

Independent Advisory Panel on Deaths in Custody

**Statistical analysis of recorded  
deaths in custody between 2016 and 2019**

November 2021

## Contents

Chair's foreword	3
Introduction	4
Part 1: Deaths by place of detention	6
Part 2: Deaths by sex	8
Part 3: Deaths by cause	10
Part 4: Deaths by age	11
Part 5: Deaths by race and ethnicity	12
Annex: Notes on methodology	13
About the Independent Advisory Panel on Deaths in Custody	15

## Lists of tables

<u>Table 1</u> : Deaths in custody in England and Wales 2016-2019	6
<u>Table 2</u> : Number and (%) of deaths in custody, and sex proportions by setting in England and Wales 2016-2019	8
<u>Table 3</u> : Rates of deaths in custody in prisons in England and Wales by sex 2016-2019	9
<u>Table 4</u> : Cause of deaths in custody by setting, 2016-19	10
<u>Table 5</u> : Deaths in custody by cause for all settings, 2016-2019	10
<u>Table 6</u> : Deaths in custody by age and cause for natural and self-inflicted causes, 2016-2019	11
<u>Table 7</u> : Number of deaths in custody in England and Wales by ethnicity 2016-2019	12

## List of charts

<u>Chart 1</u> : Total numbers of deaths across places of detention: 2016-2019	6
<u>Chart 2</u> : Average percentage of deaths across places of detention 2016-2019	7
<u>Chart 3</u> : Rates of deaths in two largest per place of detention, 2016-19	7

## **Chair's foreword**

Detailed, accurate statistics published regularly are essential to understanding what is happening in our closed institutions. Such data makes it possible to analyse trends and, crucially, inform those charged with the heavy responsibility of detaining people in all forms of state custody. Most importantly, clear information enables government ministers to meet their obligations to keep people safe and to take active steps to protect lives.

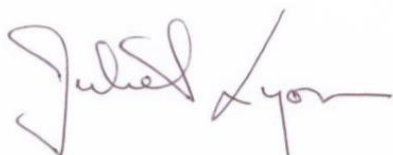
This report on deaths (2016-2019) underscores the high mortality rate for those detained in custody compared with the general population. It reveals that one in five deaths in custody are self-inflicted. While most deaths in custody occur in prisons, when rates are considered people detained under the Mental Health Act have the highest mortality rate.

Accurate data on deaths in custody must be publicly available. It should not be difficult to obtain full information, but it is. It is imperative to improve data collection and publication. Missing data distorts information and hampers efforts to prevent deaths in custody.

We would single out missing data on the ethnicity of people detained under the Mental Health Act as unacceptable. Improvements could be made in the collection and recording of self-report data on race and ethnicity. Prison, immigration and police data are largely complete in this regard. Significant gaps remain in secure health figures. To give a stark example: half of the women detained under the Mental Health Act who died in 2019 did not have their ethnicity recorded. It is also not acceptable to not have information on age for up to 5% of all deaths from natural causes.

Focussed on data and analysis of figures, essentially this report is about the deaths of people. Each one is a tragedy, for the individual and for the family. Each one is a catastrophe for a public service and a government accountable for protecting lives in state custody. Overall, the Independent Advisory Panel on Deaths in Custody (IAPDC) recognises and supports the considerable work that is done to prevent deaths in custody. We believe that more can, and must, be done to keep people safe and to avoid the devastation and cost, in every sense, of each loss of life.

We are grateful to panel member Professor Seena Fazel and his colleague Dr Stella Botchway for their analysis of data and expert advice on preparation of this report. The unique method they have used to calculate rates of death per custodial population, alongside numerical information, using routine data allows for more consistent comparison across time and different settings.

A handwritten signature in black ink, appearing to read 'Juliet Lyon', with a stylized flourish at the end.

Juliet Lyon CBE

**Chair, Independent Advisory Panel on Deaths in Custody**

## Introduction

1. This statistical bulletin provides a breakdown of all recorded deaths in custody in England and Wales from the start of 2016 to the end of 2019 in the following settings:
  - Prisons
  - Patients who have died in hospitals while detained under the Mental Health Act.
  - Immigration Removal Centres
  - Police custody
2. The Independent Advisory Panel on Deaths in Custody (IAPDC) first published a statistical analysis of deaths in state custody in October 2011<sup>1</sup>. The collection, analysis and dissemination of accurate data on deaths in custody helps to monitor trends, highlight vulnerable cohorts, and assess the impact of preventative measures.
3. This briefing firstly outlines the data by place of detention (Part 1). It then breaks down this data further by sex (Part 2), cause of death (Part 3), age (Part 4), and race and ethnicity (Part 5).
4. Unlike previous analyses, this bulletin presents and assesses deaths in custody through the calculation of population rates. Analysing deaths rates by considering target populations allows for further interpretation than simply considering number of deaths, or deaths per country inhabitants. Previously, information on rates has only been available for deaths which occur in prisons.<sup>2</sup>
5. There have been few attempts to determine a method of calculating a population of interest for rates of death while detained in custody, as it is difficult to obtain information on the total number of people who are detained each year or at a particular moment in various settings. To calculate an estimated mortality rate, data on the population at risk was sourced from the relevant governmental departments, as detailed in the Annex.<sup>3</sup>
6. Key findings evident from the data presented in this work include:
  - a. **Around one in five deaths in detention are self-inflicted.**
  - b. **Deaths in all custodial settings are much higher than the background all-cause mortality for the general population of similar age and sex.**
  - c. **Most deaths took place in prisons. The highest rate of deaths is in psychiatric hospitals.**
  - d. **While there were more deaths in men than women in all settings, when the accompanying rates are considered, the difference in deaths between men and women narrowed.**

---

<sup>1</sup> Independent Advisory Panel on Deaths in Custody, *Statistical Analysis of all recorded deaths of individuals detained in state custody between 1 January 2000 and 31 December 2011*, November 2012,

<https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5ee254b04fe9e94c206a28ec/1591891127865/Statistical-analysis-of-recorded-deaths-between-2000-and-2011.pdf>. Other statistical bulletins can be found at: <https://www.iapondeathsincustody.org/statistics>.

<sup>2</sup> Independent Advisory Panel on Deaths in Custody, *Statistical analysis of recorded deaths between 2000 and 2013*, 2013, page 8  
<https://static1.squarespace.com/static/5c5ae65ed86cc93b6c1e19a3/t/5f453aec9f6da34261a1f666/1598372591548/Statistical-analysis-of-recorded-deaths-2000-to-2013.pdf>.

<sup>3</sup> Analysis has been carried out by Dr Stella Botchway and panel member Professor Seena Fazel (University of Oxford), who drafted Parts 1-5 and the Annex.

- e. The proportion of deaths due to natural causes increased in the older age groups, and there were relatively more self-inflicted deaths in the younger age groups.**

7. Caveats and background:

- a. Data was gathered from departments between November 2020 and April 2021. The numbers, especially for 2019, are subject to change due to changes to the classification of deaths.
- b. This analysis only covers the years 2016 to 2019. It is therefore difficult to draw any long-term trends from the data. Caution should also be applied to drawing trends across these four years.
- c. Rates cannot be easily compared between police custody and the other settings due to the duration of stay being so different.

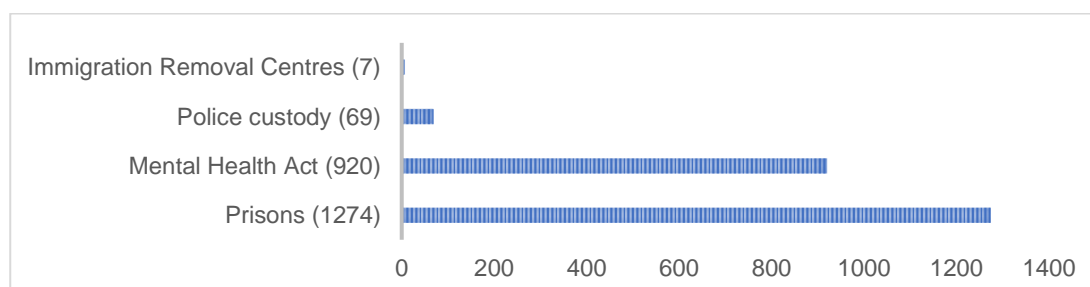
## Part 1: Deaths by place of detention

*Table 1: Deaths in custody in England and Wales 2016-2019*

Setting	Numbers, (proportion), and rates per 100,000 detainees									
	2016		2017		2018		2019		Totals	
	Numbers (%)	Rate	Numbers (%)	Rate	Numbers (%)	Rate	Numbers (%)	Rate	Numbers (%)	Rate
<b>Community<sup>4</sup></b>	<b>2,514</b>	<b>64</b>	<b>2,326</b>	<b>59</b>	<b>2,490</b>	<b>63</b>	<b>2,490</b>	<b>62</b>	<b>12,275</b>	<b>62</b>
<b>Prisons</b>	354 (56)	415	295 (54)	344	325 (58)	390	300 (57)	361	1,274 (56)	<b>378</b>
<b>Prisons<sup>5</sup></b>		298		247		285		267		274
<b>Mental Health Act (MHA)</b>	269 (42)	1334	224 (41)	1223	216 (39)	1103	211 (40)	1109	920 (41)	<b>1192</b>
<b>Mental Health Act (MHA)<sup>6</sup></b>		18,021		15,006		14,470		14,135		
<b>Police</b>	12 (2)	1	19 (3.5)	2	18 (3)	2	20 (4)	2	68 (3)	<b>2</b>
<b>Police<sup>7</sup></b>		419		741		765		851		
<b>Immigration Removal Centres (IRCs)</b>	1 (<1)	3	4 (<1)	15	1 (<1)	4	1 (<1)	4	7 (<1)	<b>7</b>
<b>Total (excluding community)</b>	<b>636</b>	<b>-</b>	<b>542</b>	<b>-</b>	<b>559</b>	<b>-</b>	<b>522</b>	<b>-</b>	<b>2,259</b>	<b>-</b>

8. Rates of deaths in detention were considerably higher than in the comparator community group. The majority of deaths in custody between 2016 and 2019 occurred in prisons (57% of all deaths in custody and 1,274 of the 2,269 in total).

*Chart 1: Total numbers of deaths across places of detention: 2016-2019*



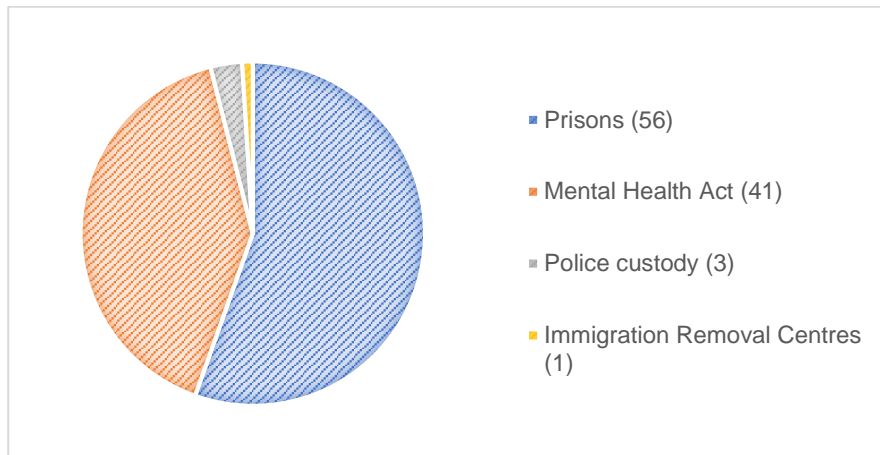
<sup>4</sup> Rates of deaths in custody are compared against an average all-cause mortality rate for 30-34 year olds in England and Wales between 2016 and 2019, obtained from the UK Office of National Statistics.<sup>12</sup>

<sup>5</sup> Adjusted for relative proportions of remand (by receptions) and sentenced prisoners (by census).

<sup>6</sup> Adjusted for estimated person time at risk.

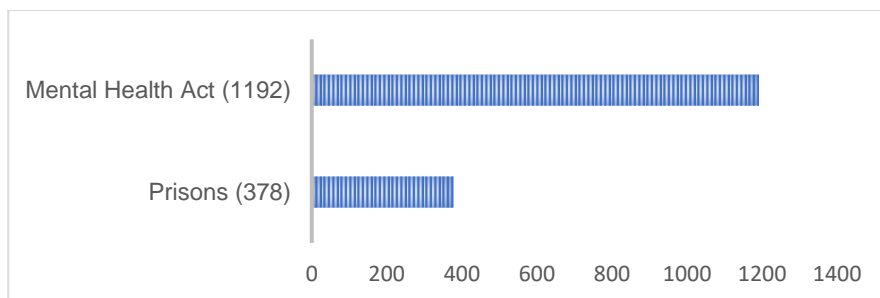
<sup>7</sup> Adjusted for estimated person time at risk (assumes arrest for one day).

Chart 2: Average percentage of deaths across places of detention 2016-2019



9. However, when rates are considered, people detained under the Mental Health Act had the highest rate of deaths. Rates ranged from 1,103 to 1,334 per 100,000 persons detained. This was around three times higher than the rate in prisons (range 344 to 415 per 100,000 prisoners). When person time at risk was considered, mortality rates of those held under the Mental Health Act was higher still.
10. Mortality in police custody and within IRCs was considerably lower in terms of numbers.

Chart 3: Rates of deaths in two largest per place of detention, 2016-19



11. The rates for deaths in police custody are high when adjusted for a day in custody, suggesting rates may be higher than initially expected. But this is dependent on the methodology and calculation based on a number of assumptions. Ideally what is needed to calculate an accurate rate is the actual number of person days in police custody in any given year.
12. The amount of total deaths per year does not fluctuate significantly over the period covered. The average total deaths over this period is 565. The numbers in 2016 are higher than the others covered by the remit of this bulletin.

## Part 2: Deaths by sex

13. The deaths in prisons by sex (see [Table 2](#)) broadly reflects the proportions of the underlying population. In hospitals, deaths in custody are slightly overrepresented in men, considering the sex proportions of the underlying population and the corresponding sex-specific mortality rates.<sup>8</sup>

*Table 2: Number and (%) of deaths in custody, and sex proportions by setting in England and Wales 2016-2019*

Setting	Deaths and (%) by sex, and sex proportion of detainees according to custodial setting							
	2016		2017		2018		2019	
	No. (%)	Sex % in setting population	No. (%)	Sex % in setting population	No. (%)	Sex % in setting population	No. (%)	Sex % in setting population
<b>Prison</b>								
Male	332 (94)	95	287 (97)	95	314 (97)	95	292 (97)	95
Female	22 (6)	5	8 (3)	5	11 (3)	5	8 (3)	5
<b>MHA</b>								
Male	173 (65)	52*	136 (61)	52	137 (64)	52	128 (62)	51
Female	95 (35)	48*	87 (39)	48	77 (36)	48	79 (38)	49
<b>Police</b>								
Male	11 (92)	85	17 (89)	85	15 (83)	85	19 (95)	85
Female	1 (8)	15	2 (11)	15	3 (17)	15	1 (5)	15
<b>IRC</b>								
Male	1 (100)	86	4 (100)	85	1 (100)	85	1 (100)	86
Female	0	14	0	15	0	15	0	14
<b>Total</b>								
Male	517 (81)		444 (82)		466 (84)		426 (83)	
Female	118 (19)		97 (18)		91 (16)		87 (17)	

\* all detentions rather than all those subject to the MHA were used to calculate the sex proportions for 2016.

14. [Table 3](#) sets out how these numbers and proportions apply to rates. By comparison, the all-cause mortality rate of the general population of England and Wales over the same time period was 80 for men and 44 for women, aged 30-34<sup>12</sup>.

<sup>8</sup> Some information was not available across all settings (see [Table 2](#)) and thus it was not possible to calculate rates in hospitals due to a lack of data on denominators. Data was not available on the sex balance for people detained in hospital under the MHA, but data was available for repeated detentions (where sex was documented) and was used as a proxy to provide information on the balance of sex in this setting. This estimate for the sex balance is based on all detentions including community treatment orders as well as detentions in hospitals ([Table 3](#)).



*Table 3: Rates of deaths in custody in prisons in England and Wales by sex 2016-2019*

Setting	Rates of death per 100,000 detainees			
	2016	2017	2018	2019
<b>Prison</b>				
Male	407	351	395	369
Female	570	201	256	211
<b>Prison<sup>9</sup></b>				
Male	297	256	293	278
Female	313	110	160	121
<b>Police</b>				
Male	1	2	2	3
Female	1	2	2	1
<b>IRC</b>				
Male	4	17	5	5
Female	0	0	0	0

<sup>9</sup> Rates adjusted for relative proportions of remand and sentenced prisoners.

### Part 3: Deaths by cause

15. Between 2016 and 2019 the majority of deaths were due to natural causes (1336, 59% of all deaths in custody), followed by self-inflicted deaths (457, 20% of all deaths) (Table 4 and 5). Self-inflicted deaths include deaths by suicide, along with other self-inflicted deaths where the intent may not have been to cause death, or where the intent was not clear.
16. Over the same period there were 195 deaths (9%) for other natural causes, a category which includes accidental overdoses, and 53 deaths as a result of restraint (2% of all deaths). Deaths due to restraint were recorded by prisons and hospitals only. In addition, there were 13 deaths (less than 1%) due to homicide, all occurring in prisons. The remainder of deaths were not categorised, mainly due to insufficient information. In some instances, particularly in the later years, these deaths may be further categorised at a later date following investigation.

*Table 4: Cause of deaths in custody by setting, 2016-2019*

Cause	Number of deaths			
	2016	2017	2018	2019
<b>Prison</b>				
Natural	206	192	168	168
External	22	27	48	12
Awaiting classification	2	3	17	36
<b>MHA</b>				
Natural	202	169	150	96
External	43	32	31	21
Awaiting classification	13	11	23	95
<b>Police</b>				
Natural	5	6	4	9
External	7	13	14	8
Awaiting classification	0	0	0	3
<b>IRC</b>				
Natural	0	1	1	1
External	1	3	0	0
Awaiting classification	0	0	0	0

*Table 5: Deaths in custody by cause for all settings, 2016-2019*

Cause	Number and (% of total deaths)				Total
	2016	2017	2018	2019	
<b>Natural</b>	408 (63)	360 (67)	310 (56)	257 (49)	1336 (59)
<b>Self-inflicted</b>	152 (24)	98 (18)	113 (20)	95 (18)	457 (20)
<b>Other natural</b>	48 (7)	54 (10)	72 (13)	20 (4)	195 (9)
<b>Restraint</b>	20 (3)	11 (2)	13 (2)	11 (2)	53 (2)
<b>Homicide</b>	3 (<1)	3 (<1)	4 (<1)	3 (<1)	13 (<1)
<b>Awaiting categorisation</b>	15 (2)	14 (3)	40 (7)	134 (26)	203 (9)

## Part 4: Deaths by age

17. More natural deaths ([Table 6](#)) occur in older detainees, with an average of 61% occurring in the over 60s over the four years, and almost 80% occurring in the over 50s.

18. For self-inflicted deaths, on average, 63% occur in those 40 and under, and 97% of deaths occurring in those under 60.<sup>10</sup>

*Table 6: Deaths in custody by age and cause for natural and self-inflicted causes, 2016-2019*

Cause of death	Numbers of deaths per year and % by cause							
	2016		2017		2018		2019	
Age group	Number	% of cause of death	Number	% of cause of death	Number	% of cause of death	Number	% of cause of death
<b>Natural</b>								
11-20	0	0	0	0	0	0	1	0
21-30	13	3	7	2	7	2	8	3
31-40	27	7	13	4	17	5	10	4
41-50	37	9	36	10	37	12	21	8
51-60	71	17	70	19	56	18	54	21
61-70	95	23	77	21	65	21	57	22
71-80	101	25	83	23	84	27	60	23
>80	54	13	66	18	42	14	33	13
Not stated	10	2	8	2	2	1	13	5
<b>Total</b>	<b>408</b>	<b>100</b>	<b>360</b>	<b>100</b>	<b>310</b>	<b>100</b>	<b>257</b>	<b>100</b>
<b>Self-inflicted</b>								
11-20	7	5	6	6	4	4	5	5
21-30	49	32	24	24	24	21	23	24
31-40	49	32	34	35	39	35	29	31
41-50	28	18	21	21	22	20	22	23
51-60	15	10	11	11	18	16	14	15
61-70	3	2	2	2	4	4	2	2
71-80	0	0	0	0	1	1	0	0
>80	1	1	0	0	1	1	0	0
<b>Total</b>	<b>152</b>	<b>100</b>	<b>98</b>	<b>100</b>	<b>113</b>	<b>100</b>	<b>95</b>	<b>100</b>

<sup>10</sup> Data on deaths in all settings, stratified by age, was available for natural and self-inflicted deaths.

## Part 5: Deaths by ethnicity

19. The majority of deaths occur in people of white ethnicity across all settings, for both males and females ([Table 7](#)). The completeness of ethnicity data varied by setting.
20. There was a large amount of missing data on ethnicity in people detained in hospitals under the MHA. For example, half of females dying in 2019 whilst detained under the Mental Health Act did not have their ethnicity recorded. This large proportion of missing data has the potential to obscure the underlying pattern of deaths by ethnicity, particularly if the data is not missing at random. In contrast, the data collected by prisons is more complete. The numbers of deaths occurring in or following custody or in IRCs are few, with largely complete ethnicity data.

*Table 7: Number of deaths in custody in England and Wales by ethnicity 2016-2019*

Setting	Numbers of deaths per year			
	2016	2017	2018	2019
<b>Prison (total)</b>	354	295	325	300
White	313	268	283	262
Black	20	9	18	14
Asian	14	10	11	12
Mixed	6	6	3	7
Other	0	2	3	3
Not stated	1	0	7	2
<b>MHA (total)</b>	268	224	216	210
White	192	100	133	106
Black	20	6	9	6
Asian	7	4	3	8
Mixed	2	2	1	1
Other	2	2	2	4
Not stated	45	110	68	85
<b>Police (total)</b>	12	19	18	20
White	9	14	15	16
Black	2	4	3	3
Asian	0	0	0	0
Mixed	1	0	0	0
Other	0	1	0	0
Not stated	0	0	0	1
<b>IRC (total)</b>	1	4	1	1
White	0	2	0	0
Black	0	0	0	1
Asian	0	1	0	0
Mixed	0	0	0	0
Other	1	1	1	0
Not stated	0	0	0	0

## Annex: Notes on methodology

21. The data used in this report was provided to the IAPDC by the different custodial sectors, and is produced with the permission of the following organisations:

- Her Majesty Prison and Probation Service (HMPPS) – for data on adult estates, YOIs and residents of Approved Premises.
- Care Quality Commission (CQC) – for data on those detained under the MHA.
- Independent Office for Police Conduct (IOPC) – for data on deaths in police custody.
- Home Office – for data from the Immigration Removal Centres.

22. Data on deaths in custody are collated annually by the IAPDC. To calculate an estimated mortality rate, data on the population at risk was sourced from the relevant governmental departments as detailed below.

### Community

23. Community rates for those aged 30-34 are provided as a comparator to custody deaths by the Office for National Statistics (ONS). This age range was deemed a suitable comparator to the custody population.

### Prisons

24. The Ministry of Justice publishes monthly and annual estimates of the prison population of England and Wales, which provides a snapshot of the number of remand and sentenced prisoners on 31 March and can be used as an approximation for the population of interest and necessary to calculate mortality rates.<sup>11</sup> Whilst this denominator can be compared across years and some other countries, it may underestimate the annual population if there is a high degree of churn among prisoners, driven by those on remand or with short sentences.

### Hospitals

25. In England, the Care Quality Commission (CQC) mandates each national and independent healthcare provider to report on deaths and the numbers of people detained subject to the MHA. The population of people detained in hospital under the MHA in England is generated from a census taken on the 31<sup>st</sup> March each year and published annually.<sup>12</sup> This census is subject to the same limitations as the above prison census. In 2016, the CQC introduced a new method of collating these data based on automatic returns. This made the data more reliable but less comprehensive, especially among independent sector hospitals, and there was a reduction of 23% of detained persons in 2017-2019, compared with the average over 2016. To account for these missing hospital patients, we added this 23% to the recent population of people detained to provide a more accurate denominator.

26. This reported rate based on annual numbers of people detained does not take into account their length of detention, so is not comparable with other settings. One alternative is to use average (median) length of detention under the MHA, which was 27 days, but this does not account for differential mortality hazards during a period of detention.

### Police

27. A death in police custody is defined as a death that happens while a person is being arrested or is taken into detention. It includes deaths of people who have been arrested or have been

---

<sup>11</sup> Her Majesty Prison and Probation Service, *Prison Population Statistics*, 2016-2020. Available at: [Prison population statistics - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/statistics/prison-population-statistics)

<sup>12</sup> Care and Quality Commission, *Monitoring the Mental Health Act*, 2020. Available at: [Monitoring the Mental Health Act in 2019/20: The Mental Health Act in the coronavirus \(COVID-19\) pandemic | Care Quality Commission \(cqc.org.uk\)](https://www.cqc.org.uk/publications/monitoring-the-mental-health-act-in-2019-20-the-mental-health-act-in-the-coronavirus-covid-19-pandemic)

detained by police for up to 36 hours under Section 136 of the Mental Health Act 1983.<sup>13</sup> It excludes deaths from road traffic accidents. Other countries may include road traffic accidents, such as during a pursuit, within their official statistics.

28. The population of interest can be defined as the arrestee population, or number of people detained by the police per year. This population is comprised of people arrested for notifiable offences and those detained under Section 136 of the MHA, for which there are official statistics, and the people arrested for non-notifiable offences, for which routine data is not collected. Notifiable offences are defined as offences which constitutes a crime under UK law and must be notified to the Home Office for the inclusion in official crime statistics. Non-notifiable offences are all other arrests, such as those for civil disobedience and minor driving offences.
29. Previous research shows that an estimated 66% of all detentions in England are due to notifiable offences<sup>14</sup>, with the remainder being made up of non-notifiable offenses and detentions under the MHA.<sup>15</sup> This proportion has proven stable over time, and so we have assigned a fixed proportion of 34% of all arrest as due to non-notifiable offences and detentions under the MHA.
30. This approach does not lend itself to comparisons with other detained settings as the duration of detention is not accounted for. At the same time, it provides a consistent and reliable way to estimate mortality rates over time in police custody. To address this, we also present estimates for mortality rates based on deaths per day at risk, in addition to rates based on deaths per year at risk, which assumes the average length of detention is one day.

#### Immigration Removal Centres

31. Data on deaths and populations in IRCs are for the UK. The Migration Observatory based at the University of Oxford publishes the numbers of people detained in UK IRCs based on Home Office Data. We used these figures as an estimate for the underlying population.<sup>16</sup>
32. The number of deaths occurring in individuals detained in IRCs were rarely more than one per year over 2016-2019. Assuming the number of people in IRCs does not change within any given year, then the estimate rate may be comparable to prisons, but not to police and hospital settings.

---

<sup>13</sup> Independent Office for Police Conduct, *Deaths during or following police contact: Statistics for England and Wales 2019/20*, October 2020. Available at: Page 2 [IOPC - Deaths during or following police contact: Statistics for England and Wales 2019/20 \(policeconduct.gov.uk\)](#)

<sup>14</sup> Lindon G, Roe S. *Deaths in police custody: A review of the international evidence*: Home Office London; 2017.

<sup>15</sup> Bucke T, Teers R, Menin S, Payne-James J, Stark M. *Near misses in police custody: a collaborative study with forensic medical examiners in London*. IPCC 2008

<sup>16</sup> Silverman S, Griffiths M, Walsh P. *Briefing: Immigration Detention in the UK*. Oxford: The Migration Observatory at the University of Oxford, 2020.

## About the Independent Advisory Panel on Deaths in Custody

The Ministerial Council on Deaths in Custody (MCDC) formally commenced operation on 1 April 2009 and is jointly sponsored by the Ministry of Justice, the Department of Health and Social Care and the Home Office. The Council consists of three tiers:

- Ministerial Board on Deaths in Custody (MBDC)
- Independent Advisory Panel (IAPDC)
- Practitioner and Stakeholder Group (PSG)

The remit of the IAPDC (and overall of the Council) covers deaths, natural and self-inflicted, which occur in prisons, in or following police custody, immigration detention, the deaths of residents of approved premises and the deaths of those detained under the Mental Health Act (MHA) in hospital. The principles and lessons learned as part of this work also apply to the deaths of those detained under the Mental Capacity Act in hospital.

The role of the IAPDC, an advisory non-departmental public body, is to provide independent advice and expertise to Ministers, senior officials and the Ministerial Board. It provides guidance on policy and best practice across sectors and makes recommendations to Ministers and operational services. It assists Ministers to meet their human rights obligations to protect life. The IAPDC's aim is to bring about a continuing and sustained reduction in the number and rate of deaths in all forms of state custody in England and Wales.

Juliet Lyon CBE chairs the IAPDC. The other members are:

- John Wadham, Chair, National Preventative Mechanism
- Jenny Talbot OBE, Prison Reform Trust
- Professor Jenny Shaw, Professor of Forensic Psychiatry, University of Manchester
- Professor Seena Fazel, Professor of Forensic Psychiatry, University of Oxford
- Deborah Coles, Director, INQUEST

Further information on the IAPDC can be found on its website:

<https://www.iapondeathsincustody.org>.

For more information on this paper – or on the IAPDC more generally - please contact: Piers Barber, Head of Secretariat ([Piers.Barber1@justice.gov.uk](mailto:Piers.Barber1@justice.gov.uk)).