

HE Briefing

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MURDER, MANSLAUGHTER & INFANTICIDE

During the last fifteen years the rate of homicides (which comprise all cases of murder, manslaughter and infanticide) occurring in England and Wales has doubled, as is shown in Figure 1. Analysis of the ages of victims shows that the homicide rate is rising most rapidly amongst males in or around their twenties, over 15 per million of whom are now killed as a result of the deliberate acts of other persons each year.

Table 1 gives a breakdown of the specific causes of homicide deaths recorded in the Registrar General's Statistical Reviews since 1950 and Figure 2 illustrates the proportional distribution of the methods used in killings recorded by the police as homicides in 1974. The figures indicate a significant rise in the numbers of homicides committed with knives or other sharp instruments over the past two decades.

About one in every three of all male homicide victims were killed by stabbing in the first half of the 1970's as opposed to only one in every seven in the 1950's. By contrast poisoning, which was about as frequent as stabbing in the 1950's, now accounts for one in every 50 homicides. Killings by firearms and explosives have accounted for an approximately constant proportion of all homicides in England and Wales since the 1950's, at about one in every ten (although this proportion rose in 1974). Strangulation was on average involved in around one in six homicides in England and Wales in the early 1970's and in about one in three of all such deaths amongst females.

Historical and international comparisons

Despite the recent increases in homicide rates in England and Wales they are still relatively low by national historical and current international standards. For example, the mean rates for England and Wales for the decades 1900-09 and 1930-39 were 9.1 and 8.9 per million respectively, that is approximately equivalent to those prevailing in 1973. And the Registrar General's figures for the year 1874 show a total of 409 homicides, implying a crude rate some 30 per cent above the 1974 figures.¹

Figure 3 compares international rates of homicide for the year 1972. It shows that those for England and Wales compare favourably with the figures for most equivalent, economically developed, nations. As regards the remainder of the United Kingdom it is to be noted that the homicide rate in Northern Ireland for males was by 1972 by far the highest in Europe (about 500 per million males aged over 15) compared with 1965 when it was one of the lowest. However, throughout the period the homicide rate for women remained relatively low. It is also of note that even in 1972 the overall crude homicide rate in Northern Ireland was somewhat below that for certain cities in the United States of America.

Figure 4 provides a breakdown of homicide rates in America between 1940 and 1973. It shows that they are particularly high amongst non-white males,² amongst whom a peak homicide rate of over 1500 per million for those in their late 20's and early 30's was recorded in 1973, 100 times the highest (non infant) age specific English rate in the same year. In the early 1970's US cities like St Louis, Cleveland and Detroit had overall homicide rates 50 times higher than those in the UK.

One reason often given for the high numbers of murders and manslaughters in the United States is the easy availability of firearms, which in 1973 accounted (together with explosives) for the deaths of just over 67 per cent of the total of 20,465 recorded victims.³ But the strong correlation with racial and linked socio-economic variables suggest that the underlying determinants of the homicide rate relate to particular cultural factors.

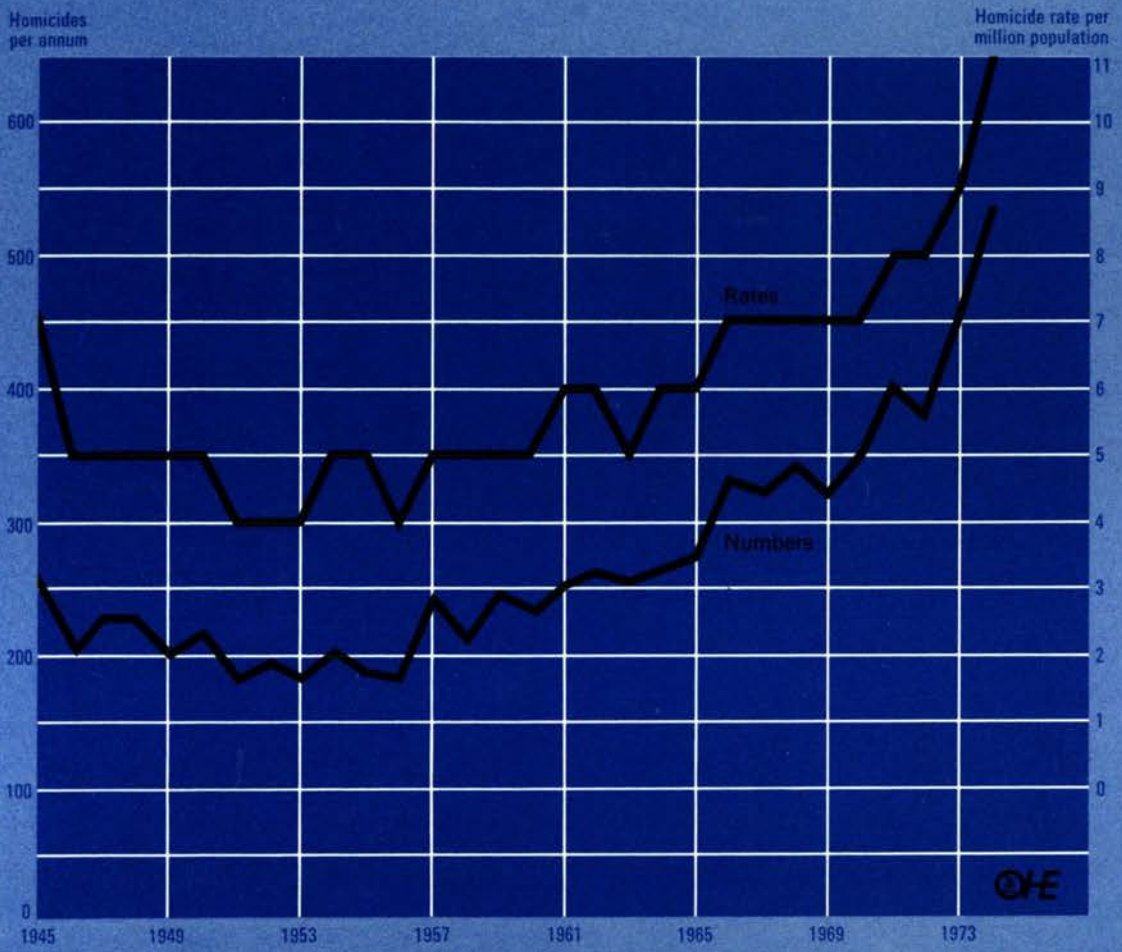
From a sociological viewpoint it is interesting to note that the available international figures suggest that there may in some circumstances be an inverse relationship between homicide rates and suicide rates, although some countries (like Spain) appear low on both scales and others (like Hungary and Bulgaria) high. However, the comparability and detail of much of the available information may be questioned. For example, crude data indicates that the US is high on both scores but more detailed analysis shows that the black American

¹It should be remembered also that in Victorian Britain the infanticide rate was probably grossly under reported.

²Classification based on US Health Education and Welfare Department Statistics. Includes Negroes (90 per cent), American Indians, Chinese and Japanese.

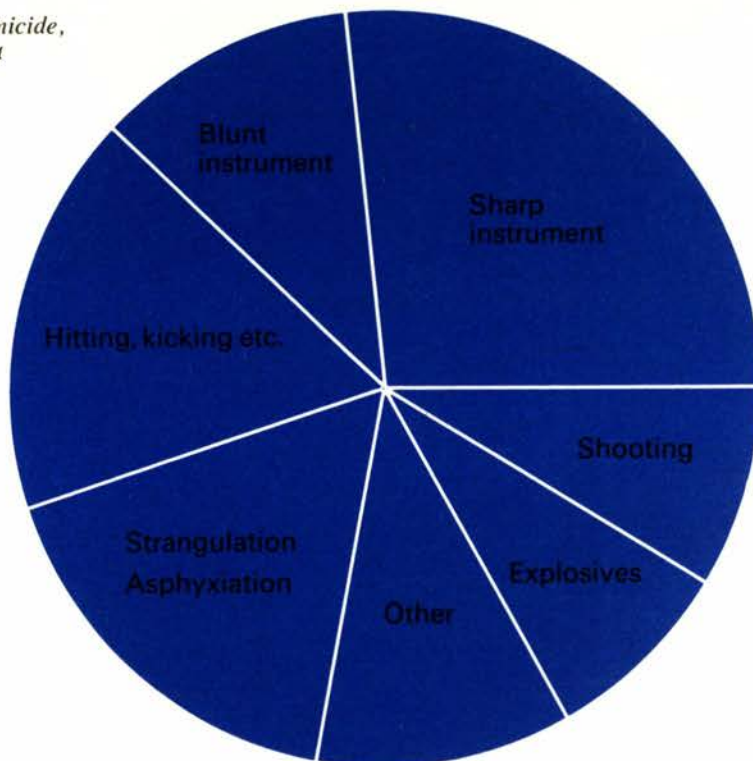
³Included in this number are 376 deaths resulting from police action.

Figure 1 Homicide in England and Wales 1945-74



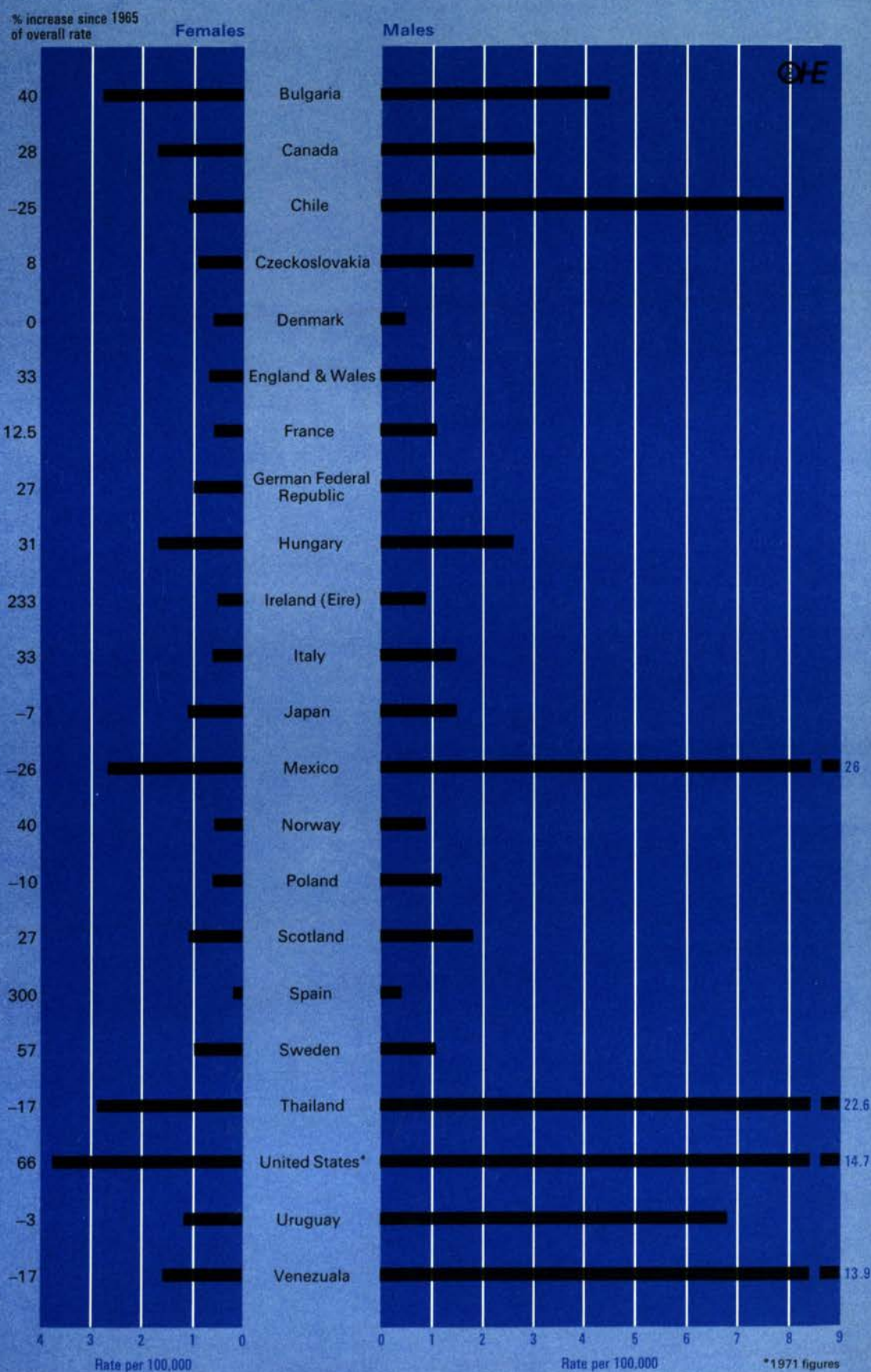
Sources Registrar General Cmnd 6168 (1974 figures)

Figure 2 Methods of homicide, England and Wales 1974



Source Cmnd 6168

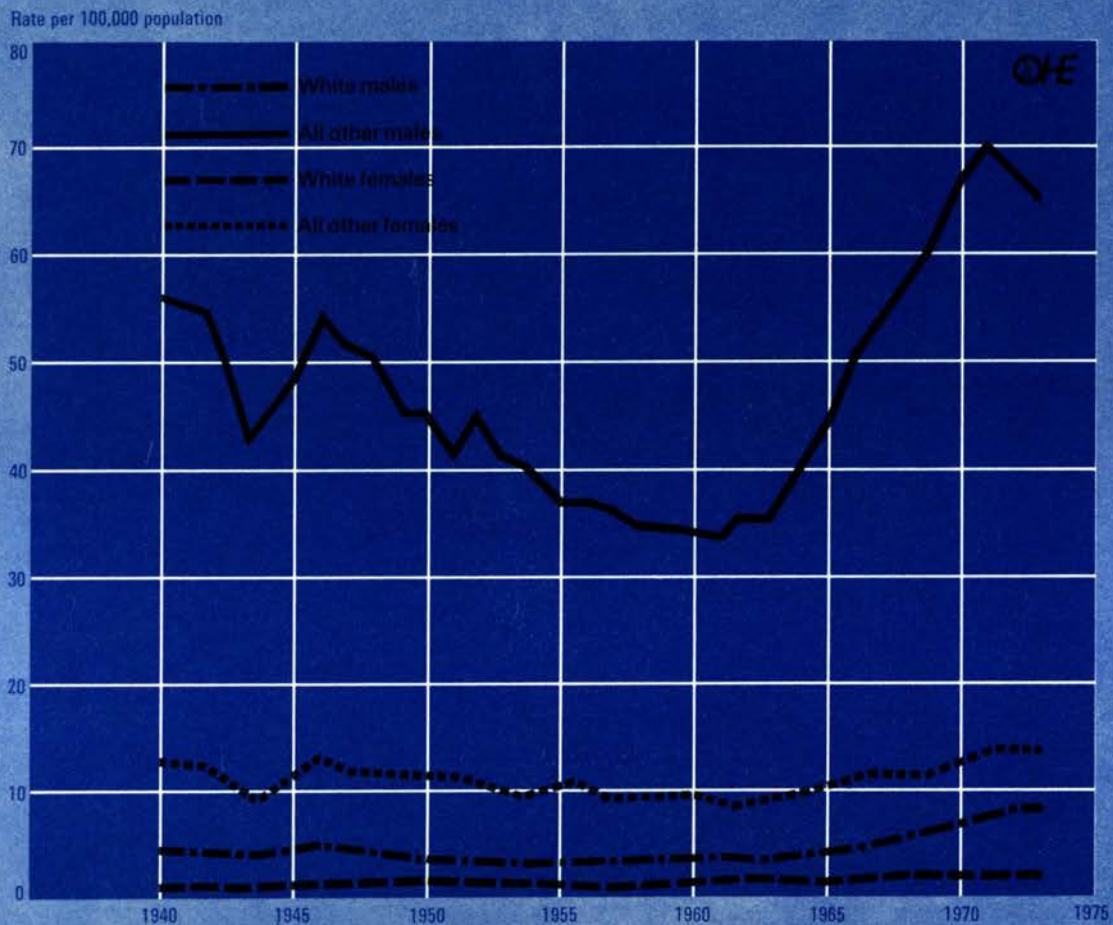
Figure 3 International homicide rates in 1972



Notes Rates may not be fully comparable because of legal variations in the definition of manslaughter and the exclusion of infanticide figures in some countries.

Source WHO 1975.

Figure 4 Homicide rates, by colour and sex United States 1940-73



Source US National Centre for Health Statistics

population markedly undercontributes to the total of suicides just as it overcontributes to that of homicides. Detailed analysis of socio-economic and associated groupings is therefore needed before the situation in specific communities can be adequately understood.

Another important aspect of the international information on homicide is that in most European countries the greatest risk of dying as a result of such a cause occurs in the first year of life. In England and Wales the infanticide rate currently stands at around 60 per million live born children, which is approximately the Western European average. However, in some countries, such as Hungary, rates as high as 240 per million were reported to the WHO in 1972.

The reasons for the occurrence of infanticide are complex although it is probable that an important factor determining the rates in modern societies are the population policies adopted (including variables such as tax structures and the availability of abortion). Changes in this, such as a reduction in access to the termination of pregnancy in a community like that of England which has to some extent come to expect such services, could have a significant effect on the infanticide rate.

Policy implications

The recent increases in homicide rates in Britain come at a time when the recorded rates of violent crime of all types are rising. Between 1971 and 1974 the number of offences recorded by the police under the category of 'violence against the person' increased by one third.

However, a close examination of the available statistics shows that homicides differ from the commonly assumed

pattern of crime in a number of important respects. For example, British and American figures suggest that there is likely to be a fairly close identity between those who commit homicide and their victims both in age and cultural background. And the latest Home Office report on Criminal Statistics suggests that approaching 60 per cent of all homicides occur within families or between lovers, as shown in Figure 5. With regard to similar statistics relating to the last decade of the nineteenth century it was commented (by Sir John Macdonell) that 'murder is not generally the crime of the so called criminal classes—in most cases it is an incident in miserable lives'. The implication of this insight is that homicides rates may be as significant or stronger an indicator of certain forms of social stress and distress as are those of suicide.

Thus the recent rises in British murder and manslaughter figures should be seen with concern by those agencies directly involved with the physical and mental health of the population.⁴ Rather than reflecting any general degeneration of 'law and order' within society they show the relative lack of ability of people within certain social subgroups to control their feelings of hostility and aggression in their daily lives, in part perhaps because of

⁴ In sociological terms the activities of health and welfare agencies are comparable with those of the institutions of law enforcement in as much as they frequently represent a process of social control. It may therefore be appropriate that the former agencies should become more concerned to see certain forms of crime in health terms. Although 'medicalising' sanctions against criminal acts could have its dangers greater awareness of health related variables could also help to 'humanise' the treatment of criminal offenders and deviant sub-groups.

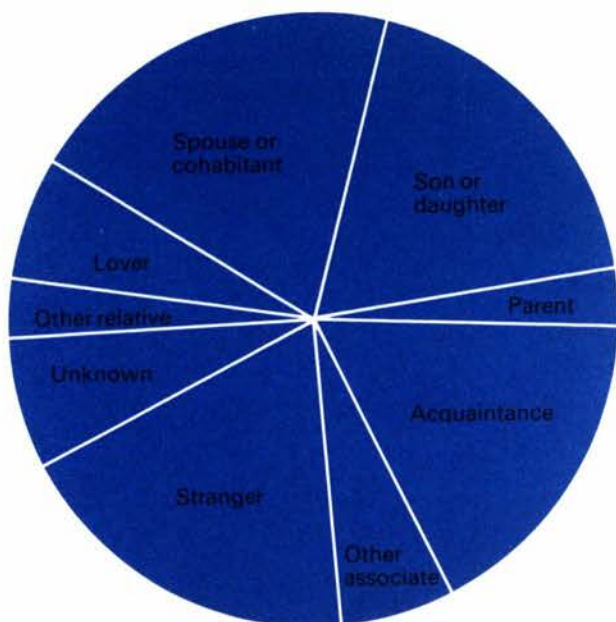
Table 1 Homicide deaths 1950-74 (England and Wales)

		1950	51	52	53	54	55	56	57	58	59	60	61	62
Homicide and injury purposely inflicted by other persons (total)	M	107	99	102	83	97	101	90	116	108	103	123	150	123
	F	107	83	93	98	104	84	91	127	102	142	108	105	138
<i>Methods and circumstances</i>														
Fight, brawl, rape	M	* ²	*	*	*	*	*	*	*	*	*	*	*	*
	F													
Poisoning	M	7	5	17	10	14	13	21	24	11	9	11	12	17
	F	8	10	12	14	23	11	14	29	15	26	11	11	14
Hanging and strangulation	M	*	*	*	*	*	*	*	*	*	*	*	*	*
	F													
Submersion (drowning)	M	*	*	*	*	*	*	*	*	*	*	*	*	4
	F													4
Firearms and explosives	M	13	3	10	9	15	6	10	14	4	7	9	14	14
	F	11	13	9	10	8	4	10	13	11	13	10	6	15
Cutting and piercing instruments	M	7	3	12	9	10	12	10	17	19	17	25	29	20
	F	17	8	18	18	16	17	15	19	14	22	20	26	20
Other	M	51	73	40	43	44	59	49	59	70	64	75	88	50
	F	77	52	54	55	56	51	52	66	62	81	67	62	49
Late effects of injuries purposely inflicted by others	M	*	*	*	*	*	*	*	*	*	*	*	*	*
	F													
Legal interventions, executions ¹	M	18	15	23	32	14	11	—	2	4	6	3	7	3
	F	1	—	—	1	1	1	—	—	—	—	—	—	—

Notes 1. Post 1962 figures exclude deaths from legal intervention in total homicides.
 2. * indicates figures not available.
 3. All 1974 figures provisional.

Sources Registrar General's Statistical Reviews for England and Wales.
 Criminal Statistics in England and Wales (1974).

Figure 5 Relationship of homicide victim to principal subject, England and Wales 1974



Source Cmnd 6168

particular strains placed upon them and in part because of particular attitudes and beliefs affecting various forms of social skill and understanding.

Hence homicide statistics deserve more detailed attention than they currently receive. It is unfortunate, for example, that no full account of the distribution of the socio-economic backgrounds of homicide victims in Britain can be derived from currently published government statistics. Such an analysis could help to dispel false assumptions about who are the most 'at risk' groups in the community and could help to clarify the problems faced by the subgroups amongst which phenomena such as murder occur most frequently. It might also cast further light onto possibly related subjects, such as suicide and certain forms of psychiatric disorder, which impose heavy burdens on society in addition to the obvious costs associated with the loss of around 500 lives each year due to homicide.

References

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 Public Health Reports, 90, 3, P 195-204.
 Registrar General's Statistical Reviews. Various years 1874-1973.
 World Health Annuals 1965 and 1972. World Health Organisation.

63	64	65	66	67	68	69	70	71	72	73	74
128	128	147	178	168	178	159	197	213	205	246	} 535 ³
127	136	129	152	157	166	161	152	191	179	201	
*	*	*	*	6	17	13	10	7	3	11	*
				-	2	1	1	-	-	-	
19	15	14	13	10	9	3	2	3	5	3	*
11	14	8	13	15	16	10	7	2	2	6	
*	*	*	*	9	23	17	20	19	11	14	} 93
				37	50	43	56	66	52	58	
4	4	4	5	5	1	2	7	1	6	7	*
4	4	4	5	5	5	3	7	3	5	10	
13	10	13	21	27	19	14	15	20	27	18	} 88
12	10	11	6	21	19	9	6	15	14	19	
30	36	45	47	44	42	43	69	81	67	88	} 146
22	26	26	32	24	28	29	25	41	30	41	
47	46	54	69	65	66	67	73	81	83	103	*
45	47	46	55	55	46	65	50	64	75	66	
*	*	*	*	2	1	-	1	1	3	2	*
				-	-	1	-	-	1	-	
2	2	-	-	3	-	-	1	-	-	1	*
-	-	-	-	2	-	-	-	-	-	-	

Office of Health Economics

The Office of Health Economics was founded in 1962 by the Association of the British Pharmaceutical Industry.

Its terms of reference are:

To undertake research on the economic aspects of medical care.

To investigate other health and social problems.

To collect data from other countries.

To publish results, data and conclusions relevant to the above.

The Office of Health Economics welcomes financial support and discussions on research problems with any persons or bodies interested in its work.