IOPC Independent Office for Police Conduct

Deaths during or following police contact

Statistics for England and Wales 2023/24

Acknowledgements

Melanie O'Connor and Aleksander Stojkowski led the production and analysis of this report, with support from Kira Godley in the research team at the Independent Office for Police Conduct (IOPC). Our thanks go to IOPC colleagues who 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

Email research@policeconduct.gov.uk if you have any questions or comments about this report.

National statistics

The UK Statistics Authority has designated these statistics as National Statistics, in accordance with the *Statistics and Registration Service Act 2007*. When statistics are designated as National Statistics it is a statutory requirement that the Code of Practice is followed.

This 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

Contents

List of tables and figures

1 Introduction

This report presents figures on deaths during or following police contact that happened between 1 April 2023 and 31 March 2024. 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 twentieth in a series of statistical reports on this subject, published annually by the IOPC.

We examine the circumstances of all deaths referred to us to produce these statistics. 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 provides a definition for each of these categories.

Please see the guidance document on the IOPC website for more detailed definitions.

More information about the report can be found in the background note on page 33.

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

Please see the guidance document on our website for detailed definitions and information about how the death cases are categorised and recorded.

In this report, the term 'police' includes police civilians, police officers and staff from all the organisations under IOPC jurisdiction. See background note 2 for more information. Deaths of police personnel or incidents involving off-duty police personnel are not included in the statistics in this report.

Road traffic fatalities include 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 attended immediately after the event as an emergency service

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

Deaths in or following police custody include deaths that happen while a person is being arrested or taken into detention. It includes deaths of people who have been arrested or 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 people 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 include 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 highest level of public concern, have the greatest potential to impact on communities, or have serious implications for the reputation of the police service. Since 2010/11, this category has only included deaths where there has been an independent investigation, or where one is ongoing. 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, including instances where the death is self-inflicted
- when the police attend a siege situation, including where a person kills themself or someone else
- after the police were contacted about concerns for a person's welfare and there is concern about the nature of the police response

2 Overall findings

During 2023/24, there were:

- 32 road traffic fatalities
- 2 fatal police shootings
- 24 deaths in or following police custody
- 68 apparent suicides following police custody
- 60 other deaths following police contact that were independently investigated by the IOPC

Demographic information about those who died is presented in the following chapters, along with details about the circumstances of their death and a summary of trend data. The appendix contains more information, such as the age, gender and ethnicity of those who died, and information about the police force or appropriate authority involved. (The appropriate authority is usually a chief officer or police and crime commissioner.)

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 based on information available at the point of analysis.

England and Wales were in lockdown owing to the coronavirus pandemic for a large part of 2020/21. At this stage, it is not possible to say with certainty what impact this had on the number or types of interactions that members of the public had with the police. Caution should be taken when comparing data from 2020/21 with previous and subsequent years.

Investigations

When we are told about a fatality, we consider the circumstances of the case and decide whether an investigation is necessary. If we decide an investigation is necessary, we then choose the mode of investigation. We can choose to investigate independently, to direct an investigation, or that the case should be investigated locally by the police force.

Each police force has a professional standards department (PSD) or equivalent department, which oversees complaint handling and certain conduct matters. In some circumstances, we decide that the PSD is best placed to investigate a case locally.

Since February 2020, supervised and managed investigations are no longer available as a mode of investigation. A new mode – 'directed investigation' – was created. These take place under IOPC direction and control, but using police resources.

Box B on page 10 includes 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 2023/24. The figures show the number of incidents. An incident leading to a single investigation can involve more than one death and so the total number of incidents for some categories may be lower than the total fatalities

presented above. In total, the IOPC independently investigated 102 incidents.

Table 2.1 no longer includes figures for supervised and managed investigations as all the fatalities in this report happened from April 2023 onwards. No incidents were dealt with by directed investigation across all death categories.

Table 2.1 Incidents by type of death and investigation type, 2023/24

Type of investigation	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following police custody	Other deaths following police contact*
Independent	23	2	20	0	57
Directed	0	0	0	0	0
Local	4	0	2	23	0
Back to force	2	0	2	45	0
Total incidents	29	2	24	68	57

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 in Table 2.2 show the number of fatalities across the different categories since 2013/14. 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, 2013/14 to 2023/24

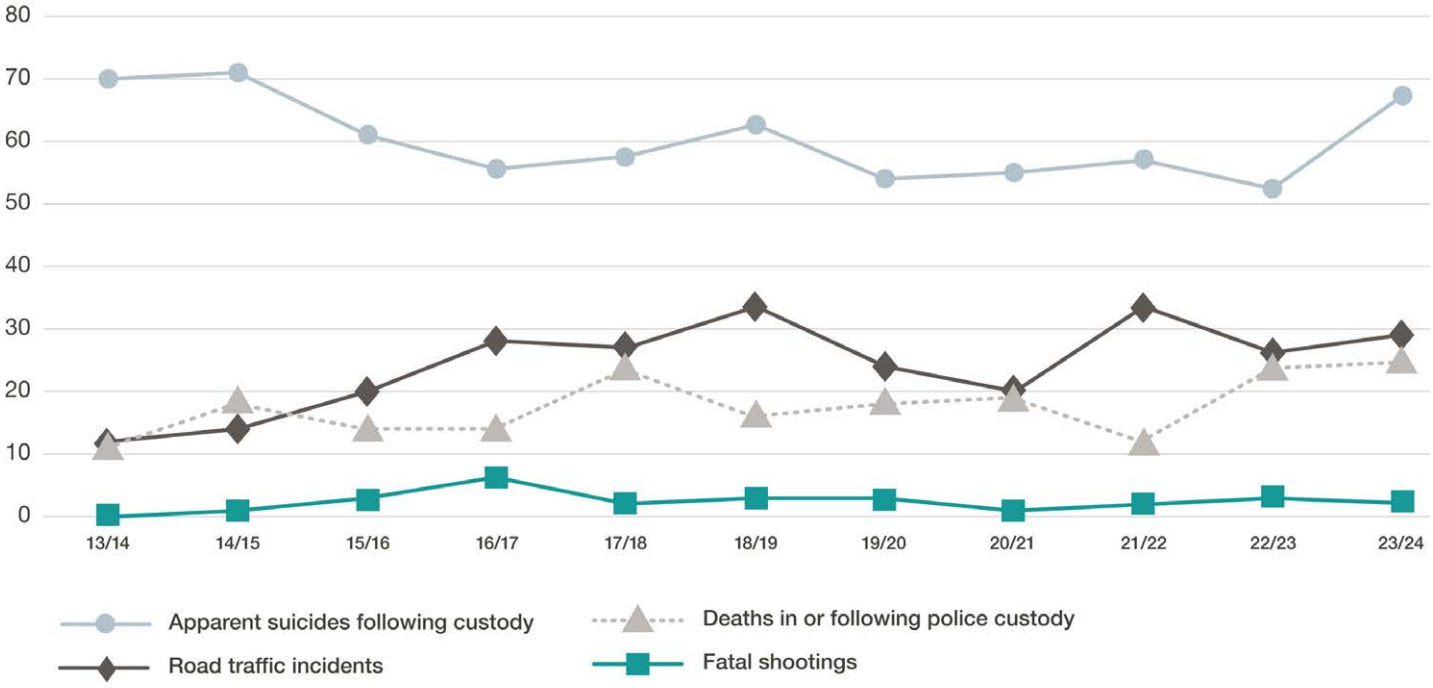
	Fatalities										
	Financial year										
Category	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**
Road traffic fatalities	12	14	21	32	29	42	24	25	40	28	32
Fatal shootings	0	1	3	6	4	3	3	1	2	3	2
Deaths in or following police custody	11	18	14	14	23	17	18	19	11	23	24
Apparent suicides following custody	70	71	61	56	57	63	54	55	57	54 ~	68
Other deaths following police contact*	44	43	106**	131	178	156	107	97	111	91~	60

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

** Expansion of 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, 2013/14 to 2023/24



The number of **fatal road traffic incidents (RTIs)** has increased this year, with 29 incidents, compared to 26 last year. This is above the average of 24 incidents recorded over the 11-year period since 2013/14. These figures are subject to fluctuation and, therefore, year-on-year comparisons should be approached with caution.

This year there were two **fatal police shootings**, compared to three recorded last year. This is below the average of three fatal shootings recorded since 2013/14.

The number of **deaths in or following police custody** has increased over the last year from 23 to 24. Over time, there have been some fluctuations in this category, with notable increases recorded in 2010/11, 2014/15, 2017/18 and 2022/23. The 2023/24 figure is higher than the average of 17 deaths over the 11-year period.

The number of recorded **apparent suicides following custody** was 68, notably higher than the 54 fatalities recorded last year. 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. It is the highest number of deaths since 2014/15, when there were 71 suicides. Reporting of these deaths relies on police forces making the link between someone's apparent suicide and them having been in custody recently. The overall increase in these deaths over the period since 2012/13, 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 public and community concerns. In 2015/16, our capacity to carry out independent investigations increased, which had a direct impact on the number of deaths reported on in this category. (See our Corporate plan 2015-18 and Strategic plan 2018-22 for more information.) This means 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. The appendix also includes data on:

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

We have published annual statistics on deaths during or following police contact since 2004/05. Previous reports and time series data are available on our website.

Box B Types of investigation

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

Directed investigations are IOPC investigations that are carried out using police resources. The IOPC sets the terms of reference for the investigation and directs the course of enquiries. At the end of the investigation, the police investigator submits the investigation report to the IOPC for review.

Local investigations are carried out by the police force. In death and serious injury cases, the force sends the report to the IOPC for review at the end of the investigation.

Referred back to force indicates 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 2023/24, there were 29 fatal police-related road traffic incidents (RTIs), resulting in 32 fatalities. Of those who died, 26 were men and six were women. Twenty-three people were White, four were Asian, three were Black and two people were of an other ethnicity.

Seven of the people were under 18 years old. A further twelve people who died were aged between 18 and 30 years, and the eldest person was 81 years old. The average age was 34 years old. The average age decreases to 25 years if the deceased was the driver or passenger in a pursued or fleeing vehicle. It increases to 46 years if the deceased was a pedestrian, cyclist or a driver or passenger in a vehicle hit by either the police or the pursued or fleeing vehicle.

Circumstances of death

Incidents are classified as 'pursuit-related' if they involved a pursuit, or situations where officers have begun to 'follow' a suspect vehicle. Not all these incidents will have entered an official pursuit phase as defined in the Authorised Professional Practice (APP) on police pursuits. (See College of Policing (2015) Authorised Professional Practice on police pursuits.)

Incidents where there was a collision involving a vehicle that was recently pursued by the police, but where the police had lost sight of the vehicle, are included. Incidents where the police were driving in the direction of a vehicle before obtaining permission to pursue are also included as pursuit-related.

Pursuit-related

There were 22 police pursuit-related incidents, which resulted in 24 fatalities. Of these fatalities:

- fourteen people were the driver of a vehicle being pursued by the police when it crashed
- four people were passengers in the car being pursued by the police
- four people were drivers or passengers of an unrelated vehicle, which was hit by the pursued car
- one person was a pedestrian who was hit by the car being pursued by the police
- one person was a pedestrian who was hit by police in pursuit

The IOPC independently investigated 18 of the pursuit-related incidents. Three were investigated locally by the police and one was returned to the force to address as they saw fit.

Emergency response-related

This category includes all incidents that involve a police vehicle responding to a request for emergency assistance. One emergency response-related incident occurred in 2023/24 resulting in one fatality. This incident is being investigated independently.

This number has halved from the two incidents and two fatalities recorded last year. The figures for this year show the lowest number of incidents and fatalities since 2016/2017, when there were zero and the same number of incidents and fatalities as in 2020/21, when there was one.

One fatality involved a police vehicle colliding with a motorcycle. The police were responding to a report of an assault taking place in public.

Other police traffic activity

This category includes RTIs that did not happen during pursuit-related activity or an emergency response. There were six incidents in 2023/24 resulting in seven fatalities. Four incidents are being investigated independently. One incident is being dealt with locally by the police force involved and we referred one incident back to the relevant police force.

Of these six incidents, two happened when a vehicle responded to the presence of the police:

- A police civilian in a marked police vehicle had a cover over its blue lights as it was being driven to be serviced. An off-road motorcycle was travelling in the opposite direction. The rider was not wearing a helmet. The rider of the motorcycle appeared to react to the police vehicle and a witness stated that the rider of the motorcycle appeared to glance over their shoulder to look in the direction of the police vehicle. The motorcycle crashed. The motorcycle driver died at the scene. We returned the case to the force to address as they saw fit.
- Officers on patrol in a marked police vehicle saw a car driving over the speed limit in the opposite direction. They decided to turn their vehicle around, activated their blue lights, and drove after the car. The officers reported that they could not see the car during this journey, so they de-activated their blue lights and turned their vehicle around to continue their original journey. At this point, officers witnessed the vehicle turning onto the opposite carriageway. The officers then turned their vehicle around to continue in the same direction as the car, but lost sight of it. They again sighted the vehicle turning onto the opposite carriageway and made the same turn. The officer in the passenger seat believed that the driver of the car was aware of the police vehicle and was trying to evade the police. Several seconds later, the officers continued along the road where they found the car had collided into two trees on the central reservation. The driver of the vehicle had been thrown from the car. Medical treatment was provided and the driver was taken to hospital, where they later died. This case was subject to an independent investigation.

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

- Officers were taking part in an authorised police motorcycle escort. This involved four specialist motorbike escorts positioned around a vehicle. One of the police motorcyclists rode towards a pedestrian crossing where they collided with a pedestrian, who was knocked to the ground. Officers and paramedics provided first aid at the scene. The pedestrian was taken to hospital where they later died. The incident was subject to an independent investigation.
- A crime scene investigator in a marked police van was attending a request for forensic support. On the way, there was a head-on collision between the police van and a car. Witnesses stated that the car was on the wrong side of the road. As a result of the collision, both the driver and passenger of the car died at the scene. This incident is being dealt with locally by the police force involved.
- Officers were driving a marked police vehicle responding to an emergency incident. The police vehicle's blue lights and sirens were activated. A member of the public was

travelling on a motorcycle ahead of the police vehicle. A car in front of the motorcycle appeared to slow down and the motorcycle rider applied his brakes. The motorcycle collided with the rear of the car. The rider was thrown from his motorcycle and landed in the opposite carriageway. The rider was then struck by an oncoming car. The motorcycle driver died at the scene. The incident was subject to an independent investigation.

- Officers arrested a man and he was placed within the rear caged area of a police van. While in the van, the man started to headbutt the side of the van, causing injuries to himself. The police activated the van's emergency blue lights and sirens before leaving the scene. The police van approached a traffic-lighted junction. The traffic lights were red and a member of the public was crossing the road. The police van continued through the red light, colliding with the person crossing the road. The member of the public was treated by both police and the ambulance service but was pronounced deceased at the scene by paramedics shortly after the collision. This incident is subject to an independent investigation.

Trends

This year, 32 people died in 29 separate incidents. There was an increase in fatalities this year from 28 to 32. This is above the average of 27 road traffic incident fatalities recorded over the 11-year period since 2013/14. The annual figures fluctuate, and year-on-year comparisons should therefore be approached with caution.

Tables 3.1 and 3.2 set out the type of road traffic fatalities and incidents over the past 11 years. The tables show the incidents in the three categories previously described: pursuit-related, emergency response-related, and other police traffic activity. Information on fatalities and incidents from 2004/05 is available in the time series tables at policeconduct.gov.uk.

This year there was an increase in the number of pursuit-related incidents. The number of 22 pursuit-related incidents is higher than the average of 17 incidents seen over the past 11 years.

There was an increase in the number of pursuit-related fatalities this year, from 20 to 24. There was also an increase in the number of pursuit-related incidents that resulted in multiple fatalities. Two incidents accounted for four fatalities, with two fatalities in each incident. The number of pursuit-related fatalities this year is higher than the average of 20 fatalities recorded over the 11-year period since 2013/14.

This year has seen a decrease in the number of emergency response-related incidents and fatalities. The figures of one incident and one fatality for this year, are lower than the average of two incidents and two fatalities since 2013/14.

The number of six incidents resulting from other police traffic activity has stayed the same as in the previous year, with the number of fatalities increasing by one. It is higher than the average of five incidents and five fatalities over the past 11 years, but approximately a third of the number of incidents recorded in 2004/05.

Table 3.1 Type of road traffic fatality, 2013/14 to 2023/24

RTI type	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
Pursuit-related	10	7	13	28	17	30	19	20	34	20	24
Emergency response-related	0	0	2	0	8	5	3	1	3	2	1
Other	2	7	6	4	4	7	2	4	3	6	7
Total fatalities	**12**	**14**	**21**	**32**	**29**	**42**	**24**	**25**	**40**	**28**	**32**

Table 3.2 Type of road traffic incident, 2013/14 to 2023/24

RTI type	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
Pursuit-related	9	6	12	24	17	21	19	15	27	18	22
Emergency response-related	0	0	2	0	7	5	3	1	3	2	1
Other	2	7	6	4	3	7	2	4	3	6	6
Total incidents	**11**	**13**	**20**	**28**	**27**	**33**	**24**	**20**	**33**	**26**	**29**

4

Fatal shootings

There were two fatal police shootings in 2023/24 compared to the three incidents recorded last year. The circumstances of the two fatal shootings are summarised below. One is subject to an ongoing independent investigation and the other one is complete.

- Officers arrived at a property following reports that an armed 30 year-old White man had allegedly broken into a property, and was trying to get into a bedroom where residents had barricaded themselves.

  Response team officers arrived and forced entry into the property. As they entered the address the two officers drew their Tasers. After they approached the man in the stairway, he swung a sword in their direction several times. One officer instructed the man to "show his hands" and challenged him with a Taser, which was not discharged. Officers withdrew and then requested assistance after it became apparent the man would not comply. A firearms unit then entered the property and also tried to negotiate with the man. The evidence indicates that the man appeared to raise a loaded crossbow towards the officers. One of the officers fired two shots at the man, hitting him in the neck and the chest. Officers immediately secured the weapons and began first aid. London Ambulance Service and the Helicopter Emergency Service (HEMS) attended, but the man died at the scene.

- The police received a call from a 40 year-old White man, who told them that he had firearms and wanted to harm himself.

  Armed Response Officers from the Metropolitan Police Service went to the man's address. Officers spoke with the man and negotiation attempts were made. Accounts from officers then describe the man coming to the front door with a black handgun in his left hand and pointing it towards two officers who fired two shots. The officers provided first aid but the man was pronounced dead at the scene. What appeared to be a non-police issue firearm was located near the man and another was recovered from inside the property.

5

Deaths in or following police custody

Demographics

In 2023/24, 24 people died in or following police custody – 22 were men and two were women. Their ages ranged from 28 to 59 years. 21 people were White, one person was Black, one person was of mixed ethnicity, one person was of an other ethnicity.

Nineteen people had mental health concerns. The types of mental health concerns included depression, anxiety, bipolar disorder, paranoid schizophrenia, personality disorder and self-harm. One person had been detained under section 136 of the *Mental Health Act 1983*.

Twenty-one 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 reported, a pathologist recorded that alcohol or drug toxicity, or long-term abuse, was likely to be a contributing factor in the deaths of nine people.

Table 5.1 on page 17 shows the reasons why people were arrested or detained by the police.

Table 5.1 Deaths in or following police custody: reason for detention, 2023/24

Reason for detention	Number of fatalities
Failure to appear in court	7*
Speeding/driving offences	3**
Violence-related (non-sexual or murder)	3
Sexual offences (images of children)	1
Obstructing/resisting a police officer	2***
Mental Health Act 1983	1
Arson	1
Possession of weapon	1
Theft	1
Threatening behaviour/harassment	1
Breach of the peace/anti-social behaviour	1^
Criminal damage	1^^
Kidnapping	1~
Total fatalities	**24**

* Two of these people were also arrested for drug/drink related offences, one person was also arrested for violence related (non-sexual or murder) offences and one person was also arrested for theft and violence related (non-sexual or murder) offences
** One of these people was also arrested for drug/drink related offences
*** One of these people was also arrested for breach of the peace/anti-social behaviour
^ This person was also arrested for violence-related (non-sexual or murder) offences
^^ This person was also arrested for breach of the peace/anti-social behaviour
~ This person was also arrested for murder/manslaughter

The data shows that 14 of the 24 people who died had some force used against them 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.

All 14 of the 24 people who had force used against them were physically restrained by the police or members of the public. The term 'restraint' refers to a range of actions, including physical holds and pressure compliance. It does not include the use of handcuffs, unless another form of restraint was also used. Of the 14 people that were physically restrained 13 were White, and one was of mixed ethnicity.

Six of the 24 incidents involving use of force included use of leg restraints. Four involved use of leg restraints alone, one incident involved leg restraints along with use of a spit hood (a mesh hood that is placed over a person's head to make it difficult for them to spit on another person), and the other incident involved leg restraints alongside use of PAVA incapacitant spray.

Circumstances of death

Cause of death according to the pathologist's report following a post-mortem examination is reported for thirteen of those who died. In a minority of cases, a post-mortem examination may not be carried out. In these cases, the cause of death is taken from the records of the doctor who certifies the death. If the cause of death is formally disputed at the time of the analysis, the cause of death will be recorded as 'awaited'. At an inquest, the cause of death is determined formally and may change from the cause of death listed in a pathologist's report. The IOPC is independently investigating 20 of the 24 deaths.

Fifteen people became ill or were identified as being unwell **in a police cell**. Eleven were taken to hospital where they later died. Four people died in a police cell.

These 15 cases are outlined below.

- A man was arrested for obstructing the police in their duties following a planned operation to stop a vehicle. The police suspected that

he had concealed drugs that had been in the vehicle. Officers restrained the man on the ground, while asking him what he had done with the drugs. The officers checked inside the man's mouth. No drugs were found. The man was taken to a police station, where he was strip searched in a police cell. No drugs were found. The man was then placed on 30-minute observations. The next day, during one check, the man appeared to be unwell in his cell and appeared to have a seizure. Medical aid was provided by custody staff and a healthcare professional until paramedics arrived and took over treatment. Paramedics performed cardiopulmonary resuscitation (CPR), but the man was pronounced dead shortly after. His cause of death is awaited.

- A woman was arrested following a domestic incident at her home. During the arrest, the woman was restrained on the ground. Officers described her as being heavily intoxicated. The woman, who disclosed that she was alcohol and drug dependent, was taken to a police station where she was put on 30-minute 'rousing' checks. At the recommendation of a healthcare professional, the checks were then changed to 'constant observations', and she was provided with medication for withdrawal symptoms. Later that day, a detention escort officer reported that the woman appeared to be having a seizure. A healthcare professional attended, but the woman became unresponsive. Paramedics arrived and performed cardiopulmonary resuscitation. The woman died at the scene shortly afterwards. Her cause of death is awaited.
- A man was stopped by officers as he was wanted on recall to prison. During his arrest, the man threw away what the officers suspected to be drugs. He was searched at the scene but officers did not find any drugs. The man was taken to custody in a police van. During transportation to custody, CCTV showed that the man appeared to swallow two packages. While in a holding cell in custody, the man stated that he was 'withdrawing'. During the booking-in procedure, the man was further arrested for a drug-related offence in relation to his actions in throwing away the suspected drugs during arrest. A strip search was carried out in custody, with a negative result. During the booking-in procedure, the man asked to see a nurse. The man was assessed by a healthcare professional and a care plan was recommended. He was placed in a CCTV-monitored cell and put on 30-minute checks. A few hours later, CCTV shows the man appearing to have several seizures in his cell. Custody staff stated that they observed CCTV and saw the man was lying in a strange position and may have had something around his neck. They carried out a welfare check. During this check, they identified that the man was unwell and when the heathcare professional attended his cell the man was in the midst of a seizure. Custody staff and the healthcare professional provided medical assistance. Paramedics then attended and took over treatment. The man was taken to hospital where he died later that day. His cause of death was reported as *1a. Cocaine toxicity*.
- A man was arrested for a drug-related offence and failure to appear in court. During his arrest, the man was restrained and handcuffed. Officers saw the man had placed something in his mouth, which they attempted to remove. The item in his mouth was believed and later confirmed to contain drugs. The man was taken to hospital by officers for a medical check before being taken to custody. The custody record states that the man informed officers he had consumed drugs that day. A strip search was carried out and no items were found. The man was then subject to 30-minute checks. During the man's detention, he was examined by a healthcare professional on several occasions and given medication for drug withdrawal. During a regular check a couple of days later, the man was found to be unresponsive. Officers performed cardiopulmonary resuscitation (CPR) until paramedics arrived and took over treatment. The man was taken to hospital by ambulance. He was pronounced dead shortly after arrival at hospital. His cause of death was reported as *1a) Morphine toxicity*.

- A man was arrested and taken to custody. During the arrest the man reportedly became aggressive and officers restrained him. The custody sergeant recorded that the man appeared to be under the influence of alcohol. The man disclosed that he suffered from alcohol withdrawal and had previously suffered from seizures. Officers restrained him, and he was placed on 30-minute checks. Shortly after, the man asked to see a force medical examiner (FME). He disclosed that he had previously had two heart attacks. The FME advised that the man could not be examined at the time as he was allegedly intoxicated. The next day, he was assessed by a FME and no medical concerns were raised. During a cell check a short while later, the man was found unresponsive. Officers performed cardiopulmonary resuscitation (CPR) until paramedics arrived and took over the first aid. The man was taken to hospital by ambulance where he died shortly after. His cause of death was reported as *1a Acute left ventricular failure, 1b Alcohol-related cardiomyopathy with myocardial fibrosis*.

- A man was arrested for breach of the peace following a report that he was suffering from a mental health episode. The man started to resist officers during attempts to detain him. Officers restrained the man and applied leg restraints, then lifted him into a police van. The officers believed the man was suffering from acute behavioural disturbance, so they took him to hospital for medical attention. While in hospital, the man was de-arrested for breach of the peace and further arrested for affray. He was discharged from hospital and taken to custody. On arrival at custody, the man was searched. He was then checked by a healthcare professional. The man was moved into a CCTV cell and placed on 30-minute observations. For the first hour of his detention, this involved rousing him. The next morning, an officer noticed on the CCTV monitor that the man was lying on the floor and appeared to be having a seizure. An officer entered the police cell and called for the healthcare professional to attend as the man was unresponsive. The officer found evidence of drugs on the man's mattress. Paramedics arrived and the man was taken to hospital by ambulance. The man died six days later.

- A man was arrested for driving while under the influence of alcohol. On arrival at the custody suite, officers saw the man's jaw moving in a chewing motion. The man was strip searched and it was recorded that no items were found. During the strip search, the man was non-compliant and physically resisting. PAVA incapacitant spray was used and officers restrained the man and applied leg restraints. The man was taken to another cell where he was assessed by a healthcare professional. During the examination, the man became unwell and unresponsive. The man was given medical aid and an ambulance was called. He was taken to hospital and died shortly after arrival. His cause of death was reported as *1a. Cocaine intoxication with coronary artery disease*.

- A man was arrested following an altercation with security staff and made threats to harm them while attending court. Officers attended the incident and while they searched the man, he appeared to fall backwards onto the court steps. The man was arrested and taken to custody in a police van. On arrival at custody, the man was placed in a cell and 'constant supervision and rousing' checks were put in place. The man was then assessed by a healthcare professional, who recommended that he be taken to hospital. That evening, he was discharged from hospital and the police returned him to custody. Additional officers were called to attend custody for close supervision of the man while he was in his cell. Shortly after this, the man was seen to fall unconscious in his cell. Officers and healthcare professionals immediately provided cardiopulmonary resuscitation (CPR) to the man, as well as attaching a defibrillator until an ambulance arrived. CPR was continued until the man had a pulse. He was then taken to hospital where he died four days later. His cause of death was reported as *1a. Bronchopneumonia and aspiration of gastric contents 1b. Hypoxic ischaemic brain injury 1c. Cardiac arrest with evidence of cocaine use*.

- A man was arrested on suspicion of kidnap and taken to custody. The next day, during a police interview, the man was further arrested for an alleged murder. He was placed on 30-minute observations because of concerns about his well-being and mental health. The next morning, the duty custody officer conducted a risk assessment review. The officer reduced the man's level of observation to 60-minute checks, because no issues had been reported during the night, and also to allow the man more time to rest. The next day, the man was found unresponsive in his cell with an improvised ligature around his neck. The man had died during the night appearing to apply the improvised ligature between cell check times. His cause of death was reported as *1a Ligature strangulation*.
- A man was arrested for breaching his bail conditions and was taken into custody. It was noted that he was intoxicated. The man disclosed that he was drug and alcohol dependent. A strip search was carried out because the man had a history of concealing drugs in custody. It was recorded that no drugs were found. The man was placed on 30-minute rousing checks. Later that day, a risk assessment was carried out and his observation level changed to 60-minute checks. He no longer had to be roused. The man was seen by a healthcare professional, and he declined an alcohol withdrawal assessment. The next day, during a routine check, the man was found unresponsive in his cell. A detention officer called for assistance. A healthcare professional arrived, and with the assistance of officers, used a defibrillator and provided cardiopulmonary resuscitation (CPR). Paramedics arrived and took over, but the man was pronounced dead a short while later. His cause of death was reported as *1a) Acute bronchopneumonia*.
- A man was arrested for driving and drug-related offences. The man was searched and several packages, thought to be controlled drugs, were found. He was taken to custody where he was searched again, placed in a cell, and placed on 30-minute 'rousing' checks. The cell contained CCTV although this was not intended to be used for continuous monitoring. The man was seen by a healthcare professional and assessed as being fit for detention. Later that morning, the custody sergeant noticed on the cell CCTV that the man was seated in an unusual position on the cell bench. The custody sergeant went to the cell, along with other officers, and found that the man appeared unwell. The custody health care professional attended and provided care to the man. During his care, officers restrained the man and put handcuffs and leg restraints on him to prevent the man from hurting himself and others. Two ambulances arrived and the paramedics took over the care of the man. The man was taken to hospital where he died the next day. His cause of death is awaited.
- A man was arrested on suspicion of arson and was taken into custody. It was noted on the custody record that he appeared to be drunk. The man was placed on constant observations and in the early hours of the following morning, he was examined by a healthcare professional. The man disclosed that he was suffering with back pain, following a fall a few days before. The man was given medication and seen on three further occasions that day by a healthcare professional who, on the first two of these occasions, provided further medication for his back pain. It was noted that the man had begun to show signs of alcohol withdrawal, however he denied this. The following day, the man was seen four further times by a healthcare professional and was provided with medication on two of these visits for withdrawal symptoms. Early the next morning, the man was seen on the CCTV monitor to be on the floor of his cell. He appeared unresponsive and an ambulance was called. Officers carried out cardiopulmonary resuscitation (CPR) before paramedics arrived and took over. The man was taken to hospital

and was pronounced dead shortly after. His cause of death is awaited.

- A man was arrested for assault and taken into custody. On arrival at custody, the man was restrained by officers because he made several attempts to headbutt them. Within an hour of arrival, officers placed a spit hood on the man. Shortly after the man was taken to a cell, a healthcare professional became concerned about the man's health as he was not responsive. The man's condition deteriorated quickly. The man's handcuffs were removed, and he was placed on the ground. Cardiopulmonary resuscitation (CPR) was performed on the man until paramedics arrived. He died in hospital shortly after. His cause of death is awaited.
- A man was arrested for assault and theft related offences and taken into custody. The man disclosed that he was alcohol and drug dependent and was placed on 'constant observations'. At the recommendation of a healthcare professional, he was observed for signs of alcohol or drug withdrawal. Later that day, following an examination by a healthcare professional, the man was given medication for alcohol and drug withdrawal. Early the next morning, following withdrawal concerns, an ambulance was called. The man was taken to hospital where he was placed on constant watch by officers. The man briefly returned to custody before being taken back to hospital for further treatment. Three days later, the man's condition deteriorated, and he was later pronounced dead. His cause of death is awaited.
- A man was arrested for failure to appear in court and was taken into custody. During the man's initial risk assessment, he disclosed that he had recently been in hospital following a fall. The man also disclosed that he was drug dependent. The man saw a healthcare professional twice during his detention. Following his initial assessment, the man was placed on general observation checks which later increased to 'close proximity' observations as enquiries made with the hospital revealed that the man had sepsis. He was taken to hospital for treatment and died a few hours later. His cause of death was reported as *1a. Haemopericardium 1b. Infective Endocarditis of the Aortic Valve with Root Abscess Formation and Perforation 1c. 2. Intravenous Drug User*.

Six people were taken ill at the **scene of arrest**. Three people were taken to hospital, where they later died. Three people died at the scene.

- Police were called to reports of a man breaking into multiple properties. Police located the man and arrested him for burglary. Following a struggle, police physically restrained the man on the floor and put handcuffs and leg restraints on him. Shortly after this, the man appeared to be having a seizure and an ambulance was requested. Officers believed he might have been experiencing acute behavioural disturbance. Shortly after, the officers noticed that the man was not breathing. Officers started cardiopulmonary resuscitation (CPR) and the handcuffs and leg restraints were removed. When the ambulance arrived, paramedics took over CPR. The man was taken to hospital where he died shortly after arrival. His cause of death was reported as *1a) Cardiac arrest caused by cocaine toxicity*.
- The police were called to a property following reports that a man was threatening to harm himself. An ambulance attended before they arrived at the property. On arrival, the police were not able to get any response and forced entry to the property. The police officers and paramedics attempted to engage with the man. He allegedly became aggressive and informed the paramedics that he had taken a large quantity of tablets. The man was physically restrained by officers and a paramedic. Soon after, he was placed in handcuffs and taken to hospital in an ambulance. During the journey to hospital the man was placed in leg restraints. The handcuffs and leg restraints were removed shortly after arriving at hospital. Owing to the man's behaviour, and further threats to harm

himself, he was restrained and detained under Section 136 of the *Mental Health Act 1983* by officers. A short time later, officers reported that the man appeared to be having a seizure. He received medical attention. After receiving medical treatment officers reapplied the leg restraints on several occasions. The man's condition deteriorated and later that evening he died in hospital. His cause of death is awaited.

- Officers went to an address to execute a search warrant. On arrival, a man was arrested, and officers searched the property. While the search took place, the man fell from a second-floor window. An ambulance was requested and officers gave cardiopulmonary resuscitation (CPR) before paramedics arrived and took over. The man died at the scene. His cause of death was reported as *1a. Multiple injuries*.
- A man was arrested for a public order offence and criminal damage. During the arrest, an officer noticed the man had an injury to his arm. The man was taken to hospital, where he remained under police guard. While at the hospital, the man allegedly became aggressive and a during a struggle he was taken to the ground. A spit hood and leg restraints were applied whilst medical staff attempted to provide treatment. The man was sedated and the spit hood and leg restraints were removed. A couple of hours later, the man suffered multiple seizures. He died shortly after. His cause of death is awaited.
- Police went to an address to arrest a man for failing to appear in court. On arrival officers forced entry to the property and arrested the man. It was noted that he was unwell and appeared to be heavily intoxicated. An ambulance was called. Soon after, officers noticed that the man was not breathing and provided medical aid. Paramedics arrived and the man was taken to hospital for further treatment. The man died later that evening. His cause of death is awaited.
- The police were called to a report of a man who had allegedly assaulted someone and who was believed to have self-harm injuries. Police attended and an ambulance was called owing to significant injuries to the man's wrists. While in the back of the ambulance receiving treatment, the man was arrested for grievous bodily harm. He disclosed that he was under the influence of alcohol and drugs. He was taken to hospital for treatment under police escort. His condition deteriorated and he later died. His cause of death was reported as *1(a) Mixed drug toxicity (cocaine, pregabalin and alcohol)*.

Two men were taken ill in a **police vehicle**. They were taken to hospital where they died.

- A man was arrested for driving while under the influence of alcohol or drugs, and for failing to provide a breath sample. A police van arrived, and the man was restrained while an officer applied handcuffs. The man was searched and placed in the caged area of the police van. During the journey to custody, the man became unwell. CCTV footage in the police van showed that while the man was on the floor he experienced multiple seizures. A short while later, an officer attempted to verbally rouse the man several times. The man did not react, and on arrival at custody, he was found to be unresponsive. He was removed from the van and two officers performed cardiopulmonary resuscitation (CPR) until paramedics arrived. Officers removed a package from the man's mouth that later tested positive for drugs. The man was taken to hospital where he died shortly after arrival. His cause of death was reported as *1a Cocaine toxicity*.
- Officers stopped a man on suspicion of committing a road traffic offence. He declined to provide his details and attempted to leave the scene. Officers arrested the man for obstructing a police officer. During the arrest the man was restrained and handcuffed, then placed in a police vehicle. An officer requested a police van to attend to transport the man to custody. While waiting for the police van, the man became unwell and the handcuffs were removed. Shortly after, the man became unresponsive. Officers removed him from the police vehicle and placed him on the ground

in the recovery position. An ambulance was requested. Officers provided cardiopulmonary resuscitation (CPR) to the man before he was taken to hospital, where he later died. His cause of death was reported as *1A Severe ischaemic heart disease*.

One woman died following **release from police custody**.

- Police were called to a report of a woman swinging an axe around at members of the public. An officer arrived at an address and arrested the woman for possession of an offensive weapon. The woman resisted the officer's attempts to place her in handcuffs. While an officer restrained her, the woman banged her nose on the ground. An officer handcuffed the woman and transported her to custody. She was assessed by a healthcare professional and taken to hospital, as she required treatment for facial injuries. The women returned to custody and a risk assessment was conducted. She was placed on 30-minute checks. Later that day, the women was released from custody. The women died three days later. Her cause of death was reported as *Bacterial Meningitis, Cerebritis and Ventriculitis Fracture Of The Right Orbit Communicating With The Sinonasal Space*.

Trends

Between 2004/05 and 2008/09, there was 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 reducing to 15 in 2011/12 and 2012/13. There was a further reduction in 2013/14 to 11.

In 2014/15, the number rose 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 ten years. This number fell to 17 fatalities in 2018/19 and increased slightly to 18 in 2019/20. In 2020/21 the number increased slightly to 19, fell notably to 11 in 2021/22, before increasing notably to 23 in 2022/23. This year, the number of deaths in or following police custody increased, to 24. The average number of deaths in or following police custody recorded since figures began in 2004/05 is 19.

This year, one person died after making an apparent suicide attempt while in a police custody suite. 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, eight people are known to have died as a result of self-inflicted acts while in a police cell.

This year four people were pronounced dead in a police cell, one more than in 2022/23, 2021/22 and 2020/21. In 2019/20, one person died in a police cell. In 2018/19, no one died in a police cell. In 2017/18 there were three such deaths.

6

Apparent suicides following police custody

Apparent suicides following time in police custody are included in these statistics if they occur within two days of the person's release from custody. They are also included if experiences in custody may have been relevant to the death, and the death was referred to the IOPC. The police may not always be told about an apparent suicide that happens after time 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. Verdicts are still pending in most cases. We include these cases only after considering the nature of death and whether the circumstances suggest that it 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 68 apparent suicides following police custody in 2023/24 – 60 men and eight women. The average age of those who died was 43 years. The most common age was between 31 and 40 years (19 people), followed by 51 to 60 years (18 people). The youngest person was 18 years old (one person). Sixty-two of those who died were White. Three people were Asian, two people were Black and one person was of Other ethnicity.

Seventy-one percent of the people (48) had known mental health concerns. Of these, two were detained under Section 136 of the *Mental Health Act 1983*. Other mental health concerns included depression, bipolar disorder, psychosis, schizophrenia, post-traumatic stress disorder, paranoia, personality disorder, anxiety, delusional disorder, obsessive compulsive disorder, previous thoughts or incidents of suicide attempts, and self-harm.

Under half of the people (31) were reported to be intoxicated with drugs and/or alcohol at the time of their arrest, or drugs and/or alcohol featured heavily in their lifestyle. Twenty-three deaths related to alcohol and 18 to drugs.

One of the people who died had force used against them whilst being detained under Section 136 of the *Mental Health Act 1983.*

Circumstances of death

Twenty-two apparent suicides happened the same day the person was released from police custody. Twenty-seven happened one day after release, and 19 happened two days after release.

Table 6.1 shows the reasons why these people were placed into custody by the police. Thirty-one of those who died had been arrested for a sexual offence. Of these, 26 related to sexual offences or indecent images involving children. Fifteen were for violence-related offences. Other

common reasons were threatening behaviour and harassment (eight), theft/burglary (six), criminal damage (five), driving offences (four), failure to appear in court (three), breach of the peace/ antisocial behaviour (three), drug/drink related (three) and possession of a weapon (two).

Table 6.1 Apparent suicides following police custody: reason for detention, 2023/24

Reason for detention	Number of detentions
Sexual offences	31
Violence related (non-sexual or murder)	15
Criminal damage	5
Threatening behaviour/harassment	8
Driving offences (including drink/drug driving)	5
Possession of a weapon	2
Theft/burglary	6
Failure to appear in court	3
Drug/drink related	3
Mental Health Act 1983	2
Breach of the peace/anti-social behaviour	3
Fraud	1
Obstructing the highway	1
False imprisonment	1
Total number of reasons for detention	**86**
Total fatalities	**68**

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

Sixteen people were detained for multiple reasons. This compares with 18 last year.

All the recorded apparent suicides following police custody were dealt with locally by the police force involved (68).

Trends

The number of apparent suicides following time in police custody is higher than the 54 recorded in 2022/23. It is the highest number of suicides since 2014/15 when there were 71. Reporting of these deaths relies on police forces making the link between an apparent suicide and someone spending time in custody recently. Increases or decreases in these deaths may therefore be influenced by identification and referral of such cases.

This year, for 46% of fatalities, the reason for custody related to alleged sexual offences. The proportion of sexual offences or indecent images involving children was 38%. These proportions are lower than the figures recorded last year (50% and 46% respectively) but higher than average figures. The average proportions for these alleged offences since 2004/05 are 36% and 30% 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 investigated independently by the IOPC, previously the IPCC.

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

Any increase or decrease in this category does not, therefore, necessarily indicate a change in the number of people who have died following some form of contact with the police.

Overall demographics

We independently investigated the deaths of 60 people who died during or following other contact with the police during 2023/24. Of these deaths:

- Thirty-nine were men and 21 were women.
- Forty-four people were White, 11 were Black, five were Asian.
- Two people were aged under 18 years, and eight people were young adults aged between 18 and 30 years. Seven people were aged over 60. The average age was 43 years old.
- Just under half of those who died (29) 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. A similar proportion of the people who died (27) were reported to have mental health concerns.

Table 7.1 Other deaths following police contact: reason for contact, 2023/24

Reason for contact		Number of fatalities
Concern for welfare	Missing person	2
	Health/injuries/intoxication/general	17
	Self-harm/suicide risk/mental health	15
	Domestic related	13
	Threatening behaviour/harassment	4
	Subtotal	**51**
Other contact	Executing a search warrant/arrest/conducting investigation enquiries	1
	Siege	2
	Avoiding contact/arrest	2
	Attending a disturbance	3
	Other	1
	Subtotal	**9**
	Total fatalities	**60**

Circumstances of death

The deaths recorded in this category involve a range of circumstances. Police contact may not have been directly with the person who died, but with a third party, as seen in some of the case examples. Where we have included the cause of death, this is taken from the pathologist's report following a post-mortem examination.

A post-mortem examination may not be carried out in a minority of cases. In this situation, the cause of death is taken from the records of the doctor who certified the death. The cause of death will be recorded as 'awaited' if it is formally disputed at the time of the analysis.

The most common reason for contact with the police was a concern for welfare, as shown in Table 7.1. Fifty one people died after concerns were raised with the police, either directly or indirectly, about their safety or well-being before their death. A further nine fatalities were recorded for other types of contact with the police.

A total of eight people who died following police contact had force used against them. Six people were White. Five were restrained by police officers or by members of the public. This does not necessarily mean that the force used contributed to the death. Three men had leg restraints applied to them and one had fast straps ('hook and loop' straps that can be quickly fastened) applied to them. One incident involved use of PAVA incapacitant spray, and two men were subject to discharge of a Taser.

Concern for welfare

Of the 51 fatalities that followed contact with the police because of a concern for welfare, two people who died had been **reported missing**. The police did not have direct contact with the person who died in these cases.

- A mother rang the police, raising concerns about her daughter who had not returned home. Details were taken and the missing woman was graded as 'high risk'. The next day, the assessment checks were reviewed, and the woman was graded as 'low risk'. After some enquiries the woman was upgraded to a 'medium risk' missing person. A few hours later, police received a report that a male had attended a police station and said something had happened to his wife and children at his address. Officers immediately went to the address, forced entry, and found the missing woman unconscious with a head injury. Officers provided cardiopulmonary resuscitation (CPR) to the woman before paramedics arrived, but she died at the scene. Her cause of death is awaited.

- A man was reported missing from his home address by fellow tenants after not being seen for eight days. Shortly after the report was made, police officers conducted intelligence work. Just over an hour since the call was made to police, the missing person report was closed, as reportedly no additional concerns were raised during the intelligence checks. A few days later, the man was found deceased by a member of the public in a public green space. His cause of death was reported as *1a Hanging*.

Seventeen fatalities related to the person's **health, possible injuries, intoxication, or general well-being**. A third party contacted the police to raise concern in most incidents. In this category

- Sixteen people were men and one was a woman.
- Twelve were White, four were Asian and one was Black.
- The most common ages were 31 to 40, with six people in this age group. The average age was 46.
- Just over half of those who died (8) 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). Four deaths were accidental.

Two incidents involved **use of force**:

- Staff working at a supported living accommodation requested police and ambulance assistance owing to concerns of a man shouting and screaming in his room. When police attended, the man could be heard shouting and screaming behind a closed bedroom door. Officers forced entry into the room, by which time they found the man unconscious but breathing. Paramedics started applying first aid, and the man regained consciousness. He then started to resist, and officers restrained him by holding onto his limbs. Paramedics sedated the man and he was transported to the hospital where he died the next day. His cause of death is awaited.
- Police responded to a report of two men injured with a knife and an ambulance was called. Upon arrival, officers spoke with the injured men and were told that their male attacker was potentially still armed with at least one knife in a room on the third floor of the building. An additional police unit was called. Upon arrival of the further police unit, officers made their way to the third floor where they found the man in his room. The man was initially sitting on a sofa and told the officers that he wanted them to leave. The officer speaking with the man had his Taser drawn but positioned behind his back. The man stood up and started moving towards a nearby open window. The officer issued a verbal warning and initially red dotted the man with the Taser. The man raised his leg onto the top of a chair that was underneath an open window. The officer discharged his Taser, and as he did so, the man exited the window, sustaining serious head injuries on landing. The ambulance service was already present on scene and immediately attended to the man after his fall. The man was conveyed to a hospital in a critical condition, where he died the next day. His cause of death was reported as *1a) Head injury*.

Fifteen fatalities related to a **concern about a person's risk of self-harm, risk of suicide, or their mental health**. In such cases, the person is not reported or considered as missing - the concerns are usually raised with the police by a third party, about a person with known mental health concerns. For example, the person may have failed to attend an appointment or welfare check, or they had showed signs of being at risk of self-harm or suicide. Of these:

- Thirteen people were men and two were women.
- Eleven were White, four were Black.
- The ages of the people ranged from 21 to 57. The most common ages were 31 to 40 and

51 to 60, with five people in each age group. The average age was 41.

- Death by self-inflicted means was the most common classification (12 people).
- Eight people 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.

Two incidents involved **use of force**:

- Police received a call expressing concern for the safety of a man. The caller reported that the man was very agitated, and believed his mental health had recently deteriorated. Officers went to the man's address and called an ambulance. Police officers attended and restrained the man. The officers suspected that he was suffering from acute behavioural disturbance. Officers applied handcuffs then limb restraints while waiting for the ambulance. The man was taken to hospital accompanied by officers, but became unwell during the journey. The ambulance stopped while emergency treatment was given. The ambulance continued to the hospital where he died two days later. His cause of death is awaited.
- Police were called to a concern for welfare for a man who was threatening to jump from a fifth-floor balcony. Officers attended the property, forced entry and located the man on the balcony. A police negotiator was called, and officers engaged with the man, trying to persuade him to come back into the property. The man briefly came back inside the property where he was met by the officers before returning to the balcony. One officer discharged his Taser in an attempt to stop the man jumping, however the man continued towards the balcony. While the man was on the balcony, the second officer discharged his Taser twice at the man, who fell to the ground. The man was immediately provided medical attention by paramedics. He was taken to hospital by an ambulance where he later died. His cause of death was reported as *1a) Multiple injuries consistent with a fall from a height*.

Thirteen fatalities were **domestic-related**. This means that the police responded 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:

- All of those who died were women.
- Eleven of the women were White, one was Black and one was Asian.
- The average age was 41. The youngest woman was 27 and the eldest was 55.
- The deaths were classified as alleged murder in 10 instances. One death was self-inflicted, one was accidental, and one was due to natural causes.

Four 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:

- Three people were men. One was a woman.
- Three people were White. One person was Black.
- Two classifications of death were alleged murder. One death was self-inflicted and one was not known.

Two incidents involved **use of force**:

- The police were called to a report of harassment by a man. When officers arrived, the man appeared to be agitated and distressed. The man was seen to climb out of a ground floor window. Seconds later, the man appeared from a side gate into the front garden. Officers believed that the man was trying to cover himself in petrol and used PAVA incapacitant spray to subdue him. The man was reported to be on fire. An officer ran to his police vehicle to get a fire extinguisher, and was able to put out the flames seconds later. Officers applied first aid and an ambulance was called to the scene. The man was taken to hospital where he died six days later. His cause of death was reported as *1a Multi organ*

failure 1b Pneumonia 1c Self inflicted burn and inhalation injury.

- The police attended reports of a man making threats and causing damage with a baseball bat. When the officers arrived, they believed that the man was under the influence of drugs and that he was in need of immediate medical attention. Officers requested an ambulance as they suspected that the man was experiencing acute behavioural disturbance. While waiting for the ambulance, the officers' concern for the man's health increased. With the assistance of members of the public, the officers carried the man to a police van to help the man cool down. The man became agitated, and head butted the police van. While officers attempted to place the man in the van, he resisted. Officers restrained him and applied leg restraints. Soon after, the man's health deteriorated, and officers provided cardiopulmonary resuscitation (CPR) until an ambulance arrived. The man was taken to hospital where he died later that day. His cause of death is awaited.

Other contact

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

Two men died in an attempt to **avoid police contact or arrest**:

- Officers attempted to stop a vehicle, which involved an initial pursuit. The driver of the suspect vehicle got out of the car and fled onto railway tracks. Officers searched the area and located the man on the railway tracks. He died at the scene. His cause of death was reported as *1a. Electrocution*.
- Police identified a man who was wanted for an alleged murder offence. He was believed to be in possession of a gun. That evening, the police surveillance team located the man driving his car. Armed response vehicles were deployed to the area. The officers located the man's car, and following a short pursuit they carried out a tactical stop on the vehicle. Officers reported that it was visible through the driver's window that the man appeared be holding a firearm. Police officers approached the car and found the man unconscious with a significant head injury. The officers provided first aid until the paramedics arrived. The man died at the scene. His cause of death was reported as *1a Shotgun wound to the head*.

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

- A member of the public contacted the police to report a disturbance. The caller described hearing screaming and shouting and the sound of furniture being moved. They stated that similar disturbances occurred regularly at the address. Police graded the incident for immediate response; however, no police unit was able to attend. Later that day, another member of the public called the police and reported that they received information about a woman falling and struggling to breathe at the same address. They also reported that they had called the ambulance service. The police were contacted by the ambulance service who confirmed that paramedics had been to the address and had found a woman unconscious with multiple significant injuries to her head and face. Paramedics reported that a man was present at the address and said they suspected he had assaulted the woman. They requested that the police come to the address. Officers arrived and the male was arrested on suspicion of assault. The woman was taken to the hospital in an ambulance. She died two days after the incident. Her cause of death was reported as blunt force head injuries.
- Police received multiple calls about a man acting suspiciously, entering properties and causing damage to one of them. He was reported to be in possession of a golf club. Officers were sent to the area and the man was restrained and handcuffed. The man became unwell whilst with the officers, resulting in them requesting medical assistance and removing the handcuffs. Cardiopulmonary resuscitation (CPR) was administered until the ambulance arrived. He was taken to hospital where he died the following day. His cause of

death was reported as *1 (a) complications of cocaine intoxication*.

- Police were called to reports of a disturbance where a man could be heard shouting, screaming and potentially causing damage within a property. When the police arrived, the man was located in a first floor bathroom. An officer managed to push open the bathroom door and saw that there was blood and water on the floor. Officers gained access and the man was pulled out into the landing area. The man was handcuffed and restrained on the floor while other residents of the property called for an ambulance. Officers believed that the man was suffering from acute behavioural disturbance (ABD) and this information was communicated to the ambulance service. After the arrival of other officers, fast straps were applied. An ambulance arrived and the man remained controlled in handcuffs and fast straps on the floor. He was taken to hospital where he later died. His cause of death was reported as *1a Acute bacterial meningitis*.

One man died after contact with the police who were **conducting investigation enquiries**:

- A child was arrested and detained by the police on suspicion of voyeurism. His phone was seized, and he was interviewed and bailed with conditions not to buy, have or use electronic devices, including mobile phones. Approximately four months later, because of human error on the part of the police force, the child's bail conditions had lapsed, and a 'release under investigation' had been authorised, meaning that the police were continuing to investigate the alleged criminal offence, but without a time limit or bail conditions. The police force communicated to the family's solicitor that the bail had ended, however, it is not known whether this information was directly relayed to the child or his family. The following month, one of the child's family members received a call from his school. The school explained that he had been found in possession of a mobile phone. The child was found hanging in his home the same day. Paramedics provided extensive treatment before transferring the child to hospital, where his death was pronounced later that day. His cause of death was reported as *1a Hanging by ligature around neck*.

Two people died in one incident during a **siege situation** with the police:

- Officers were called to an address following a domestic incident where a man was said to be in possession of a handgun and threatening to harm his partner. Officers went to the address but moved away after the man made them aware that he had a handgun, which he then fired. Armed officers were deployed to the scene, and a police negotiator was called in. The negotiator spoke with the man for approximately two hours. A shot was then heard, followed by a further two loud bangs as officers threw stun grenades into the property. Officers believed that these were further gun shots, and used a battering ram to gain access. The man was believed to have shot his partner before shooting himself. The woman and man received immediate first aid and were taken to hospital where they both died. Their cause of death was reported as *1a Gun shot wound to the head*.

One woman died **following other contact with the police**:

- A member of the public contacted the police to report that his car had broken down on the motorway in a live lane, with him and his wife in the car. The call handler took their location and advised the couple to remain inside the vehicle. The call handler confirmed the car's hazard lights were on and stated that help was on its way. Minutes later, a heavy goods vehicle collided with the broken-down car. The man and the woman were taken to hospital, where the woman died two days later. Her cause of death is awaited.

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 recorded in this category is directly linked to the number of cases independently investigated. It would 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 85% of the deaths following police contact that were independently investigated – a lower proportion than in 2022/23.

During 2023/24, a quarter of investigations into deaths following police contact related to reports of concerns about a person's risk of self-harm, risk of suicide, or mental health. Twenty two percent of the deaths following police contact were domestic-related. These types of concern for welfare link to current areas of thematic work for the IOPC. This may result in the number of these types of investigations increasing and/or forming a larger proportion of the 'other contact' deaths that the IOPC investigates independently.

8 Background note

1. Under the *Police Reform Act 2002*, forces in England and Wales have a statutory duty to refer to the IOPC all deaths during or following police contact where there is an allegation or indication that police contact, directly or indirectly, contributed to the death. We consider the circumstances of all referrals and decide whether an investigation is necessary.

2. Since April 2006, the IOPC, previously the IPCC, has also received mandatory referrals for cases where someone has died during or following contact with:
   - His Majesty's Revenue and Customs known as HMRC (Regulation 34 of the *Revenue and Customs (Complaints and Misconduct) Regulations 2005*).
   - the Gangmasters and Labour Abuse Authority known as the GLAA (Regulation 36 of the *Gangmasters and Labour Abuse Authority (Complaints and Misconduct) Regulations 2017*).
   - The Serious Organised Crime Agency (later replaced by the National Crime Agency).

   Since October 2013, we have also received mandatory referrals from the National Crime Agency (NCA). Up until March 2013, we received cases from the UK Border Agency (UKBA) (Regulation 25 of the *UK Border Agency (Complaints and Misconduct) Regulations 2010)*. At this time UKBA's executive agency status was ended. 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 continues to have jurisdiction over these officials and contractors. Therefore, this report includes deaths during or following contact with staff from all of these organisations.

3. The IOPC replaced the IPCC in January 2018. This change was set out in the *Policing and Crime Act 2017*.

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. You can find out more in our 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, three fatalities have been added to previous year's figures. The following adjustments have been made to the trend figures:

- For 2022/23, one death has been added to the 'other deaths following police contact' figure and two deaths have been added to the 'apparent suicides following police custody' figure.

These changes have been made to reflect the year of death more accurately for fatalities that had been retrospectively added to previous years' trend figures. These are cases that were either not subject to an independent investigation or had not been referred to us when the report for that financial year was released. In line with our revisions policy, in these instances the figures for the published annual report were not amended.

7. Table 6.1 sets out the reasons for detention for apparent suicides following police custody. In previous years, this table showed the number of fatalities with footnotes to highlight where there were additional reasons for detention. Owing to the high volume of fatalities with multiple reasons for detention in 2023/24, the figures shown in Table 6.1 are the total number of different reasons for detention. We have taken this approach since our 2018/19 report.

Methods and definitions

8. See our guidance document for more detailed definitions and for information about how the death cases are categorised and recorded. This document also provides suggestions for further reading.

Policies and statements

9. We produce a number of policies and statements in connection with this report. These are available on our 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 was used, can be found in the user engagement feedback document. It also summarises any feedback received on the annual deaths report, our response to it, and any impact this may have on either the information contained in the report or 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 to identify, take action, and/or review policy to help prevent such deaths from happening again where possible.

12. We also produce in-depth studies and learning publications to support learning.

13. Users of these statistics should take care 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.

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 is 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.

14. The user engagement strategy is found in section eight of the policies and statements document.

Further information

15. All our annual reports on deaths in or following police contact are available on our website.

16. Electronic versions of the tables in this 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 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.

17. In addition to our annual reports on deaths, we also periodically produce research studies that examine in more detail some of the issues associated with these cases. These studies are available on the research and information pages of our website.

18. Following a recommendation by the National Statistician in 2012, this annual report was assessed by the UK Statistics Authority and granted National Statistics designation.

19. Email research@policeconduct.gov.uk if you have any questions or comments about our annual death reports.

20. Estimated publication date for our next report covering data for 2024/25 is July 2025.

Appendix A: additional tables

Table A1 Incidents by type of death and financial year, 2013/14 to 2023/24

Incidents											
	Financial year										
Category	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24
Road traffic incident	11	13	20	28	27	33	24	20	33	26	29
Fatal shootings	0	1	3	6	2	3	3	1	2	3	2
Deaths in or following police custody	11	18	14	14	23	17	18	19	11	23	24
Apparent suicides following custody^	70	71	61	56	57	63	54	55	57	54~	68
Other deaths following police contact*	41	43	103**	128	172	151	104	96	104	86~	57

^ 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, 2023/24

Gender	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Male	26	2	22	60	39
Female	6	0	2	8	21
Total fatalities	**32**	**2**	**24**	**68**	**60**

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

Table A3 Type of death by age group, 2023/24

Age group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Under 18	7	0	0	0	2
18 - 20	4	0	0	3	1
21 - 30	8	1	4	7	7
31 - 40	5	1	9	19	21
41 - 50	2	0	6	17	11
51 - 60	2	0	5	18	10
61 and over	4	0	0	4	8
Total fatalities	**32**	**2**	**24**	**68**	**60**

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

Table A4 Type of death by ethnicity, 2023/24

Ethnicity group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
White	23	2	21	62	44
Black	3	0	1	2	11
Asian^	4	0	0	3	5
Mixed	0	0	1	0	0
Other	2	0	1	1	0
Not known	0	0	0	0	0
Total fatalities	**32**	**2**	**24**	**68**	**60**

* 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, 2023/24

Appropriate authority**	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Avon & Somerset	0	0	0	3	4
Bedfordshire	0	0	0	0	0
Cambridgeshire	0	0	0	3	0
Cheshire	0	0	1	3	0
City of London	0	0	0	0	0
Cleveland	0	0	1	0	0
Cumbria	0	0	0	1	0
Derbyshire	1	0	0	0	1
Devon & Cornwall	1	0	2	6	0
Dorset	1	0	0	0	0
Durham	0	0	0	0	0
Dyfed-Powys	0	0	0	1	0
Essex	1	0	0	0	1
Gloucestershire	0	0	0	0	1
Greater Manchester	3	0	3	1	6
Gwent	0	0	0	1	1
Hampshire	0	0	1	2	4
Hertfordshire	2	0	0	1	0
Humberside	0	0	0	3	2
Kent	0	0	0	5	2
Lancashire	0	0	0	3	1
Leicestershire	1	0	1	0	2
Lincolnshire	0	0	0	0	2
Merseyside	0	0	3	0	4
Metropolitan	6	2	5	4	7
Norfolk	1	0	0	1	2
North Wales	0	0	0	3	0
North Yorkshire	0	0	0	1	0
Northamptonshire	0	0	0	2	2
Northumbria	0	0	1	3	0
Nottinghamshire	3	0	0	0	1
South Wales	2	0	1	0	0
South Yorkshire	1	0	0	2	1
Staffordshire	0	0	1	0	3
Suffolk	0	0	1	1	2
Surrey	0	0	0	0	0
Sussex	0	0	0	6	1
Thames Valley	1	0	0	1	1
Warwickshire	1	0	0	1	1
West Mercia	2	0	0	2	0
West Midlands	3	0	3	4	1
West Yorkshire	0	0	0	4	2
Wiltshire	1	0	0	0	0
British Transport Police & Metropolitan Police	0	0	0	0	1
West Midlands Police & Staffordshire Police	1	0	0	0	0
Greater Manchester Police & Lancashire Constabulary	0	0	0	0	2
Greater Manchester Police & South Wales Police & Gwent Police	0	0	0	0	1
British Transport Police	0	0	0	0	1
Home Office ~	0	0	0	0	0
Her Majesty's Revenue and Customs	0	0	0	0	0
Ministry of Defence	0	0	0	0	0
National Crime Agency	0	0	0	0	0
Total fatalities	**32**	**2**	**24**	**68**	**60**

* This category includes only cases subject to an independent investigation

~ This includes UKBF, UKIE and UKVI

** Most cases involve one appropriate authority, where two are involved these are shown in the table on a separate line to the main counts for those appropriate authorities

To find out more about our work or to request this report in an alternative format, you can contact us in a number of ways:

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**

Text relay: **18001 020 8104 1220**

We welcome telephone calls in Welsh
Rydym yn croesawu galwadau ffôn yn y Gymraeg

October 2024

ISBN 978-1-7394778-0-6