



> Deaths during or following police contact:

Statistics for England and Wales
2018/19

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National statistics

The UK Statistics Authority has designated these statistics as National Statistics, in accordance with the Statistics and Registration Service Act 2007. This shows compliance with the Code of Practice for Official Statistics.

Designation means that the statistics:

- > meet identified user needs
- > are well explained and readily accessible
- > are produced according to sound methods
- > are managed impartially and objectively in the public interest

When statistics are designated as National Statistics it is a statutory requirement that the [Code of Practice](#) is followed.

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1

Introduction

This report presents figures on deaths during or following police contact that happened between 1 April 2018 and 31 March 2019. It provides a definitive set of figures for England and Wales, and an overview of the nature and circumstances in which these deaths occurred.

This publication is the fifteenth in a series of statistical reports on this subject, published annually by the IOPC, formerly the Independent Police Complaints Commission (IPCC). On 8 January 2018, the IPCC became the IOPC. This change was set out in the Policing and Crime Act 2017¹.

To produce these statistics, we examine the circumstances of all deaths that are referred to us. We decide whether the deaths meet the criteria for inclusion in this report under one of the following categories:

- > road traffic fatalities
- > fatal shootings
- > deaths in or following police custody
- > apparent suicides following police custody
- > other deaths following police contact that were subject to an independent investigation

[Box A](#) on page 2 provides a definition for each of these categories. For more detailed definitions please see the [guidance document](#) on the IOPC website. Further supporting information about the report can be found in the [background note](#).

¹ Find out more about becoming the IOPC on our [website](#).



Box A Definitions of the categories of deaths during or following police contact

For more detailed definitions and for information about how the death cases are categorised and recorded please see the [guidance document](#) on our website.

In this report the term 'police' includes police civilians, police officers and staff from the other organisations under IOPC jurisdiction². Deaths of police personnel or incidents that involve off-duty police personnel are not included in the statistics in this report.

Road traffic fatalities includes deaths of motorists, cyclists or pedestrians arising from police pursuits, police vehicles responding to emergency calls and other police traffic-related activity.

This does not include:

- > deaths following a road traffic incident (RTI) where the police have attended immediately after the event as an emergency service

Fatal shootings includes fatalities where police officers fired the fatal shot using a conventional firearm.

Deaths in or following police custody includes deaths that happen while a person is being arrested or taken into detention. It includes deaths of people who have been arrested or have been detained by police under the Mental Health Act 1983. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

This includes deaths that happen:

- > during or following police custody where injuries that contributed to the death happened during the period of detention
- > in or on the way to hospital (or other medical premises) during or following transfer from scene of arrest or police custody
- > as a result of injuries or other medical problems that are identified or that develop while a person is in custody
- > while a person is in police custody having been detained under Section 136 of the Mental Health Act 1983 or other related legislation

This does not include:

- > suicides that occur after a person has been released from police custody
- > deaths that happen where the police are called to help medical staff to restrain individuals who are not under arrest

Apparent suicides following police custody includes apparent suicides that happen within two days of release from police custody. This category also includes apparent suicides that occur beyond two days of release from custody, where the time spent in custody may be relevant to the death.

Other deaths following police contact includes deaths that follow contact with the police, either directly or indirectly, that did not involve arrest or detention under the *Mental Health Act 1983* and were subject to an independent investigation. An independent investigation is determined by the IOPC for the most serious incidents that cause the greatest level of public concern, have the greatest potential to impact on communities, or that have serious implications for the reputation of the police service. Since 2010/11, this category has included only deaths that have been subject to an independent investigation. This is to improve consistency in the reporting of these deaths.

This may include deaths that happen:

- > after the police are called to attend a domestic incident that results in a fatality
- > while a person is actively attempting to avoid arrest; this includes instances where the death is self-inflicted
- > when the police attend a siege situation, including where a person kills themselves or someone else
- > after the police have been contacted following concerns about a person's welfare and there is concern about the nature of the police response
- > where the police are called to help medical staff to restrain individuals who are not under arrest

² See [background note 2](#).



2

Overall findings

In 2018/19, In each category there were:

- > **42** road traffic fatalities
- > **three** fatal police shootings
- > **16** deaths in or following police custody
- > **63** apparent suicides following police custody
- > **152** other deaths following police contact that were independently investigated

Demographic information about those who died is presented in the following chapters, along with details about the circumstances of the deaths and a summary of trend data. The appendix contains additional information such as the age, gender and ethnicity of those who died, and information about the police force or appropriate authority³ involved.

Some of the investigations into the deaths recorded in this report are ongoing at the time of publication. Details about the nature and circumstances of these cases are therefore based on information available at the point of analysis.

Investigations

When we are told about a fatality, we consider the circumstances of the case and decide whether to investigate independently, or to manage or supervise a police investigation. In some circumstances, we decide that the local police force professional standards department (PSD)⁴ or other equivalent department is best placed to investigate a case.

[Box B](#) on page 7 has a description of each type of investigation.

³ The appropriate authority is usually a police force's chief officer or police and crime commissioner.

⁴ Each force has a professional standards department, which oversees complaints.

Table 2.1 Incidents by type of death and investigation type, 2018/19

Type of investigation	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Independent	31	3	15	6	147
Managed	0	0	0	0	0
Supervised	0	0	0	0	0
Local	1	0	1	48	0
Back to force	1	0	0	9	0
Total incidents	33	3	16	63	147

Note: Investigation type as recorded on the IOPC case system at the time of analysis.

* This category includes only cases subject to an independent investigation.

Table 2.1 shows the type of investigation at the time of analysis for all incidents involving a fatality recorded in 2018/19. The figures show the number of incidents; an incident leading to a single investigation can involve more than one death and so the totals for some categories may be lower than the total fatalities presented above. In total, 202 incidents were independently investigated. Across all death categories, and as in recent years, no incidents were subject to a managed or supervised investigation.

Trends

The figures presented in Table 2.2 show the number of fatalities across the different categories since 2008/09. It would not be meaningful to produce trend analysis across all five categories. This is because of the wide variation in the circumstances and changes to how the category of 'other deaths following police contact' is defined.

Table 2.2 Fatalities by type of death and financial year, 2008/09 to 2018/19

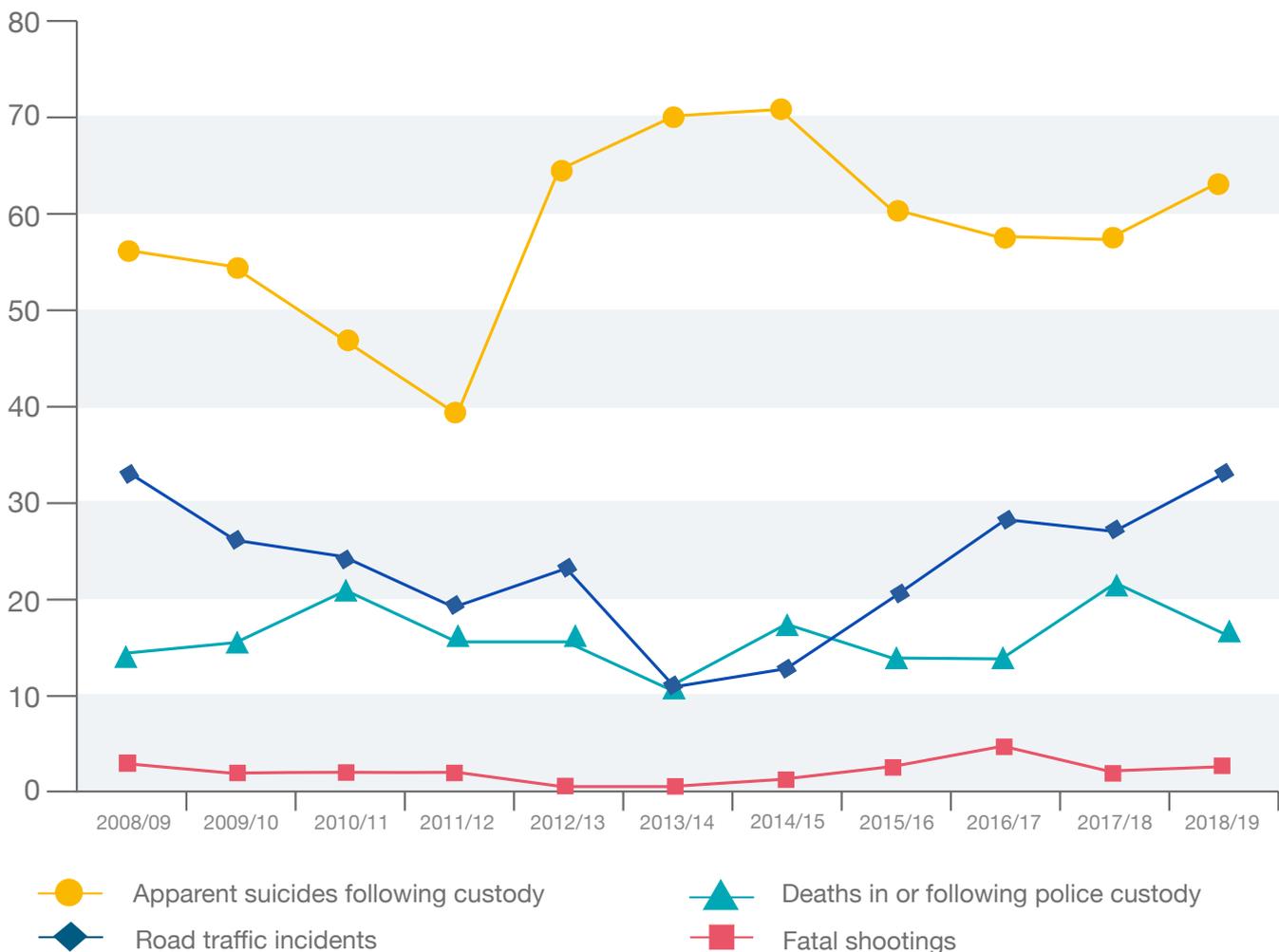
Category	Fatalities										
	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Road traffic fatalities	40	29	26	19	31	12	14	21	32	29	42
Fatal shootings	3	2	2	2	0	0	1	3	6	4	3
Deaths in or following police custody	15	17	21	15	15	11	18	14	14	23	16
Apparent suicides following custody	56	54	46	39	65	70	71	60	57	57	63
Other deaths following police contact*	35	39	57*	47	22	44	43	105**	132	175~	152

* Change in definition of 'other deaths following contact' in 2010/11 to include only cases subject to an independent investigation.

** Expansion of IOPC investigative resource and capacity to carry out more independent investigations into serious and sensitive matters – this has a direct impact on the number of 'other contact deaths' that are reported.

~ This table presents the most up-to-date set of figures for these categories; any changes to previously published data are indicated.

Figure 2.1 Incidents by type of death and financial year, 2008/09 to 2018/19



The number of fatal **road traffic incidents** (RTIs) has increased this year from 27 to 33. While this figure has fluctuated over the past 11 years, this year's figure represents the joint highest number of RTIs recorded since 2008/09.

This year there were three fatal **police shootings**, compared to four recorded last year. This is the third highest figure recorded since 2008/09. The number of **deaths in or following police custody** has decreased to 16 following a ten-year high of 23 deaths last year. There have been some fluctuations in this category over time, with notable increases recorded in 2010/11, 2014/15 and 2017/18. The figure is in-line with the average over the 11-year period.

The number of recorded **apparent suicides following custody** was 63, an increase on the figures recorded in the previous three years. The number of deaths in this category remains higher than the average number recorded over the years before 2012/13, when there was a notable increase. Reporting of these deaths relies on police forces making the link between someone's apparent suicide and the person having been in custody recently. The overall increase in these deaths over the 11-year period may be influenced by improved identification and referral of such cases.

The category of '**other deaths following police contact**' is not included in Figure 2.1. The inclusion of a death in this category depends on whether we decide to open an independent investigation into the circumstances surrounding it. The criteria for making this decision may vary over time

– for example, in response to current public and community concerns. In addition, there has been an increase in our capacity to carry out independent investigations⁵. This has had a direct impact on the number of deaths reported on in this category. Therefore, trend analysis of deaths recorded in this category would not be meaningful.

Figures on all fatal incidents (as distinct from fatalities) are provided in Table A1 in the [appendix](#). There is further data in the appendix on:

- > ethnicity
- > age
- > gender
- > police force
- > category of death

Data since 2004/05, when this data was first published, is on our [website](#).

⁵ See our [Corporate Plan 2015–18](#) and [Strategic Plan 2018-2022](#) for more information.



Box B Type of investigation

Independent investigations are carried out by the IOPC's own investigators. In an independent investigation, IOPC investigators have all the powers of the police.

Managed investigations are carried out by the police, usually by the force's PSD under the direction and control of the IOPC.

Supervised investigations are carried out by police PSDs, under their own direction and control. The IOPC will set the terms of reference for a supervised investigation and receive the investigation report when it is complete. There is a right of

appeal to the IOPC at the end of a supervised investigation.

Local investigations are carried out by police officers when the IOPC decides that the force has the necessary resources and experience to carry out an investigation.

Referred back to force are cases where the IOPC has reviewed the circumstances and returned the matter back to the police force to be dealt with as it considers appropriate.



3

Road traffic fatalities

Demographics

In 2018/19, there were 33 fatal police-related road traffic incidents (RTIs), resulting in 42 fatalities. Of these, 27 people were men and 15 were women. Thirty-one people were reported to be White. Nine people were Asian, one was Black and one was of Mixed heritage.

Twenty-two of the people who died were aged between 18 and 30 and eight were aged over 60. The eldest was 93. The average age was 36. The average decreases to 29 if the deceased was the driver or passenger in a pursued or fleeing vehicle. It increases to 48 if the deceased was a pedestrian, cyclist or a driver or passenger in a vehicle hit by either the police or a pursued or fleeing vehicle.

Circumstances of death

Incidents are classified as 'pursuit-related' if they involved a pursuit, or if they involved the police driving in the same direction as a suspect vehicle. Not all of these incidents will have entered an official pursuit phase as defined in the Authorised Professional Practice (APP) on police pursuits⁶. Incidents where there was a collision involving a vehicle that had recently been pursued by the police, but where the police had lost sight of the vehicle, are included. Incidents where the police are driving in the direction of a vehicle before obtaining permission to pursue are also included as pursuit-related.

⁶ See College of Policing (2015) [Authorised Professional Practice](#) on police pursuit. In 2011, the Association of Chief Police Officers (ACPO) issued guidance in a statutory code of practice for police pursuits. ACPO was replaced by the National Police Chiefs' Council (NPCC) in April 2015. [The College of Policing](#) now manages [Authorised Professional Practice](#).

Pursuit-related

There were 21 police pursuit-related incidents that resulted in 30 fatalities. Of these:

- > Twelve people were the driver of a vehicle being pursued by the police when it crashed. One of these people was riding a motorbike.
- > Eight people were passengers in the car being pursued by the police.
- > Seven people were the driver or passenger of an unrelated vehicle that was hit by the car being pursued by the police.
- > Three people were pedestrians who were hit by the pursued or suspect vehicle.

All but one of the pursuit-related incidents were investigated independently by the IOPC.

Emergency response-related

This category includes all incidents that involve a police vehicle responding to a request for emergency assistance. There were five emergency response-related incidents resulting in five fatalities. All of these incidents are being investigated independently. This number has decreased slightly from seven incidents and eight fatalities recorded last year. This year is the third highest number of incidents and fatalities recorded since 2004/05.

One fatality happened when a police car that was responding to an emergency call collided with another vehicle. In this incident, the police were driving an unmarked police car with its lights and sirens on. They were responding to a call to provide assistance to a suicidal man.

The call required an immediate response. The police attempted to overtake a car. As the police car was passing it, the car appeared to move into the path of the police vehicle. The police hit the rear of the car, forcing it onto the opposite carriageway where it overturned. The driver of the car was taken to hospital where he died.

Four fatalities involved police vehicles colliding with pedestrians while responding to an emergency call. The type of incidents the police were responding to included:

- > a domestic-related incident
- > a potential risk to the life of a young child
- > reports of a disturbance
- > assistance with a road safety hazard

Other police traffic activity

This category includes RTIs that did not happen during pursuit-related activity or an emergency response. There were seven incidents resulting in seven fatalities. Six are being investigated independently. The remaining one is being dealt with locally by the police force.

Of these seven incidents, four happened when a vehicle responded to the presence of the police:

- > Officers on patrol in a marked vehicle saw a parked car. They approached the car to ask the driver to explain why it was there. As the officers approached the car on foot, the car drove off at speed. Shortly after, the officers found the car, which had collided

with a wall. The driver of the car was taken to hospital where he later died. The incident is being independently investigated.

- > Officers in an unmarked police vehicle fitted with emergency equipment saw a scooter carrying two people. The police stopped behind the vehicle to carry out some checks on it. The rider turned to look at the unmarked police vehicle and made-off at speed. The officers briefly activated their blue lights and sirens to indicate that the scooter should stop. The police did not attempt to pursue. The scooter continued down the road and collided with a pedestrian. She died at the scene. The incident was subject to an independent investigation.
- > Two officers were patrolling in an unmarked police vehicle that was fitted with automatic number plate recognition cameras. This identified that the owner of a nearby motorcycle had an outstanding arrest warrant. The officers pulled alongside the vehicle to speak to the rider who rode off, out of sight of the officers. The officers later came across a road traffic collision involving the motorcycle. The rider died at the scene. The incident was subject to an independent investigation.
- > Police officers were driving a marked vehicle with its lights and sirens on. They were responding to an incident that required an immediate response. A car pulled out into the path of the police vehicle. The vehicle responded to the presence of the police vehicle and made-off on the wrong side of the road. The officers later saw the same vehicle being driven in a dangerous manner before it collided into a wall. The passenger in the vehicle died at the scene. This case was dealt with locally by the police force.

The remaining three incidents happened while the police were on routine patrol or driving duties:

- > Officers in a marked police vehicle were taking a detainee to police custody when they received reports that a man was lying in the road. The officers then saw a car driving in front of them swerve unexpectedly. The police vehicle was unable to move in time and struck the man's legs. The police vehicle stopped immediately. One officer attempted to stop oncoming traffic. An ambulance that was on its way back to hospital, struck the head of the man lying in the road. He died at the scene. It is not known if the injuries caused by the police vehicle contributed to the man's death. The incident was subject to an independent investigation.
- > Officers were driving a marked police van on general patrol. A pedestrian, aged 93, appeared to fall in the road in very close proximity to the police van. Paramedics and a doctor attended the scene. She was taken to hospital where she later died. The independent investigation focused on whether there was any direct contact between the police vehicle and the pedestrian, and on the actions of the police driver.
- > Police were driving a marked vehicle when a car driving erratically on the wrong side of the road collided head on with the police vehicle. The driver of that vehicle was taken to hospital by air ambulance where she later died. The incident was subject to an independent investigation.

Trends

This year, 42 people died in 33 separate incidents. This is the highest number of fatalities recorded in the past ten years and the third highest recorded over the 15-year period since 2004/05, when these statistics were first published. These figures are subject to fluctuation and, therefore, year-on-year comparisons should be approached with caution.

Tables 3.1 and 3.2 set out of the type of road traffic fatalities and incidents over the past 11 years⁷. The tables show the incidents in the three categories previously described: pursuit-related, emergency response-related, and other police traffic activity.

This year there has been an increase in the number of pursuit-related incidents that resulted in multiple fatalities. Five of these incidents accounted for 14 fatalities. The number of fatalities is the second highest recorded since 2004/05, when these statistics were first published. The number of incidents is the fourth highest since 2004/05.

This year there has been a decrease in the number of emergency response-related incidents. It is the third highest number of emergency response incidents and fatalities recorded since 2004/05.

The number of incidents resulting from other police traffic activity has more than doubled compared to last year. It is similar to figures recorded four years ago, however it is almost half the number recorded in 2004/05.

⁷ Information on fatalities and incidents from 2004/05 is available in the time series tables on our [website](#).

Table 3.1 Type of road traffic fatality, 2008/09 to 2018/19

Fatalities											
RTI type	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Pursuit-related	22	19	13	12	27	10	7	13	28	17	30
Emergency response-related	6	3	4	2	2	0	0	2	0	8	5
Other	12	7	9	5	2	2	7	6	4	4	7
Total fatalities	40	29	26	19	31	12	14	21	32	29	42

Table 3.2 Type of road traffic incident, 2008/09 to 2018/19

Incidents											
RTI type	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Pursuit-related	16	17	13	12	19	9	6	12	24	17	21
Emergency response-related	6	3	3	2	2	0	0	2	0	7	5
Other	11	6	8	5	2	2	7	6	4	3	7
Total incidents	33	26	24	19	23	11	13	20	28	27	33



4

Fatal shootings

This year there were three fatal shootings by police. This figure is lower than the four fatalities recorded in 2017/18. The circumstances of the three fatal police shootings are described below. All three incidents are subject to ongoing independent investigations.

Armed officers from the Metropolitan Police Service responded to an incident where a white man, aged 38, was at the forecourt of a petrol station with a firearm. He had called the police earlier within the hour to indicate that he had taken an overdose, had a gun and would shoot if the police turned up. On arrival at the scene, two officers instructed the man to put down his firearm, but he did not comply with the instruction. He was shot twice, once by each officer. An ambulance attended and the man received medical attention, but died at the scene.

Officers from West Midlands Police Firearms Operations Unit attended an address in Coventry to execute a Section 8 PACE search warrant⁸. The police had authority to force entry. This was an intelligence-led policing operation. Officers forced entry at the front door of the address using a chainsaw. A short time later, a white man, aged 31, left the rear of the property where he was shot once by an armed police officer. He was given fast aid⁹ treatment by officers and paramedics but he died at the scene.

A firearms unit from West Midlands Police attended an address in Birmingham as part of an operation by the Public Protection Unit. This was in relation to alleged possession of a firearm and revenge pornography. They used a set of keys to enter the property and called out to notify

⁸ This gives police officers the power to enter a property where they believe that a criminal offence has occurred and an item in the property could be used as evidence in investigating the offence.

⁹ This is a bag containing specific medical equipment to treat gun-shot wounds and other serious injuries of a similar nature. The bag contains equipment to create a chest seal and a CPR mask.

occupants of their presence. Police spoke with a Black man, aged 52, but he did not come to the door. An officer fired a single shot, which struck the man. Officers applied first aid and an ambulance attended, but the man died at the scene. A non-police issue firearm was recovered from the scene.



5

Deaths in or following police custody

Demographics

Sixteen people died in or following being taken into police custody. Fourteen of these were men and two were women. Their ages ranged from 26 to 73 years. Fifteen people were White and one was Black.

Ten people were identified as having mental health concerns. The types of mental health concerns identified included bipolar, depression, anxiety and self-harm or suicidal tendencies.

Thirteen people were known to have a link to alcohol and/or drugs. This meant that at the time of their arrest they had recently consumed, were intoxicated

by, in possession of, or had known issues with alcohol and/or drugs. Where cause of death is known, a pathologist recorded that alcohol or drug toxicity, or long-term abuse, was likely to be a contributing factor in the deaths of eight people.

Table 5.1 shows the reasons why people were arrested or detained by the police. Four people were arrested for an alleged assault – of these, one man was also arrested for breach of the peace and drug offences, and another man also arrested for drug offences. A further two people were arrested for an offence relating to alcohol or drugs, with one person also being arrested for robbery. Two people were arrested for

criminal damage and theft; one of these was also arrested for breach of the peace. Other reasons for detention included; Section 136 of the Mental Health Act 1983¹⁰; harassment

or threatening behaviour; a sexual offence relating to images of children; and drink driving.

Table 5.1 Deaths in or following police custody: reason for detention, 2018/19

Reason for detention	Number of fatalities
Violence-related (non-sexual or murder)	4*
Drug / alcohol-related (excluding drink driving)	2**
Criminal damage and theft	2^
Breach of the peace / anti-social behaviour	2
Breach of bail / recall to prison	2
Mental Health Act 1983	1
Harassment / threatening behaviour	1
Sexual offence	1
Driving offences, including drink driving	1
Total fatalities	16

* One man was also arrested for drug offences and breach of the peace and another man for drug offences.

** One man was also arrested for robbery.

^ One man was also arrested for breach of the peace.

Six of the 16 people who died had some force used against them either by officers or members of the public before their deaths. It is important to note that the use of restraint, or other types of force, did not necessarily contribute to the deaths.

White. Three incidents also included these other methods of force:

- > a contamination hood¹²
- > incapacitant spray¹³

All six people were physically restrained¹¹ by the police or non-police, such as security staff or members of the public. All six people were

10 This power allows the police to remove a person from a public place, who appears to be suffering from a mental illness and needs immediate care or control, to a place of safety. A place of safety can be a hospital, mental health unit or hospital, a police station or any other suitable place.

11 The term 'restraint' refers to a range of actions, including physical holds and pressure compliance. It does not include the routine use of handcuffs, unless another use of restraint was also used.

12 A hood designed to cover the whole of the face made of thin, light fabric designed to allow the person to breathe easily while others are protected from their spitting or biting.

13 Two types of incapacitant spray are used by the police: PAVA and CS spray. They are used to incapacitate someone by irritating the skin, causing them to experience tears and coughing.

Circumstances of death

In the circumstances of the deaths described, cause of death according to the pathologist's report following a post-mortem¹⁴ is reported for 14 of the people who died. At an inquest, the cause of death is determined formally and may change from the cause of death listed in a pathologist's report. All but one death is being independently investigated.

Six people were taken ill or were identified as being **unwell in a police cell**. All were taken to hospital where they died on arrival, or sometime later. These six cases are outlined below:

- > A man was arrested following a domestic incident at his home. On arrival at custody it was noted that he had been drinking. Within an hour of being placed in a cell, the custody sergeant and nurse checked on the man and he produced a small bag containing cocaine, which had been concealed in his mouth. An ambulance was requested and, prior to paramedics attending, the man began fitting in his cell and stopped breathing. CPR was performed on the man until paramedics arrived. He died in hospital shortly after. His cause of death was reported as *cocaine and alcohol toxicity*.
- > One woman stated on arrival at custody that she had recently suffered a stroke and had a trauma to the brain. She was seen by a medical professional while in police custody and reported having a headache. Shortly after being interviewed, she was found collapsed in her cell. She was taken to

hospital by ambulance where an MRI scan showed a significant bleed on the brain. Medical care was provided, but she later died. Her cause of death was reported as *spontaneous intracerebral haemorrhage*.

- > One man was put on constant observation because of his level of intoxication when he arrived at police custody. This was reviewed while the man was in the custody cell and the number of checks were gradually reduced. During one check the man was found to be unresponsive. Medical assistance was provided and an ambulance was called. He was taken to hospital where he died the following day. His cause of death was reported as *1a) acute myocardial infarction due to 1b) coronary artery atheroma contributing conditions were II: the effects of alcohol and acute pyelonephritis*. This case was dealt with locally by the police force.
- > One man was a known drug user who was provided methadone by a healthcare professional (HCP)¹⁵ while in police custody. A couple of days later, while still in custody, the man became unwell in his cell and complained of a pain in his head. At hospital a CT scan showed a bleed on the brain. He died the next day. His cause of death was reported as *1a) intracerebral haemorrhage 1b) brain abscess 1c) prosthetic valve infective endocarditis*.
- > One man disclosed when being booked into custody that he suffered from sleep apnoea and required medication and a breathing machine. These items were collected and given to the man. Shortly after, the

¹⁴ In a minority of cases, a post-mortem may not be carried out. In these instances, the cause of death will be taken from the records of the certifying doctor. If the cause of death is formally disputed at the time of analysis, the cause of death will be recorded as 'awaited'.

¹⁵ This can be a doctor or a nurse whose professional training would have included working in a custody environment. They have responsibility for the welfare of detainees, including prescribing medication and examining and recording any injuries.

man reported that he was unwell and he subsequently had a seizure. Medical aid was provided, and he was taken to hospital by ambulance. The man died three days later. His cause of death was reported as *cocaine toxicity*.

- > One man was strip searched when he arrived into custody. Drugs were removed that were found in his shoes. While in custody the man was given medication for drug withdrawal and was regularly checked. During one check by custody staff, the man was found unresponsive. Officers and the custody nurse entered the cell and medical care was provided. An ambulance was called and took him to hospital. Drugs were found that had been concealed internally. The man remained in a critical condition and he died several days later. His cause of death was reported as *severe brain damage and cardiac arrest due to acute cocaine intoxication*.

Six people were taken ill at the **scene of arrest**. All were taken to hospital where they died on arrival, or sometime later. These six cases are outlined below:

- > The police received several reports about a man behaving erratically in the street. He was reported to have several physical injuries. The police located the man and he was physically restrained. An ambulance was called and the man was taken to hospital. He died shortly after arriving at hospital. His cause of death is awaited.
- > The police attended a scene following concern about a man's behaviour. He was detained under Section 136 of the Mental Health Act 1983. At one point the man fell to the floor and he was briefly physically restrained by officers. The police were informed that the man had 'taken something'. Soon after, the man became unwell. Medical

aid was provided and an ambulance was called. He died shortly after arriving at hospital. His cause of death was reported as *methylenedioxymethamphetamine and cocaine toxicity*.

- > The police were called following reports of a man feeling unwell in a hotel lobby. He was arrested for a public order offence, possession of class A drugs and assault. Following a struggle, the police used incapacitant spray and restrained the man on the floor. The man became unresponsive and medical aid was provided. An ambulance was called and took the man to hospital where he died shortly after arrival. His cause of death was reported as *sudden death in association with increased exertion during physical restraint and acute cocaine intoxication*.
- > The police were called to a reported theft at a shop. When they arrived, a man was lying face-down on the floor, being supervised by a member of staff who was kneeling over him. The officers were told that he had acted in an aggressive manner towards the staff and therefore he had been physically restrained on the floor. The man was arrested and then became unwell. The officers provided medical attention and called for an ambulance. The man was taken to hospital by air ambulance where he later died. His cause of death was reported as *1a) multi organ hypoxic/ischaemic injury 1b) respiratory and cardiac arrests 1c) restraint in the prone position*.
- > One man was arrested at his home for malicious communication offences and he was placed in handcuffs. Shortly after he complained about feeling unwell. As the man left the house with the police he became unresponsive. Medical aid was provided, and the handcuffs were removed. An ambulance

attended and took him to hospital where he died shortly after arrival. His cause of death was reported as *1a) myocardial infarction 1b) coronary artery atheroma*.

- > One man was arrested for breaching his bail conditions. He told the police he had taken an overdose of medication. An ambulance was called and took him to hospital where he died a few hours after arrival. His cause of death was reported as *1a) multiple organ failure 1b) dinitrophenol overdose*.

Two men were taken ill in a **police vehicle** while being taken from the scene of arrest to the police station.

- > During the arrest of one man, officers noted that he was short of breath and asked the man if he suffered from any medical conditions. He confirmed he had respiratory issues and required medication. The police collected his medication and put the man in a police car. The man continued to be short of breath during transportation and officers decided to take him to hospital. The man's condition deteriorated, and the police pulled over. Officers provided medical aid and called an ambulance. The man died shortly after being placed in the ambulance. His cause of death was reported as *1a) pulmonary embolism 1b) ileo femoral vein thrombosis 2) morbid obesity*.
- > One man was arrested for domestic breach of the peace. During the arrest he allegedly became obstructive and there was a struggle with the police. Officers used incapacitant spray three times and delivered approximately seven knee strikes to the man's stomach. An officer also used distraction strikes. Two pairs of handcuffs were used owing to the man's size. The man was then carried to a police van. On arrival at the custody building, the man was found

unresponsive in the van. The police provided medical aid until paramedics arrived. His cause of death is awaited.

Two people died following their **release from police custody**:

- > One man was arrested for being drunk and disorderly. The man was epileptic and did not have access to medication when in custody. In his pre-release assessment, social services reported having doubts about the man's ability to find his way home independently. He lived approximately 15 miles away and was given a bus ticket to return home. There was a bus stop outside the custody building, but this may not have been in use at that time. Passers-by reported seeing him unsteady on his feet. The following day the man was found behind the bus stop in a ditch filled with water. His cause of death was reported as *drowning*.
- > The police were called to a road traffic collision. One woman was arrested on suspicion of driving over the legal alcohol limit. She was taken into custody and the custody officer assessed her as being fit to detain. The woman was offered general medical assistance and treatment for a minor injury to her thumb, which she declined. She had no other visible injuries. Almost an hour later the woman provided a negative breath test and was released from custody without charge. The following evening the woman was found collapsed at her home. She was taken to hospital where she died a week later. Her cause of death was reported as *1) acute subdural haemorrhage 2) atrial treated with Rivaroxaban*, which was believed could have been caused by a mild head injury from the traffic collision that may have progressed slowly while in custody.

Trends

Between 2004/05 and 2008/09, there has been a year-on-year reduction in the number of deaths in or following police custody. These deaths reduced from 36 in 2004/05 to 15 deaths in 2008/09. Over the next two years, the number of deaths in custody increased to 21 in 2010/11, before falling back to 15 in 2011/12 and 2012/13. There was a further reduction, to 11, in 2013/14. In 2014/15, the number rose again to 18 and then declined and remained stable at 14 in 2015/16 and 2016/17. In 2017/18 there were 23 fatalities, the highest number recorded for 10 years. This year, the number has fallen to 16 fatalities, in-line with average figures.

This year, no one died after making an apparent suicide attempt in police custody¹⁶. The last incident of this kind was in 2016/17. Before that, there was one incident in 2014/15 and one in 2008/09. Since 2004/05, seven people are known to have died as a result of self-inflicted acts while in a police cell.

¹⁶ While this year there is a death from a self-inflicted act of taking an overdose, this was prior to the person being arrested and in police custody.



6

Apparent suicides following police custody

Apparent suicides following time in police custody are reported if they take place within two days of the person's release from custody. They are also reported if experiences in custody may have been relevant to the death, and the death has been referred to us. The police may not always be told about an apparent suicide that happens after detention in custody, as the association may not be clear. Therefore, there may be more deaths in these circumstances than are reported here.

The term 'suicide' does not necessarily relate to a coroner's verdict because, in most cases, verdicts are still pending. In these instances, the case is only included

if, after considering the nature of death, the circumstances suggest that death was an intentional, self-inflicted act – for example, a hanging, or where there was some evidence of 'suicidal ideation', such as a suicide note.

Demographics

There were 63 apparent suicides following police custody. Of these, 55 were men and eight were women. The average age of those who died was 41. The most common age was between 41 and 50 years (16 people), followed by 21 to 30 and 51 to 60 years (13 people in each group). The youngest person was

17-years-old. Fifty-nine people were reported to be White. Two people were Black, one was Asian, and one person was from a Mixed ethnic group.

Three-quarters of the people (47) had known mental health concerns. Of these, seven had been detained under Section 136 of the Mental Health Act. Other mental health concerns included; depression, post-traumatic stress disorder, bipolar, psychosis, borderline personality disorder, previous thoughts or incidents of suicide attempts and self-harm.

Over half of the people (38) were reported to be intoxicated with drugs and/or alcohol at the time of the arrest, or drugs and/or alcohol featured heavily in their lifestyle. Twenty-six of these related to alcohol and 20 to drugs.

Circumstances of death

Nineteen apparent suicides happened the same day the person was released from police custody. Twenty-nine were one day after release, and 15 happened two days after release.

Table 6.1 shows why these people had been detained by the police. Twenty-one of those who died had been arrested for a sexual offence. Of these, 15 were related to sexual offences or indecent images involving children. Sixteen detentions were for violence-related offences. Seven detentions were under Section 136 of the Mental Health Act 1983. Other common detention reasons were driving offences (seven), breach of the peace / anti-social behaviour (seven) and threatening behaviour / harassment (seven).

Table 6.1 Apparent suicides following police custody: reason for detention, 2018/19

Reason for detention	Number of detentions
Sexual offences	21
Violence-related (non-sexual or murder)	16
Mental Health Act 1983	7
Driving offences (including drink driving)	7
Breach of the peace / anti-social behaviour	7
Threatening behaviour / harassment	7
Criminal damage	6
Drug-related	4
Possession of a weapon	4
Burglary	1
Endangering safety with intent	1
Total number of reasons for detention	81
Total fatalities	63

This table counts the number of different reasons for detention. Each person may have been detained for one or more reason.

There were 15 people who were detained for multiple reasons. This compares to eight last year. Seven people who were arrested for violence-related offences were also arrested for other reasons. Possession of a weapon was always in combination with another detention reason.

The majority of recorded apparent suicides following custody were dealt with locally by the police force (57). Six are being investigated independently. In these cases, the matters being considered by the investigations included:

- > the risk assessment conducted, and support and advice provided when the person was released from custody
- > the sharing of relevant information about a detainee between custody officers
- > the recording of risks in custody records and conducting searches on police databases to identify known concerns
- > referral to other agencies such as social services and mental health professionals

Trends

The number of apparent suicides following time in police custody is higher than the 57 recorded last year. It is the fourth highest number recorded over the 15-year period since 2004/05. Reporting of these deaths relies on police forces making the link between an apparent suicide and someone having spent time in custody recently. Increases in these deaths may therefore be influenced by improved identification and referral of such cases.

This year, for 33% of fatalities, the reason for detention related to alleged sexual offences. The proportion of sexual offences or indecent images involving children was 24%. These proportions are lower than the figures recorded last year (51% and 44% respectively) but in-line with average figures. The average proportions for these alleged offences since 2004/05 are 34% and 27% respectively.



7

Other deaths following police contact: independent investigations only

In 2010/11, a change was made to the definition of this category. It now includes only those deaths following police contact that were investigated independently by the IOPC, previously the IPCC.

During 2014/15, the IPCC started a significant period of change and expansion. This was in response to the Home Secretary's announcement that there should be more independent investigations into serious and sensitive matters¹⁷. This had a direct impact on the number of deaths we recorded as 'other deaths following police contact', because inclusion of this type of case in this annual report is based on these being independently investigated.

The increase in this category does not, therefore, necessarily indicate an increase in the number of people who have died following some form of contact with the police. It is worth noting that over the past few years, before 2015/16, on average, there were about 430 referrals each year where someone had died following police contact. In 2013/14 and 2014/15, approximately one in ten (10%) of these referrals were independently investigated. In 2015/16 and 2016/17, in-line with the increase in resources, one in four (25%) referrals relating to deaths following police contact were investigated independently. In 2017/18, this figure rose again to about one in three (33%) such referrals being independently investigated. This year, the

¹⁷ See our [Corporate Plan 2015–18](#) and [Strategic Plan 2018-2022](#) for more information.

figure drops back to approximately one in four (24%).

Overall demographics

We independently investigated the deaths of 152 people who died during or following other contact with the police during 2018/19. Of these deaths:

- > 108 were men and 44 were women
- > 135 people were White, seven were Black, four were Asian, two were of Mixed heritage and three people were from an Other ethnic

group. The ethnicity for one person was not known at the time of publishing

- > Seven people were aged under 18, and 17 people were young adults aged between 18 and 24. The average age was 43
- > Over half the people who died (90) were reported to be intoxicated by drugs and/or alcohol at the time of the incident, or drugs and/or alcohol featured heavily in their lifestyle. Over two-thirds of the people who died (104) were reported to have mental health concerns

Table 7.1 Other deaths following police contact: reason for contact, 2018/19

Reason for contact		Number of fatalities
Concern for welfare	Missing person	35
	Self-harm / suicide risk / mental health	31
	Health / injuries / intoxication / general	25
	Domestic related	23
	Threatening behaviour / harassment	7
	Other	6
	<i>Subtotal</i>	<i>127</i>
Other contact	Execute search / arrest warrant / investigation enquiries	13
	Attending a disturbance	6
	Avoiding contact / arrest	3
	Siege	2
	Assist medical staff	1
	<i>Subtotal</i>	<i>25</i>
	Total fatalities	152

Circumstances of death

This category includes deaths in a range of circumstances. The police contact may not have been with the deceased directly, but with a third party, as illustrated by some of the case examples. Where stated, the cause of death is taken from the pathologist's report following a post-mortem¹⁸.

As shown in Table 7.1, the most common reason for contact with the police related to a **concern for welfare**. That is, 127 people died after concerns were raised with the police, either directly or indirectly, about the safety or well-being of the deceased before their death. There were a further 25 fatalities recorded relating to **other types of contact** with the police.

A total of eight people who died following police contact had force used against them. This does not necessarily mean that the use of force contributed to the death. Four people were White, two were Black and two were Mixed heritage. Seven people who died were known to have been restrained by police officers or by members of the public. Of these, one man also had leg restraints and a contamination hood used on him. One man had CS-spray used on him.

Concern for welfare

Of the 127 fatalities that followed contact with the police about a concern for welfare, 35 people died following a report of a **missing person**. The police generally did not have direct contact with the deceased in these circumstances. Of these, 25 people were also

identified as at risk of self-harm or suicide. For these 25:

- > Twenty people who died were men and five were women. Twenty-three people were White, one person was Black, and one was Asian.
- > The ages of people in this category ranged from 14 to 64. The most common age group was 51 to 60 (seven people). The average age was 37.
- > For 16 people, alcohol and/or drugs featured heavily in their lifestyle. All 25 people who died were known to have mental health concerns.
- > In 19 incidents, the person's death was from an apparent self-inflicted act.

For the remaining ten people **reported missing** to the police, there were no specific risks of self-harm or suicide. In these cases:

- > Eight people who died were men and two were women. All ten were White.
- > The ages of people in this category varied from 14 to 66 years. Two people were aged under 18 and four people were over 50 years.
- > For eight people, alcohol and/or drugs featured heavily in their lifestyle. Six people were known to have mental health concerns.
- > The classification of death for three people appeared accidental. A further two were alleged murders, two were from natural causes and one was from an apparent self-inflicted act.

¹⁸ In a minority of cases, a post-mortem may not be done. In these instances, the cause of death will be taken from the records of the certifying doctor. If the cause of death is formally disputed at the time of analysis, the cause of death will be recorded as 'awaited'.

Thirty-one fatalities related to concern about a person's **risk of self-harm, risk of suicide, or mental health**. In these instances, the concern is most often raised with the police by a third party, about a person with known mental health concerns. The people may, for example, fail to attend an appointment or welfare check, or show signs of being at risk of self-harm or suicide. The person is not reported or considered missing. Of these:

- > Twenty people were men and 11 were women.
- > Thirty people who died were White and one person was Black. The proportion of White people in this category of contact is higher compared to all other deaths in or following police contact.
- > The ages of the people ranged from 18 to 62 years. The majority of people were aged between 31 and 50 years (18 people). The average age was 39.
- > Death by self-inflicted means was the most common classification (29 people).
- > For 20 people, alcohol and/or drugs featured heavily in their lifestyle.

Twenty-five fatalities related to the person's **health, possible injuries, intoxication, or general well-being**. In most incidents, a third party raised the concern. In this category:

- > Eighteen people were men and seven were women.
- > Twenty-three people were White, one person was Black, and one was Asian.
- > The majority of people (21) were aged over 40, with six people aged over 60. The average age was 51, older than for the other types of contact.
- > Over-half (15 people) of those who died were reported to be under the influence of alcohol

and/or drugs at the time of the incident, or these featured heavily in their lifestyle.

- > The most common form of death classification was natural causes (seven people). Six deaths were deemed accidental and five were the result of a self-inflicted act.

Twenty-three fatalities were **domestic-related**. This means that the police were responding to a domestic incident, or the circumstances of the contact involved a history of domestic violence, or threats made against the deceased and/or family members. In this category:

- > Sixteen people who died were women and seven were men. Women were a higher proportion in this category than in all the other independently investigated deaths following police contact.
- > Twenty people were White, two were from an Other ethnic group and one person was Black.
- > The most common age range was 31 to 50 (eight people). The average age was 43.
- > In 13 instances, the deaths were classified as an alleged murder. Six were self-inflicted and three were from natural causes. One classification was not known. All but one of those who were allegedly murdered were women.
- > Two incidents each resulted in two fatalities. In one of these incidents, a person was apparently murdered, and the suspected perpetrator then died by a self-inflicted act.

Seven people died following **concern about threatening behaviour**. These incidents involve threatening behaviour or harassment among people in non-domestic situations, such as between neighbours or strangers. In this category:

- > All seven people were men. Four people were White, two were Asian, and one was Black.
- > Five people were aged between 35 and 46, and the eldest was 96.
- > Four classifications of death were alleged murders. Two deaths were self-inflicted, and one was deemed accidental.
- > One incident involved police use of force. The police were called because a dementia patient, aged 96, told hospital staff that he had a knife in his pocket and would use it. The police arrived and when they approached the man he became agitated. He swung his walking stick at the officers and hit one in the chest. The force behind the swing caused the man to fall over. He was searched, but no knife was found. The man was sat on the floor and when a nurse went to help he grabbed a pair of scissors from their pocket. Officers struggled with the man to retrieve the scissors and his arms were restrained. After the scissors were removed and the restraint released, the man complained of pain in his hip and it transpired that it was broken. The man had surgery on his hip, but his condition deteriorated, and he died a day later. His cause of death was reported as *1a) coronary artery disease 2) fractured left neck of femur (operated) / diabetes mellitus / essential hypertension / dementia*.

Six people died following **other types of concern for welfare** that are not covered by the above categories. In all these incidents, the concern for welfare related to reports to

the police of erratic or bad driving. The six deaths occurred across three separate incidents:

- > The police received a number of reports about a car being driven erratically. Police did not attend the address the car was registered to. The next day the same car was driven across multiple lanes of traffic and collided with oncoming cars. The driver of the car, a man aged 21, died at the scene. He had recently displayed behaviours of self-harm and suicide, which the police were aware of.
- > In one incident, the police received a report from someone whose car had been damaged by another driver. The report indicated that the damage had been caused by an elderly man, aged 80, and the person expressed concern about his driving. The matter was placed in a queue to be reviewed. Five days later, before the matter had been fully reviewed, the elderly driver drove down the wrong side of a road and was involved in a collision. The incident resulted in three fatalities; the driver and passenger in the car driving the wrong way, and the driver of the vehicle that was hit.
- > The police received calls about a person driving on the wrong side of the road. Police vehicles responded and attempted to set-up a road block to protect the public. A police helicopter was dispatched and provided updates. The police vehicles travelled in the correct direction and tried to get the driver to respond, but they did not react nor adjust their driving. The car collided head-on with a car travelling on the correct side of the road. Both the driver, a woman aged 71, in the car on the wrong side of the road, and the driver of the car hit, died at the scene.

Other contact

The 25 deaths recorded as relating to other types of contact took place in the following circumstances.

There were 13 deaths after or during contact with the police who were **executing a search, or an arrest warrant, or conducting investigation enquiries.**

- > All but one were men and all were White.
- > The majority (ten) were aged over 40 years. The average age was 48 years.
- > In all but one incident, the death was self-inflicted. The remaining case was from an accidental overdose, taken before contact with the police.
- > In nine incidents, the police were making investigation enquiries, or following-up breach of bail conditions linked to allegations of sexual-related offences. In one of these incidents, this was with the victim of an alleged sexual offence.

Six people died after police officers attended a **report of a disturbance:**

- > The police were called to reports of an altercation at a shop that involved a Black man, aged 45 who allegedly had a knife. When officers arrived, the man was being restrained on the floor by shop staff. The police handcuffed the man and soon after found that he was unresponsive. The handcuffs were removed, and first aid was provided. He was taken by ambulance to hospital where he later died. His cause of death was reported as *1a) acute myocardial insufficiency 1b) cocaine toxicity and coronary artery atheroma.*
- > The police attended a property after receiving a report that a man, of Mixed ethnicity, aged 33, was trying to gain entry to a house. He was partially clothed and appeared incoherent. The man refused to communicate with the police. He was subsequently handcuffed by the police and they momentarily placed him on his knees and held him there. He was then walked to the police van and was placed on his side on the floor of the rear caged area of the van. Shortly after, the man became unresponsive. He was removed from the van and the handcuffs were taken off. Medical care was provided until an ambulance arrived. He was taken to hospital where he was pronounced dead soon after arrival. His cause of death was reported as *acute cocaine toxicity caused by the toxic effects of an acute overdose of cocaine.*
- > A number of calls were made to the police after a man had driven into several parked cars. The man, aged 31 and of Mixed ethnicity, ran from the scene into a nearby home. He ran through the house and locked himself and the family who lived there in the bathroom. The man then escaped through a window onto a garage roof when he fell and injured his face. The police arrived, and the man allegedly began kicking out at them. They believed he was under the influence of drugs. The police restrained the man and placed a contamination hood over him. An ambulance was called, and paramedics treated his injuries. The man was taken to hospital where he later died from the injuries received from the fall.
- > The police were called to a facility for homeless people after reports of criminal damage and someone trying to break into the premises. Police attended on two occasions. They attempted to secure the premises and provided advice to the residents. A short

while after the police left, the facility was reported as being on fire. The police, fire and ambulance service attended. A resident from the facility died in the fire.

- > The police were called to a hotel where a White man, aged 29, was causing damage to his room. When the police entered the man's room, he was lying on the floor in need of medical attention. An ambulance and further police support was requested. Shortly after, the man began moving about uncontrollably. The police physically restrained the man's arms and legs and he soon became calm. The man's condition deteriorated, and he had three seizures. Medical aid was provided. He was taken to hospital where he died shortly after arrival. His cause of death was reported as *cocaine toxicity*.
- > The police were called to a casino following reports of a man, aged 37 of Other ethnicity, behaving aggressively and threatening other customers. The police handcuffed the man and removed him from the casino to prevent further breach of the peace. The officers took the man to an address he provided, which was his family's shop. The handcuffs were removed during transportation. Shortly after dropping the man off, a family member reported to the police that they could see the man in the shop on CCTV attempting to take his own life. The police arrived and provided medical attention. He was taken to hospital where he died.

Three men died while attempting to **avoid police contact or arrest:**

- > Police were called to reports of an assault. The officers spotted the suspect, a White man, aged 26, and pursued on foot through a park. An officer caught up with the man and drew his PAVA spray as the man was thought to have a knife. The spray was

not discharged. The man ran off again and jumped into a river. He swam half way across when he was seen to go under the water. A helicopter was called, and police remained near the scene. When it was light the following day, a dive-team attended. The man's body was found four days later.

- > Immigration officers attended a business address to conduct searches. They initially spoke to a man, Black, aged 23, who then said he would go find his employer. The man then ran from the scene onto roof buildings and officers lost sight of him. He was then found on the floor in an annex building. Medical aid was provided, and he was taken to hospital by ambulance where he later died from his injuries.
- > While on patrol, police officers saw something being passed between two men known to the police for drug-related activity. As officers approached, one of the men put something in his mouth. The officers placed the man in handcuffs and instructed him to spit out what he had in his mouth. The man started to struggle for breath. The officer slapped the man on the back several times and administered 'abdominal thrusts' (Heimlich manoeuvre), to try to dislodge the item. Officers gave the man CPR until an ambulance arrived. Paramedics removed a package from the man's throat that contained small bags of drugs. The man was taken to hospital where he died shortly after arrival. His cause of death was reported as *obstruction of airway caused by a foreign body*.

Two men died during a **siege situation** with the police:

- > Officers were called to an address following reports of a domestic incident where a White man, aged 46, was described as

uncontrollable. He was threatening to harm himself and others. The man was reported to be an epileptic, heavily intoxicated and in possession of a knife. A police support unit¹⁹ attended the address and a police negotiator was called. The police spoke with the man on the phone briefly. When the police negotiator called the man there was no answer. The police were concerned that the man had self-harmed and forced entry to the property. Paramedics were with the police and provided medical attention, but the man died at the scene.

- > A woman contacted the police to say that she had returned home to find a suicide note left by her husband. The police determined that he was a registered shotgun holder and it was assumed that the man was in possession of the shotgun. Armed officers were deployed to search the nearby farm and woodland area, which began around 10pm. Air support was also requested, and a police negotiator was called. A few hours later, air support reported sight of the man sitting by a tree with a shotgun. The negotiators spoke with him for approximately ten hours. A shot was heard. The man, White, aged 63, died at the scene from a non-police gunshot wound.

travelled with him to hospital. On the way to hospital, the man's condition deteriorated and he died in the ambulance. His cause of death was reported as *lacerated liver and aortic injuries*.

Trends

In 2010/11, a change was made to the definition of this category. It now includes only those deaths following other police contact that were investigated independently by the IOPC, formerly the IPCC. The number of cases therefore recorded in this category is directly linked to the number of cases independently investigated. It would, therefore, not be meaningful to provide any trend analysis for this category. The deaths included in this category happen in a range of circumstances, which makes it difficult to identify a specific set of events that accounts for changes in the number of fatalities. The overall proportion of cases relating to a concern for welfare made up 84% of the deaths following police contact that were independently investigated – last year, the proportion was 86%. This year, almost a quarter of investigations into deaths following police contact related to incidents where there was a report of a missing person.

One man died after police were called to **assist medical staff:**

- > In this incident, the ambulance service called the police to assist with a White man, aged 28, who they were treating at the roadside following a road traffic collision. The paramedics found it difficult to treat the man as he was allegedly flailing his arms around. The police attended and restrained the man. He was put into an ambulance and the police

¹⁹ Police officers who are highly trained to deal with a variety of public order situations.



8

Background note

Background note

- 1** Under the Police Reform Act 2002, forces in England and Wales have a statutory duty to refer to the IOPC a death during or following police contact where there is an allegation or indication that police contact, directly or indirectly, contributed to the death²⁰. We consider the circumstances of all referrals and decide whether to investigate the death.
- 2** Since April 2006, the IOPC (previously the IPCC) has also received cases where someone has died, mandatorily referred from Her Majesty's Revenue and Customs (HMRC)²¹, and the Serious Organised Crime Agency (SOCA), and since October 2013, SOCA's replacement, the National Crime Agency (NCA). Up until March 2013, it also received cases from the UK Border Agency (UKBA)²², when UKBA's executive agency status was ended, and its functions were brought back into the Home Office as UK Visas and Immigration (UKVI); UK Immigration Enforcement (UKIE); and UK Border Force (UKBF). The IOPC has continued to have jurisdiction over those officials and contractors. Deaths during or following contact with staff from these organisations are therefore also presented in this report.
- 3** In January 2018, we became the IOPC. This change was set out in the Policing and Crime Act 2017. Before

²⁰ Paragraph 4(1)(a), 13(1)(a), 14c(1). Schedule 3, Part 1, Police Reform Act 2002 as amended by the Serious Organised Crime and Police Act 2005, Schedule 12.

²¹ Regulation 34 of the Revenue and Customs (Complaints and Misconduct) Regulations 2005.

²² Regulation 25 of the UK Border Agency (Complaints and Misconduct) Regulations 2010.

this, we were the Independent Police Complaints Commission (IPCC).

Changes and revisions

- 4 In 2010/11, a change was made to the definition of the ‘other deaths following police contact’ category. It now includes only those deaths following police contact that were investigated independently by the IOPC, or previously by the IPCC. As a result, we have changed the approach to how this category is presented in this report. Further information about this category can be found in the [guidance document](#). No other changes have been made to the definitions of the death categories.
- 5 In 2007, the IPCC issued an operational advice note to forces to address inconsistencies in the referral of ‘apparent suicides following release from police custody’. Forces were asked to refer any suicides that happened within two days of release from police custody, or apparent suicides that happened more than two days after release, but where there was a possible link between the time the person spent in custody and their death.
- 6 This report presents the most up-to-date set of figures for each death category. In this release, five fatalities have been added to the category ‘other deaths following police contact’, for the 2017/18 figure. These deaths were either not subject to an independent investigation or they had not been referred to us when the previous report was released.

- 7 Table 6.1 counts the number of different reasons for detention for apparent suicides following police custody. In previous years, this table has shown the number of fatalities with footnotes to highlight where there were additional reasons for detention. Due to the high volume of fatalities with multiple reasons for detention in 2018/19, the figures shown in Table 6.1 are the total number of different reasons for detention.

Methods and definitions

- 8 For more detailed definitions and for information about how the death cases are categorised and recorded, see the [guidance document](#). This document also provides suggestions for further reading on associated themes.

Policies and statements

- 9 A number of [policies and statements](#) are produced in relation to this report. These are available on the IOPC website. They include information about:
 - > confidentiality and security of data
 - > statement of administrative sources
 - > revisions policies
 - > announcing changes to methods
 - > quality assurance
 - > pre-release access
 - > user engagement strategy
 - > pricing policy

Users, uses and engagement

- 10 Information about key users of the data contained in this report, and how it has been used, can be found in the [user engagement feedback](#) document. This also summarises feedback received on the annual deaths report, our response, and any impact this may have on the information contained in the report or on the data collection process.
- 11 This report provides data and information about a highly sensitive topic area. It is used to promote and inform debate and discussion among police forces and other stakeholders and interested parties. It provides users with an opportunity to learn from the cases that appear in the report and identify, take action, and/or review policy to help prevent such deaths from happening again where possible.
- 12 Additional [in-depth studies](#) and [learning publications](#) have been produced to help learning.
- 13 Users of the statistics should be aware that care needs to be taken when looking at the time series of the data. There may be discontinuities owing to changes in category definition and the varied nature of the circumstances of the cases. The small numbers involved also mean readers should be cautious about drawing conclusions from trend analysis as variances can be large.
- 14 We make every effort to make sure that all relevant deaths are included in this report through an extensive validation

exercise with internal colleagues and police forces. However, at times, a case may come to light after the report has been published. Read our [revision policies](#) for information about how we manage routine amendments and errors to published data.

While comparisons to other countries and jurisdictions can be made, care needs to be taken, because the data is unlikely to be directly comparable. This is because of differences in death classifications, or how other details have been collated.

- 15 The user engagement strategy is found in section eight of the [policies and statements](#) document.

Further information

- 16 On 30 October 2017, Dame Elish Angiolini's DBE QC [independent review](#) of deaths and serious incidents in police custody was published. Dame Angiolini had been appointed by the then Home Secretary, the Rt Hon Theresa May MP, to examine 'the procedures and processes surrounding deaths and serious incidents in police custody, including the lead up to such incidents, the immediate aftermath, and through to the conclusion of official investigations'.

The investigation of deaths and serious injuries following contact with the police is one of the IOPC's most important functions. For that reason, we welcomed the independent review and published our response on the same day, which is available on our [website](#).

17 Dame Angiolini's report contained 110 recommendations spanning the policing, criminal justice and healthcare sectors. We are supporting the work of the Home Office and the Ministerial Board on Deaths in Custody, which has been given responsibility for taking forward the Government's response to the review. The findings from the review are also being used to inform our operational improvement work.

18 Dame Angiolini recommended that the Government adopt the IOPC's (formerly the IPCC's) draft guidance on 'achieving best evidence in death or serious injury investigations'. In October 2018, the IOPC submitted an updated version of the draft guidance to the Home Office. This was approved by the then Home Secretary on 17 January 2019, placing it on a statutory footing. It sets out what the police are expected to do following incidents where a member of the public dies or is seriously injured during or following police contact. This includes:

- > identifying and preserving all potentially relevant evidence and scenes and bringing them to the investigator's attention
- > gathering the names and contact details of all potential non-policing witnesses prior to the arrival or involvement of the IOPC
- > taking concrete measures to prevent police witnesses from conferring about the incident

19 In 2014 the IOPC reviewed how we investigate deaths. This reinforced the principle that engaging with communities and the wider public during an investigation has important implications for confidence, both in our investigations and in the police complaints system as a whole. In response

to this, we developed and agreed an interim approach to community and stakeholder engagement during critical investigations.

20 During 2018/19, we provided engagement support to eight investigations. The purpose of this work was to:

- > increase community and stakeholder confidence in our work
- > improve public and stakeholder understanding of our role and remit
- > contribute to the handling of local community tensions, or concerns when these are related to incidents requiring independent investigation, or to the wider police complaints system

21 We have a formal agreement, known as a [concordat](#), with Her Majesty's Inspectorate of Constabulary and Fire and Rescue Services (HMICFRS) and the College of Policing. This sets out how we intend to work together to promote best practice. Examples of where the IOPC is working with HMICFRS and the College of Policing to raise standards are: sharing information with Her Majesty's Inspectorate of Prisons (HMIP) to support HMIP/HMICFRS joint inspections of custody facilities. These inspections consider, among other things, the progress the force being inspected has made in implementing IOPC recommendations relevant to police custody. In addition, we provide input to the College of Policing, based on our operational experience, in relation to the development of guidance for police forces.

22 In 2018, the Home Office ran a consultation on proposed changes to the law, guidance and training governing police pursuits. In our [response](#), submitted in August 2018, we broadly welcomed the proposals

for change set out in the consultation document. However, we also noted that any change to legislation must not have the unintended consequence of reducing public safety or undermine the ability to hold the police to account effectively. The Home Office published its response to the consultation in May 2019. We are continuing to work with the Home Office in relation to its proposals.

23 Significant changes are due to be made to the police complaints and disciplinary systems as a result of the Policing and Crime Act 2017. These will impact on the work of the IOPC and on the organisation itself. One of the changes that has already been made is the introduction of police ‘super-complaints’, which came into effect on 1 November 2018. This is a mechanism for organisations to raise concerns about systemic issues in policing which are, or appear to be, significantly harming the interests of the public.

24 We have continued to publish our Learning the Lessons magazines. Since March 2018, we have added new feature content to the magazine from external contributors to:

- > provide an insight into stakeholder or service user perspectives
- > signpost related training, guidance or research
- > showcase good practice in police forces or policing organisations

25 The issue of Learning the Lessons magazine February 2019, covers areas relevant to mental health and the issues that arise in custody and detention in relation to vulnerable people.

26 All annual reports on deaths in or following police contact can be found on our [website](#).

27 Electronic versions of the tables in the report are available on our website. In addition, [time series tables](#) are available. These look at the ethnicity, age, and gender of the people who have died, and the forces involved. The time series tables are arranged by the category of death, from 2004/05 up to the current reporting year.

28 In addition to the annual reports on deaths, we also periodically produce research studies that examine in more detail some of the issues associated with these cases. To read these related studies please visit the [research and information](#) pages on our website.

29 Following a recommendation by the [National Statistician](#) in 2012, this annual report was assessed by the UK Statistics Authority and granted National Statistics designation.

30 If you have any questions or comments about our annual death reports, please email the research team at research@policeconduct.gov.uk.

31 Estimated publication date for the 2019/20 report: July 2020.



Appendix A: additional tables

Table A1 Incidents by type of death and financial year, 2008/09 to 2018/19

Category	Incidents										
	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19
Road traffic incident	33	26	24	19	23	11	13	20	28	27	33
Fatal shootings	3	2	2	2	0	0	1	3	6	2	3
Deaths in or following police custody	15	17	21	15	15	11	18	14	14	23	16
Apparent suicides following custody [^]	56	54	46	39	65	70	71	60	57	57	63
Other deaths following police contact*	33	37	49*	37	20	41	43	102**	129	169~	147

[^] Operational advice note issued in 2007 on the referral of these deaths.

* Change in definition of 'other deaths following contact' in 2010/11 to include only cases subject to an independent investigation.

** Expansion of our investigative resource and capacity to conduct more independent investigations into serious and sensitive matters – this has a direct impact on the number of other contact deaths that are reported.

~ This table presents the most up-to-date set of figures for these categories; any additions to previously published data are indicated.

Table A2 Type of death by gender, 2018/19

Gender	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Male	27	3	14	55	108
Female	15	0	2	8	44
Total fatalities	42	3	16	63	152

* This category includes only cases subject to an independent investigation.

Table A3 Type of death by age group, 2018/19

Age group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Under 18	1	0	0	1	7
18 - 20	10	0	0	4	6
21 - 30	12	0	2	13	24
31 - 40	6	2	6	11	30
41 - 50	2	0	3	16	34
51 - 60	3	1	3	13	28
61 and over	8	0	2	5	22
Total fatalities	42	3	16	63	152**

* This category includes only cases subject to an independent investigation.

** The age group of one person was unknown at the time of analysis.

Table A4 Type of death by ethnicity, 2018/19

Ethnicity group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
White	31	2	15	59	135
Black	1	1	1	2	7
Asian [^]	9	0	0	1	4
Mixed	1	0	0	1	2
Other	0	0	0	0	3
Not known	0	0	0	0	1
Total fatalities	42	3	16	63	152

* This category includes only cases subject to an independent investigation.

[^] Following changes to ethnicity classification by the Office for National Statistics, since 2015/16 the Asian ethnic group now includes Chinese. This was previously recorded under the 'Other' ethnic group.

Table A5 Type of death by appropriate authority, 2018/19

Appropriate authority	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Avon and Somerset	0	0	0	2	6
Bedfordshire	0	0	0	2	0
Cambridgeshire	1	0	0	0	2
Cheshire	1	0	0	1	2
City of London	0	0	0	0	0
Cleveland	0	0	0	2	1
Cumbria	0	0	0	0	2
Derbyshire	2	0	0	0	1
Devon and Cornwall	0	0	0	3	8
Dorset	1	0	0	1	2
Durham	0	0	0	1	0
Dyfed-Powys	0	0	0	0	3
Essex	1	0	0	0	5
Gloucestershire	0	0	0	0	1
Greater Manchester	1	0	2	5	11
Gwent	0	0	1	0	1
Hampshire	0	0	1	2	4
Hertfordshire	1	0	0	2	0
Humberside	0	0	0	2	1
Kent	3	0	0	1	8
Lancashire	1	0	0	1	4
Leicestershire	1	0	0	0	3
Lincolnshire	0	0	1	2	0
Merseyside	1	0	0	4	4
Metropolitan	7	1	2	2	15
Norfolk	1	0	1	0	3
North Wales	0	0	1	0	0
North Yorkshire	0	0	0	3	1
Northamptonshire	1	0	1	0	2
Northumbria	1	0	2	0	3
Nottinghamshire	0	0	0	1	2
South Wales	2	0	0	0	2
South Yorkshire	5	0	1	4	7
Staffordshire	1	0	1	1	3
Suffolk	0	0	0	0	1
Surrey	0	0	0	2	2
Sussex	0	0	0	1	5
Thames Valley	0	0	0	3	8
Warwickshire	1	0	1	1	1
West Mercia	1	0	0	3	1
West Midlands	2	2	0	4	10
West Yorkshire	5	0	1	2	8
Wiltshire	1	0	0	0	2
British Transport and Avon and Somerset	0	0	0	1	0
British Transport and Derbyshire	0	0	0	1	0
British Transport and Staffordshire	0	0	0	1	0
Cleveland and Cheshire	0	0	0	0	1
South Yorkshire and Essex	0	0	0	0	1
Surrey and Metropolitan	0	0	0	0	1
Surrey and Sussex	0	0	0	0	1
West Mercia and West Midlands	0	0	0	0	1
West Mercia and Staffordshire	0	0	0	0	1
British Transport	0	0	0	2	0
Home Office~	0	0	0	0	1
HMRC	0	0	0	0	0
Ministry of Defence	0	0	0	0	0
National Crime Agency	0	0	0	0	0
Total fatalities	42	3	16	63	152

* This category includes only cases subject to an independent investigation.

~ This includes UKBF, UKIE and UKVI.

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