland ranges from 3 years lower than in England and 2 years lower than Wales. Overall, more people die early in Scotland than in any other western European country.

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<sup>1</sup> Hicks, J. and Allen, G. 1999. *A Century of Change: Trends in UK statistics since 1990*. House of Commons Research Paper. Available at: <http://www.parliament.uk/documents/commons/lib/research/rp99/rp99-111.pdf> Accessed 25/08/2010.

Finally, there are significant differences in life expectancy between members of different socio-economic groups. Men in the highest socio-economic group can expect to live around 7 years longer than men in the lower groups. For women, the gap is the same. Evidence also suggests that people from lower socio-economic groups may be more susceptible to such risks to life as smoking-related cancers and suicide.

## Introduction

Of all the measures reported on in this Review, life expectancy demonstrates most clearly and objectively Britain's continued development as a society. The average life expectancy has risen consistently since the Second World War; today, it exceeds by far the averages seen in our great-grandparents' lifetime.

However, there remain differences between the life expectancy of different groups. Some of these are widely recognised. Perhaps the best-known is the fact that women live longer than men, which has long been the subject of scientific research and public speculation. This chapter shows that there are other differences besides, and some of them are substantial.

Many factors can affect life expectancy, including income, living conditions, and genetic predisposition. It is wise to exercise caution in interpreting differences in life expectancy between different groups, and in general we do not seek to define the extent to which these differences are the result of intrinsic or extrinsic factors. In some cases, however, the differences in overall life expectancy are so stark that it is possible to infer with some confidence that they are indicative of the cumulative impact of unequal outcomes experienced by different groups throughout their lives. This is particularly true in relation to socio-economic background.

Overall expectancy, though, is not the only relevant indicator for assessing society's performance. International human rights agreements defend the right to life. This means the state has a positive duty to protect people from unlawful killing and death through negligence. The evidence here suggests that the state discharges that duty towards some minority groups less well than it does towards the majority of the population. There is some evidence to show that different groups are particularly vulnerable to risks including homicide and deaths in institutions.

**Indicators**

- 1. Life expectancy**
- 2. Mortal illness**
- 3. Suicide**
- 4. Accidental death**
- 5. Homicide**
- 6. Deaths in Institutions**

For **life expectancy**, we give the average life expectancy at birth and at ages 20, 65 and 80.

For **mortal illness**, we give annual age-standardised death rates from ischaemic (coronary) heart disease, cerebrovascular disease (strokes) and cancer.

Under **suicide**, we give suicide rates standardised for age.

Under **accidental death**, we give the number of accidental deaths and rates by age.

Under **homicide**, we give the numbers of murders, infanticides and manslaughters per million of the population.

Under **deaths in institutions**, we give the rates of deaths during and following contact with police, and of self-inflicted deaths in prisons.

As in the rest of Part II, this chapter explores what we know about these indicators and what the evidence tells us about the experiences of different groups. We end by examining gaps in our knowledge and what we need to know.

## 6.1 What we know about life expectancy

### Measure:

Life expectancy – measured at birth and age 20, 65 and 80

### How this measure works:

Life expectancy data are taken from the Office for National Statistics (ONS) and the General Register Office of Scotland. For this measure we are able to report for Britain, England, Scotland and Wales.

Direct estimates of life expectancy by ethnic group cannot be computed since ethnic group is not recorded on death registration certificates in Britain. We cite some studies that have used country of birth as a proxy; this has serious limitations, as the British-born ethnic minority population is not covered and not all foreign-born people are from an ethnic minority. These studies also rely in part on the 1991 and 2001 Census data and are therefore dated.

For different socio-economic categories, the ONS longitudinal study is used for 'at birth', and 'at age 65' life expectancy, which is available for England and Wales only.

There is very limited related literature for this measure for groups defined by disability (disability is not recorded on death certificates), religion or belief, sexual orientation and transgender, therefore they are not covered in this section.

As data relating to these groups are limited we examine some of the available literature. With all these studies, samples are generally small which limits the extent to which we can make any generalisations to the wider population.

### Overview

**Life expectancy has improved steadily in England, Scotland and Wales over the past few decades** yet different groups in Britain continue to have considerably different chances in terms of how long they can expect, on average, to live.

**The three clearest differences are between different parts of Britain, between men and women and between members of different socio-economic groups.**

## What we know about the overall situation and trends

Figure 6.1.1. below shows life expectancy has increased over the past decades across the UK and England, Scotland and Wales. Women live on average longer than men, but the gap has narrowed over time to around 4 years in 2007 for the UK as a whole, as this table shows. Life expectancy is expected to continue to rise for both genders with the gap between the genders growing smaller. ONS projected life expectancies for people born in 2008 are 88.6 years for men and 92.2 years for women.<sup>2</sup>

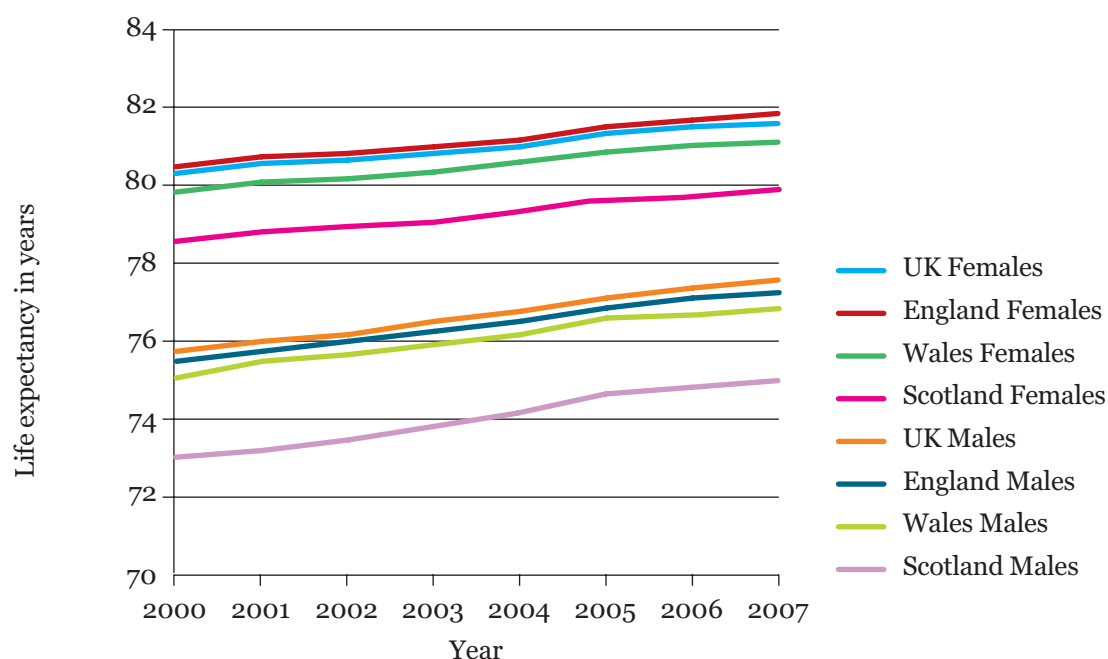
These trend data show that in Scotland, life expectancy has been persistently shorter than it is in England and in Wales. Scottish people are more likely to die early (before age 65) than people in any other Western European country.<sup>3</sup>

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<sup>2</sup> Alkire, S., Bastagli, F., Burchardt, T., Clark, D., Holder, H., Ibrahim, S., Munoz, M., Terrazas, P. and Tsang, T., and Vizard, P. 2009. *Developing the Equality Measurement Framework: selecting the indicators*. Research Report 31. Manchester: Equality and Human Rights Commission. Chapter 8. Page 22.

<sup>3</sup> Allmark, P., Salway, S. and Piercy, H. 2010. *Life and Health: An evidence reviews and synthesis for the Equality and Human Rights Commission*. University of Sheffield Hallam Analysis of Scotland's Population 2008 – The Registrar General's Annual Review of Demographic Trends – Chapter 3 Deaths. Available at: <http://www.gro-scotland.gov.uk/statistics/publications-and-data/annual-report-publications/annual-review-2008/figures-chapter-3.html> Chapter 8. Page 27.

**Figure 6.1.1** Period expectation of life at birth (years) in the UK, England, Wales and Scotland, 2000-07<sup>4</sup>



Source: ONS Interim Life Tables.

Note: All figures are based on a three-year period, so that for instance 2003 represents 2002-04. The population estimates used to calculate these life expectancies are the latest available at time of publication of the 2006-08 interim life tables (21 October 2009). All figures are based on death registrations.

## What we know about the situation for different groups

### Gender and age

While women live longer than men, this may mean that a portion of these years are spent in ill health, which increases with age<sup>5</sup> – this is set out further in Chapter 9: Health. Life expectancy in Scotland ranges from nearly 3 years lower than England at the widest point (life expectancy for men at birth), although the gap closes over the age range.

<sup>4</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 22.

<sup>5</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 53.

**Table 6.1.1** Life expectancy at birth, 20, 65 and 80 years by gender in England, Wales and Scotland, 2006-08<sup>6</sup>

	England				Wales				Scotland			
	Birth	20	65	80	Birth	20	65	80	Birth	20	65	80
<b>Males</b>	77.7	58.4	17.5	7.9	76.9	57.5	17.1	7.7	75.0	55.7	16.2	7.3
<b>Females</b>	81.9	62.4	20.2	9.2	81.2	61.8	19.8	9.1	79.9	60.4	18.8	8.6

Source: ONS Interim Life Tables.

### Socio-economic groups

The gap in life expectancy at birth between the top and bottom socio-economic groups is wider than the gender gap and the evidence shows that people in higher socio-economic groups can expect longer lives. The gender and socio-economic gap combined is particularly large – a woman from social class 1 (professional) can expect to live nearly 12 and a half years longer than a man from social class 5 (partly skilled). The gap narrows by age 65 to 7.9 years between a woman from social class 1 and a man from social class 5.

<sup>6</sup> Allmark, P. *et al.* 2010. Chapter 8. Pages 21-25.

**Table 6.1.2** Life expectancy at birth and at age 65 by social class and gender in England and Wales, 2002-05<sup>7</sup>

2002-05 men			2002-05 women		
Social Class	Life exp.	95% CI (+/-)	Social Class	Life exp.	95% CI (+/-)
<b>At birth</b>			<b>At birth</b>		
1 Professional	80	1	1 Professional	85.1	1.1
2 Managerial and technical/intermediate	79.4	0.5	2 Managerial and technical/intermediate	83.2	0.5
3 Skilled non-manual	78.4	0.7	3 Skilled non-manual	82.4	0.5
4 Skilled manual	76.5	0.4	4 Skilled manual	80.5	0.5
5 Partly skilled	75.7	0.6	5 Partly skilled	79.9	0.6
6 Unskilled	72.7	1.1	6 Unskilled	78.1	1.2
7 Unclassified	73.8	1.1	7 Unclassified	77.9	0.9
All men	77	0.2	All women	81.1	0.2
Non-manual	79.2	0.4	Non-manual	82.9	0.3
Manual	75.9	0.3	Manual	80	0.3
Difference	3.3	0.5	Difference	2.9	0.5
<b>At age 65</b>			<b>At age 65</b>		
1 Professional	18.3	0.6	1 Professional	22	0.9
2 Managerial and technical/intermediate	18	0.3	2 Managerial and technical/intermediate	21	0.3
3 Skilled non-manual	17.4	0.5	3 Skilled non-manual	19.9	0.3
4 Skilled manual	16.3	0.3	4 Skilled manual	18.7	0.4
5 Partly skilled	15.7	0.4	5 Partly skilled	18.9	0.3
6 Unskilled	14.1	0.7	6 Unskilled	17.7	0.6
7 Unclassified	15.1	0.8	7 Unclassified	17.6	0.5
All men	16.6	0.2	All women	19.4	0.2
Non-manual	17.9	0.3	Non-manual	20.5	0.2
Manual	15.9	0.2	Manual	18.6	0.2
Difference	2	0.3	Difference	1.9	0.3

Source: Office for National Statistics: Longitudinal Survey.

<sup>7</sup> Allmark, P. *et al.* 2010. Chapter 4. Page 24.

**Disability**

It is not possible to report on this indicator for disabled people because data are not collected on death certificates. For some disability groups, research suggests very poor life expectancy:

- A study in the 1990s found that people with learning disabilities are 58 times more likely to die before the age of 50 than the general population.<sup>8</sup>
- A second study in 2009 calculated standardised mortality rates from a small sample of people with learning disabilities in three counties in a region of England, and found the mortality rate to be over two times the average for men and over three times for women.<sup>9</sup>

**Ethnicity**

Life expectancy cannot be measured directly by ethnicity because this is not documented on death certificates. Some studies have attempted to estimate standardised mortality rates (SMR) based on country of origin data (SMR means the ratio of observed deaths for a particular group, compared to expected deaths for the general population. SMRs equal to 100 imply that the mortality rate is the same as the standard mortality rate. A number higher than 100 implies an excess mortality rate whereas a number below 100 implies below average mortality).<sup>10</sup> Other studies have estimated life expectancy by ethnicity based on illness rates. Overall, on this basis although results should be treated with caution, in the absence of other data these studies appear to show that men and women born in Ireland, Scotland and Africa, and men born in south Asian countries have the lowest life expectancy.

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<sup>8</sup> British Medical Association 2007. *Disability Equality Within Healthcare: The Role of Healthcare Professionals*. London: British Medical Association. Page 15.

<sup>9</sup> Allmark, P. *et al.* 2010. Chapter 6. Page 12.

<sup>10</sup> See London health observatory at: [http://www.lho.org.uk/LHO\\_Topics/Data/Methodology\\_and\\_sources/agestandardisedrates.aspx](http://www.lho.org.uk/LHO_Topics/Data/Methodology_and_sources/agestandardisedrates.aspx) Accessed 26/08/2010.

For example, the worst SMRs are for these groups of people:

**Table 6.1.3** Poorest (significant) standardised mortality rates (SMR) by country of birth (age 20+) in England and Wales, 2001<sup>11</sup>

	Country of Birth	SMR
<b>Men</b>	Ireland	128
	Bangladesh	120
	West Africa	117
	Scotland	113
	East Africa	105
<b>Women</b>	West Africa	121
	Ireland	113
	Scotland	109
	East Africa	108
	Pakistan	106
	India	104

Source: Indirect age-standardisation using 2001 census population of England and Wales.

Note: All people resident in England and Wales in 2001, SMR = 100.

Alternatively, Table 6.1.4 shows the results of calculating mortality rates of ethnic groups by exploring the relationship between reported long-term limiting illness, and local mortality rates. It should be noted that these indirect estimates are based upon self-reported limiting long-term ill health/disability, a measure that may well be sensitive to cultural (linked to ethnicity and/or gender) variation in the experience and expression of ill health. However the results indicate poorer life expectancy for Bangladeshi, Pakistani, White/Black Caribbean and Other Black men and women.

<sup>11</sup> Allmark, P. *et al.* 2010. Chapter 7. Page 35.

**Table 6.1.4** Indirect estimates of life expectancy at birth ( $e_0$ ) by ethnicity and gender in England, 2001<sup>12</sup>

<b>Ethnic group</b>	<b>Women <math>e_0</math></b>	<b>Men <math>e_0</math></b>
White British	80.5	75.9
White Irish	80.3	74.9
Other White	81.3	76.9
Indian	79.3	75.5
Bangladeshi	77.7	72.7
Pakistani	77.3	73.1
Other Asian	79.5	75.2
Black Caribbean	79.1	74.4
Black African	80.4	76.1
Other Black	78.5	73.4
Chinese	82.1	78.1
White/Asian	80.0	75.1
White/Black Caribbean	78.7	73.4
White/Black African	79.5	74.2
Other Mixed	79.9	74.6
Other Ethnic	81.5	76.2
All groups	80.5	76.0

Source: Standardised Illness Ratio method using Census 2001.

Localised studies suggest that life expectancy for Gypsies and Travellers is below the norm, but possibly improving over time. One study found that 13% of Gypsies and Travellers were older than 65 compared to 17% local population.<sup>13</sup>

<sup>12</sup> Allmark, P. *et al.* 2010. Chapter 7. Page 38.

<sup>13</sup> Home, R. and Greenfields, M. 2006. *Cambridge Sub-Region Traveller Needs Assessment*. Chelmsford: Anglia Ruskin University.

**Box 6.1.1** Related issue: Infant and maternal mortality

**Infant mortality:** remains much higher in all nations in Britain than in many other European countries.<sup>14</sup> Rates are notably higher in England than in Scotland or Wales.

**Table 6.1.5** Infant mortality rates by gender in UK, England, Wales and Scotland, 2006/08

	Deaths in first year of life per 1,000 live births		
	Males	Females	Difference (male-female)
<b>UK</b>	5.34	4.37	0.97
<b>England</b>	5.38	4.43	0.95
<b>Wales</b>	5.24	3.74	1.50
<b>Scotland</b>	4.97	3.96	1.01

Source: Figures produced from interim life tables prepared and supplied by ONS.

Black Caribbean and Pakistani babies are the most likely to die, with twice the death rate (9.6 and 9.8 deaths per 1,000 live births) as those least likely to die (which are White British at 4.5 per 1000 and Bangladeshi at 4.2 per 1000). Overall, all ethnic minority groups are found to have lower birth weights than the majority White British population.<sup>15</sup>

**Maternal mortality:** In 2008 the Committee on the Elimination of Discrimination against Women expressed concern over ‘The high rate of maternal mortality among all ethnic minorities [as well as high numbers of miscarriages and stillbirths particularly of women from Traveller communities]’<sup>16</sup> Black African women who are asylum seekers are estimated to have a mortality rate seven times higher than for White women, partly due to problems in accessing maternal healthcare.<sup>17</sup>

<sup>14</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 29.

<sup>15</sup> Allmark, P. *et al.* 2010. Chapter 7. Page 41.

<sup>16</sup> See also Parry, G., Van Cleemput, P., Peters, J., Walters, S., Thomas, K. and Cooper, C. 2007. ‘Health Status of Gypsies and Travellers in England’. *Journal of Epidemiology and Community Health*, 61, 3. Pages 198–204.

<sup>17</sup> Aspinall, P. and Watters, C. 2010. *Refugees and asylum seekers: A review from an equality and human rights perspective*. Research Report 52. Manchester: Equality and Human Rights Commission.

## 6.2 What we know about mortal illness

### Measures:

**IHD and CBD** – Annual age-standardised death rates from Ischaemic (coronary) heart disease (IHD) and Cerebrovascular disease (strokes) (CBD)

**Cancer** – Annual age-standardised death rates from all cancers

### How these measures work:

Mortality data taken from the Office for National Statistics (ONS) and the General Register Office of Scotland are used for these measures, enabling us to report on Britain, England, Scotland and Wales.

These specific mortality causes were selected in the Equality Measurement Framework consultation in order to capture Department of Health targets to reduce mortality rates for specific diseases.<sup>18</sup>

Social class is not collected in the General Register Office Census Longitudinal Study (for England and Wales). We are able to cite data for England up to 2006 for ‘Spearhead’ areas (The Spearhead Areas include 70 Local Authorities and 88 Primary Care Trusts, taken from the bottom 5th nationally for certain indicators – set out further in Socio-economic section below). For Scotland we refer to the results for the Scottish Index of Multiple Deprivation.

As disability is not recorded on death certificates it is not possible to report on this indicator but we are able to use some small relevant studies. With all these studies, samples are generally small which limits the extent to which we can make any generalisations to the wider population.

Similarly to life expectancy, there are no direct estimates of cause-specific death rates by ethnicity for the nations of Britain. Estimates used here rely on country of origin, and are imprecise and should therefore be treated with caution.

There is very limited related literature for this measure for groups defined by religion or belief, sexual orientation and transgender, therefore they are not covered in this section.

Evidently these measures only look at a small range of illnesses and will therefore be limited in use, as the range of illnesses and health conditions experienced by different equality groups are so diverse. Illness that is specific to

<sup>18</sup> Alkire, S. *et al.* 2009. Page 74.

a particular group have not been examined, as our aim is to compare common experiences. However some further information can be found in the background paper on Health and Life prepared for this report.<sup>19</sup>

### ***IHD and CBD***

Cardiovascular disease (CVD) encompasses a range of diseases of the circulatory system, among which the major killers, both measured here, are ischaemic (coronary heart diseases) (IHD) and cerebrovascular diseases (including stroke) (CBD). It is important to distinguish between these types of cardiovascular disease because they affect people differently, for example men and women, and have some different risk factors.

## Overview

Risk of death from cardiovascular diseases and cancer varies only slightly in England, Scotland and Wales. Rates for cardiovascular diseases are relatively similar for men and women, but for cancer, men are disadvantaged compared to women.

In terms of ethnicity, death from cardiovascular diseases is particularly high for Pakistani and Bangladeshi born men and women, and men born in West Africa and the West Indies.

Data are very limited for disabled people – some small studies point to issues of concern, but this is an area where further research is needed to establish where inequality may lie.

## What we know about the overall situation

The leading cause of death for both women and men in England, Scotland and Wales is Ischaemic Heart Disease (IHD).

Among women in all three nations and men in England, cerebrovascular disease (CBD) is the second leading cause of death, while this is the third biggest killer of men in Wales and in Scotland also, behind lung cancer.<sup>20</sup>

Premature death from circulatory diseases is higher throughout Britain than on average in the EU, and since the 1980s, Scotland has had the highest IHD mortality rates in Western Europe.<sup>21</sup>

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<sup>19</sup> Allmark, P *et al.* 2010.

<sup>20</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 32.

<sup>21</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 41.

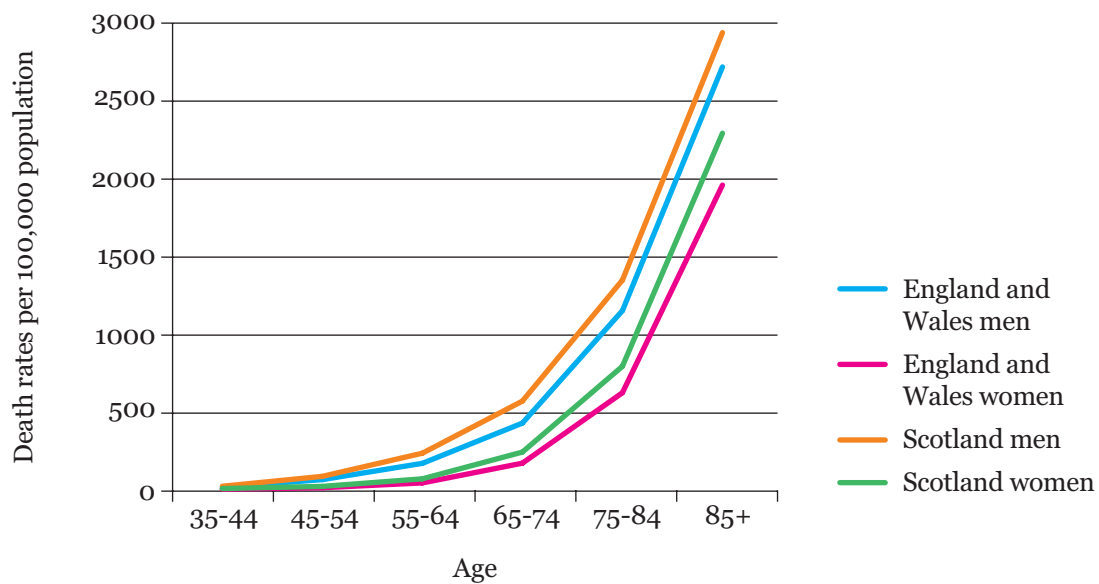
## What we know about the situation for different groups

### Gender and age

#### *IHD and CBD*

For both men and women, advancing age affects the number of deaths from both these diseases, which increase across England, Scotland and Wales after 65 years.

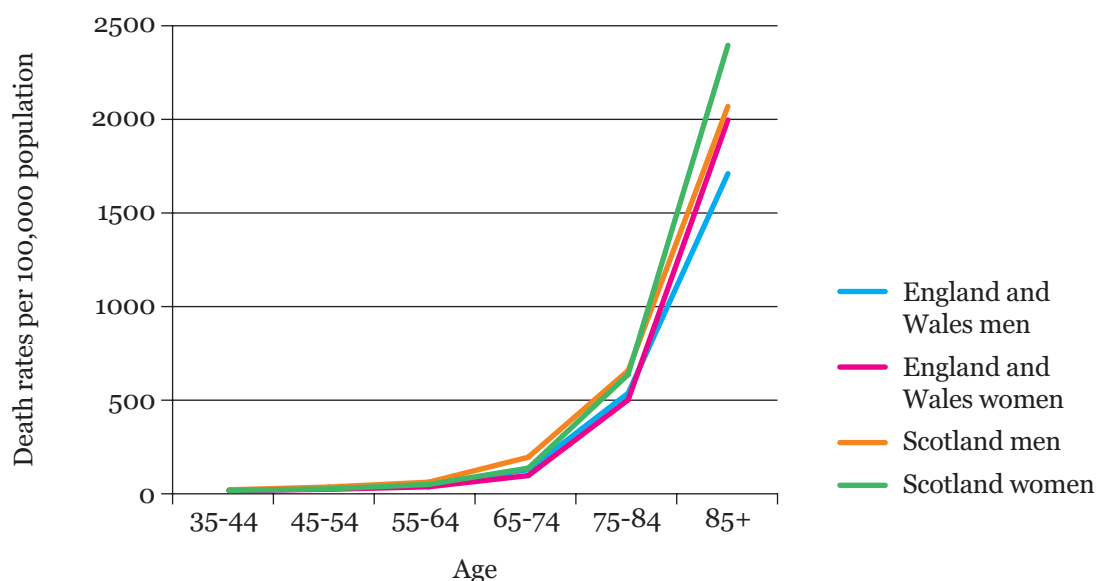
**Figure 6.2.1** Death rates per 100,000 population from ischaemic heart disease by gender and age-group in England and Wales, and Scotland, 2008<sup>22</sup>



Source: ONS Mortality statistics and the Scottish Registrar General's Annual Review of Population.

<sup>22</sup> Office for National Statistics Mortality statistics: Deaths registered in 2008 and Scottish Registrar General's Annual Review of Population. Table 6.2.

**Figure 6.2.2** Death rates per 100,000 population from cerebrovascular disease by age group in England and Wales, and Scotland, 2008<sup>23</sup>



Source: ONS Mortality statistics and the Scottish Registrar General's Annual Review of Population.

### Cancer

Men continue to experience excess cancer-related deaths overall when compared to women, although women have a higher rate in a number of age groups. In England and Wales in 2008, the overall cancer mortality rate for all ages was 206 per 100,000 for men and 150 per 100,000 for women. Overall cancer rates are far higher in Scotland for both men and women. In 2008, Scottish men had an overall cancer mortality rate of 309 per 100,000 and women had a slightly lower rate of 283 per 100,000. The gender differentials for different age groups are shown below in Table 6.2.1, and are particularly large at older ages.

<sup>23</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 35.

**Table 6.2.1** Age-specific death rates from all cancers (deaths per 100,000 population) by gender in England and Wales, and Scotland, 2008<sup>24</sup>

	15-24	25-34	35-44	45-54	55-64	65-74	75-84	85+
<b>England and Wales</b>								
Men	4	8	25	97	351	906	1,877	3,039
Women	3	11	37	111	296	625	1,169	1,732
<b>Scotland</b>								
Men	5	6	30	120	424	1,111	2,068	3,409
Women	4	8	39	116	329	768	1,410	2,002

Source: ONS Mortality statistics Deaths and Scottish Registrar General's Annual Review of Population.

Although there is a higher number of cancer deaths in the over 65s, cancer causes a greater proportion of deaths in younger people. Three-quarters of cancer deaths (76%) occur in people aged 65 years and over, but cancer caused more than a third (36%) of all deaths in the under 65s in the UK in 2008, compared with 25% of all deaths in the over 65s.<sup>25</sup>

### Socio-economic groups

#### *IHD and CBD*

Data are available on the absolute gap in death rates from ischaemic heart disease, cerebrovascular disease and all other diseases of the circulatory system between the so-called Spearhead Group aimed at reducing some specific areas of health inequality,<sup>26</sup> and the population as a whole. Figure 6.2.3 below shows that there is inequality in the death rates between the Spearhead group and the wider population: that gap was 37% in 1994 and 24% in 2006, although the gap for these deprived areas has been declining over time. Similar data are not available for Wales.

<sup>24</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 41.

<sup>25</sup> Cancer Research UK 2010. *Cancer in the UK*. Website publication, available at: [http://info.cancerresearchuk.org/prod\\_consump/groups/cr\\_common/@nre/@sta/documents/generalcontent/018070.pdf](http://info.cancerresearchuk.org/prod_consump/groups/cr_common/@nre/@sta/documents/generalcontent/018070.pdf) Accessed 26/08/2010.

<sup>26</sup> The Spearhead Group is made up of 70 Local Authorities and 88 Primary Care Trusts, based upon the Local Authority areas that are in the bottom fifth nationally for 3 or more of the following 5 indicators: Male life expectancy at birth, Female life expectancy at birth, Cancer mortality rate in under 75s, Cardiovascular disease mortality rate in under 75s, Index of Multiple Deprivation 2004 (Local Authority Summary), average score. See Department of Health 2004. *Tackling Health Inequalities The Spearhead Group of Local Authorities and Primary Care Trusts*. London: DoH.

**Figure 6.2.3** Absolute gap in death rates from CVDs between the Spearhead group and the population as a whole, for under 75s in England, 1994-2006<sup>27</sup>



Source: Office for National Statistics 2009.

Note: Data are for under 75s, and are shown compared to the inequalities target rate of 22% set in 2006 to be met by 2010. The 2010 inequalities target will be calculated based on a 3 year rolling average from 1st January 2009 to 31st December 2011, meaning that final data on this target will not be published until spring 2012 at the earliest.

It is possible to examine rates for Scotland based on area deprivation. Standardised mortality rates for both coronary and cerebrovascular disease for 2004-08 by age group, against the Scottish indices of multiple deprivation, show that there is some association between level of deprivation and mortality rates for these illnesses. This association is stronger for coronary heart disease across all age ranges, and for both diseases for under 65s particularly.<sup>28</sup>

### **Cancer**

Evidence also points to an association between smoking related cancers and greater deprivation.<sup>29</sup>

### **Disability**

Little data are available on specific cause mortality and disability.

<sup>27</sup> Allmark, P. *et al.* 2010 Chapter 4. Page 36.

<sup>28</sup> For these results in full see Allmark, P. *et al.* 2010. Chapter 4. Page 39.

<sup>29</sup> Allmark, P. *et al.* 2010. Chapter 4. Page 44.

One small-scale study raises some potential issues, indicating the need for better impairment-specific understanding of mortality rates. This study, which calculated standardised mortality rates from a small sample of people with learning disabilities in three counties in a region of England, found:<sup>30</sup>

- There was no obvious increased likelihood of cancer deaths.
- Standardised mortality rates for people with learning difficulties were more than doubled for cerebrovascular disease (men: SMR=241; women: SMR=245).
- The largest differences in underlying causes were:
  - Deaths caused from congenital malformations (SMR = 8560).
  - Diseases of the nervous system and sense organs (SMR = 1630).
  - Disease of the genitourinary system (SMR = 603).

## Ethnicity

### *IHD and CBD*

To understand mortality rates for different ethnic minority groups, data are more complex. We can look at standardised mortality rates for ischaemic heart disease and cerebrovascular disease rates by country of birth only (analysis based on the 2001 Census). The results for the groups who fare worst are set out in Table 6.2.2 below.

Death rates from ischaemic heart disease are highest for Pakistani and Bangladeshi born men and women. Death from cerebrovascular diseases such as strokes is highest for Pakistani and Bangladeshi men and women, and also men born in West Africa and the West Indies. Much more needs to be understood about these patterns and their causes in order to address differences in risk rates effectively.

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<sup>30</sup> Allmark, P. *et al.* 2010. Chapter 6. Page 14.

**Table 6.2.2** Poorest (significant) standardised mortality rates (SMR) by country of birth in England and Wales, 2001-03<sup>31</sup>

	Ischaemic heart disease		Cerebrovascular disease	
	Country of birth	SMR	Country of birth	SMR
<b>Men</b>	Bangladesh	175	Bangladesh	249
	Pakistan	162	West Africa	234
	East Africa	141	West Indies	160
	India	131	Pakistan	141
	Ireland	118	Ireland	127
<b>Women</b>	Pakistan	174	Bangladesh	207
	Bangladesh	167	Pakistan	139
	India	149	West Indies	137
	East Africa	130	West Africa	131
	Ireland	108	India	122

Source: 2001 Census population of England and Wales and mortality data for 2001-03 (for people aged 20 years and over).

Notes: Indirect age-standardisation using 2001 census population of England and Wales by gender and 5 year age group as standard. All people resident in England and Wales in 2001 SMR= 100.

### Cancer

Using a similar approach we are able to set out estimated standardised mortality rates for cancer for England and Wales, based on country of birth.<sup>32</sup>

- Statistically significantly higher mortality from all cancers combined, lung and colorectal cancer was found among people born in Scotland and Ireland.
- Lower mortality for all cancers combined, breast and prostate cancer was found among people born in Bangladesh (except for lung cancer in men), India, Pakistan and China/Hong Kong.
- Lower lung cancer mortality was found among people born in West Africa and the West Indies. Higher breast cancer mortality was seen among women born in West Africa and higher prostate cancer mortality among men born in West Africa and the West Indies.

<sup>31</sup> Allmark, P. *et al.* 2010. Chapter 7. Page 47.

<sup>32</sup> Allmark, P. *et al.* 2010. Chapter 7. Page 50.

## 6.3 What we know about suicide

### Measure:

**Suicide** – Suicide rate standardised for age

### How this measure works:

Data are available for gender and age using mortality data taken from the Office for National Statistics and the General Register Office of Scotland. We are able to report on England, Scotland and Wales.

Ethnicity is not available for this indicator – we are able to cite some studies that help elaborate on this area using standardised mortality ratios. With all these studies, samples are generally small which limits the extent to which we can make any generalisations to the wider population.

Socio-economic data are reliant on area deprivation rather than socio-economic categories.

For sexual orientation and transgender groups, reliance is on small-scale and qualitative work.

### Overview

Generally, rates of suicide are falling over time, but men are more likely to commit suicide than women.

There is evidence that particular groups are more vulnerable to suicide: the rate for people with mental health conditions is high but some research suggests that prevention of these suicides could be improved.

Some studies indicate possible high levels of attempted suicide reported among transgender people, which points to the need to understand the experiences of transgender people much more comprehensively.<sup>33</sup>

Some studies also suggest a high prevalence of suicide/self-harm among LGB people. These patterns are warning signs that society may not be protecting such vulnerable groups to a level that meets their needs.

<sup>33</sup> Allmark, P. *et al.* 2010. Chapter 11. Page 11. See also Mitchell, M. and Howarth, C., 2009. *Transgender Research Review*. Research Report 27. Manchester: Equality and Human Rights Commission. Page 55.

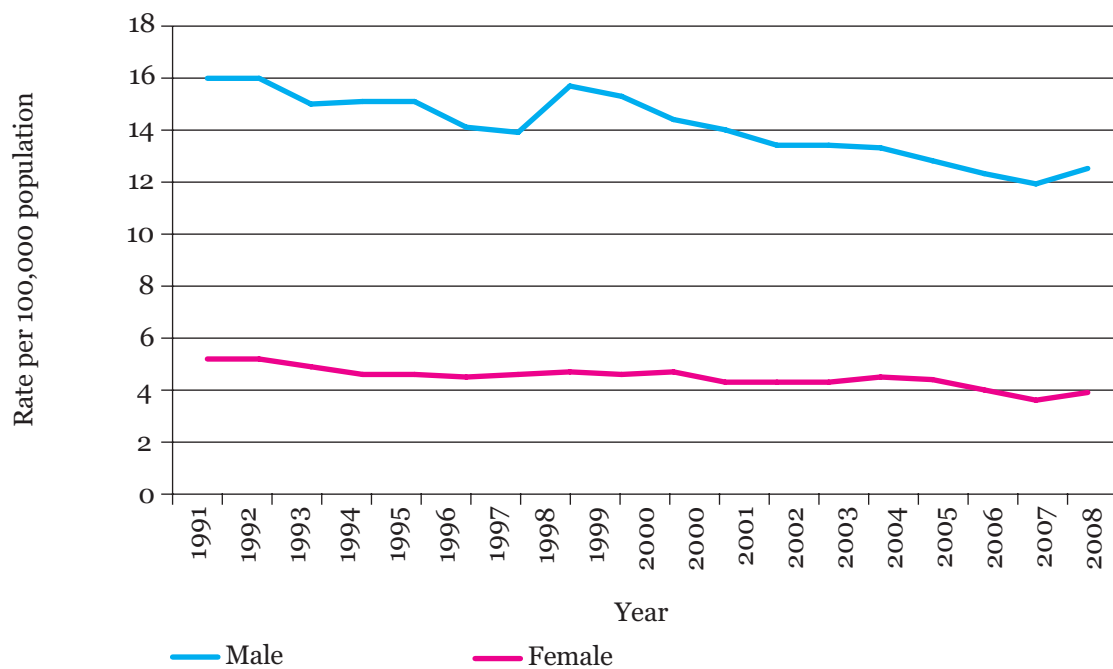
## What we know about the overall situation and trends

Across the whole of the UK there were 5,706 suicides in 2008. The trend in suicide rates has been generally downwards since 1991, despite a peak in 1998. Men are more likely to commit suicide than women; in 2008 the suicide rate for men was 17.7 suicides per 100,000 population compared with 5.4 per 100,000 for women.<sup>34</sup>

Despite downward trends, there has been a notable increase in absolute numbers among men in Scotland: absolute numbers increased from under 500 in 1981 to 630 in 2008.

The patterns of suicide over time for England, Wales and Scotland are shown in the figures below (note that age-standardised figures are not available for Scotland and are given in absolute figures, therefore we cannot compare the nations).

**Figure 6.3.1** Age-standardised overall suicide rates per 100,000 population by gender in England and Wales, 1991/2008<sup>35</sup>



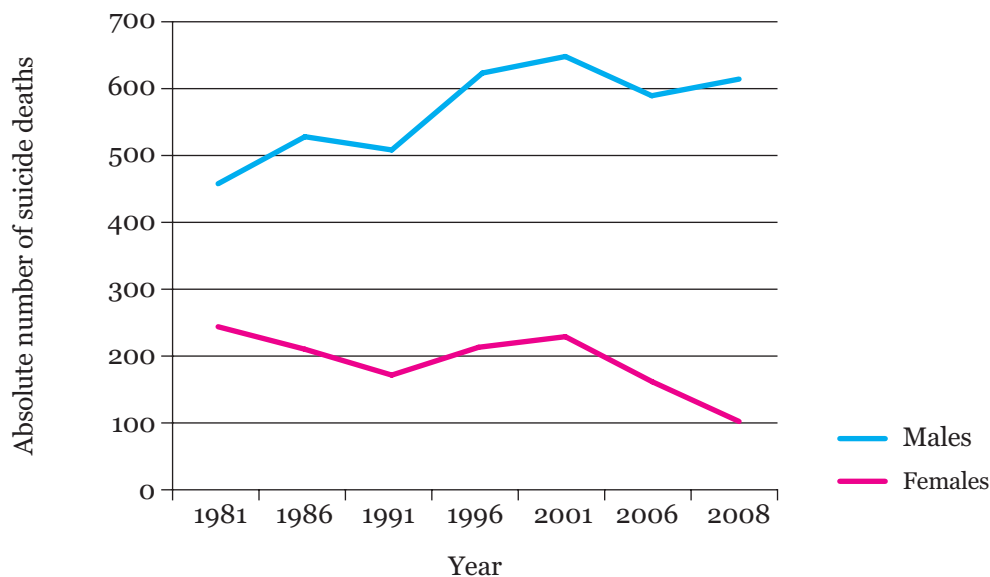
Source: ONS: Mortality statistics.

Notes: Includes deaths classified by underlying cause as due to intentional self-harm and event of undetermined intent (ICD codes X60-X84 and Y10-Y34).

<sup>34</sup> Office for National Statistics 2010. *Statistical Bulletin: Suicide Rates in the UK 1991-2008*. Available at: <http://www.statistics.gov.uk/pdffdir/sui0110.pdf> Accessed 28/08/2010.

<sup>35</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 46.

**Figure 6.3.2** Absolute numbers of suicide deaths by gender in Scotland, 1981-2008<sup>36</sup>



Source: Scottish Registrar General's Annual Review of Population.

Note: This figure shows absolute numbers and therefore cannot be compared directly to the trends in England and Wales above.

## What we know about the situation for different groups

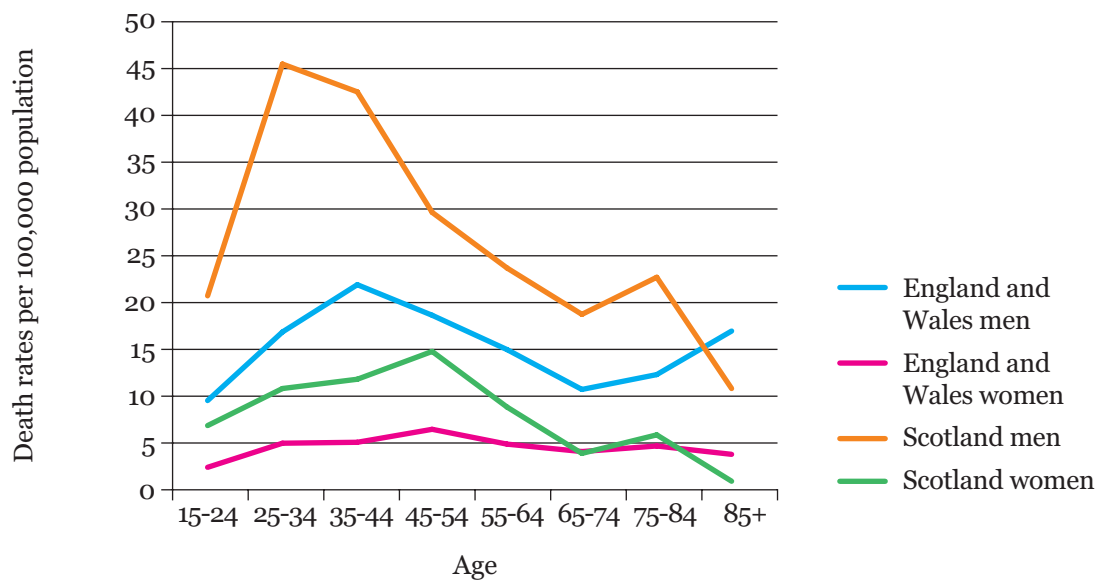
### Gender and age

Although suicide has fallen for most groups in recent years, it remains a disturbing cause of early death, especially among younger adults whom it affects the most. Around three times as many men as women committed suicide in Britain in 2008. The suicide rate in Scotland is higher than that in England and Wales for both women and men in most age groups, and is particularly high in Scotland for men aged 25-34 and 35-44. There is also an increase for men in England and Wales for older age groups (75+).

In 2008 the UN Committee on the Covenant on Economic, Social and Cultural Rights raised concerns about increasing suicide rates in Scotland particularly among mental health patients who face difficulties in accessing the complaints system.

<sup>36</sup> Allmark, P. *et al.* 2010. Chapter 8. Page 47.

**Figure 6.3.3** Suicide rates per 100,000 population by age and gender in England and Wales, and Scotland, 2008<sup>37</sup>



Source: ONS Mortality statistics Deaths and Scottish Registrar General's Annual Review of Population.

### Socio-economic groups

In all three nations there is an association between the deprivation of an area and the suicide rate. In England and Wales, men and women living in the most deprived areas are twice as likely to commit suicide as those in the least deprived.<sup>38</sup> In Scotland, data suggest the difference in suicide rates is even greater. The 2010 Marmot Review into Health Inequalities also commented on a link between unemployment and suicide.<sup>39</sup>

### Disability

It is not possible to identify disability or impairment from the data collected, therefore further study is needed that takes into account different impairments – particularly in the case of mental ill health. Where mental health conditions such as depression are categorised as a disability, higher suicide rates might be expected. However, evidence suggests that some suicides connected with mental health conditions may have been avoided; one study estimated 20% of suicides of people with current or recent mental health conditions may have been preventable, suggesting some individuals' needs are not being met.<sup>40</sup>

<sup>37</sup> Allmark, P. *et al.* 2010. Chapter 5. Page 35.

<sup>38</sup> Allmark, P. *et al.* 2010. Chapter 4. Pages 51-55.

<sup>39</sup> Marmot, M., Atkinson, T., Bell, J., Black, C., Broadfoot, P., Cumberlege, J., Diamond, I., Gilmore, I., Ham, C., Meacher, M. and Mulgan, G. 2010. *Fair Society, Healthy Lives: The Marmot Review*. London: The Marmot Review.

<sup>40</sup> Allmark, P. *et al.* 2010. Chapter 6. Page 16.

### Ethnicity

No recent estimates of suicide by ethnicity are available. The standardised mortality ratios (SMRs) of suicide following contact with mental health services were calculated by one study for four ethnic minority groups in England and Wales: Black African, Black Caribbean, South Asian (Indian, Pakistani, and Bangladeshi) and White (ethnicity was clinician-assigned).<sup>41</sup> Overall, compared with the SMRs for their White counterparts (SMR=100), the results were:

- Low SMRs were found for South-Asian men and women (SMR 50 for men and SMR 70 for women).
- Overall SMRs did not differ significantly from the White group for Black Caribbean or Black African people.
- High SMRs were found for Black Caribbean and Black African men aged 13–24 (SMR 290 for Black Caribbean men and SMR 250 for Black African men). High SMRs were also found for young women aged 25–39 of South-Asian origin (SMR 280), Black Caribbean origin (SMR 270), and Black African origin (SMR 320).

In 2008 the UN Committee on the Elimination of Discrimination against Women is recorded as expressing concern over the higher rates of depression and mental illness in ethnic minority women as well as the higher suicide and self-harm rates of women of Asian descent.<sup>42</sup>

### Sexual orientation

Studies suggest there may be a higher of risk of and attempted suicide among LGB people, with research indicating it is directly linked to sexual orientation, or depression, or relationship problems and difficulties with family.<sup>43</sup> There is an indication that younger age LGB groups may be particularly vulnerable to thoughts of suicide (compared to LGB groups of other ages).<sup>44</sup>

<sup>41</sup> Allmark, P. *et al.* 2010. Chapter 7. Page 55.

<sup>42</sup> Committee on the Elimination of Discrimination Against Women 2008. 41st session (30 June-18 July 2008). *Concluding observations to the United Kingdom of Great Britain and Northern Ireland*. UN document number: CEDAW/C/UK/CO/6.

<sup>43</sup> Allmark, P. *et al.* 2010. Chapter 10. Pages 15-17.

<sup>44</sup> Allmark, P. *et al.* 2010. Chapter 10. Page 16. See also Mitchell, M., Howarth, C., Kotecha, M. and Creegan, C. 2008. *Sexual Orientation Research Review 2008*. Research Report 34. Manchester: Equality and Human Rights Commission. Page 223.

### Transgender

Some evidence provided by a survey of transgender people reported that 34% of respondents of those surveyed (N=872) had attempted suicide at least once.<sup>45</sup>

There is evidence that transgender people who have experienced mental health difficulties are more likely to have had serious thoughts of suicide – the Brighton and Hove ‘Count me in too survey’ of transgender and LGB people found transgender respondents were more likely (56%, n=22) than LGB (28%, n=168) to have experienced difficulties with suicidal thoughts ( $p = .0005$ ).<sup>46</sup>

### Other groups

Carers: Research suggests that this group face particular pressures and are likely to display symptoms that could indicate depression, perhaps leading to suicide attempts:<sup>47</sup>

- One study found that almost three-quarters (74%) of carers questioned felt their role as a carer has pushed them to breaking point at least once.
- Some had contemplated suicide because of the pressure they found themselves under as a carer. Common reasons included ‘frustration with bureaucracy’, followed by the deteriorating health of the person in their care, lack of sleep and financial concerns.

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<sup>45</sup> Allmark, P. *et al.* 2010. Chapter 11. Page 11; see also Mitchell, M. and Howarth, C. 2009. *Transgender Research Review*. Research Report 27. Manchester: Equality and Human Rights Commission. Page 55.

<sup>46</sup> Allmark, P. *et al.* 2010. Chapter 11. Page 11.

<sup>47</sup> Carers Week website 2009. *Carers at breaking point*. Available at: [http://www.carersweek.org/newsroom\\_page.asp?id=194](http://www.carersweek.org/newsroom_page.asp?id=194) Accessed 03/09/2010.

## 6.4 What we know about accidental death

### Measure:

**Accidents** – Number of accidental deaths and rates by age

### How this measure works:

There are only data for gender and age, using mortality data taken from the Office for National Statistics (ONS) for England and Wales and the General Register Office of Scotland.

There are very limited data for ethnicity. Some studies have been referred in this section, which use estimations based on country of birth, but are very general and not all results are statistically significant.

There is very limited related literature for this measure for groups defined by socio-economic background, disability, religion or belief, sexual orientation and transgender, therefore they are not covered in this section.

### Overview

**Based on this limited evidence, accidental death rates are higher for men than women of all ages except the very elderly.** This may be due in part to the prevalence of work based accidents in male dominated occupations.

While accidents have a wide range of causes, not all of which are preventable, **there is scope to reduce deaths in some categories** – this is particularly relevant to the increasing number of accidents (probably mainly falls) experienced by older people.

### What we know about the overall situation

Although more recent data are not easily obtainable, trend data are available up to 1998, which show that the accident rate was declining.

**Table 6.4.1** Accidental death rates (per million population) by gender and age in England and Wales, 1961-98<sup>48</sup>

		Under 15	15-24	25-54	55-74	75 and over
<b>1961-70</b>	Male	236	555	326	542	2,436
	Female	130	110	94	362	2,731
<b>1971-80</b>	Male	162	505	272	425	1,694
	Female	88	118	91	289	2,026
<b>1981-90</b>	Male	106	397	229	314	1,223
	Female	58	92	69	204	1,284
<b>1991-98</b>	Male	59	290	205	254	1,074
	Female	32	76	59	152	1,072

Source: ONS Mortality statistics.

## What we know about the situation for different groups

### Gender and age

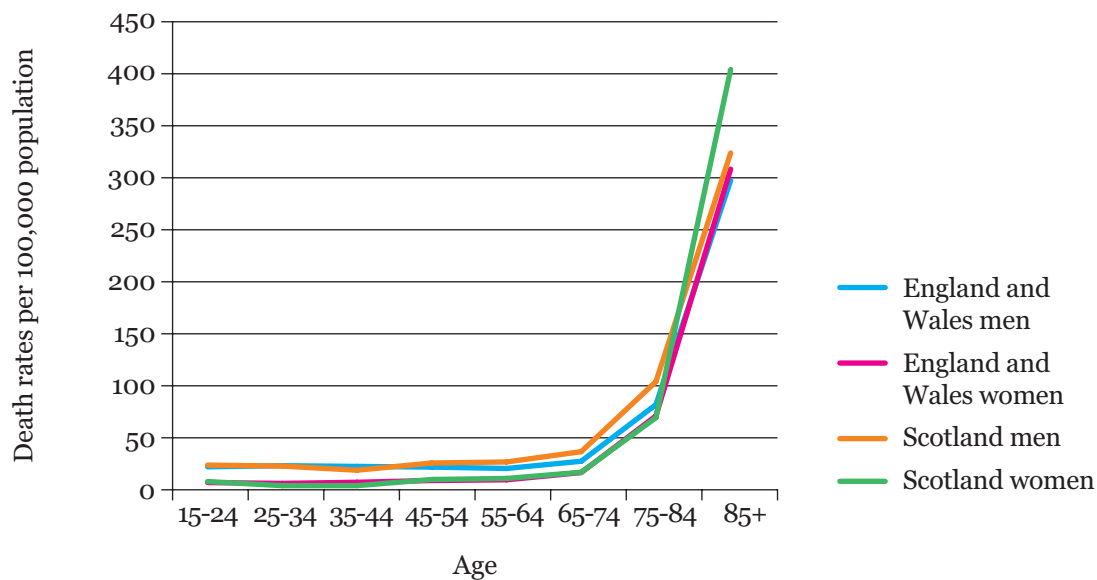
Men have higher rates of accidental death than women in every age group except 85+, and linked to this difference, almost all people killed at work are men: only four fatalities (out of 129) at work in 2008/09 were women.<sup>49</sup>

The risk of accidental death rises rapidly in very old age for both men and women. Because of women's greater life expectancy, a higher number of older women than older men die from accidents.

<sup>48</sup> ONS, Accidental death rates: by gender and age, 1901-1910 to 1991-1998: Social Trends 30. Available at: <http://www.statistics.gov.uk/STATBASE/xsdataset.asp?vlnk=667> Accessed 28/08/10.

<sup>49</sup> Health and Safety Executive. Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995. Available at: <http://www.hse.gov.uk/statistics/tables/agegen2.htm> Accessed 27/08/2010.

**Figure 6.4.1** Accident death rates (deaths per 100,000 population) by age and gender in England and Wales, and Scotland, 2008<sup>50</sup>



Source: ONS Mortality statistics and Scottish Registrar General's Annual Review of Population.

**Box 6.4.1** Related issue: Children and traffic accidents

In the forthcoming Children's Measurement Framework, it is proposed that there is a specific indicator on the numbers of children in fatal traffic accidents. The number of children that have been killed or seriously injured in traffic accidents has been decreasing overtime. The number of children killed or seriously injured in road or traffic accidents in 2009 was 2,671 (down 5% on 2008). Of those, 1,660 were pedestrians, 7% down on 2008. 81 children died on the roads, 43 less than in the previous year, a reduction of over a third.<sup>51</sup>

However a study carried in 2003 by the AA Foundation for Road Safety Research found that in Britain:<sup>52</sup>

- Children from ethnic minorities are up to twice as likely as average to be involved in road accidents while walking or playing.

<sup>50</sup> Allmark, P. *et al.* 2010. Chapter 5. Page 41.

<sup>51</sup> See Department for Transport 2009. *Reported Road Casualties Great Britain Main Results: 2009*. Available at: <http://www.dft.gov.uk/pgr/statistics/datatablespublications/accidents/casualtiesmr/rrcgbmainresults2009> Accessed 03/09/2010.

<sup>52</sup> The AA Motoring Trust 2003. *AA Foundation for road safety research*. Available at: [http://www.theaa.com/public\\_affairs/reports/facts\\_about\\_road\\_accidents\\_and\\_children.pdf](http://www.theaa.com/public_affairs/reports/facts_about_road_accidents_and_children.pdf) Accessed 28/08/2010.

**Box 6.4.1** Continued

- Children with hearing difficulties are 10 times as likely to be involved in road accidents while walking or playing.
- Children from low income families are five times more likely to be killed in road accidents as those from high income families.

**Ethnicity**

In the absence of other data, the following analysis uses the 1991 Census, using country of birth to estimate accident rates for ethnic minority groups - this is fairly limited in the results it can show, hence the very few countries listed. This shows for accidental deaths, men born in the Indian sub-continent had a lower risk compared to the standard, but mortality was elevated for both men and women born in Scotland or in Ireland.

**Table 6.4.2** Accidental injury standardised mortality ratios (SMR) by country/region of birth in England and Wales, 1991/93<sup>53</sup>

Country/Region of birth	Men	Women
	Accident	Accident
Caribbean	121	103
Indian sub-continent	<b>80</b>	<b>93</b>
Scotland	<b>177</b>	<b>201</b>
Ireland	<b>189</b>	<b>160</b>

Source: Census 1991.

Notes: For people aged 20-64 years. SMR for all people resident in England and Wales 1991 = 100. Bold indicates statistically significantly different from the standard England and Wales population.

<sup>53</sup> Allmark, P. *et al.* 2010. Chapter 7. Page 54.

## 6.5 What we know about homicide

### Measure:

**Homicide** – murder, infanticide and manslaughter per million of the population

### How this measure works:

The Home Office collects homicide data from police forces in England and Wales.<sup>54</sup> The Scottish Government collects similar data for Scotland.<sup>55</sup>

The Home Office's Homicide Index contains data disaggregated by gender, age, ethnicity and sexual orientation.<sup>56</sup> We present information relating to homicides in England and Wales, classified by gender, age, and ethnicity, since these data are quality-assured. The Scottish data are disaggregated by age and gender only.

The small numbers involved make it hard to assess the risk of homicide as it falls across different social groups, although the Crown Prosecution Service has collected data for 3 years on homicides resulting from hate crime in England and Wales in the following categories:

- Race and religion
- Disability
- Homophobia and transphobia.

There is very limited related literature for this measure for groups defined by socio-economic background therefore they are not covered in this section.

<sup>54</sup> Smith, K., Flatley, J., Coleman, K., Osborne, S., Kaiza, P and Roe, S. 2010. *Homicides, Firearm Offences and Intimate Violence 2008/09*. London: Home Office.

<sup>55</sup> Scottish Government 2007. *Homicide in Scotland, 2006-07. Criminal Justice Series*. Edinburgh: Scottish Government. Table 6. Available at: <http://www.scotland.gov.uk/Resource/Doc/207004/0054998.pdf> – see also Scottish Government Statistical Bulletin/Justice Analytical Statistics.

<sup>56</sup> Data on homicide victims' and suspects' visual ethnicities are collected by the Home Office; a 3-year combined total is supplied to the Ministry of Justice to include in their annual section 95 *Race and the Criminal Justice System* publication. Information about homicide victims' sexual orientation has been collected by the Home Office only since April 2007 and has not yet been through a quality assurance process.

## Overview

**Infants, young adults and Black people all have an increased risk of being killed by others.**

**Women victims are more likely than men to have been killed in domestic contexts – the majority by partners; men are more likely than women to have been killed by strangers, friends or acquaintances.**

## What we know about the overall situation and trends

The homicide rate in England and Wales has been fairly constant over the past 10 years (see Figure 6.5.1, below), with the sharp rise in 2002/03 reflecting 172 homicides attributed to Dr. Harold Shipman – all recorded by police in that year.

The homicide rate in Scotland is higher than that in England and Wales, and has fluctuated more over time.

**Figure 6.5.1** Homicide rate per million in England and Wales, and Scotland, 1999/00-2008/09<sup>57 58</sup>



Source: Home Office, 2010. Scottish Government, 2010.

Notes:

- 1 In England and Wales, a separate offence is recorded for each victim of homicide, so that in an incident in which several people are killed, the number of homicides counted is the total number of persons killed.
- 2 Data for England and Wales were correct as at 24 November 2009; figures are subject to revision as cases are dealt with by the police and by the courts, or as further information becomes available.
- 3 Data for Scotland were correct as at January 2010. The initial classification of a case as homicide is made by the police; this will generally be murder. This classification may be altered as a result of decisions taken in the course of criminal proceedings. Some cases initially classified as homicide will, on the basis of criminal proceedings, no longer be classified as such at a later date. This happens in cases where it is found that a homicide had not in fact taken place at all, for example where the main accused person is found guilty of a lesser offence, such as serious assault; or where the decision has been made not to proceed with the case, for example if it is concluded that the victim committed suicide. For these reasons, and as a result of continual data checking, the figures for 2009-10 and for previous years which will appear in the next bulletin may differ slightly from those given here.

<sup>57</sup> Smith, K. *et al.* 2010. Table 1.01, page 20.

<sup>58</sup> Scottish Government 2010. *Statistical Release – Crime and Justice Series: Homicide in Scotland 2008-09*. Available at: <http://www.scotland.gov.uk/Publications/2010/02/19113939/2> Table 1.

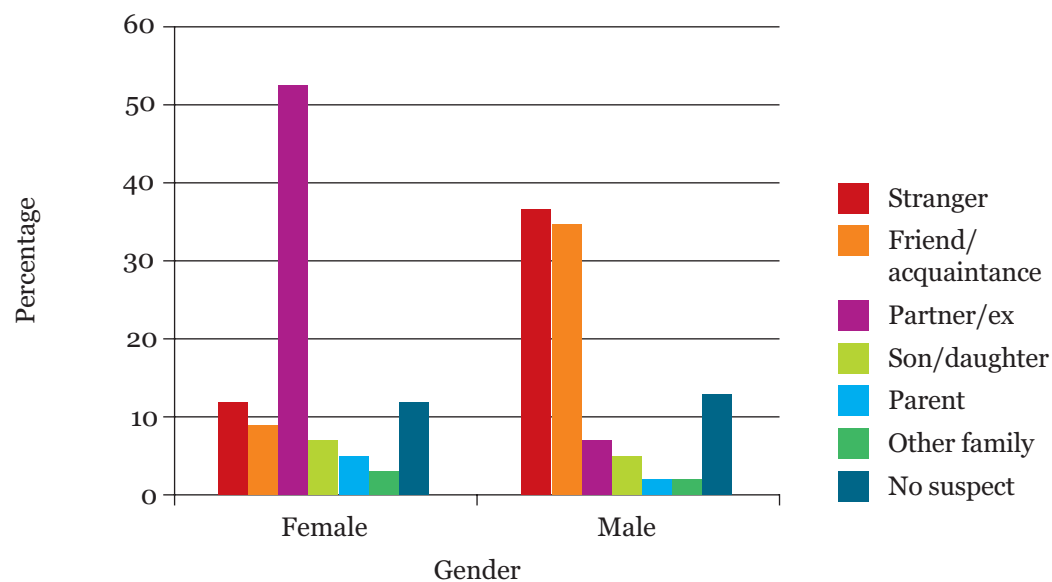
## What we know about the situation for different groups

### Gender

In 2008/09, 71% of homicide victims in England and Wales were male. While male victims were more commonly killed by friends/acquaintances or strangers, female victims were far more likely to be killed by partners or ex-partners (see Figure 6.5.2, below).

There has been a general downward trend in homicides carried out by partners or ex-partners since 2004/05 in England and Wales. However, the number of females killed by a partner or ex-partner rose above 100 for the first time in 4 years in 2008/09<sup>59</sup> – a year in which domestic violence (including by partners, ex-partners and family members) accounted for 68% of female homicides and 15% of male homicides (see Figure 6.5.2, below).<sup>60</sup>

**Figure 6.5.2** Percentage of homicides by victim's gender and relationship to principal suspect in England and Wales, 2008/09<sup>61</sup>



Source: Home Office 2010.

Notes:

- 1 Stranger figures include cases where the suspect is not known.
- 2 Data for England and Wales were correct as at 24 November 2009; figures are subject to revision as cases are dealt with by the police and by the courts, or as further information becomes available.

The situation is similar in Scotland, where domestic violence (including by family members, partners and ex-partners) accounted for 53% of female homicides and

<sup>59</sup> Smith, K. *et al.* 2010. Table 1.05, page 25.

<sup>60</sup> Walby, S., Armstrong J. and Strid, S. 2010. *Physical and Legal Security and the Criminal Justice System: An analytical research overview*. UNESCO Chair in Gender Research Group. Lancaster University.

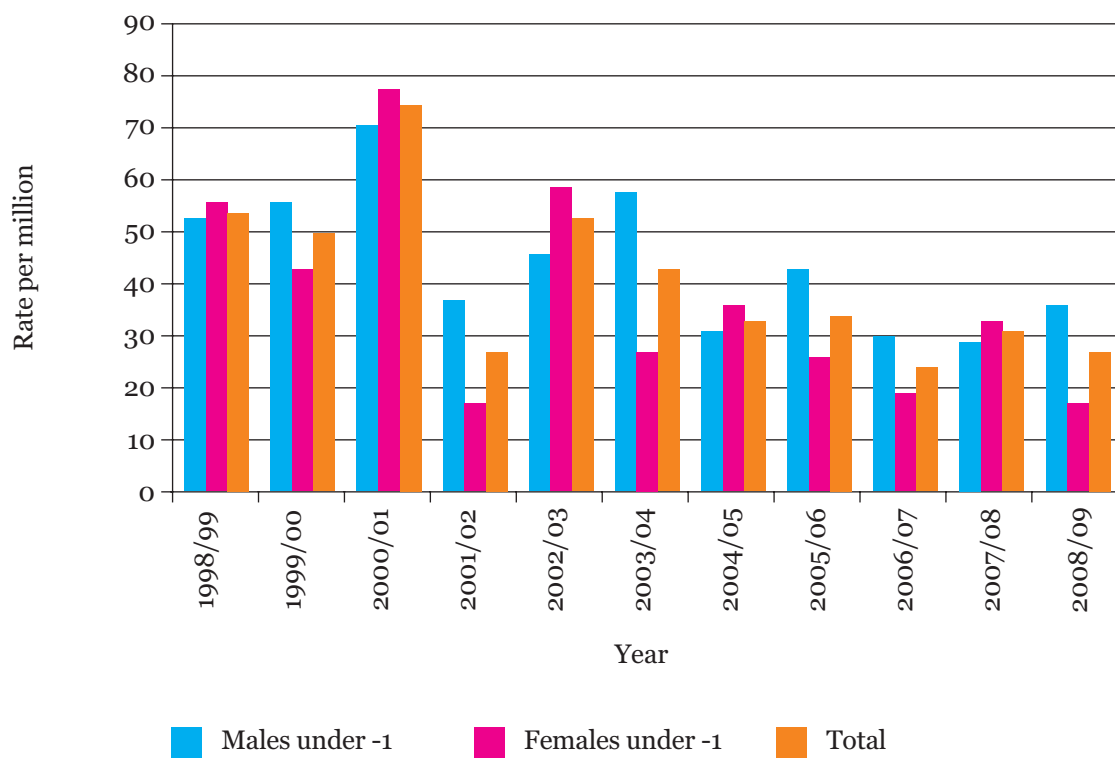
<sup>61</sup> Smith, K. *et al.* 2010. Table 1.05, page 25.

20% of male homicides. The majority of female victims of homicide were killed by a partner/ex-partner in 2008/09 (46%), with an additional 7% by family members; the respective numbers for men were 7% and 13% – as in England and Wales, a larger proportion of male victims of homicide were killed by an acquaintance (65%).<sup>62</sup>

### Age

Children aged under 1 are more likely to die as a result of homicide than any other age group in England and Wales. However, in 2008/09, the rate was half that of a decade ago (see Figure 6.5.3, below).

**Figure 6.5.3** Homicide rate per million of infants aged under 1 by gender in England and Wales, 1998/99-2008/09<sup>63</sup>



Source: Home Office 2010.

Notes:

- 1 As at 24 November 2009; figures are subject to revision as cases are dealt with by the police and the courts, or as further information becomes available.
- 2 For the year 2000/01 there were 58 victims (54 male and 4 female) of unknown age.
- 3 For the year 2003/04 there was one victim of unknown age.
- 4 For the year 2004/05 there were six victims of unknown age.
- 5 For the year 2005/06 there were two victims of unknown age.
- 6 For the year 2006/07 there was one victim of unknown age.

<sup>62</sup> Walby, S. *et al.* 2010. Table 4.2.

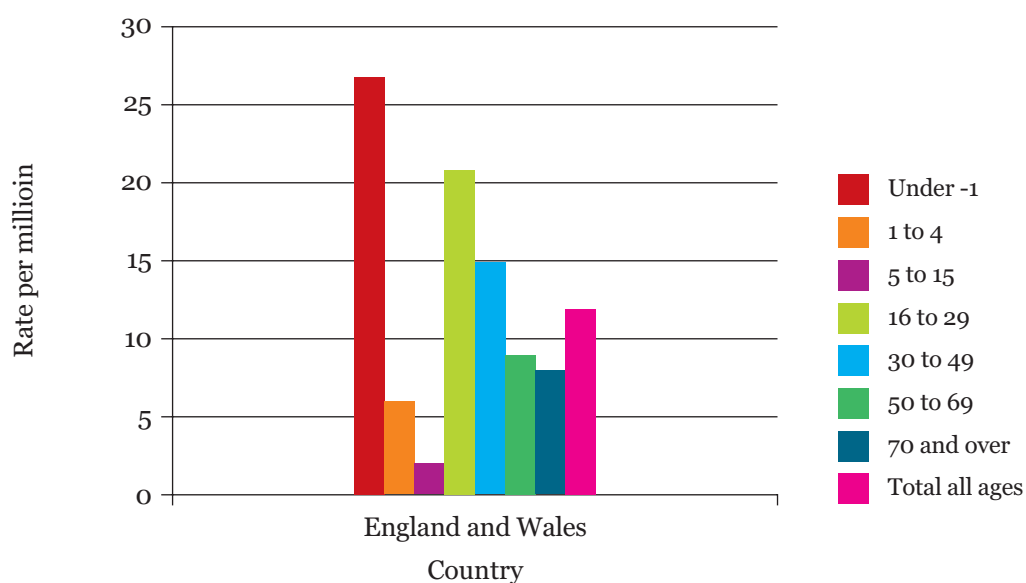
<sup>63</sup> Smith, K. *et al.* 2010. Table 1.07, page 28.

On average one child aged under 16 died as a result of cruelty or violence each week in England and Wales in 2008/09 – two-thirds of them aged under five. The majority of child homicide victims were killed by their parents.<sup>64</sup>

Where a parent was responsible for the homicide of a child in England and Wales between 1998/99 and 2008/09, mothers were the main suspect in a third of the deaths and fathers in two-thirds; in cases where a stranger was involved, the main suspect was disproportionately likely to be a man (86%).<sup>65</sup>

Trend data suggest that homicide victimisation rates among adults peak before the age of 30. In England and Wales, the rate for victims aged 16-29 in 2008/09 was 21 per million;<sup>66</sup> in Scotland, the rate for victims aged 16-30 was higher at 34 per million (see Figure 6.5.4, below).<sup>67</sup>

**Figure 6.5.4** Homicide rates per million population by victim age in England and Wales,<sup>68</sup> and Scotland,<sup>69</sup> 2008/09



Continued...

<sup>64</sup> Smith, K. *et al.* 2010. Tables 1.04 and 1.07, pages 23, 24, 28.

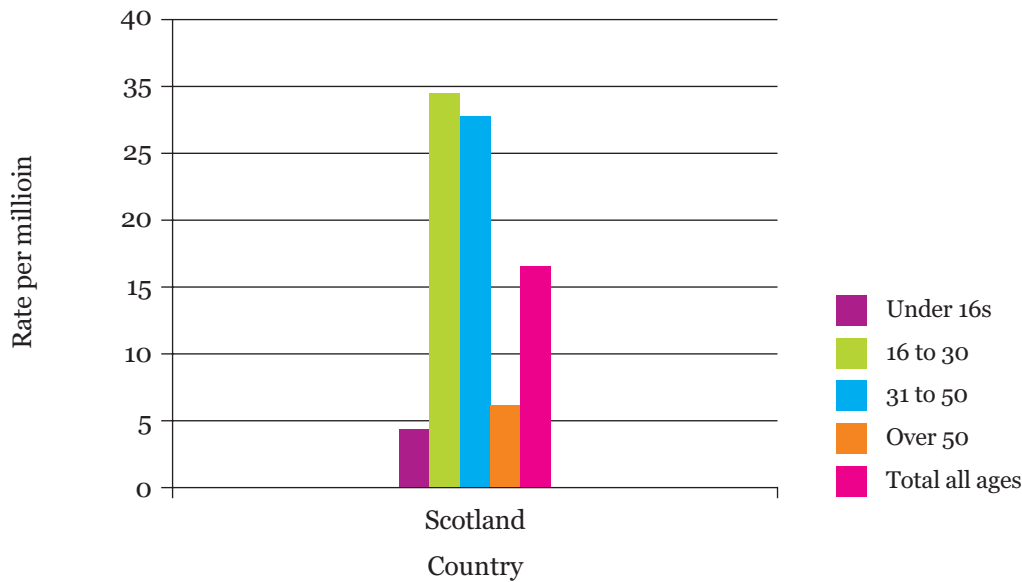
<sup>65</sup> Information supplied via personal communication with the Home Office.

<sup>66</sup> Smith, K. *et al.* 2010. Table 1.07, page 28.

<sup>67</sup> See Scottish Government 2010. *Statistical Release Crime and Justice Series: Homicide in Scotland, 2008-09*. Table 3.

<sup>68</sup> Smith, K. *et al.* 2010. Table 1.07, page 28.

<sup>69</sup> Scottish Government 2010. *Statistical Release Crime and Justice Series: Homicide in Scotland, 2008-09*. Table 3.

**Figure 6.5.4 Continued**

Source: Home Office, 2010. Scottish Government 2010.

Notes:

1. The age-bands used for England and Wales are different to those used in Scotland, so the charts are not directly comparable, although they indicate the broad age trends described in the text.
2. For English and Welsh data, see notes under Figure 6.5.3.
3. Data for Scotland were correct as at January 2010. The initial classification of a case as homicide is made by the police; this will generally be murder. This classification may be altered as a result of decisions taken in the course of criminal proceedings. Some cases initially classified as homicide will, on the basis of criminal proceedings, no longer be classified as such at a later date. This happens in cases where it is found that a homicide had not in fact taken place at all, for example where the main accused person is found guilty of a lesser offence, such as serious assault; or where the decision has been made not to proceed with the case, for example if it is concluded that the victim committed suicide. For these reasons, and as a result of continual data checking, the figures for 2009-10 and for previous years which will appear in the next bulletin may differ slightly from those given here.

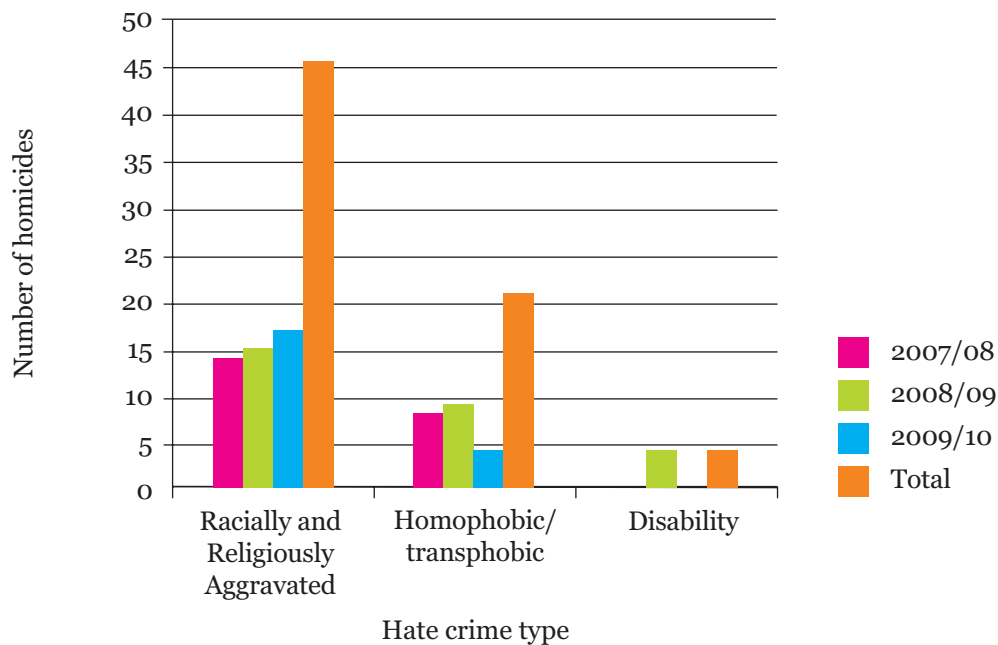
### **Ethnicity, religion or belief, disability, sexual orientation and transgender status**

Of the 2,210 homicides recorded in England and Wales between 2006/07 and 2008/09 where the ethnic identity of the victim is known, 516 were from ethnic minorities, and just over half of these ethnic minority victims were Black – highlighting disproportionality in relation to population size.<sup>70</sup>

<sup>70</sup> Ministry of Justice 2010. *Statistics on Race and the Criminal Justice System: 2008/09*. London: MOJ. Table S2.04.

Over 70 homicides were identified to have resulted from hate crimes between 2007/08 and 2009/10, of which 46 were classified as religiously and racially aggravated, 21 homophobic or transphobic and 4 arose from violence targeting disabled people (see Figure 6.5.5, below).<sup>71</sup>

**Figure 6.5.5** Prosecuted homicides arising from hate crime in England and Wales, 2007/08-2009/10<sup>72</sup>



Source: Homicides Linked to Hate Crime – data provided by the Crown Prosecution Service Management Information System.

Notes:

- 1 These figures are the number of completed defendant prosecutions **not** charged cases.
- 2 These prosecutions have been recorded on a Principal Offence basis, in this case the category 'Homicide'. The 'Homicide' principal offence category comprises a range of offences including:
  - a Murder and Attempted Murder
  - b Making Threats to Kill
  - c Conspiring to Commit Murder
  - d Manslaughter
  - e Causing Death by Dangerous Driving
- 3 The principal offence category indicates the most serious offence with which the defendant is charged at the time of finalisation.

<sup>71</sup> Data supplied by the Crown Prosecution Management Information System. It should be noted that these figures do not necessarily reflect all deaths that resulted from hate crime – rather, they reflect those cases that were charged as such.

<sup>72</sup> Data supplied by the Crown Prosecution Management Information System.

## 6.6 What we know about deaths in institutions

### Measures:

Deaths during and following contact with the police  
Self-inflicted deaths in prisons

### How these measures work:

#### Deaths during and following contact with the police

The main data source regarding deaths during or following police custody in England and Wales – the Independent Police Complaints Commission – provides data about gender, age and ethnicity.<sup>73</sup>

We are unable to obtain any disaggregated data about the numbers of people from our other equality strands who die during or following contact with the police in England and Wales.

We are unable to obtain any data about deaths following contact with the police in Scotland.

We have no information about the number of deaths (including suicides) which occur after a person has been released from police custody, except for those individuals who have been transferred to the care of another agency<sup>74</sup> and subsequently die while in their care.<sup>75</sup>

#### Self-inflicted deaths in prisons

Data relating to deaths in prisons are produced by the Ministry of Justice and disaggregated by gender, ethnicity and broadly by age for prisoners in England and Wales.<sup>76</sup> They are also broadly disaggregated by nationality and sentence type.

<sup>73</sup> Independent Police Complaints Commission 2009. *Deaths during or following police contact: Statistics for England and Wales 2008/09*. IPCC.

<sup>74</sup> Hospitals and hospices data including unpublished data supplied by Ministry of Justice, *Annual statistical bulletin on deaths, self-harm and violence in prison custody*. MoJ, 2010. Available at: <http://www.justice.gov.uk/safer-custody.htm> Accessed 11/08/2010.

<sup>75</sup> This means that if someone attempts suicide in prison, the police may not be aware of the risk of them self-harming if they are subsequently re-arrested on release.

<sup>76</sup> See Ministry of Justice 2010. *Annual statistical bulletin on deaths, self-harm and violence in prison custody*.

Due to small numbers, we are not able to disaggregate information about our other equality strands from official data on prison deaths, or draw any conclusions about trends.

There are no published data sources about self-inflicted deaths in Scottish prisons.

We have not included deaths occurring in secure mental health facilities.

There is very limited related literature for this measure for groups defined by socio-economic background, religion or belief, sexual orientation and transgender, therefore they are not covered in this section.

## Overview

**People in prison are far more likely than the general population to die of self-inflicted causes although the rate has been falling.**

**There is a clear link between mental health conditions and deaths during and following police custody.** There is also a link between mental health conditions, drug dependency and length of stay in prison with an increased risk of self-inflicted death in prison.

## What we know about the overall situation and trends

### Deaths during and following contact with the police

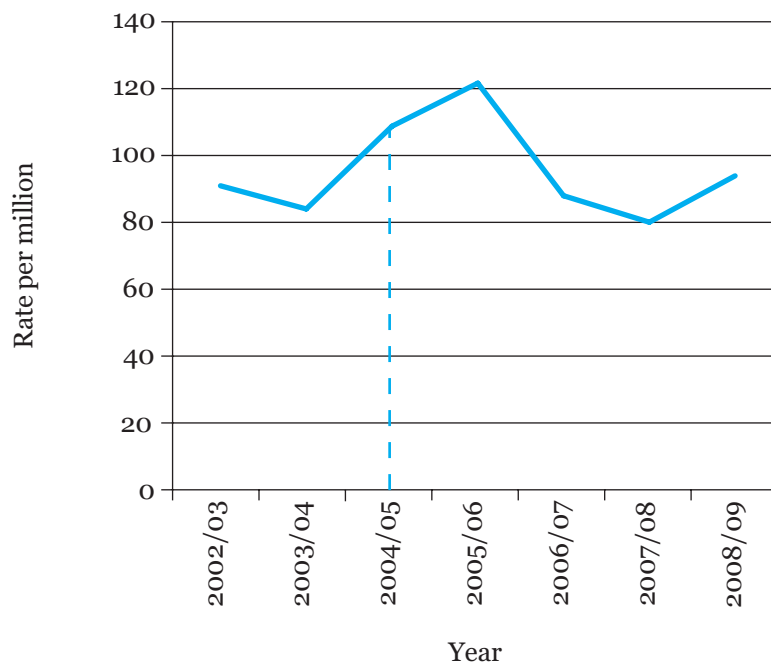
Deaths during and following contact with the police include deaths that occur in non-institutional contexts – for example, during car pursuit – and include ‘lawful’ killings. In 2005/06, when the number of deaths occurring during or following contact with the police reached its peak, 48 of the 120 fatalities were the result of road traffic accidents; 5 were the result of shootings; 39 were classified as ‘other’; and 28 occurred in custody. In the following years, deaths in custody accounted for between a third and a sixth of all fatalities that occurred during or following contact with the police.<sup>77</sup>

The number of deaths during or following contact with the police is currently lower than it was when it reached its peak in the mid-2000s, although they rose slightly between 2007/08 and 2008/09 (see Figure 6.6.1, below).

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<sup>77</sup> See overview figures on fatalities during or following contact with the police: [http://www.ipcc.gov.uk/deaths\\_during\\_or\\_following\\_police\\_contact\\_statistics\\_for\\_england\\_and\\_wales\\_2008\\_09.pdf](http://www.ipcc.gov.uk/deaths_during_or_following_police_contact_statistics_for_england_and_wales_2008_09.pdf)

**Figure 6.6.1** Deaths during or following contact with the police in England and Wales, 2002/03-2008/09<sup>78</sup>



Source: Independent Police Complaints Commission (2004/05 and 2008/09 reports).

Notes:

- 1 'Contact with police' includes: road traffic fatalities, fatal shootings, death during or following police custody, other deaths following police contact.
- 2 The change in the definition in 2004/05 means that any trend analysis of this category should be treated with caution. Figures for 2002/03 and 2003/04 are likely to **under-represent** the actual number of deaths which occurred. Walby *et al.* 2010 suggest that the respective numbers are 104 and 100.<sup>79</sup>

### Self-inflicted deaths in prisons

There was a 30% fall in the overall number of self-inflicted deaths in prisons in England and Wales between 2002 and 2009 – despite a peak in 2007: however, the number of recorded attempts at self-harm have risen in England and Wales (from 19,550 in 2004 to 24,686 in 2008).<sup>80</sup> Over the same period, there was a rise in the number of prisoner deaths attributed to 'natural causes' (see Figure 6.6.2, below).

<sup>78</sup> Independent Police Complaints Commission. *Deaths during or following police contact: Statistics for England and Wales 2008/09*. Table 2.1 of the 2004/05 report (2002/03 to 2004/05) and Table 1.1 of the 2008/09 report (2005/06 to 2008/09).

<sup>79</sup> Walby, S. *et al.* 2010. Table 4.24.

<sup>80</sup> Walby, S. *et al.* 2010. Table 4.25. As noted in the report, the rise is in part due to improved systems of reporting such incidents since 2002 by NOMS.

**Box 6.6.1** Related issue: Risk of self-inflicted deaths in prison

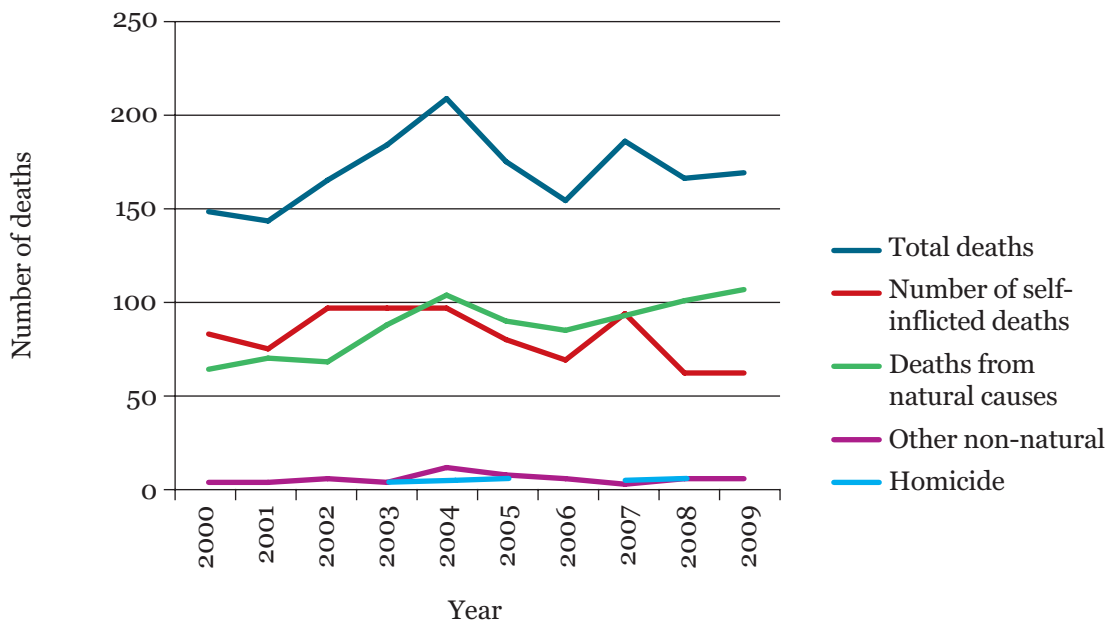
One academic study estimates that people in prison are 10 times more likely than the general population to die from self-inflicted causes where intervention is not used.<sup>81</sup>

In general, self-inflicted deaths are more common among pre-sentence prisoners; for example, this group made up less than 20% of the total prison population in 2003, yet accounted for 54% of self-inflicted deaths in prisons that year.<sup>82</sup>

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<sup>81</sup> See Bird, S.M. 2008. 'Changes in Male Suicides in Scottish Prisons: Ten Year Study', *British Journal of Psychiatry*, 192. Pages 446-449.

<sup>82</sup> House of Lords and House of Commons, Joint Committee on Human Rights, 2004. *Deaths in Custody: Third Report of Session 2004-5, Vol. 1*. Available at: [http://www.preventingcustodydeaths.org.uk/jchr\\_deaths\\_in\\_custody\\_report\\_\\_3rd\\_report\\_of\\_session\\_04-05\\_.pdf](http://www.preventingcustodydeaths.org.uk/jchr_deaths_in_custody_report__3rd_report_of_session_04-05_.pdf)

**Figure 6.6.2** Number of deaths in prison in England and Wales, 2002-09<sup>83</sup>

Source: Ministry of Justice Safety in Custody data (2008/09).

Notes:

- 1 Deaths in prison custody statistics are derived from the National Offender Management Service (NOMS) deaths in the custody database which contains details of all deaths in prison custody for England and Wales from 1978.
- 2 Self-harm statistics are derived from the NOMS incident reporting system. A new system for monitoring self-harm was introduced in December 2002 and as a result recording improved throughout 2003. Statistics collected before 2004 are not comparable with more recent figures. Due to the large number of incidents to process the final figures for 2009 will not be available until later in 2010.
- 3 Assault statistics are also derived from the NOMS incident reporting system. As with self-harm, the final assault figures for 2009 will not be ready until later in 2010.

## What we know about the situation for different groups

### Gender

#### ***Deaths during and following contact with the police***

While men constitute the majority of deaths during or following contact with the police, the proportion of women dying following contact with the police is growing:

<sup>83</sup> Ministry of Justice 2010. *Safety in custody statistics 2008/2009*. Ministry of Justice Statistical Bulletin. Table 1: Summary statistics.

in 1999/2000, 3 out of the 70 mortalities that occurred in this context were women, while in 2008/09, women accounted for 18 out of 92 deaths.<sup>84</sup>

### ***Self-inflicted deaths in prisons***

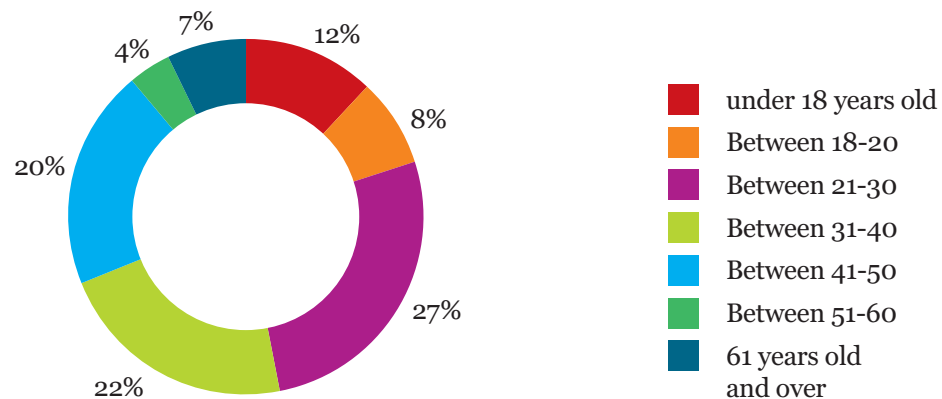
The data on self-inflicted deaths in part match the patterns of suicide in the general population – that is, that men are more likely than women to die in this way (see Figures 6.6.4 and 6.6.5, below). However, women prisoners during the early 2000s were disproportionately likely to die from self-inflicted causes.<sup>85</sup>

### **Age**

#### ***Deaths during and following contact with the police***

Data for England and Wales highlight the uneven age distribution of those dying during or following contact with the police in 2008/09 (see Figure 6.6.3, below).

**Figure 6.6.3** Age distribution of deaths following contact with the police in England and Wales, 2008/09<sup>86</sup>



Source: IPCC report into Deaths during or following police contact: statistics for England and Wales, 2008/09.

Note: 'Contact with police' includes: road traffic fatalities, fatal shootings, death during or following police custody, other deaths following police contact.

<sup>84</sup> Independent Police Complaints Commission. *Deaths during or following police contact: Statistics for England and Wales*. See Walby, S. *et al.* 2010. Table 4.24 for data from 1998/99, although note that this table is disaggregated by gender and ethnicity only.

<sup>85</sup> For example, in 2003 self-inflicted deaths among female inmates were at their peak: women made up 6% of the prison population yet 15% of self-inflicted deaths in prisons occurred among female inmates – see Walby, S. *et al.* 2010. (particularly Table 4.26a). See also House of Lords and House of Commons, Joint Committee on Human Rights, *Deaths in Custody: Third Report of Session 2004-5*, Vol. 1, 2004.

<sup>86</sup> Independent Police Complaints Commission, *Deaths during or following police contact: Statistics for England and Wales, 2008/9*. Table A1.2.

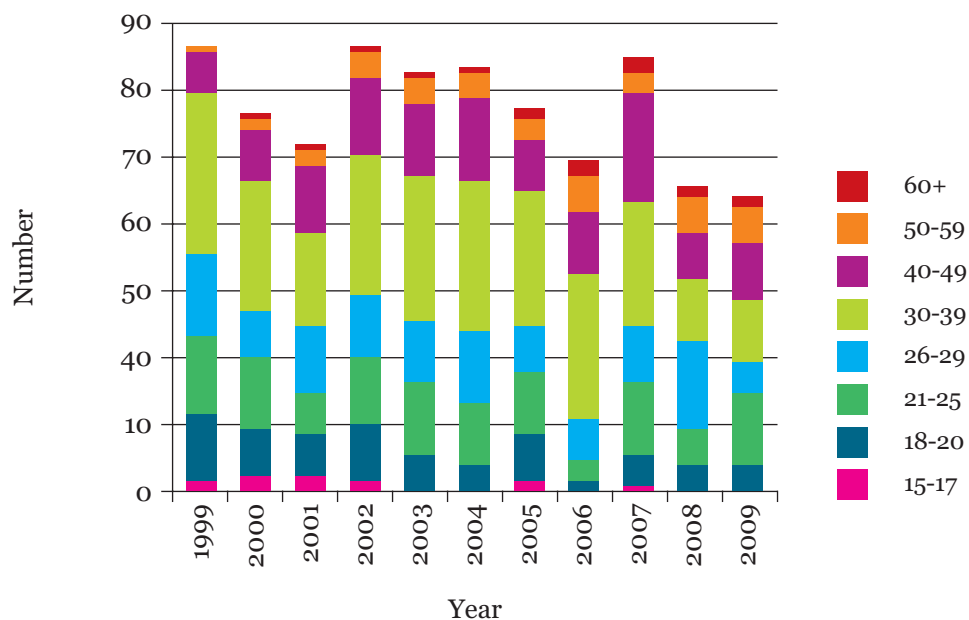
Data spanning 9 years suggest that this age distribution of deaths during or following police custody has remained fairly consistent.<sup>87</sup>

### Self-inflicted deaths in prisons

From 1999 to 2009, male prisoners aged between 30 and 39 were more likely than prisoners of any other age to die from self-inflicted causes (in line with the general suicide trends discussed above) – see Figure 6.6.4, below.

There was a spike in the number of women inmates aged between 18 and 20 who died from self-inflicted causes in prisons in 2003; there have been no self-inflicted deaths in this age-group since 2005 (see Figure 6.6.5, below).

**Figure 6.6.4** Number of self-inflicted deaths in prison (men) by age group in England and Wales, 1999-2009<sup>88</sup>

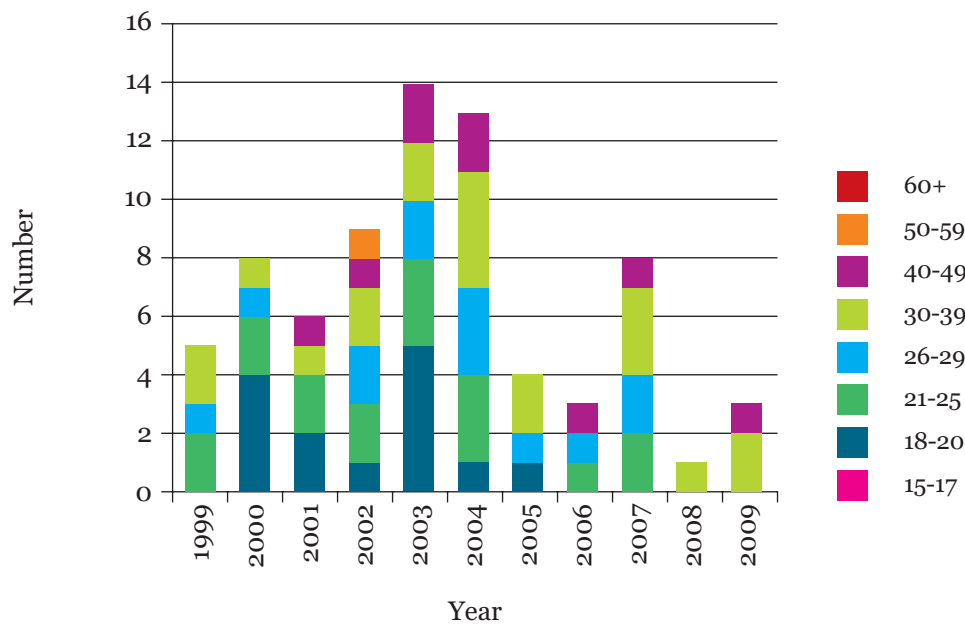


Source: Ministry of Justice Safety in Custody data (2008/09).

<sup>87</sup> Independent Police Complaints Commission. *Deaths during or following police contact: Statistics for England and Wales*. See Table A1.2 of the 2004/05 report (2002/03 to 2004/05) and Table A1.2 of the 2008/09 report (2005/06 to 2008/09).

<sup>88</sup> Ministry of Justice 2009. *Safety in Custody Statistics: Statistical Tables on deaths*. Table 6. Available at: <http://www.justice.gov.uk/saftey-custody-deaths-statistics.xls>

**Figure 6.6.5** Number of self-inflicted deaths in prison (women) by age group in England and Wales, 1999-2009<sup>89</sup>



Source: Ministry of Justice Safety in Custody data (2008/09).

### ***Deaths during and following contact with the police***

According to the Joint Committee on Human Rights (JCHR) report into deaths in police custody, just over half of those who die following contact with the police had prior indications of mental health conditions.<sup>90</sup>

### ***Self-inflicted deaths in prisons***

The JCHR report cites evidence that suggests there is a clear link between mental health conditions, drug dependency, length of stay in prison and an increased risk of self-inflicted death.<sup>91</sup>

### **Ethnicity**

#### ***Deaths during and following contact with the police***

A disproportionate number of deaths following contact with the police since 2004 were of Black people, who comprise around 2% of the population (see Figure 6.6.6, below, which shows percentages rather than numbers to illustrate disproportionality).<sup>92</sup>

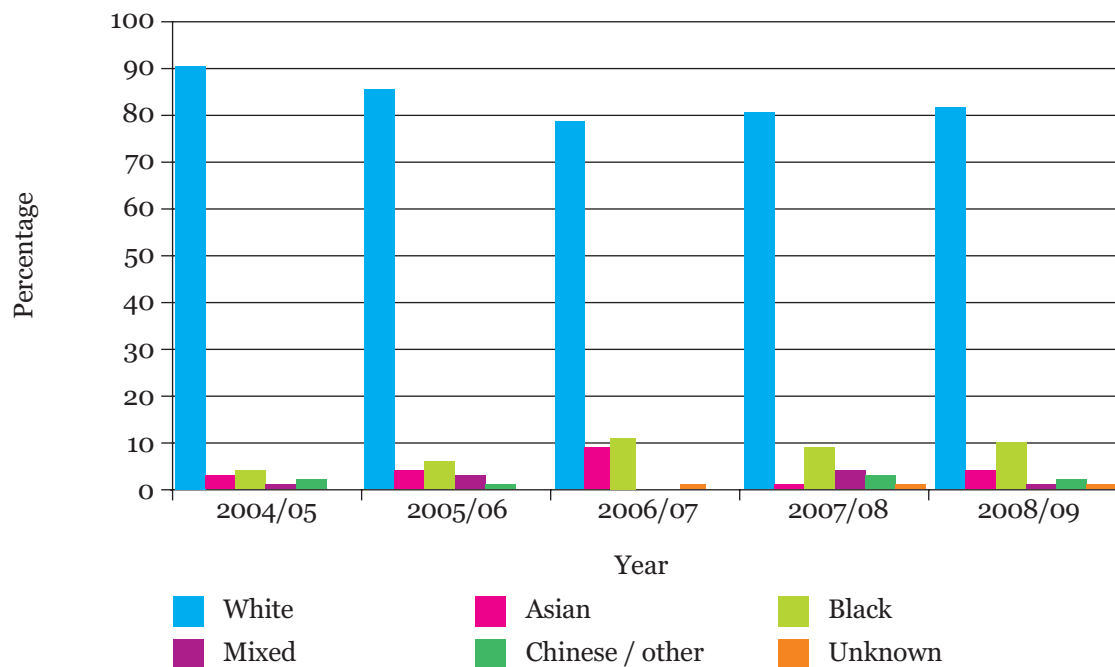
<sup>89</sup> Ministry of Justice 2009. *Safety in Custody Statistics: Statistical Tables on deaths*. Table 6.

<sup>90</sup> House of Lords and House of Commons, Joint Committee on Human Rights 2004. *Deaths in Custody: Third Report of Session 2004-5*, Vol. 1.

<sup>91</sup> House of Lords and House of Commons, Joint Committee on Human Rights 2004.

<sup>92</sup> See Office for National Statistics website: <http://www.statistics.gov.uk/cgi/nugget.asp?id=273>

**Figure 6.6.6** Percentage of deaths following contact with the police by ethnicity in England and Wales, 2004/05-2008/09<sup>93</sup>



Source: Independent Police Complaints Commission, (2004/05, 2005/06, 2006/07, 2007/08 and 2008/09 reports on Deaths During or Following Police Contact: Statistics for England and Wales).

Note: 'Contact with police' includes: road traffic fatalities, fatal shootings, death during or following police custody, other deaths following police contact.

**Box 6.6.2** Related issue: Control and restraint – deaths during or following contact with the police

The UK Parliament's Joint Committee for Human Rights notes that between 1998 and 2003, 18% of those who died in police custody overall were from ethnic minorities: restraint was involved in a higher proportion of the deaths of ethnic minority people coming into contact with the police (22%) than of White people (12%).<sup>94</sup>

### Self-inflicted deaths in prisons

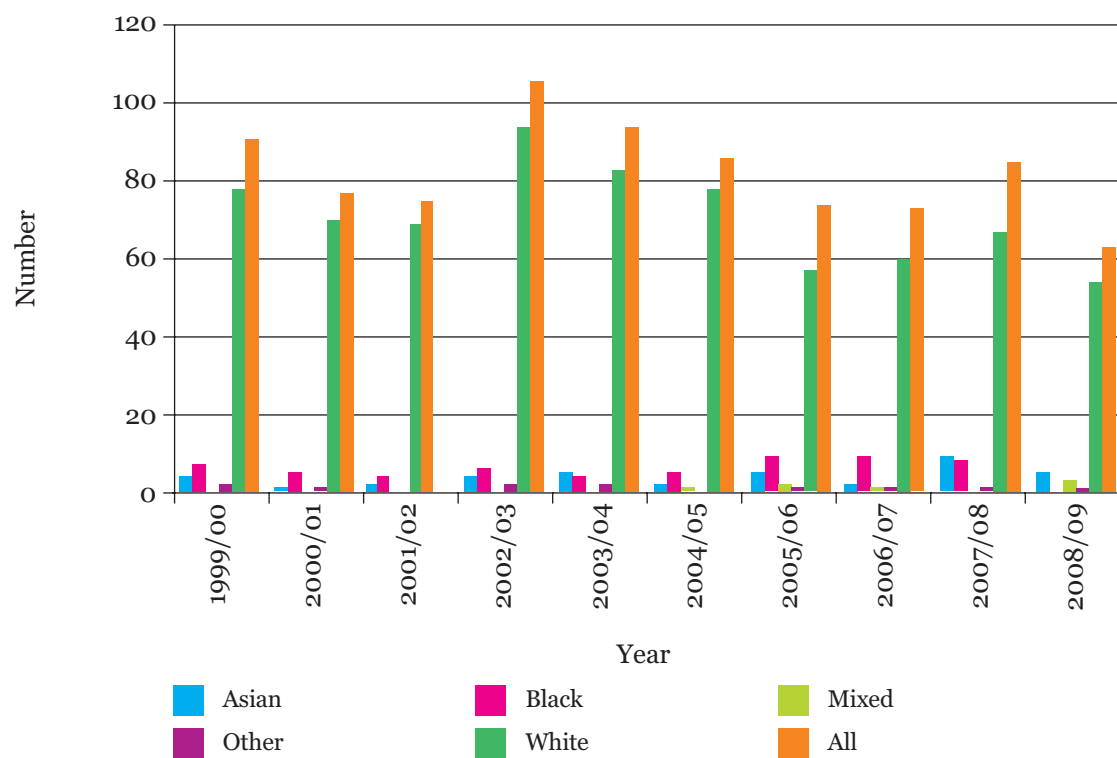
The number of ethnic minority prisoners who are reflected in the self-inflicted death statistics from prisons in England and Wales tends to fluctuate; in 1997,

<sup>93</sup> Independent Police Complaints Commission. *Deaths during or following police contact: Statistics for England and Wales 2008/09*. Table A1.3. 2004/05, 2005/06, 2006/07, 2007/08 and 2008/09 reports.

<sup>94</sup> House of Lords and House of Commons, Joint Committee on Human Rights, 2004. *Deaths in Custody: Third Report of Session 2004-5*, Vol. 1.

there were 6 such deaths, 23 in 2007 and 5 in 2009.<sup>95</sup> The patterns of self-inflicted deaths in prisons are shown in Figure 6.6.7, below. White people consistently account for the largest proportion of self-inflicted deaths in prison custody.

**Figure 6.6.7** Number of self-inflicted deaths in prison by ethnicity in England and Wales, 1999/2000-2008/09<sup>96</sup>



Source: Ministry of Justice, 2010.

<sup>95</sup> Ministry of Justice. *Safety in Custody Statistics. Statistical Tables on deaths.* Table 9.

<sup>96</sup> Ministry of Justice 2010. *Statistics on Race and the Criminal Justice System: 2008/09.* Table S5.12 (financial). Available at: <http://www.justice.gov.uk/publications/docs/stats-on-race-in-the-cjs-supplementary-tablesa.zip>

**Box 6.6.3** Related issue: Foreign National Prisoners

Asylum seekers and Foreign National Prisoners are considered to be at particular risk of self-inflicted deaths in custody. Negative experiences of detention, delays in processing cases, a lack of information and legal support, mental health conditions and experiences of discrimination and racism all lead to an increased risk of self-harm. The HM Chief Inspector of Prisons stated: ‘The treatment of foreign national prisoners over recent years has been an object lesson in systems and procedures that lack both efficiency and humanity.’<sup>97</sup>

<sup>97</sup> See reports from HM Inspector of Prisons:

HM Inspectorate of Prisons 2006. *Foreign National Prisoners: A Thematic Review*. London: HM Inspectorate of Prisons. Available at: <http://www.justice.gov.uk/inspectorates/hmi-prisons/docs/foreignnationals-rps.pdf>.  
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 See also Prison Reform Trust 2004. *Forgotten Prisoners: The Plight of Foreign National Prisoners in England and Wales*. London: Prison Reform Trust. Available at: <http://www.prisonreformtrust.org.uk/temp/Forgottenspisoners.pdf>

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### Web links

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