



Deaths during or following police contact:

Statistics for England and Wales
2019/20

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National statistics

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

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

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

Contents

1	Introduction	1
2	Overall findings	3
3	Road traffic fatalities	8
4	Fatal shootings	12
5	Deaths in or following police custody	14
6	Apparent suicides following police custody	21
7	Other deaths following police contact: independent investigations only	25
8	Background note	33
A	Appendix A: additional tables	36

List of tables and figures

Table 2.1	Incidents by type of death and investigation type, 2019/20
Table 2.2	Fatalities by type of death and financial year, 2009/10 to 2019/20
Figure 2.1	Incidents by type of death and financial year, 2009/10 to 2019/20
Table 3.1	Type of road traffic fatality, 2009/10 to 2019/20
Table 3.2	Type of road traffic incident, 2009/10 to 2019/20
Table 5.1	Deaths in or following police custody: reason for detention, 2019/20
Table 6.1	Apparent suicides following police custody: reason for detention, 2019/20
Table 7.1	Other deaths following police contact: reason for contact, 2019/20
Table A1	Incidents by type of death and financial year, 2009/10 to 2019/20
Table A2	Type of death by gender, 2019/20
Table A3	Type of death by age group, 2019/20
Table A4	Type of death by ethnicity, 2019/20
Table A5	Type of death by appropriate authority, 2019/20



1

Introduction

This report presents figures on deaths during or following police contact that happened between 1 April 2019 and 31 March 2020. 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 sixteenth in a series of statistical reports on this subject, published annually by the IOPC, formerly the Independent Police Complaints Commission (IPCC). On 8 January 2018, the IPCC became the IOPC. This change was set out in the Policing and Crime Act 2017¹.

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

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

[Box A on page 2](#) provides a definition for each of these categories.

For more detailed definitions please see [the guidance document](#) on the IOPC website.

Further supporting information about the report can be found in [the background note](#).

¹ Find out more about becoming the IOPC at [policeconduct.gov.uk](https://www.policeconduct.gov.uk).

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

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

In this report the term ‘police’ includes police civilians, police officers and staff from the other organisations under IOPC jurisdiction. For more information about this see [background note 2](#). Deaths of police personnel or incidents that involve off-duty police personnel are not included in the statistics in this report.

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

This does not include:

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

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

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

This includes deaths that happen:

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

This does not include:

- > suicides that occur after a person has been released from police custody
- > deaths that happen where the police are called to help medical staff to restrain 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 includes deaths that follow contact with the police, either directly or indirectly, that did not involve arrest or detention under the Mental Health Act 1983 and were subject to an independent investigation. An independent investigation is determined by the IOPC for the most serious incidents that cause the greatest level of public concern, have the greatest potential to impact on communities, or have serious implications for the reputation of the police service. Since 2010/11, this category has included only deaths that have been subject to an independent investigation. This is to improve consistency in the reporting of these deaths.

This may include deaths that happen:

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



2

Overall findings

During 2019/20, in each category there were:

- > **24** road traffic fatalities
- > **three** fatal police shootings
- > **18** deaths in or following police custody
- > **54** apparent suicides following police custody
- > **107** other deaths following police contact that were independently investigated

Demographic information about those who died is presented in the following chapters, along with details about the circumstances of the deaths and a summary of trend data. The appendix contains additional information such as the age, gender and ethnicity of those who died, and information about the police force or appropriate authority² involved.

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

Investigations

When we are told about a fatality, we consider the circumstances of the case and decide whether to investigate independently, or to manage or supervise a police investigation³. In some circumstances, we decide that the local police force professional standards department (PSD)⁴ or other equivalent department is best placed to investigate a case. [Box B on page 7](#) includes a description of each type of investigation.

² The appropriate authority is usually a police force's chief officer or police and crime commissioner.

³ From February 2020 supervised and managed investigations are no longer available as a mode of investigation. A new mode – 'directed investigation' – has been created. These take place under IOPC direction and control, but using police resources.

⁴ Each force has a professional standards department, which oversees complaint handling and certain conduct matters.

Table 2.1 shows the type of investigation at the time of analysis for all incidents involving a fatality recorded in 2019/20. The figures show the number of incidents; an incident leading to a single investigation can involve more than one death and so the totals for

some categories may be lower than the total fatalities presented above. In total, 147 incidents were independently investigated. Across all death categories, and as in recent years, no incidents were subject to a managed or supervised investigation.

Table 2.1 Incidents by type of death and investigation type, 2019/20

Type of investigation	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Independent	22	3	16	2	104
Managed	0	0	0	0	0
Supervised	0	0	0	0	0
Local	1	0	1	28	0
Back to force	1	0	1	24	0
Total incidents	24	3	18	54	104

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

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

Trends

The figures presented in Table 2.2 show the number of fatalities across the different categories since 2009/10. 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, 2009/10 to 2019/20

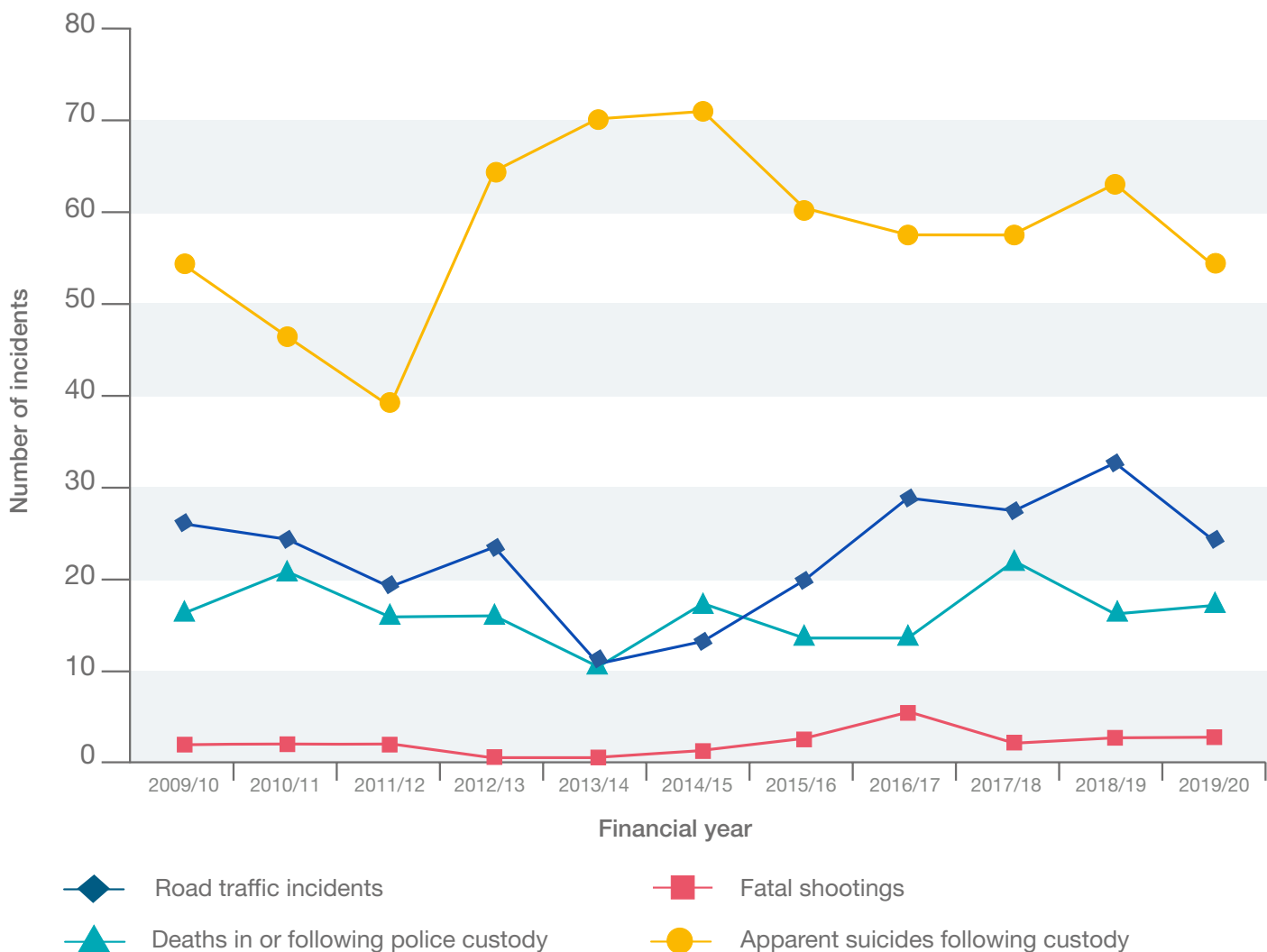
Category	Fatalities										
	Financial year										
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Road traffic fatalities	29	26	19	31	12	14	21	32	29	42	24
Fatal shootings	2	2	2	0	0	1	3	6	4	3	3
Deaths in or following police custody	17	21	15	15	11	18	14	14	23	17~	18
Apparent suicides following custody	54	46	39	65	70	71	60	57	57	63	54
Other deaths following police contact*	39	57*	47	22	44	43	105**	132	176~	157~	107

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

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

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

Figure 2.1 Incidents by type of death and financial year, 2009/10 to 2019/20



The number of fatal **road traffic incidents** (RTIs) has decreased this year from 33 to 24. This is the seventh lowest number recorded over the 16-year period since 2004/05, when these statistics were first published. It is the lowest number of incidents since 2015/16, when there were 20 RTIs. These figures are subject to fluctuation and, therefore, year-on-year comparisons should be approached with caution.

This year there were three fatal **police shootings**, the same as last year. This is the second highest figure recorded since 2009/10. The number of **deaths in or following police custody** has increased slightly over the last year from 17 to 18. There have been some fluctuations in this category over time, with notable increases recorded in 2010/11, 2014/15 and 2017/18. The figure is in-line with the average over the 11-year period.

The number of recorded **apparent suicides following custody** was 54, a decrease from the 63 fatalities recorded last year. This is the lowest figure recorded since 2012/13 when there was a notable increase in this category. However, the number still remains higher than the average before 2012/13. Reporting of these deaths relies on police forces making the link between someone's apparent suicide and the person having been in custody recently. The overall increase in these deaths over the 11-year period may be influenced by improved identification and referral of such cases.

The category of '**other deaths following police contact**' is not included in Figure 2.1. The inclusion of a death in this category depends on whether we decide to open

an independent investigation into the circumstances surrounding it. The criteria for making this decision may vary over time – for example, in response to current public and community concerns. In addition, there has been an increase in our capacity to carry out independent investigations⁵. This has had a direct impact on the number of deaths reported on in this category. This means that 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

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

⁵ See our [Corporate Plan 2015-18](#) and [Strategic Plan 2018-22](#) for more information.

Box B Type of investigation

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

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

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

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

Referred back to force 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 2019/20, there were 24 fatal police-related road traffic incidents (RTIs), resulting in 24 fatalities. Of these, 20 people were men and four were women. Sixteen people were reported to be White. One person was Asian, four were Black. The ethnicity of three people were not known at the time of publishing.

Three of the people who died were under 18 years old. The youngest was aged 14 years old. A further thirteen people were aged between 18 and 30 years and five people were aged over 60 years. The eldest was 84 years old. The average age was 35 years old. The average age decreases to 23 years if the deceased was the driver or passenger in a pursued or fleeing vehicle. It increases to 55 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 if they involved the police driving in the same direction as a suspect vehicle. Not all of these incidents will have entered an official pursuit phase as defined in the Authorised Professional Practice (APP) on police pursuits⁶. Incidents where there was a collision involving a vehicle that had recently been pursued by the police, but where the police had lost sight of the vehicle, are included. Incidents where the police were driving in the direction of a vehicle before obtaining permission to pursue are also included as pursuit-related.

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

Pursuit-related

There were 19 police pursuit-related incidents, which resulted in 19 fatalities. Of these fatalities:

- > eight people were the driver of a vehicle being pursued by the police when it crashed. All vehicles involved were cars
- > four people were passengers in the car being pursued by the police
- > two people were pedestrians and one person was a cyclist who was hit by the pursued or suspect vehicle
- > three people were pedestrians who were hit by a police vehicle
- > one person was the driver of a vehicle being pursued by the police. The driver had left the vehicle. Shortly after this, the driver was hit by the police car that was in pursuit

All but one of the pursuit-related incidents were investigated independently by the IOPC. The PSD of the force involved carried out an investigation into the circumstances of the other case.

Emergency response related

This category includes all incidents that involve a police vehicle responding to a request for emergency assistance. There were three emergency response-related incidents resulting in three fatalities. All of these incidents are being investigated independently. This number has almost halved from five incidents and five fatalities recorded last year. The figures for this year show the lowest number of incidents and fatalities since 2016/17, when there were zero.

All fatalities involved police vehicles colliding with pedestrians while responding to a call. Police were responding to the following incidents:

- > a call for assistance to apprehend a suspect
- > reports of a person being threatened with a knife
- > a colleague's call for assistance

Other police traffic activity

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

Both incidents happened when a vehicle responded to the presence of the police:

- > Officers in an unmarked police vehicle responded to a report of a car driving dangerously. The officers attempted to stop the car by activating their lights and sirens to signal that the driver should pull over. The car slowed down initially, but as an officer walked to the car, it drove off at speed. The police did not attempt to pursue the vehicle. Soon after, the car was found to have collided into a tree. The driver of the vehicle died at the scene. Our investigators carried out an independent investigation.
- > Officers on patrol in an unmarked police traffic control vehicle wanted to speak with a driver about the way he was driving and about his driving documents. The officers drove their vehicle in front of the car and used the information board and rear blue lights to indicate the car should follow them.

The car drove off at speed. The officers carried out a brief search for the car, but did not locate it. Shortly after, it was reported that the car had collided into the back of a lorry. The passenger in the car died at the scene. After considering a referral, we returned the case to the force to address as it saw fit.

Trends

This year, 24 people died in 24 separate incidents. There was a notable fall in fatalities this year from 42 to 24. This is the fifth lowest figure recorded over the 16-year period since 2004/05, when these statistics were first published. The annual figures fluctuate and year-on-year comparisons should be approached with caution.

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

This year there was a decrease in the number of pursuit-related incidents and fatalities. The number of pursuit-related incidents remains slightly higher than the average seen over the past 11 years. The number of pursuit-related fatalities is in line with the average seen over previous years. There were no pursuit-related incidents that resulted in multiple fatalities in 2019/20.

This year has seen a reduction in the number of emergency response-related incidents. The data shows the third lowest number of emergency response-related incidents and fatalities recorded since 2004/05.

The number of incidents resulting from other police traffic activity has more than halved compared to the previous year. It is the lowest number since 2013/14 and less than a fifth of the number recorded in 2004/05.

⁷ Information on fatalities and incidents from 2004/05 is available in the time series tables at [policeconduct.gov.uk](https://www.policeconduct.gov.uk).

Table 3.1 Type of road traffic fatality, 2009/10 to 2019/20

Fatalities											
RTI type	Financial year										
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Pursuit-related	19	13	12	27	10	7	13	28	17	30	19
Emergency response-related	3	4	2	2	0	0	2	0	8	5	3
Other	7	9	5	2	2	7	6	4	4	7	2
Total fatalities	29	26	19	31	12	14	21	32	29	42	24

Table 3.2 Type of road traffic incident, 2009/10 to 2019/20

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



4

Fatal shootings

This year there were three fatal shootings by police. This figure is the same as that recorded in 2018/19. Two of these incidents were terrorism-related. In one of these incidents officers from two different police forces fired shots. Since these statistics were first published there has been one other such incident that involved officers from more than one police force, which was in 2017/18. The circumstances of the three fatal police shootings are described below. All three incidents are subject to ongoing independent investigations.

Armed officers from City of London police and the Metropolitan Police Service (MPS), responded to an incident involving an Asian man, aged 28 years. The man was alleged to have stabbed members of the public at an event. Two members of the public were killed and three were injured. After the attacks the man made his way on foot to London Bridge and was tackled by members

of the public. The man was armed with knives and wearing what appeared to be an improvised explosive device (IED) vest. One officer used a Taser⁸, and the man was shot by officers from both the MPS and City of London Police (CoLP). The man died at the scene.

Armed surveillance officers from the MPS were involved in an ongoing police operation relating to an Asian man, aged 20 years. The man was observed entering a shop and was reported to have taken a knife from the premises. After leaving the shop the man stabbed two members of the public, causing serious injuries. The man was challenged by two armed surveillance officers, who instructed him to put down the knife. He did not comply with the instruction. Two officers fired a total of six bullets. The man was wearing what appeared to be an IED. The man died at the scene.

⁸ The technical name for a Taser is a Conducted Energy Device (CED). It is a tool that uses electric shocks to stun and immobilise. These devices release short bursts of 1,500 volts in either drive stun (manual use) or through two spiked barbs.

Two Ministry of Defence officers were on patrol in London in a marked police vehicle when they came across a Black man, aged 30 years. The officers were concerned about the man's behaviour and got out of their vehicle to speak to him. The man produced two knives and the officers used their Tasers three times. One officer activated his emergency button and units from the MPS and City of London Police responded to the call for assistance.

The man left the scene on foot but was met by officers from the MPS. One MPS officer used a Taser on the man twice. The man then made his way to Great Scotland Yard. Officers from CoLP arrived and challenged him. One officer from CoLP used his Taser. The other officer from CoLP fired a single shot, which struck the man. He was given CPR by officers before the ambulance service arrived to provide further medical treatment, but he died at the scene.



5

Deaths in or following police custody

Demographics

Eighteen people died in or following police custody. Seventeen of these were men and one was a woman. Their ages ranged from 20 to 71 years. Fourteen people were White and three were Black. The ethnicity of one person was unknown at the time of publication.

Eleven people were identified as having mental health concerns. The types of mental health concern included: bipolar, depression, schizophrenia, psychosis, agoraphobia, anxiety and self-harm or suicidal tendencies.

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

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

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

Seven people were arrested for an alleged assault. A further two people were arrested for an offence relating to alcohol or drugs; one of these was also arrested for drug driving. Two people were arrested for a sexual offence, one of these was also arrested for a breach of a Sexual Offences Prevention Order.

Two people were detained under the *Mental Health Act 1983*⁹. Other reasons for detention included breach of the peace, breach of bail, failure to appear in court, child neglect, and alleged child abduction.

Table 5.1 Deaths in or following police custody: reason for detention, 2019/20

Reason for detention	Number of fatalities
Violence-related (non-sexual or murder)	7
Drug / alcohol-related (excluding drink driving)*	2
Breach of bail / failure to appear in court	2
<i>Mental Health Act 1983</i>	2
Sexual offence**	2
Breach of the peace / anti-social behaviour	1
Other	2
Total fatalities	18

* One man was also arrested for drug driving

** One person was also arrested for breach of a sexual offences prevention order

Eight of the 18 people who died had some force used against them either by officers or members of the public before their deaths. It is important to note that the use of restraint, or other types of force, did not necessarily contribute to the deaths.

All eight people were physically restrained¹⁰ by the police or non-police, such as members of the public. One was restrained only by non-

police. Of the people who were physically restrained, six were White and two were Black. Two incidents also involved use of leg restraints¹¹.

⁹ This power allows the police to remove a person who appears to be suffering from a mental illness and needs immediate care or control, from a public place to a place of safety. A place of safety can be a hospital, mental health unit or hospital, a police station or any other suitable place.

¹⁰ The term 'restraint' refers to a range of actions, including physical holds and pressure compliance. It does not include the routine use of handcuffs, unless another form of restraint was also used.

¹¹ This device is used to restrict the movement of limbs. Its application should prevent a person from kicking and punching, and allow for safe transportation of the person.

Circumstances of death

In the circumstances of the deaths described, cause of death according to the pathologist's report following a post-mortem¹² is reported for twelve of the people who died. At an inquest, the cause of death is determined formally and may change from the cause of death listed in a pathologist's report. All but two deaths are being independently investigated by the IOPC.

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

- > A man was arrested and taken into custody. While in custody his mental health appeared to deteriorate. The man was moved to a CCTV cell and officers restrained him while he was being placed in the cell. The man was seen by a healthcare professional¹³ (HCP) and later, he was also seen by force medical examiner (FME) who advised that he needed a mental health assessment. A short while after the mental health assessment was carried out, the man was found unresponsive in his cell. CPR was carried out and an ambulance was called, but he was pronounced dead. His cause of death was reported as *alcoholic ketoacidosis*.
- > One woman disclosed her medical information when being booked into custody, including that she had pancreatitis. A HCP conducted an assessment, during which the woman stated she was in pain and asked to go to hospital. The HCP noted that she appeared to be under the influence

of alcohol, but that she was fit to detain, did not require hospital treatment, and would be re-assessed when sober if she was still in pain. Later that day a different HCP conducted a medical exam and stated that the woman required further assessment at hospital. She was taken to hospital by officers and released under investigation. The woman died two days later. Her cause of death was reported as *1a) acute broncho-pneumonia due to 1b) multi-organ failure due to 1c) alcoholic liver disease and acute-on-chronic pancreatitis*.

- > A man was arrested for assault. He had barricaded himself in a bedroom so police forced entry in order to arrest him. During the arrest, the man was restrained and distraction strikes were used. He was then taken to police custody. Shortly after being admitted to custody the man became unresponsive. A HCP provided medical care 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 cannot be reported at this time.
- > One man became unwell while being booked into police custody. He appeared to have a seizure and then fell backwards, hitting his head on the floor. Officers provided CPR until paramedics arrived. The man was taken to hospital by ambulance where he died later that day. His cause of death is awaited.
- > One man was arrested for assault and taken to custody. During the initial custody risk assessment, he was described as under the influence of drugs or alcohol and placed on 30-minute observations. During one check the man was found to

¹² In a minority of cases, a post-mortem may not be carried out. In this situation, 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'.

¹³ This can be a doctor or a nurse whose professional training would have included working in a custody environment. They have responsibility for the welfare of detainees, including prescribing medication and examining and recording any injuries.

be unresponsive. First aid was provided, and the man was taken to hospital by ambulance. He died shortly after arrival. His cause of death is awaited.

- > One man disclosed when being booked into custody that he had a heart murmur and aorta aneurism. The man then collapsed. First aid was provided by an officer and a HCP prior to paramedics attending. The man was taken to hospital by ambulance where he was pronounced dead shortly after arrival. His cause of death was reported as *1a. ischaemic heart disease II. Essential hypertension, hypercholesterolaemia.*
- > One man was arrested for assault and taken into custody. While being booked into police custody, he disclosed that he had been at the hospital for an infection in his legs, groin and chest. He also disclosed that he was a drug user and was at that time withdrawing. The Custody Sergeant implemented a care plan for the man which monitored the frequency of the cell visits by Detention Officers to check on the man's welfare. The man was searched by a Detention Officer and placed in a cell. While in custody, he was medically assessed by Health Care Professionals (HCPs).

On two occasions, the HCPs administered medication to assist with his withdrawal symptoms. The man was charged with the offence of assault and bail was refused so he could be taken to court after the weekend. The next day, the man disclosed to staff that he had consumed three wraps of drugs. The man was taken to hospital by officers.

During admission to hospital the man became unwell. While in hospital his condition deteriorated. Officers left him in the care of the hospital and he died just under three weeks later. His cause of death was reported as *1a. multi organ failure 1b.*

acute on chronic mycotic aneurysms 1c. bacterial endocarditis due to intravenous drug abuse.

Ten men were taken ill at the **scene of arrest**. Seven were taken to hospital where they died on arrival, or sometime later. Three people died at the scene. These ten cases are outlined below:

- > Police were called to a report of a man assaulting a doorman. When they arrived, they found a man on the floor being restrained by a member of the public. Officers instructed him to let the man go, which can be heard on the body worn video recording taken during the incident. The police arrested the man and handcuffed him as he lay on the floor. Officers turned him over and noticed that he was unresponsive and that there was a plastic bin liner covering his face. The man's handcuffs were removed and he was given CPR by officers until paramedics arrived. He was taken to hospital where he died several days later. His cause of death is awaited. The investigation into the circumstances of this death was dealt with locally by the police force.
- > Police were called to reports of a shoplifter who had threatened staff. Two officers arrived to find a man being restrained outside the store by two shop workers. One officer approached the man on the floor, arrested him, and applied handcuffs. The members of the public who were restraining the man then stepped away. The officer noticed that the man was unresponsive and moved him onto his side. An ambulance was requested. Shortly afterwards, the officers noticed that the man was not breathing. They removed the handcuffs and began CPR. Paramedics arrived and provided first aid, but the man died at the scene. His cause of death is awaited.

- > Police were called to reports of a man who had allegedly stabbed himself. His partner had apparently barricaded herself in a bedroom and called an ambulance. The man then left the house. Officers arrived and the man was arrested nearby for affray. His injuries, which were described as superficial, were assessed in an ambulance. As the man was being assessed he became unwell and went into cardiac arrest. He was taken to hospital where he was pronounced dead on arrival. His cause of death was reported as *cardiorespiratory arrest*. After considering a referral, we returned the case to the force to address as it saw fit.
- > The police and ambulance service were called to reports of a man who appeared to be in distress. Officers arrived to find the man lying in the road. He got up and began to walk in and out of the road. Three officers took the man to the floor and applied handcuffs. A fourth officer arrived and all the officers continued to restrain the man on the floor while waiting for the ambulance. The man had been detained under s.136 of the *Mental Health Act 1983* by the officers. One officer used one distraction strike to the man's leg, and officers applied leg restraints. Paramedics arrived and when being placed in the back of the ambulance, the man became unresponsive and he briefly stopped breathing. His leg restraints were removed, and a short time later his handcuffs were also removed. The man was taken to hospital where his condition deteriorated and he died the next day. His cause of death was reported as *consequences of cocaine toxicity and coronary artery atheroma in temporal association to restraint due to agitation*.
- > A man was stopped by officers for a speeding offence. Following a roadside drug test, he was arrested, placed in handcuffs, and seated in the back of a police car. While in the stationary car the man experienced multiple seizures. Medical assistance was requested, and the man remained in the car before paramedics arrived. He was taken to hospital, where his handcuffs were removed. As he waited there with the officers he had a further seizure, and the officers assisted medical staff in restraining him. The man's condition deteriorated and he died in hospital later that day. His cause of death is awaited.
- > Police were called to reports of a drunk man running in traffic. They arrived and approached the man. After speaking to him, the officers decided to take him to his friend's house in a police van. During the journey the man was behaving erratically so the driver stopped and the man was detained under s.136 of the *Mental Health Act 1983*. The man was taken out of the van onto his knees and handcuffed. An ambulance was called. He was restrained on the ground by officers and leg restraints were applied. The man was taken to hospital by ambulance, accompanied by officers. While in the ambulance he had a seizure. He was taken to intensive care where he was sedated. He remained in a coma for three weeks. The man's condition stabilised briefly, though he still required medical support. He died the day after this apparent stabilisation. His cause of death was reported as *I(a) hospital acquired pneumonia I(b) pulmonary thromboembolism I(c) amphetamine overdose*.
- > Police attended a report of a disturbance. On arrival they identified a man who appeared to be having an asthma attack. During the disturbance he had force used against him by members of the public. The man was also allegedly in possession of a weapon and was suspected of committing a

violent offence earlier in the day. The officers could not find the man's asthma medication and requested an ambulance. Based on the allegations made against the man, he was arrested and handcuffed. After approximately 20 minutes of monitoring, he was placed inside a police vehicle to remove him from the heat of the sun. While inside the police vehicle the man's condition deteriorated and he appeared to stop breathing. He was taken out of the vehicle and his handcuffs were removed. He was given CPR by officers until ambulance staff arrived. The man was taken to hospital where he died later that day. His cause of death was reported as *1a. acute cardiorespiratory failure in an individual with focally severe atherosclerotic stenosis of the coronary arteries, in association with acute behavioural disturbance, emphysema, a clinical history of asthma, and restraint.*

- > On their commute to work two off-duty police officers spoke with a man who was travelling on the same train as them. Concerned about the man's behaviour, one of the off-duty officers requested that police meet the train at the railway station. Officers were present on the platform as the train pulled in and arrested the man, placing him in handcuffs. However, the man was able to run away and evaded officers by walking down onto the train tracks where he was electrocuted and died. His cause of death was reported as *electrocution.*
- > Police attended an address in order to arrest a man. The man was informed that he was under arrest, and he closed and secured the door. Officers forced entry and found that the man had hanged himself. Officers gave him CPR until paramedics arrived, but he died at the scene. His cause of death was reported as *hanging.*

- > Police responded to reports of a man behaving erratically. An officer arrived and stated that the man was being restrained by members of the public. The officer arrested and handcuffed the man, and assisted in restraining him. Additional officers arrived and took over restraint of the man, and an ambulance was called. While being placed in the back of a police van the man reportedly attempted to grab an officer's Taser. He was restrained and taken to the ground before being placed in the van.

The man was under constant monitoring while in the van waiting for the ambulance. He began to have a seizure and was removed from the van and placed in the recovery position. An ambulance arrived and the handcuffs were removed. The man went into cardiac arrest immediately after being placed in the ambulance and again as he was transported to hospital. He was placed under sedation in hospital where he died five days later. His cause of death was reported as *1a. hypoxic-ischaemic brain damage following cardio-respiratory arrest 1b. multiple drug use with acute behavioural disturbance.*

One man was taken ill in a **police vehicle** while being taken from the scene of arrest to the police station:

- > A man was arrested for drugs offences and transported to custody in the caged area of a police van. As the van arrived at custody it became apparent that he had vomited. The man appeared to be having a seizure. An officer took the man out of the van and medical assistance was given by the custody paramedic. An ambulance arrived and took the man to hospital, where he later died. His cause of death was reported as *cocaine intoxication.*

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, to 11, in 2013/14.

In 2014/15, the number rose again to 18 and then declined and remained stable at 14 in 2015/16 and 2016/17. In 2017/18 there were 23 fatalities, the highest number recorded for ten years. This number fell to 17 fatalities in 2018/19. This year the number increased slightly to 18, this remains in line with average figures.

This year, no one died after making an apparent suicide attempt while in a police custody suite¹⁴. 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, a total of seven people are known to have died as a result of self-inflicted acts while in a police cell.

This year one person was pronounced dead in a police cell. In 2018/19 no-one died in a police cell. In 2017/18 there were three such deaths.

¹⁴ While this year there is a death from a self-inflicted act of hanging, this happened during the arrest and prior to the person being taken into a custody suite.



6

Apparent suicides following police custody

Apparent suicides following time in police custody are included if they take place 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 has been referred to us. The police may not always be told about an apparent suicide that happens after detention in custody, as the association may not be clear. Therefore, there may be more deaths in these circumstances than are reported here.

The term 'suicide' does not necessarily relate to a coroner's verdict because, in most cases, verdicts are still pending. These cases are included only if, after considering the nature of death, 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 54 apparent suicides following police custody in 2019/20 – 49 men and five women. The average age of those who died was 41 years. The most common age was between 41 and 50 years (14 people), followed by 31 to 40 years (13 people). The youngest person was 18 years. Forty-eight of those who died were reported to be White. Three people were Black, one was Asian, and one

person was from a Mixed ethnic group. The ethnicity of one person was unknown at the time of publication.

Over two thirds of the people (37) had known mental health concerns. Of these, three had been detained under Section 136 of the *Mental Health Act 1983*. Other mental health concerns included depression, schizophrenia, antisocial personality disorder, bipolar, psychosis, borderline personality disorder, previous thoughts or incidents of suicide attempts and self-harm.

Almost half of the people (26) 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-two of these related to alcohol and 16 to drugs.

Circumstances of death

Nineteen apparent suicides happened the same day the person was released from police custody. 22 happened one day after release, and 11 happened two days after release.

There were two cases where the apparent suicide took place over two days after release. In one case, the apparent suicide happened three days after release. This case was subject to independent investigation. In the other case, the apparent suicide happened eight days after release. The investigation into the circumstances of this death is being dealt with locally by the police force. In both these cases the pre-release risk assessment is being examined.

Table 6.1 shows the reasons why these people were detained by the police. Sixteen of those who died had been arrested for a sexual offence. Of these, 12 were related to sexual offences or indecent images involving children. Nineteen detentions were for violence-related offences. Eight detentions were for driving offences. Other common reasons for detention were criminal damage (seven) and theft-related offences (five).

Table 6.1 Apparent suicides following police custody: reason for detention, 2019/20

Reason for detention	Number of detentions
Violence-related (non-sexual or murder)	19
Sexual offences	16
Driving offences (including drink / drug driving)	8
Criminal damage	7
Theft / burglary / robbing / handling / shoplifting	5
Threatening behaviour / harassment	4
Drug / drink related	3
Possession of a weapon	3
<i>Mental Health Act 1983</i>	3
Fraud	2
Breach of the peace / anti-social behaviour	1
Failure to appear in court / breach of bail / recall to prison	1
Murder / manslaughter	1
Other	1
Total number of reasons for detention	74
Total fatalities	54

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

Seventeen people were detained for multiple reasons, compared to 15 last year. Nine people who were arrested for violence-related offences were also arrested for other reasons.

The majority of recorded apparent suicides following police custody were dealt with locally by the police force involved (52). Two are being investigated independently. In addition to the one case on page 22, the other independent investigation is considering the arrest, detention and release on bail of a person and the subsequent response to a missing person report made about that individual.

Trends

The number of apparent suicides following time in police custody has decreased from the 63 fatalities recorded last year to 54 this year. This is the sixth lowest number recorded over the 16-year period since 2004/05.

Reporting of these deaths relies on police forces making the link between an apparent suicide and someone having spent time in custody recently. Increases in these deaths may therefore be influenced by improved identification and referral of such cases.

This year, for 30% of fatalities, the reason for

detention related to alleged sexual offences. The proportion of sexual offences or indecent images involving children was 22%. These proportions are slightly lower than the figures recorded last year (33% and 24% respectively) but in-line with average figures. The average proportions for these alleged offences since 2004/05 are 33% and 26% respectively.



7

Other deaths following police contact: independent investigations only

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

During 2014/15, the IPCC started a significant period of change and expansion in response to the then Home Secretary's announcement that there should be more independent investigations into serious and sensitive matters¹⁵. 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 this annual report is based on them being independently investigated.

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

In 2018/19 the IOPC began a phased move to thematic case selection. The thematic areas include domestic abuse, RTIs, abuse of authority for sexual or financial gain, mental health and discrimination.

Thematic case selection involves independently investigating more cases where these themes may be a factor. This will enable us to develop a body of evidence for learning and prevention work. The move to thematic case selection may have an impact on the

¹⁵ See our [Corporate Plan 2015–18](#) and [Strategic Plan 2018–2022](#) for more information.

number and proportion of cases involving particular circumstances of death – such as concerns for welfare based on mental health, or domestic-related incidents.

Overall demographics

We independently investigated the deaths of 107 people who died during or following other contact with the police during 2019/20. Of these deaths:

- > 74 were men and 33 were women
- > 89 people were White, six were Black, seven were Asian and one person was from an Other ethnic group. The ethnicity for four people was not known at the time of publishing

- > six people were aged under 18 years, and eight people were young adults aged between 18 and 24 years. The average age was 41 years old.
- > half of those who died (54) were reported to be intoxicated by drugs and/or alcohol at the time of the incident, or drugs and/or alcohol featured heavily in their lifestyle. Over two-thirds of the people who died (75) were reported to have mental health concerns

Table 7.1 Other deaths following police contact: reason for contact, 2019/20

Reason for contact		Number of fatalities
Concern for welfare	Missing person	18
	Self-harm / suicide risk / mental health	32
	Health / injuries / intoxication / general	11
	Domestic related	27
	Threatening behaviour / harassment	4
	<i>Subtotal</i>	92
Other contact	Execute search / arrest warrant / investigation enquiries	3
	Attending a disturbance	4
	Avoiding contact / arrest	3
	Assisting medical staff	2
	Other	3
	<i>Subtotal</i>	15
Total fatalities		107

Circumstances of death

This category includes deaths that occur in a range of circumstances. The police contact may not have been directly with the person who died, but with a third party, as illustrated by some of the case examples. Where we have included the cause of death, this is taken from the pathologist's report following a post-mortem¹⁶.

As shown in Table 7.1, the most common reason for contact with the police related to a **concern for welfare**. Ninety-two people died after concerns were raised with the police, either directly or indirectly, about their safety or well-being before their death. A further 15 fatalities were recorded that relate to **other types of contact** with the police.

A total of nine people who died following police contact had force used against them. All nine were restrained by police officers or by members of the public. This does not necessarily mean that the force used contributed to the death. Seven people were White, one was Black and the ethnicity of one person was not known at the time of publishing. Seven people were known to have been restrained by police officers. Of these, one man also had leg restraints used on him. Two people were restrained by members of the public only.

Concern for welfare

Of the 92 fatalities that followed contact with the police about a concern for welfare, 18 people died following a report of a **missing person**. The police generally did not have direct contact with the deceased in these circumstances. Of these 18 people, nine

were also identified as being at risk of self-harm or suicide.

For these nine:

- > all nine were men. Seven people were White, one was Asian and one was Black
- > the ages of those included in this category ranged from 17 to 60 years. The most common age group was 31 to 40 (three people). The average age was 39 years old
- > for four people, alcohol and/or drugs featured heavily in their lifestyle. All nine people who died were known to have mental health concerns
- > in eight incidents, the person's death was caused by an apparent self-inflicted act

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

- > seven of those who died were men and two were women. Eight were White and one was Asian
- > the ages of the people in this category varied from 15 to 74 years. Three people were aged under 18 years and two people were aged between 41 and 50 years. The average age was 37 years
- > for three people, alcohol and/or drugs featured heavily in their lifestyle. Five people were known to have mental health concerns
- > the classification of death for two of these people was alleged murder. One death was caused by an apparent self-inflicted act, one death was from natural causes, one death appeared to be accidental, and one death was from an accidental overdose. Three classifications are not known at this time

¹⁶ In a minority of cases, a post-mortem may not be carried out. In this situation, 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'.

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

- > twenty-five people were men and seven were women
- > twenty-six were White, two were Asian, one was Black and one person was from an Other ethnic group. The ethnicity of two people was not known
- > the ages of the people ranged from 19 to 67 years. The majority were aged between 41 and 50 years (thirteen people). The average age was 42 years old
- > death by self-inflicted means was the most common classification (26 people)
- > for 17 people, alcohol and/or drugs featured heavily in their lifestyle
- > one case involved police use of force. A man was reported to be acting erratically in the street. He had a number of altercations with members of the public and was struck by several vehicles. The man made his way to an exhibition centre where he was restrained by security guards. Police arrived and took over restraint from the security guards and placed the man in handcuffs. The man was then rolled onto his side and it became clear he was not responsive. Officers removed the handcuffs and gave him CPR before paramedics arrived. The man was taken to hospital where he died later that day. His cause of death was reported as *cardiorespiratory arrest in association with restraint and acute behavioural disturbance*.

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

In this category:

- > ten people were men and one was a woman
- > eight were White, two were Black, and the ethnicity of one person was unknown
- > the majority of people (eight) were aged under 40 years and four were aged under 30 years. The average age was 38 years old
- > almost three quarters of those who died (seven) 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 accidental overdose (four people). Three deaths were deemed accidental
- > two cases involved police use of force. In one case an off-duty police officer was driving when he saw a man in traffic. He stopped to engage with the man who continued to run in traffic and then climbed onto, fell off and rolled underneath a lorry that stopped in the road. The police officer eventually restrained the man in a central reservation. A second off-duty officer also arrived at the scene and applied handcuffs. Additional police units and ambulance crew attended soon after and the handcuffs were removed. The man was transported to hospital where he died the next day. His cause of death was reported as *1a. multi-organ failure with clostridium septicum sepsis 1b. cocaine toxicity*.

> In the other case, while on patrol, police officers saw a man in the road, banging on car windows. The officers escorted the man off the road and onto a roundabout. The man was described as extremely agitated and flailing his arms and legs around. Officers placed handcuffs on the man, and then attempted to restrain him over the bonnet of the police car. It became clear that this was causing the man discomfort and he was moved away from the car. A short while later he was assisted to the ground by officers, and an ambulance was called.

While sat on the floor the man began to struggle and was briefly pinned to the ground by officers before being rolled onto his side. The man appeared to be losing consciousness and his handcuffs were removed. An ambulance arrived, by which point the man had regained consciousness. The officers and paramedics agreed to handcuff the man again. He was placed into the ambulance, where he had a cardiac arrest. The man died in hospital three days later. His cause of death was reported as *cocaine intoxication*

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

- > twenty of those who died were women and seven were men. Women were a higher proportion in this category than in all the other independently investigated deaths following police contact
- > twenty-three people were White, two were Asian and two were Black
- > the most common age range was 31 to 40 years (11 people). The average age was 38 years. The youngest was one year old

- > in 16 instances, the deaths were classified as alleged murder. Eight were self-inflicted, one was an accidental overdose and one was from natural causes. One classification was not known. All but four of those who were allegedly murdered were women
- > two incidents each resulted in two fatalities. In one of these incidents, a person was apparently murdered, and the suspected perpetrator then died as a result of a self-inflicted act. In the other incident two people were allegedly murdered

Four people died following concerns about **threatening behaviour**. These incidents involved threatening behaviour or harassment among people in non-domestic situations – for example, neighbours or strangers. In this category:

- > two of those who died were men and two were women. All were White
- > two people were aged between 41 and 50 years, and the eldest was 63 years
- > two classifications of death were alleged murders. One death was self-inflicted, and one was the result of natural causes

Other contact

The 15 deaths recorded as relating to other types of contact took place in the following circumstances.

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

- > all three were men and all were White
- > all were aged over 40 years
- > in two incidents, the death was the result of natural causes. One death was self-inflicted
- > One case involved police use of force.

Officers attended a property to carry out a search. Following police entry to the property a man was found in an upstairs bedroom. He was restrained and handcuffs were applied. Some time later, when the search was still continuing, the man became unwell. An ambulance was called and the handcuffs were removed. Police provided first aid before paramedics arrived and assisted with the treatment of the man. The man was taken to hospital where he was pronounced dead shortly after arrival. His cause of death was reported as *1a Ischaemic heart disease*.

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

- > A White man, aged 33 years, was reported to be behaving erratically. He was restrained by approximately five members of the public. Police and paramedics arrived and helped to restrain the man. One officer applied leg restraints. The man was handcuffed and taken to hospital while restrained where he died four days later. His cause of death was reported as *1a multi-organ failure and hypoxic ischaemic brain injury 1b acute cocaine toxicity*.
- > Police received a number of calls stating a White man, aged 25 was smashing vehicles with a sledgehammer and had been detained by members of the public who had apparently restrained him. When they arrived, officers realised the man was unwell. An ambulance was called and first aid was administered. The man was taken to hospital where he died later that day. His cause of death is awaited.
- > Officers responded to a call about an ongoing neighbour dispute. When they arrived, they found a White man, aged 44 years lying unresponsive on the ground. He had apparently been restrained by another man. The officers carried out CPR before

the man was taken to hospital, where he died the next day. His cause of death was reported as *1a.hypoxic-ischaemic brain injury 1b. cardiac arrest 1c.period of restraint with neck compression II. coronary artery atheroma, ethanol and cocaine*.

- > Police responded to a report that a man had been shot with an air gun. The suspect, a White man aged 52 years, was handcuffed and placed in the back of a police vehicle, where he was assessed by a paramedic. While in the vehicle the man became unwell and received further medical treatment. He was taken to hospital, where he died later that day. His cause of death was reported as *cocaine toxicity*.

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

- > Officers were alerted to a White man, aged 28, suspected of being involved in drug offences. They attempted to speak to him, but he fled on foot along a river path. The officers pursued the man on foot. He entered the river and began to swim across to the opposite bank. The man began to struggle and disappeared beneath the surface of the water. Police officers, fire and rescue, and rescue boat services conducted a search of the river for approximately two hours before the man was recovered. Paramedics pronounced him deceased at the scene. His cause of death was reported as *drowning*.
- > Police attended an address in order to locate and arrest a 27-year-old White man. The occupants of the house advised the police officers that the man was not there, and they allowed the officers to search the property. The man was not found. As the officers left the address, movement was seen from the roof and they returned to the attic room of the house. The officers heard noises and realised a man had fallen from

the roof. He was found on the ground and identified as the man they had visited the property to arrest. The officers called an ambulance and gave the man first aid before paramedics arrived. He was then transferred to hospital where he died the next day. His cause of death was reported as *1(a) blunt force head injury*.

- > An officer was on patrol in a town centre during the coronavirus lockdown. While on patrol, the officer engaged with a 52-year-old man who was driving a mobility scooter. The officer detained this man for a drugs search. The officer stated that before the search began he noticed what appeared to be a drugs wrap in the man's mouth. The officer stated that he tried to remove the item, which was apparently resisted by the man. The man was then restrained by the officer and taken to the ground. Two members of the public assisted the police officer in restraining the man, and one of these members of the public helped to apply handcuffs. Other officers arrived and the man became unwell. The handcuffs were removed and an ambulance was requested. Officers performed CPR on the man before paramedics arrived and took over treatment. The man was taken to hospital where he was pronounced dead shortly after arrival. His cause of death is awaited.

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

- > Officers attended the home of an Asian man, aged 77, after receiving a request from paramedics for assistance in taking him to hospital. The man had been deemed mentally incapable of refusing hospital treatment by the paramedics and was required to go to hospital. Officers helped to carry the man down the stairs and out

of the house onto a stretcher. He struck one of the paramedics and an officer applied handcuffs. The man was put into an ambulance and the handcuffs were removed. The man's condition deteriorated and he was transported to hospital where he was pronounced dead shortly after arrival. His cause of death is awaited.

- > Officers attended an approved premises¹⁷ to help ambulance staff transport a White man, aged 34, to hospital. The man was believed to have taken a drugs overdose and had been found unresponsive. Ambulance staff reported that he lacked capacity and was resisting going to hospital. They also said that he had been aggressive. The police attended and handcuffed the man, which involved physical restraint. They then attempted to assist him to leave the building, but he appeared unable to walk and was placed on to the floor. He then went into cardiac arrest. His handcuffs were removed, and ambulance staff began CPR assisted by the officers. The man was taken to hospital where he died four days later. His cause of death was reported as *1a. hypoxic brain injury 1b. cardiac arrest 1c. aspiration pneumonia 1l. use of heroin and cocaine*.

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

- > One man was under investigation for malicious communications. This involved threats to run children over. There was also a suspected sighting of the man driving around a school. While under investigation, the man allegedly deliberately ran over children outside the school. One child died following this incident.
- > One man had his firearms certificate revoked following his arrest, during which he had made comments that suggested suicidal

¹⁷ An approved premises is a residential unit which houses ex-offenders in the community.

intent. Officers attended the man's home with him and removed his guns. Just over two weeks later the man fatally shot his wife and then himself with a gun he had not told the police he owned.

Trends

In 2010/11, a change was made to the definition of this category. It now includes only those deaths following other police contact that were investigated independently by the IOPC, formerly the IPCC. The number of cases therefore recorded in this category is directly linked to the number of cases independently investigated. It would 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 86% of the deaths following police contact that were independently investigated – in 2018/19, the proportion was 84%.

During 2019/20, just under a third of investigations into deaths following police contact related to incidents where someone had reported being concerned about a person's risk of self-harm, risk of suicide, or mental health. A quarter of investigations into deaths following police contact were domestic-related. These two types of concern for welfare are both linked to current thematic work areas. 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 independently investigates.



8

Background note

Background note

- 1 Under the *Police Reform Act 2002*, forces in England and Wales have a statutory duty to refer to the IOPC 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 to investigate the death.
- 2 Since April 2006, the Independent Office for Police Conduct (IOPC), previously the Independent Police Complaints Commission (IPCC), has also received mandatory referrals for cases where someone has died during or following contact with Her Majesty's Revenue and Customs (HMRC)¹⁸; the Gangmasters and Labour Abuse Authority (GLAA)¹⁹, and the Serious Organised Crime Agency (SOCA), and since October 2013, SOCA's replacement, the National Crime Agency (NCA). Up until March 2013, we have also received cases from the UK Border Agency (UKBA)²⁰, when UKBA's executive agency status was ended, and its functions were brought back into the Home Office as UK Visas and Immigration (UKVI); UK Immigration Enforcement (UKIE); and UK Border Force (UKBF). The IOPC has continued to have jurisdiction over those officials and contractors. Therefore, this report also includes deaths during or following contact with staff from these organisations.
- 3 In January 2018, we became the IOPC. This change was set out in the *Policing and Crime Act 2017*. Before this, we were the IPCC.

¹⁸ Regulation 34 of the Revenue and Customs (Complaints and Misconduct) Regulations 2005.

¹⁹ Regulation 36 of the Gangmasters and Labour Abuse Authority (Complaints and Misconduct) Regulations 2017

²⁰ Regulation 25 of the UK Border Agency (Complaints and Misconduct) Regulations 2010.

Changes and revisions

- 4 In 2010/11, a change was made to the definition of the ‘other deaths following police contact’ category. It now includes only those deaths following police contact that were investigated independently by the IOPC, or previously by the IPCC. As a result, we have changed the approach to how this category is presented in this report. Further information about this category can be found in [the guidance document](#). No other changes have been made to the definitions of the death categories.
- 5 In 2007, the IPCC issued an operational advice note to forces to address inconsistencies in the referral of ‘apparent suicides following release from police custody’. Forces were asked to refer any suicides that happened within two days of release from police custody, or apparent suicides that happened more than two days after release, but where there was a possible link between the time the person spent in custody and their death.
- 6 This report presents the most up-to-date set of figures for each death category. In this release, seven fatalities have been added to previous years’ figures. One fatality has been added to the category ‘other deaths following police contact’ for the 2017/18 figure. Five fatalities have been added to the category ‘other deaths following police contact’ for the 2018/19 figure. These deaths were either not subject to an independent investigation or they had not been referred to us when the previous report was released. One fatality has been added to the category ‘deaths in or following police custody’ for the 2018/19 figure.

- 7 Table 6.1 sets out the reasons for detention for apparent suicides following police custody. In previous years, this table has shown the number of fatalities with footnotes to highlight where there were additional reasons for detention. Due to the high volume of fatalities with multiple reasons for detention in 2019/20, the figures shown in Table 6.1 are the total number of different reasons for detention. The same approach was taken in our 2018/19 report.

Methods and definitions

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

Policies and statements

- 9 A number of [policies and statements](#) are produced 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 has been used, can be found in the [user](#)

[engagement feedback document](#). This 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 note that care needs to be taken when looking at the time series of the data. There may be discontinuities owing to changes in category definition and the varied nature of the circumstances of the cases. The small numbers involved also mean readers should be cautious about drawing conclusions from trend analysis as variances can be large.

We make every effort to make sure that all relevant deaths are included in this report through an extensive validation exercise with internal colleagues and police forces. However, at times, a case may come to light after the report has been published. Read [our revision policies](#) for information about how we manage routine amendments and errors to published data.

While comparisons to other countries and jurisdictions can be made, care needs to

be taken, because the data is unlikely to be directly comparable. This is because of differences in death classifications, or how other details have been collated.

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

Further information

- 15 [All 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 If you have any questions or comments about our annual death reports, please email research@policeconduct.gov.uk.
- 20 Estimated publication date for our next report covering data for 2020/21: July 2021.



Appendix A: additional tables

Table A1 Incidents by type of death and financial year, 2009/10 to 2019/20

Category	Incidents										
	Financial year										
	09/10	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20
Road traffic incident	26	24	19	23	11	13	20	28	27	33	24
Fatal shootings	2	2	2	0	0	1	3	6	2	3	3
Deaths in or following police custody	17	21	15	15	11	18	14	14	23	17~	18
Apparent suicides following custody^	54	46	39	65	70	71	60	57	57	63	54
Other deaths following police contact*	37	49*	37	20	41	43	102**	129	170~	152~	104

^ 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, 2019/20

Gender	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Male	20	3	17	49	74
Female	4	0	1	5	33
Total fatalities	24	3	18	54	107

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

Table A3 Type of death by age group, 2019/20

Age group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Under 18	3	0	0	0	6
18 - 20	4	1	1	5	1
21 - 30	9	2	5	8	19
31 - 40	2	0	6	13	30
41 - 50	0	0	1	14	25
51 - 60	1	0	3	12	15
61 and over	5	0	1	2	11
Total fatalities	24	3	18**	54	107

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

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

Table A4 Type of death by ethnicity, 2019/20

Ethnicity group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
White	16	0	14	48	89
Black	4	1	3	3	6
Asian [^]	1	2	0	1	7
Mixed	0	0	0	1	0
Other	0	0	0	0	1
Not known	3	0	1	1	4
Total fatalities	24	3	18	54	107

* 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, 2019/20

Appropriate authority	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Avon & Somerset	2	0	0	1	2
Bedfordshire	0	0	0	1	1
Cambridgeshire	0	0	0	1	1
Cheshire	1	0	0	1	3
City of London	0	1 [^]	0	0	0
Cleveland	0	0	1	1	0
Cumbria	0	0	0	0	0
Derbyshire	0	0	0	0	6
Devon & Cornwall	0	0	0	2	4
Dorset	0	0	0	0	1
Durham	1	0	1	0	0
Dyfed Powys	0	0	1	1	0
Essex	0	0	0	2	3
Gloucestershire	0	0	0	0	1
Greater Manchester	5	0	3	1	11
Gwent	0	0	0	1	1
Hampshire	1	0	1	1	2
Hertfordshire	1	0	0	2	0
Humberside	0	0	0	2	2
Kent	1	0	0	2	0
Lancashire	0	0	0	2	1
Leicestershire	0	0	0	1	2
Lincolnshire	0	0	0	1	2
Merseyside	1	0	0	0	1
Metropolitan	7	1	3	3	18
Norfolk	0	0	0	1	2
North Wales	0	0	0	0	1
North Yorkshire	0	0	1	0	2
Northamptonshire	1	0	0	1	1
Northumbria	0	0	0	4	0
Nottinghamshire	0	0	1	0	1
South Wales	0	0	1	1	5
South Yorkshire	0	0	0	2	3
Staffordshire	0	0	0	4	4
Suffolk	0	0	1	2	1
Surrey	0	0	0	1	3
Sussex	0	0	1	3	3
Thames Valley	0	0	1	3	2
Warwickshire	0	0	0	1	0
West Mercia	1	0	0	0	2
West Midlands	1	0	1	2	4
West Yorkshire	1	0	0	3	6
Wiltshire	0	0	0	0	1
City of London and Metropolitan	0	1	0	0	0
Hampshire and Dorset	0	0	0	0	1
British Transport Police and Greater Manchester & Lancashire	0	0	0	0	1
West Midlands and South Wales	0	0	0	0	1
Greater Manchester and Cheshire	0	0	0	0	1
British Transport Police	0	0	1	0	0
Home Office~	0	0	0	0	0
HMRC	0	0	0	0	0
Ministry of Defence	0	0	0	0	0
National Crime Agency	0	0	0	0	0
Total fatalities	24	3	18	54	107

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

[^] This incident involved officers from other forces but the shot was fired by an officer from the City of London police

~ This includes UKBF, UKIE and UKVI.

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:

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

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