



> Deaths during or following police contact:

Statistics for England and Wales
2017/18

Acknowledgements

Kerry Grace led the production and analysis of this report, with support from Melanie O'Connor in the research team at the Independent Office for Police Conduct (IOPC). Our thanks go to colleagues from the policy and engagement, investigations and communications teams, all of whom helped to gather and check the information in this report or to support its release. We would also like to thank officers and staff at police forces across England and Wales who provided information and responded to our enquiries.

Contact details

If you have any questions or comments about this report, please contact Kerry Grace at research@policeconduct.gov.uk

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.

Contents

1	Introduction	1
2	Overall findings	3
3	Road traffic fatalities	8
4	Fatal shootings	12
5	Deaths in or following police custody	13
6	Apparent suicides following police custody	19
7	Other deaths following police contact: independent investigations only	22
8	Background note	30
A	Appendix A: Additional tables	36

List of tables and figures

Table 2.1	Incidents by type of death and investigation type, 2017/18
Table 2.2	Fatalities by type of death and financial year, 2007/08 to 2017/18
Figure 2.1	Incidents by type of death and financial year, 2007/08 to 2017/18
Table 3.1	Type of road traffic fatality, 2007/08 to 2017/18
Table 3.2	Type of road traffic incident, 2007/08 to 2017/18
Table 5.1	Deaths in or following police custody: reason for detention, 2017/18
Table 6.1	Apparent suicides following police custody: reason for detention, 2017/18
Table 7.1	Other deaths following police contact: reason for contact, 2017/18
Table A1	Incidents by type of death and financial year, 2007/08 to 2017/18
Table A2	Type of death by gender, 2017/18
Table A3	Type of death by age group, 2017/18
Table A4	Type of death by ethnicity, 2017/18
Table A5	Type of death by appropriate authority, 2017/18



1

Introduction

This report presents figures on deaths during or following police contact that happened between 1 April 2017 and 31 March 2018. 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 fourteenth in a series of statistical reports on this subject, published annually by the IOPC, formerly the Independent Police Complaints Commission (IPCC). On January 8 2018, IPCC became the IOPC. This change was set out in the Policing and Crime Act 2017. The change was made because the IPCC had doubled in size since 2013, taking on six times as many investigations – and we asked the Government for structural changes to better suit our much-expanded organisation.¹

To produce these statistics, the IOPC examines the circumstances of all deaths that are referred to us. We decide whether the deaths meet the criteria for inclusion in the 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 the [IOPC 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 the IOPC 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 the 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) following or during 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 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 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 2017/18, there were the following number of fatalities in each category:

- > 29 road traffic fatalities
- > four fatal police shootings
- > 23 deaths in or following police custody
- > 57 apparent suicides following police custody
- > 170 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 their age, gender, ethnicity, and the associated police force or appropriate authority.

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

Investigations

When the IOPC is told of a fatality, it considers the circumstances of the case and decides whether to investigate independently, or to manage or supervise a police investigation. In some circumstances, the IOPC decides that the local police Professional Standards Department (PSD) or other equivalent department is best placed to investigate a case. [Box B](#) on page 7 has a description of each type of investigation.

Table 2.1 shows the type of investigation at the time of analysis for all incidents involving a fatality recorded in 2017/18. 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, 218 incidents were

independently investigated. This is higher than previous years because of the increase in the IOPC’s resources and capacity to investigate independently³, where it is appropriate to do so, more ‘other deaths following police contact’. Across all death categories, and as in recent years, no incidents were subject to a managed or supervised investigation.

Table 2.1 Incidents by type of death and investigation type, 2017/18

Type of investigation	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Independent	24	2	23	5	164
Managed	0	0	0	0	0
Supervised	0	0	0	0	0
Local	3	0	0	39	0
Back to force	0	0	0	13	0
Total incidents	27	2	23	57	164

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.

Trends

The figures presented in Table 2.2 show the number of fatalities across the different categories since 2007/08⁴. 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.

³ See the IOPC’s [Corporate Plan 2015/18](#) for more information about expansion.

⁴ Information on fatalities from 2004/05 is available on the [IOPC website](#).

Table 2.2 Fatalities by type of death and financial year, 2007/08 to 2017/18

Category	Fatalities										
	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18
Road traffic fatalities	24	40	29	26	19	31	12	14	21	32	29
Fatal shootings	5	3	2	2	2	0	0	1	3	6	4
Deaths in or following police custody	22	15	17	21	15	15	11	18	14	14	23
Apparent suicides following custody	45 [^]	56	54	46	39	65	70	71	60	57 [~]	57
Other deaths following police contact [*]	31	35	39	57 [*]	47	22	44	43	105 ^{~**}	132 [~]	170

[^] 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 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, 2007/08 to 2017/18



The number of fatal **road traffic incidents (RTIs)** has slightly decreased this year from 28 to 27. While this figure has fluctuated over the past 11 years, this year's figure represents the third highest number of RTIs recorded since 2007/08.

This year there were four fatal **police shootings**, compared to six recorded last year. This is the second highest figure recorded since 2007/08. The number of **deaths in or following police custody** has increased to 23, the highest figure recorded in 10 years. While there have been some fluctuations in this category with notable increases recorded in 2010/11 and 2014/15, this is the biggest increase recorded over the 11-year period.

The number of recorded **apparent suicides following custody** was 57, similar to the figures recorded in the previous two 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 recently been in custody. 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 is dependent on the decision of the IOPC to investigate a death independently. The criteria for making this decision may vary over time, for example in response to current public and community concerns. In addition, over the

past year, the IOPC has increased its 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 the [IOPC website](#).

⁵ See the IOPC's [Corporate Plan 2015/18](#) for more information about expansion.



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 police, usually by the 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.

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 2017/18, there were 27 fatal police-related road traffic incidents (RTIs), resulting in 29 fatalities. Of these, 20 people were male and nine were female. Ten people who died were aged over 60 and nine were aged between 21 and 30. The eldest was 91. The average age was 47. The average decreases to 26 if the deceased was the driver or passenger in the pursued or fleeing vehicle. It increases to 70 if the deceased was a pedestrian, cyclist or a driver in a vehicle hit by either the police or the pursued or a fleeing vehicle. Twenty-five people were reported to be White. Three people were Asian and one was Black.

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 17 police pursuit-related incidents that resulted in 17 fatalities. Of these:

- > Seven people were the driver of a vehicle being pursued by the police when it crashed. Of these, one person was riding a motorbike, and in another incident the person was riding a moped.
- > Four people were passengers in the car being pursued by the police. One further person was either the driver or passenger in the car being pursued by the police.
- > Two people were passengers of an unrelated vehicle that was hit by the pursued car.
- > Two people were pedestrians who were hit by the pursued or suspect vehicle.
- > One person was a pedestrian that was hit by a police vehicle in pursuit.

Fifteen of the pursuit-related incidents were investigated independently by the IOPC. The remaining two were dealt with locally by the relevant police force.

Emergency response-related

This category includes all incidents that involve a police vehicle responding to a request for emergency assistance. There were seven emergency response-related incidents resulting in eight fatalities. This is the highest figure recorded since 2004/05. All incidents are being independently investigated.

Three fatalities, from two incidents, happened when the police car, responding to an emergency call, collided with another vehicle:

- > In one of the incidents, the police were driving an unmarked police-dog vehicle with their lights and sirens on. They were responding to a call to find an alleged offender who had fled the scene of a traffic collision. The call required immediate response. A car pulled out into the path of the police vehicle and the police vehicle collided with the side of the car. The passenger and driver of that car died.
- > In the other incident, the police were driving to a report of a disturbance requiring immediate response. On the way, there was a head-on collision involving another car. The passenger of that car died⁷.

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

- > immediate risk to life with reports of suicide or self-harm
- > concern for the safety of a woman shouting for help
- > immediate concern for welfare
- > assistance with detaining suspects of serious assault

Other police traffic activity

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

⁷ The police driver of the responding car also died in this incident. Fatalities of police officers are not included in these statistics.

- > An officer riding a motorbike was taking part in a joint HMRC and police training exercise when there was a collision between the motorbike and a car. As a result of the collision, the passenger of the vehicle died at the scene⁸. The incident is being independently investigated.
- > An officer on patrol in a marked vehicle saw a car travelling at speed in the opposite direction. The officer reported the car on his radio and turned his vehicle around to search for the car. Emergency equipment was not used. Shortly after, another officer found the car, which had collided with a central reservation. The passenger of the car was taken to hospital where she later died. The incident was subject to an independent investigation.
- > In a similar incident, officers in two marked police vehicles searching for a suspicious van, heard a car travelling at speed in the opposite direction. One officer turned his car around, briefly switching on the emergency lights. The lights were turned off and the officer travelled within the speed limit. Soon after, he found the car had collided with an unoccupied parked car. Both the driver and passenger were taken to hospital where they later died.

Trends

This year there were 29 deaths from 27 separate incidents. This is the third highest figure of fatalities recorded in the past eight years and is the seventh highest figure recorded over the 14-year period since 2004/05, when these statistics were first published. These figures are subject

to fluctuation and, therefore, we should be cautious when making year-on-year comparisons.

Tables 3.1 and 3.2 have details of the type of road traffic fatalities and incidents over the past 11 years⁹. 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 a decrease in the number and proportion of pursuit-related incidents. The figure has decreased to the average seen over the previous years before the spike recorded in last year's figures. There were no pursuit-related incidents that resulted in multiple fatalities.

This year there has been an increase in the number of emergency response-related incidents. It is the highest number of emergency response incidents and fatalities recorded since 2004/05, when these statistics were first published. There was one emergency response-related incident that resulted in two fatalities.

The number of incidents resulting from other police traffic activity is similar to previously recorded figures, and the average recorded in the previous eight years. There was one other police traffic incident that resulted in two fatalities.

⁸ The police officer riding the motorbike also died in this incident. Fatalities of police officers are not included in these statistics.

⁹ Information on fatalities and incidents from 2004/05 is available in the time series tables on the [LOPC website](#).

Table 3.1 Type of road traffic fatality, 2007/08 to 2017/18

Fatalities											
RTI type	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18
Pursuit-related	17	22	19	13	12	27	10	7	13	28	17
Emergency response-related	2	6	3	4	2	2	0	0	2	0	8
Other	5	12	7	9	5	2	2	7	6	4	4
Total fatalities	24	40	29	26	19	31	12	14	21	32	29

Table 3.2 Type of road traffic incident, 2007/08 to 2017/18

Incidents											
RTI type	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18
Pursuit-related	11	16	17	13	12	19	9	6	12	24	17
Emergency response-related	2	6	3	3	2	2	0	0	2	0	7
Other	5	11	6	8	5	2	2	7	6	4	3
Total incidents	18	33	26	24	19	23	11	13	20	28	27



4

Fatal shootings

This year there were four fatal shootings by police. This figure is the third highest recorded since 2004/05. Three people died from one incident, which was terrorism-related. This is the first incident since figures have been reported that involved officers from two different police forces. The circumstances of the four fatal police shootings are described below. One incident is subject to an ongoing independent investigation and other one is complete.

Armed officers from the City of London police and Metropolitan Police Service (MPS), responded to an incident involving a white van occupied by two Asian men, aged 27 and 30, and a 22-year-old man of Mixed race. They drove over London Bridge, hitting and injuring pedestrians. After crashing the van, the three suspects made their

way on foot, armed with knives. They stabbed and killed eight people on the street and in restaurants. The three suspects were wearing items strapped to their chests that appeared to be improvised explosive devices (IEDs)¹⁰. Armed officers from City of London Police and the MPS arrived and fired 46 bullets. All three suspects died at the scene.

Armed officers from Avon and Somerset Constabulary responded to an incident involving a White man, aged 29, travelling on the motorway with a handgun, with which he had threatened another motorist. The vehicle was stopped by armed police. Officers approached the car and challenged the driver. Officers fired hitting the driver. The man received medical attention, but died at the scene. A non-police issue firearm was recovered from the scene.

¹⁰ A type of unconventional explosive weapon, handmade from a variety of components that can take any form and be activated in several different ways.



5

Deaths in or following police custody

Demographics

Twenty-three people died in or following police custody. Twenty-one were men and two were women. Their ages ranged from 21 to 82. Sixteen people were reported to be White, six were Black, and one was in the Other category for ethnicity.

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

Eighteen 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 was known, a pathologist said that alcohol or drug toxicity, or long-term abuse, was likely to be a contributing factor in their deaths for nine people.

Table 5.1 shows the reasons why people were arrested or detained by the police. Eight people were arrested for an alleged assault – four of these people were also arrested for other reasons including possession of weapon, drug offences and criminal damage. A further four people were detained under Section 136 of the Mental Health Act 1983¹¹. Three people were arrested for an offence relating to alcohol or

¹¹ 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.

drugs, with one person also being arrested for shoplifting. Three further people were arrested for a breach of the peace or anti-social behaviour. Other reasons for detention

included: driving offences, possession of a weapon, breach of bail conditions, and one person was arrested for burglary and criminal damage.

Table 5.1 Deaths in or following police custody: reason for detention, 2017/18

Reason for detention	Number of fatalities
Violence-related (non-sexual or murder)	8**
Mental Health Act	4
Drug / alcohol-related (excluding drink driving)	3^
Breach of the peace / anti-social behaviour	3
Driving offences, including drink driving	2*
Possession of a weapon	1
Breach of bail	1
Burglary and criminal damage	1
Total fatalities	23

** Two men were also arrested for possession of a weapon; one man for drug offences; and one further man for criminal damage and resisting arrest.

^ One man was also arrested for shoplifting.

* One man was also arrested for drug offences.

It is known that 11 of the 23 people had some force used against them by officers or by 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.

All 11 people were physically restrained¹² by the police or non-police, such as security staff or members of the public. Six people

were White and five people were Black. Six incidents also included these other methods of force:

- > leg restraints¹³
- > a contamination hood¹⁴
- > a baton
- > incapacitant spray¹⁵ and a baton
- > Taser, incapacitant spray, leg restraints and baton

12 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.

13 This device is used to restrict the movement of limbs. Its application should prevent a person from kicking and punching, and allow for safe transportation of the person.

14 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.

15 Two types of incapacitant spray 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-mortem¹⁶ is reported for 16 of the 23 people who died. At the time of reporting, the cause of death was pending for seven people. All but one of the cases await an inquest. 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 the 23 deaths are being independently investigated by the IOPC.

Eight people were taken ill, or were identified as being **unwell in a police cell**. Three of these people died in a police cell. Five were taken to hospital where they died on arrival, or sometime later. Of these eight:

- > One man reported being under the influence of drugs when arrested. He was known to be drug-dependent. He was seen by a doctor for stomach pain and leg ulcers. He was put on half-hourly checks. During one check, he appeared unwell. Medical aid was provided and an ambulance was called. He died shortly after their arrival. His cause of death was reported as *poly-drug toxicity*.
- > When being booked into police custody, one man collapsed from an apparent seizure. Medical aid was provided. He died shortly after. His cause of death was reported as *acute cocaine intoxication*.
- > One man was arrested for drug possession and shoplifting and taken into custody. During a routine check, he was found unresponsive in his cell. Medical assistance was provided. He died shortly after. His cause of death was reported as *coronary artery atheroma influenced by cocaine usage*.
- > One man was arrested for drug possession. On the way to the police custody suite, and when he arrived there, the man complained of feeling unwell. He was seen by a medical professional. Soon after, he started to fit. An ambulance was called and he was taken to hospital where he later died. His cause of death was reported as *cocaine toxicity*.
- > One man, who had been arrested on suspicion of assault and drug possession, was suspected of concealing drugs in his body. An examination, before he went into custody, failed to find anything. Several hours later, he was found unresponsive in his cell. Medical aid was given and an ambulance was called. He was taken to hospital and died shortly after arrival. His cause of death was recorded as *toxicity of morphine derived from heroin with some contribution from the effects of cocaine*.
- > One woman stated on arrival at custody that she might be pregnant and was taken to hospital. She was returned to custody after her pregnancy was confirmed. She was deemed fit to be detained, although still under the influence of alcohol. During one of the cell checks, she was found unresponsive. Medical aid was provided. She was taken to hospital by ambulance where she died shortly after arriving. Her cause of death is awaited.
- > A man was arrested for domestic assault. On arrival in police custody, he became aggressive and assaulted officers. A contamination hood was placed over his head and leg restraints were applied. He was carried to his cell and the restraints were removed, and the officers left the cell. Shortly after officers left the cell, concerns were raised for his health. They re-entered the cell and provided medical aid. He was taken to

¹⁶ 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'.

hospital by ambulance where he died a few days later. His cause of death is awaited.

- > As one man was being booked into custody, police believed he had something in his mouth. He was restrained and taken to the ground as officers urged the man to spit the item out. He did not spit anything out and denied having swallowed anything. He was returned to his feet. The custody CCTV was reviewed by custody staff and it was believed the man may have swallowed the item. An ambulance was called and he was taken to hospital as a precaution. His condition deteriorated at the hospital where he died the next day. His cause of death is awaited.

Nine people were taken ill at the **scene of arrest**. All were taken to hospital where they died on arrival, or sometime later. Of these nine:

- > One man, shortly after being arrested at his home, became unwell. Medical assistance was provided and paramedics attended. He was taken to hospital by ambulance where he died shortly after arrival. His cause of death was reported as *1a) ischaemic heart disease 1b) coronary artery atheroma 2) hypertension chronic obstructive pulmonary disease*.
- > Police officers found a man lying in a field. They described the man as appearing to be having a mental health crisis and they requested the assistance of an ambulance. The man was restrained before the ambulance arrived. While paramedics were at the scene the man's condition deteriorated. He was taken by ambulance to hospital where he later died. His cause of death is awaited.
- > Police attended a scene following concern about a man's erratic behaviour. He apparently became aggressive and the care home where he lived refused to drive him home. The police detained him under the Mental Health Act. An ambulance was called to take him to a hospital as place of safety because a police van was not suitable, due to the man having a skin complaint. On arrival at the hospital, there were concerns for his health and he was taken to the emergency ward. The police remained with him because he was aggressive. The man's condition deteriorated and he died shortly after. His cause of death was reported as *ischaemic heart disease*.
- > One man contacted the police to report that he planned to jump off a bridge. The police arrived at the scene. The fire service secured him with a rope and escorted him off the bridge to the road. He was detained under the Mental Health Act and put in the attending ambulance. Soon after, he got out of the ambulance, and ran back onto the bridge. He could not be reached and fell shortly after. He was taken to hospital where he died from the injuries sustained in the fall.
- > One man was stopped by police when his vehicle was identified as being involved in a drug offence. Intelligence reported that the man was wanted on suspicion of burglary and criminal damage – he was arrested for these offences. The man was seen to chew something and then swallow it. His condition deteriorated rapidly. An ambulance was called and he was taken to hospital. He died some time later. His cause of death was reported as *hypoxic, ischaemic brain injury, cardiorespiratory arrest, airway obstruction by foreign body*.
- > The police attended a scene following reports of a man who appeared unwell, behaving aggressively and not wearing any clothes. The police used incapacitant spray, a baton and physical restraint during his arrest. The man was taken directly to hospital due to

his injuries. He was de-arrested and stayed in hospital for nine days. He died the day after he left hospital. His cause of death was reported as *pulmonary embolism and thrombosis*. It could not be proved or disproved that the injuries sustained to his legs during his arrest (likely caused by the police baton) contributed to his death.

- > Police were called following concern about a man's behaviour which was considered to present a risk to himself and others. During the contact, various methods of force were used including Taser, incapacitant spray and a baton. He was arrested for breach of the peace and placed in handcuffs. Police decided to take him straight to hospital and the man was placed in a police van. While at hospital his condition deteriorated. He died nine days later in hospital. His cause of death cannot be reported at this time.
- > A man, who had allegedly been threatening the public with a knife, was restrained on the floor of a café by members of the public. The police arrived, then restrained the man and applied handcuffs. He was arrested for possession of a knife and assault. The man was asthmatic and not breathing well and an ambulance was called. He was placed into a police van because he was resisting and tried to run away. The man was monitored in the stationary van until the arrival of the ambulance. He was taken to hospital where he was found to be suffering from an incurable medical complication. He died the following day. His cause of death was reported as *a) multiple organ failure b) acute complications from cocaine misuse causing significant damage to bowel*.
- > The police were called to a fight between neighbours. When the police arrived, one of the men was being restrained on the floor by members of the public. The police arrested the man who was being restrained

and applied handcuffs. Shortly after, the police noted that the man was unwell. The handcuffs were removed and an ambulance was called. The police provided medical aid until the paramedics arrived. The man was taken to hospital where he died the following day. His cause of death is awaited.

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

- > The police were called to a scene where a man had refused to leave another man's home and allegedly caused damage and assaulted someone. The man calling the police reported that he had put the man in a choke hold. Police arrested the man for breach of peace and after a small struggle placed him in the police van. While travelling, the man stopped breathing. Medical assistance was given and an ambulance called. He was taken to hospital by ambulance where he died shortly after arrival. His cause of death is awaited.
- > One man was arrested for breaching his community behaviour order. He was put in a police van and taken to a custody suite. During the journey, the man became unwell. While in the van bay of the custody suite, the man was found to be unresponsive. Medical assistance was provided. Paramedics attended, but the man died shortly after their arrival. His cause of death was reported as *a) anomalous origin of right coronary artery b) acute and chronic alcoholism*.
- > Police were called to a scene of a fight that reportedly involved a knife. One suspect had fled the scene. Police located him at his property. During the arrest, the man was restrained and a baton was used. The man was handcuffed and two knives were found in his possession. While being taken

to custody, officers were concerned for his welfare and believed he had something in his mouth. Medical assistance was provided and an ambulance called. Paramedics attended and removed an item from his mouth. He was taken to hospital where further drug packages were found concealed internally. He died soon after. His cause of death is awaited.

- > Police attended the home of a man who was suspected of being involved in an earlier road traffic collision. While being taken to custody, the man became unwell. Medical assistance was provided and an ambulance was called. He was taken to hospital where he died shortly after arrival. His cause of death cannot be reported at this time.

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

- > One woman was detained under the Mental Health Act following concerns for her welfare. Handcuffs and leg restraints were applied. She was taken to one hospital and then another for a full mental health assessment. She was then held in a mental health unit until she died nine days later. Her cause of death was recorded as *1a) pulmonary thromboembolism 1b) deep vein thrombosis*. It could not be proved or disproved that the use of the leg restraints during her detention contributed to her death.
- > While in custody, one man who had been arrested on suspicion of driving while unfit, appeared disorientated apparently under the influence of drugs. The man still showed signs of being confused and drowsy when he was released in the early hours of the morning. He walked to the car depot that was located near train tracks to collect his car. He was then hit by a train, apparently having failed to get out of the way, possibly due to his confused state. He died from the *multiple injuries* sustained.

Trends

Between 2004/05 and 2008/09, there was a year-on-year reduction in the number of deaths in or following police custody. They reduced from 36 deaths 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. This year the figures have increased to 23 fatalities, the highest recorded number in the past 10 years.

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



6

Apparent suicides following police custody

Apparent suicides following police custody are reported if they take place within two days of 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 the IOPC. 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 57 apparent suicides following police custody. Of these, 55 were men and two were women. The average age of those who died was 40. The most common age was between 41 and 50 (19 people), followed by 31 to 40 (16 people). The youngest person was 18-years-old. Forty-seven people were

reported to be White. Six people were Black, three were Asian, and one person was from a Mixed ethnic group.

Almost three-quarters of the people (41) had known mental health concerns. Of these, two had been detained under Section 136 of the Mental Health Act. Other mental health concerns included; depression, schizophrenia, post-traumatic stress disorder, bi-polar, psychosis, previous thoughts or incidents of suicide attempts and self-harm.

Half of the people (29) 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-one of these related to alcohol and 13 to drugs.

Circumstances of death

Fourteen apparent suicides happened on the day of release from police custody. Twenty-eight were one day after release, and 15 happened two days after release.

Table 6.1 shows why these people had been detained. Twenty-nine of those who died had been arrested for a sexual offence. Of these, 25 were related to sexual offences or indecent images involving children. Sixteen people had been arrested for violence-related offences. Other reasons for detention, included driving offences (three) and being detained under Section 136 of the Mental Health Act (two). Drug-related offences was an additional arrest reason for three people, and criminal damage was an additional arrest reason for a further three people.

Table 6.1 Apparent suicides following police custody: reason for detention, 2017/18

Reason for detention	Number of fatalities
Sexual offences	29*
Violence-related (non-sexual or murder)	16^
Driving offences (including drink driving)	3
Mental Health Act	2
Failure to appear in court	2
Theft	1
Drug / alcohol-related (excluding drink driving)	1
Possession of a weapon and trespassing	1
Criminal damage	1
Threatening behaviour	1
Total fatalities	57

* Three men were also arrested for drug offences.

^ Two men were also arrested for criminal damage; one man for being drunk and disorderly; one man for harassment; and one man for theft and criminal damage.

The majority of recorded apparent suicides following custody were dealt with locally by the police force (52). Five are being investigated independently. In these cases, the investigations considered:

- > The mental health and risk assessment of a man in police custody. On the same day he was released from custody, the man took his own life in the way he told officers he would.
- > The decision to release a man when there was information to suggest that he was potentially at high risk of self-harm and whether further safeguarding actions could have prevented him taking his own life the following day.
- > The actions and considerations taken for a man's welfare while he was in custody and if these were appropriate.
- > The level of information shared with the court about a man's intention to take his own life, if released. He was released on bail and the pre-release risk assessment noted his suicide intentions. The man was found the next day having taken his own life using a rope that was returned to him when released.
- > The appropriate safeguarding measures for a man with limited mental capacity.

a recent period of custody. Increases in these deaths may therefore be influenced by improved identification and referral of such cases.

This year, for 51% of fatalities, the reason for detention related to alleged sexual offences. The proportion of sexual offences or indecent images involving children was 44%. These are the second highest proportions recorded since 2004/05. The average proportions for these alleged offences over the 14-year period are 34% and 27% respectively.

Trends

The number of apparent suicides following custody is the same as the 57 recorded last year. It is the fifth highest recorded over the 14-year period since 2004/05. It is in-line with the average figure, since the release of the operational advice note in 2007/08. Reporting of these deaths relies on police forces making the link between an apparent suicide and



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 recorded as 'other deaths following police contact', because inclusion of these types of case into 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, the IOPC (operating as the IPCC) received about 430 referrals each year where someone had died following police contact. In 2013/14 and 2014/15, the IOPC investigated independently approximately one in ten (10%) of these referrals. 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. This year, about one in three (33%) such referrals were independently investigated.

¹⁷ See the IOPC's [Corporate Plan](#) 2015/18 for more information.

Overall demographics

The IOPC independently investigated the deaths of 170 people who died during or following other contact with the police during 2017/18. Of these:

- > One-hundred and twelve were men and 58 were women.
- > One-hundred and forty-seven people were White, eight were Asian, four were Black, two were of Mixed heritage and one person was from an Other ethnic group. The ethnicity for eight people was not known at the time of reporting.
- > Seven people were aged under 18, and 23 people were young adults aged between 18 and 24. The average age was 42.
- > Over half the people who died (93) 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. Almost three-quarters of the people who died (120) were reported to have mental health concerns.

Table 7.1 Other deaths following police contact: reason for contact, 2017/18

Reason for contact		Number of fatalities
Concern for welfare	Missing person	45
	Self-harm / suicide risk / mental health	43
	Health / injuries / intoxication / general	24
	Domestic related	21
	Threatening behaviour / harassment	11
	Other	2
	<i>Subtotal</i>	<i>146</i>
Other contact	Execute search / arrest warrant / investigation enquiries	13
	Avoiding contact / arrest	4
	Assist medical staff	2
	Attending a disturbance	2
	Other	3
	<i>Subtotal</i>	<i>24</i>
	Total fatalities	170

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, 146 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 24 fatalities recorded relating to other types of contact with the police.

A total of six 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. Three people were Black and three were White. One man had leg restraints used on him. Five people who died were known to have been restrained by police officers or by members of the public. In three of these cases, other methods of force used included:

- > Taser
- > incapacitant spray
- > leg restraints

Concern for welfare

Of the 146 fatalities that followed contact with the police about a concern for welfare, 45 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, 29 people were also identified as at risk of **self-harm or suicide**. For these 29:

- > Twenty people who died were men and nine were women. Twenty-five people were White and two were Asian. One person was Black and one was of Other ethnicity.
- > The ages of people in this category ranged from 22 to 86. The most common age group was 21 to 30 (10 people). The average age was 42.
- > For 13 people, alcohol and/or drugs featured heavily in their lifestyle. All 29 people who died were known to have mental health concerns.
- > In 27 incidents, the person's death was from an apparent self-inflicted act. Two people died from natural causes.

For the remaining 16 people **reported missing** to the police, there were no specific risks of self-harm or suicide. In these cases:

- > Eleven people who died were men and five were women. Thirteen people were White and one was Asian. The ethnicity for two people was not known.
- > The ages of people in this category ranged from 15 to 51. The most common age groups were 18 to 20 (five people) and 31 to 40 (five people).
- > For 10 people, alcohol and/or drugs featured heavily in their lifestyle. Thirteen people were known to have mental health concerns.
- > The classification of death for eight people

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'.

was from an apparent self-inflicted act. Four deaths appeared accidental and two were alleged murders. One death was from natural causes and one classification is awaited pending further investigation.

Forty-three 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-two people were men and 21 were women. Women accounted for a higher proportion of this category of contact than in all the other following contact deaths.
- > Forty-two people who died were White. The ethnicity for one person was unknown. 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 21 to 67. The most common age group was 41 to 50 (16 people) followed by 21 to 30 (11 people). The average age was 42.
- > Death by self-inflicted means was the most common classification for death (37 people).
- > For 27 people, alcohol and/or drugs featured heavily in their lifestyle. This is a higher proportion in this concern for welfare category than in all the other deaths in or following police contact that were independently investigated.

Twenty-four 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:

- > Nineteen people were men and five were women. The proportion of men was higher in this concern for welfare contact type compared to all other deaths during or following police contact.
- > Twenty people were White and one was Asian. The ethnicity of three people was unknown.
- > The majority of people (20) were aged over 40, with eight people aged over 60. The average age was 56, older than for the other types of contact.
- > Over-half (13 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 (11 people).
- > In one incident restraint equipment was used. The police attended a call that a White man, aged 22, had taken a quantity of tablets and had been drinking. The ambulance service was also on their way. The man was shaking and behaving erratically. He was handcuffed to the front and leg restraints were used. He was taken to hospital by ambulance and died soon after arrival. His cause of death was reported as *multi-drug toxicity*.

Twenty-one 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:

- > Twelve people who died were women and nine were men. Women were a higher proportion in this category than in all the

other independently investigated deaths following police contact.

- > Nineteen people were White, one was Asian and one person was of Mixed ethnicity.
- > The most common age group was 31 to 40 (six people). The average age was 37. This is lower than the average age compared to the other deaths in or following police contact.
- > In 11 instances, the classification of death was an alleged murder. Seven were self-inflicted. All but two of those who were allegedly murdered were women. The two males who were allegedly murdered were children.
- > Two incidents each resulted in two fatalities. In one of these incidents, two family members were allegedly murdered. In the other incident a person was apparently murdered and the suspected perpetrator then died by a self-inflicted act.

Eleven 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:

- > Eight people were men and three were women. Nine people were White, one was Asian and one was of Mixed ethnicity.
- > Eight classifications of death were alleged murder. Two deaths were self-inflicted and one was considered accidental.
- > Two incidents resulted in six fatalities. In one incident there were two deaths; one person was apparently murdered and the suspected perpetrator then died by a self-inflicted act. In the other incident, there were four fatalities – these were four children from the same family who were murdered in a fire.

- > One incident involved police use of force. The police were called to reports of a White man, aged 30, threatening people in the street with a knife. When officers arrived, the man attempted to self-harm. Taser and physical restraint were used and the man was disarmed. An ambulance was called. He was taken to hospital where he died shortly after arrival. His cause of death was reported as *1a) sudden unexpected death following the use of cocaine, an episode of altered behaviour including self-harm, excitement, exertion and restraint including the discharge of a Taser X26 device.*

Two people died following **other** types of concern for welfare that are not covered by the above categories. The circumstances in this category vary:

- > The police were contacted with concerns about the way a van was being driven. Shortly after, there was a road traffic collision that involved the van hitting a car. The passenger in the car died in the helicopter on the way to the hospital.
- > One man, White, was reported to the police to be running in-between traffic. The police attended the scene and found the man. The man was considered as behaving strangely. A struggle with police followed and the man was restrained and put in handcuffs. Soon after, he appeared unwell. Medical aid 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 *combined effects of acute-on chronic cocaine intoxication, excitement, exertion, restraint and hyperthermia with terminal bronchopneumonia.*

Other contact

The 24 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, who was Asian, were White. All were men. The majority (10) were aged over 40. In 11 incidents, the death was self-inflicted. In 12 of the 13 deaths, the police were making investigation enquiries, or following-up breach of bail conditions linked to allegations of sexual-related offences.

Two men, both White, died after police were **called to assist medical staff**:

- > In one incident, the ambulance service called the police to assist with a White man, aged 42, at his home who they were trying to treat. He was described as acting oddly and he had become aggressive towards the ambulance crew. He was also believed to have taken an unknown drug. An officer held the man's arm while the paramedic inserted a cannula to sedate the man. He was placed on a stretcher and taken downstairs. The man's condition deteriorated and first aid was provided. He was taken to hospital where he died shortly after arrival. His cause of death is *1) amphetamine toxicity with 2) morbid obesity with coronary artery atheroma and cardiomegaly*.
 - > One man, White, aged 51, who suffered from health problems due to long-term alcohol abuse, required emergency medical treatment. The ambulance service attended and called for police assistance because the man was allegedly acting violently towards them while they tried to treat him. The officers attended and handcuffed the man because he continued to lash out. His condition deteriorated rapidly as he was moved into the ambulance. The handcuffs were then removed. Soon after, he died in the ambulance. His cause of death was reported as *1a) acute gastrointestinal haemorrhage 2b) rupture oesophageal varices and portal hypertension 3c) chronic alcohol liver disease*.
- Four men died while attempting to **avoid contact or arrest** by the police:
- > Police were called to a train station shop where a White man, aged 33, had allegedly stolen a bottle of alcohol. Police took statements from the shop owner and the man. The man then ran off. The police followed but briefly lost sight of him. They then saw the man on top of a parked train. The police commanded the man to get down. Soon after, the man was struck with electricity from the overhead power cables. His cause of death was reported as *1a) severe burns following high voltage electrocution*.
 - > A man, White, aged 52, was reported to the police for allegedly stealing handbags from a stall. Two police community support officers were in the area and saw the man who then ran away. He was seen jumping over a barrier onto a junction. He was hit by a vehicle. The man died at the scene from his injuries.
 - > An officer ran after a man, Black, aged 20, and followed him into a shop. The man had fled when the officer attempted to stop a vehicle the man was in earlier. The officer restrained the man on the floor, with assistance from a member of the public. The officer then attempted to open the man's mouth to check inside. The officer

told the man to spit out what he believed had been swallowed. The man's condition soon deteriorated. Medical assistance was provided and an ambulance took him to hospital where he died soon after arrival. His cause of death was reported as *1a) cardiac arrest 1b) upper airway obstruction by foreign body.*

- > The police stopped a car. One of the occupants, a Black man, aged 25, was taken to the floor by a number of officers following a struggle. Incapacitant spray was also used on the man. Drug packages that were in the man's mouth fell onto the floor. He soon became unwell. Medical care was provided and an ambulance was called. He was taken to hospital where he later died. His cause of death was reported as *1a) hypoxic ischaemic encephalopathy 1b) cardiorespiratory arrest 1c) foreign body upper airway obstruction.*

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

- > One woman, White, aged 27, contacted the police because she thought she heard someone in her home. The police attended and searched the property but no one was found. She was known to the police to have a history of mental health concerns and to be a drug user. A few hours after the police left, the woman took her own life.
- > Officers were called to an attempted robbery. When they arrived, one of the suspects, a Black man, aged 30, was being restrained by an off-duty officer and members of the public. The off-duty officer identified himself as police, putting him on duty. The police arrived and put the man in handcuffs and leg restraints. A passing ambulance stopped to assist. While being restrained, the man became unwell. He was treated by the paramedics and taken to hospital where he

died the next day. His cause of death was reported as *1a) global brain ischaemia and multiple organ failure 1b) cardiorespiratory arrest 1c) period of physical restraint.*

Three deaths occurred following **other contact** with the police:

- > One man applied to the police for a firearms licence. Information was gathered as part of the application review. The licence was granted. Approximately six weeks later, the man took his own life using one of the firearms.
- > One man was wanted for breaching his bail conditions. There were several reminders to the police to action his arrest but this did not happen. While wanted for arrest, the man assaulted another man who later died.
- > One woman, in her professional capacity, wrote a report concerning an officer's welfare, for an ongoing misconduct investigation. She was allegedly told by a member of police staff that she would be sued in relation to her report. Soon after, the woman took her own life and referred to a Police Federation officer in her suicide note.

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. 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 one specific set of events that account for changes in the number of fatalities.

The number of cases that fall into this category has increased because the IOPC is carrying out more independent investigations into these matters. The overall proportion of cases relating to a concern for welfare made up 86% of the deaths following police contact that were independently investigated – last year, the proportion was 80%. This year, over a quarter of investigations into deaths following police contact related to incidents where there was a report of a missing person.



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 death¹⁹. 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)²⁰, and the Serious Organised Crime Agency (SOCA), and since
 - 3 The IOPC (previously the IPCC) has been going through a significant period of change and expansion,
- October 2013, SOCA's replacement, the National Crime Agency (NCA). Up until March 2013, it also received cases from the UK Border Agency (UKBA)²¹, 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 these organisations or individuals, therefore, are also presented in this report.

¹⁹ 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.

²⁰ Regulation 34 of the Revenue and Customs (Complaints and Misconduct) Regulations 2005.

²¹ Regulation 25 of the UK Border Agency (Complaints and Misconduct) Regulations 2010.

which has seen them carry out significantly more independent investigations into serious and sensitive cases. This has had an impact on the number of deaths recorded in the category of ‘other deaths following police contact that were subject to an independent investigation’. As a result, we have changed the approach to how this category is presented in this report.

- 4 In January 2018, we became the IOPC. Before this, we were the Independent Police Complaints Commission (IPCC). Since 2013, we have doubled in size and now take on six times as many investigations. This led us to ask the Home Office for structural changes to better suit our much-expanded organisation. These changes were formalised in the Policing and Crime Act 2017. You can [read more about this process and changes](#) here.

Changes and revisions

- 5 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. 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.
- 6 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.

- 7 This report presents the most up-to-date set of figures for each death category. In this release, 11 fatalities have been added to previous years’ figures. In the category ‘other deaths following police contact’, one fatality has been added for the year 2015/16, and a further eight fatalities to the 2016/17 figure. Two ‘apparent suicides following police custody’ have been added to the 2016/17 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.

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, the IOPC's 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 due 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 due to 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 23 July 2015 the then Home Secretary, the Rt Hon Theresa May MP announced a major review into deaths and serious incidents in police custody. Dame Elish Angiolini DBE QC was appointed to lead the review and 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 [independent review](#) was published on 30 October 2017 and contained 110 recommendations spanning policing, criminal justice and healthcare sectors. 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 can be read on our [website](#). The findings from the review are being used to inform the organisation's operational improvement work. We are also 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.

17 In the findings of the independent review Dame Elish Angiolini recommended that the Government adopt the IOPC's draft guidance on 'achieving best evidence in death or serious injury investigations'. If approved, it will be published on a statutory footing.

18 In March 2017, we held a family listening day. Working with the charity INQUEST, which provides support to families who have been bereaved following contact with the police, the event gave families the opportunity to feed back on their experiences of the IPCC investigation process.

We listened carefully to what families had to say and as a result we made a number of changes to the way we work. The family listening day report was published earlier this year and can be found on INQUEST's [website](#).

19 In 2014 we reviewed the way in which 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.

In 2017/18, we provided engagement support to 13 investigations. The purpose of this work was to:

- > increase community and stakeholder confidence in the organisation's work
- > improve public and stakeholder understanding of the IOPC's 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

20 The IOPC has 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 these organisations 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 has made in implementing IOPC recommendations relevant to police custody. We also worked with the College of Policing on its revision of Authorised Professional Practice (APP) on mental health. The revised guidance was published in August 2016.

- 21** In August 2017 the IOPC, then the IPCC, wrote to the College of Policing and the National Police Chiefs' Council (NPCC) following a number of deaths involving individuals suspected of swallowing or attempting to swallow packages. We highlighted that there was some inconsistency in the guidance on whether force should ever be used to deal with someone who may have something in their mouth. The NPCC are currently reviewing their guidance in this area. The Metropolitan Police Service additionally has since suspended the practice of using force to carry out mouth searches. We have also issued a number of repeated recommendations in recent years, stating that forces must treat such circumstances as a medical emergency.
- 22** In September 2017, the Home Office announced their review of the law, guidance and practice surrounding police pursuits and emergency response drives. The IOPC welcomed the review and submitted evidence in relation to its work. We will be responding to the proposals for change set out in the consultation published in May 2018.
- 23** The Policing and Crime Act amended sections 135 and 136 of the Mental Health Act. These came into effect on 11 December 2017. Owing to the changes, it is now unlawful to use a police station as a place of safety for anyone under the age of 18 in any circumstances. Other changes include; restricting the use of police cells for adults to very specific circumstances, such as when there is an imminent risk of injury or death; and decreasing the maximum detention time from 72 to 24 hours. Additionally, section 136 powers may now be exercised anywhere other than in a private dwelling. For guidance on the changes please visit the [Home Office website](#).
- 24** In March of this year, the IOPC published the 32nd edition of [Learning the Lessons](#), which has specific learning relevant to the issues that arise in custody and detention. It also covers areas relevant to mental health and personal safety.
- 25** Significant changes are due to be made to the police complaints and disciplinary systems. These will impact on the work of the IOPC and the organisation itself. These changes were given effect by the Policing and Crime Act 2017.
- 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, the IOPC also periodically produces 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 the annual death reports, please email the IOPC research team at research@policeconduct.gov.uk.

31 Estimated publication date for 2018/19 report: July 2019.



Appendix A: additional tables

Table A1 Incidents by type of death and financial year, 2007/08 to 2017/18

Category	Incidents										
	07/08	08/09	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18
Road traffic incidents	18	33	26	24	19	23	11	13	20	28	27
Fatal shootings	4	3	2	2	2	0	0	1	3	6	2
Deaths in or following police custody	22	15	17	21	15	15	11	18	14	14	23
Apparent suicides following custody	45 [^]	56	54	46	39	65	70	71	60	57 [~]	57
Other deaths following police contact*	30	33	37	49 [*]	37	20	41	43	102 ^{**~}	129 [~]	164

[^] 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 IOPC 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, 2017/18

Gender	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Male	20	4	21	55	112
Female	9	0	2	2	58
Total fatalities	29	4	23	57	170

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

Table A3 Type of death by age group, 2017/18

Age group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Under 18	2	0	0	0	7
18 - 20	1	0	0	3	9
21 - 30	9	4	5	10	36
31 - 40	3	0	6	16	27
41 - 50	3	0	7	19	39
51 - 60	1	0	3	6	34
61 and over	10	0	2	3	18
Total fatalities	29	4	23	57	170

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

Table A4 Type of death by ethnicity, 2017/18

Ethnicity group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
White	25	1	16	47	148
Black	1	0	6	6	4
Asian [^]	3	2	0	3	8
Mixed	0	1	0	1	2
Other	0	0	1	0	1
Not known	0	0	0	0	7
Total fatalities	29	4	23	57	170

* 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, 2017/18

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	1	0	0	0
Bedfordshire	0	0	0	2	3
Cambridgeshire	0	0	0	2	1
Cheshire	1	0	1	2	3
City of London	0	0 [^]	0	0	0
Cleveland	0	0	0	2	2
Cumbria	0	0	0	0	1
Derbyshire	3	0	1	0	1
Devon and Cornwall	0	0	1	1	9
Dorset	0	0	0	0	5
Durham	0	0	0	2	3
Dyfed-Powys	0	0	0	1	1
Essex	0	0	1	1	7
Gloucestershire	0	0	0	1	3
Greater Manchester	0	0	1	0	19
Gwent	0	0	0	0	1
Hampshire	0	0	1	3	1
Hertfordshire	0	0	1	3	3
Humberside	0	0	0	0	3
Kent	1	0	1	1	6
Lancashire	4	0	0	0	3
Leicestershire	0	0	0	1	2
Lincolnshire	0	0	0	0	1
Merseyside	2	0	1	1	6
Metropolitan	5	3 [^]	4	6	12
Norfolk	1	0	0	0	2
North Wales	0	0	0	1	2
North Yorkshire	0	0	1	2	2
Northamptonshire	0	0	0	0	3
Northumbria	0	0	0	1	3
Nottinghamshire	0	0	3	3	1
South Wales	1	0	0	3	5
South Yorkshire	1	0	0	2	2
Staffordshire	0	0	0	1	4
Suffolk	0	0	0	0	0
Surrey	0	0	0	1	1
Sussex	2	0	1	3	5
Thames Valley	3	0	2	3	3
Warwickshire	0	0	1	0	2
West Mercia	0	0	0	1	3
West Midlands	2	0	1	3	18
West Yorkshire	3	0	1	2	10
Wiltshire	0	0	0	0	2
Lancashire and Merseyside	0	0	0	0	1
Leicestershire and Derbyshire	0	0	0	0	1
West Midlands and Warwickshire	0	0	0	0	1
Humberside and Lincolnshire	0	0	0	0	1
West Mercia and Staffordshire	0	0	0	0	1
British Transport	0	0	0	1	1
Home Office~	0	0	0	0	0
HMRC	0	0	0	0	0
Ministry of Defence	0	0	0	0	0
National Crime Agency	0	0	0	1	0
Total fatalities	29	4	23	57	170

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

~ This includes UKBF, UKIE and UKVI.

^ Officers from City of London and Metropolitan Police, were involved in one incident that resulted in three fatalities.

Independent Office for Police Conduct

10 South Colonnade

Canary Wharf

London

E14 4PU

Tel: 030 0020 0096

Email: enquiries@policeconduct.gov.uk

Website: www.policeconduct.gov.uk

July 2018

ISBN: 978-0-9573365-9-9