IOPC Independent Office for Police Conduct

Deaths during or following police contact

Statistics for England and Wales 2025/26

Acknowledgements

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Contact details

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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*. 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 2025 and 31 March 2026. 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 twenty-second in this series of statistical reports, published annually by the IOPC.

The IOPC examines 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 on page 33 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 were 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 developed 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.

The IOPC will decide to conduct an independent investigation 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 was 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 2025/26, there were:

- 15 road traffic fatalities
- 4 fatal police shootings
- 27 deaths in or following police custody
- 67 apparent suicides following police custody
- 63 other deaths following police contact that were independently investigated by the IOPC

Demographic information about people who died is provided 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 informed 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 decide to investigate the case independently, direct a police force to investigate the case under IOPC control, or decide 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 were no longer available as a mode of investigation. A new type – 'directed investigation' – was created. Directed investigations take place under IOPC direction and control, but use 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 2025/26. The figures show the number of incidents. An incident leading to a single investigation can involve more than one death, so the total

number of incidents for some categories may be lower than the total fatalities set out above. In 2025/26, the IOPC independently investigated 103 incidents.

Table 2.1 no longer includes figures for supervised and managed investigations as all the fatalities in this report happened from April 2025 onwards. There were no directed investigations in any of the death categories.

Table 2.1 Incidents by type of death and investigation type, 2025/26

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	12	3	25	1	62
Directed	0	0	0	0	0
Local	0	0	2	15	0
Back to force	3	0	0	51	0
Total incidents	15	3	27	67	62

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 2015/16. 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, 2015/16 to 2025/26

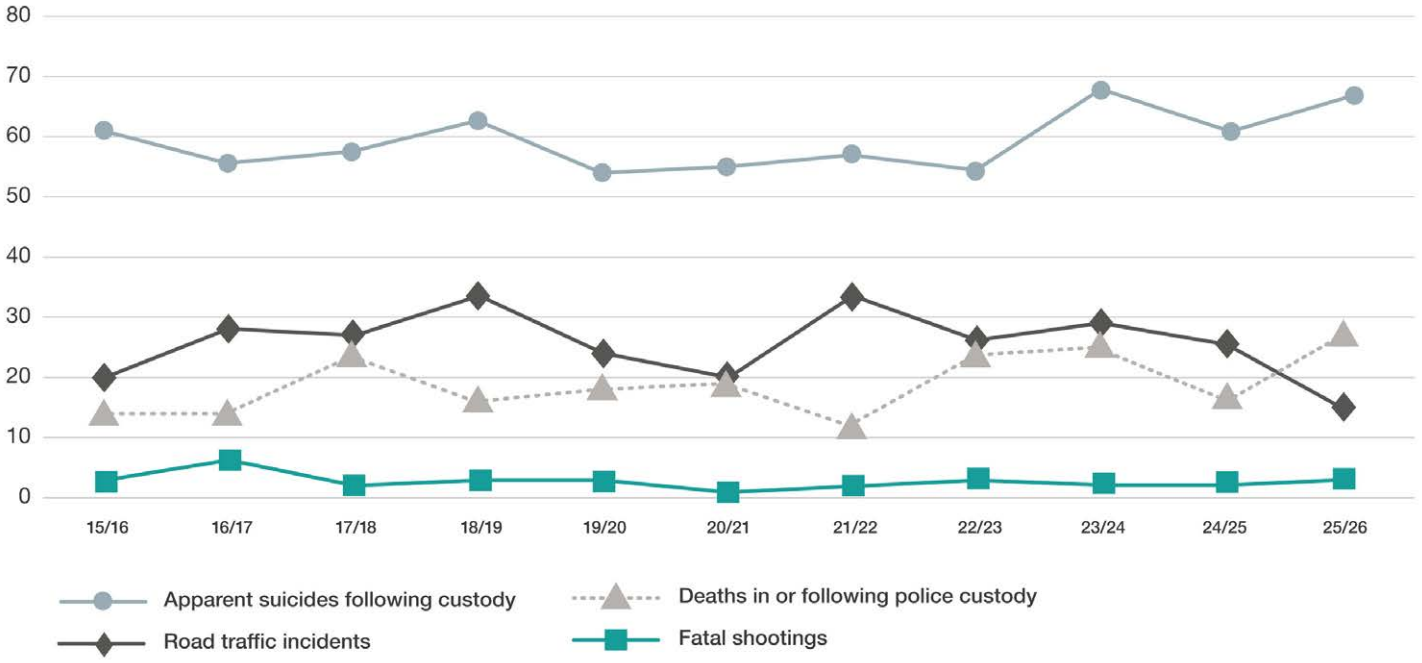
	Fatalities										
	Financial year										
Category	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**	**23/24**	**24/25**	**25/26**
Road traffic fatalities	21	32	29	42	24	25	42~	28	32	26	15
Fatal shootings	3	6	4	3	3	1	2	3	2	2	4
Deaths in or following police custody	14	14	23	17	18	19	12~	23	25	18~	27
Apparent suicides following custody	61	56	57	63	54	55	57	54	68	61~	67
Other deaths following police contact*	106**	131	178	156	107	97	113	92~	63~	53~	63

* 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, 2015/16 to 2025/26



The number of **fatal road traffic incidents (RTIs)** has decreased this year, with 15 incidents, compared to 25 last year. This is lower than the average of 26 incidents recorded over the 11-year period since 2015/16. These figures are subject to fluctuation and, therefore, year-on-year comparisons should be approached with caution.

This year there were four **fatal police shootings**, compared to two recorded last year. This is higher than the average of three fatal shootings recorded since 2015/16.

The number of **deaths in or following police custody** has increased over the last year from 18 to 27. Over time, there have been some fluctuations in this category, with notable increases recorded in 2014/15, 2017/18 and 2022/23. The 2025/26 figure is higher than the average of 19 deaths over the 11-year period.

The number of recorded **apparent suicides following custody** was 67, higher than the 61 fatalities recorded last year. The number of deaths in this category remain higher than the average number recorded over the years before 2012/13, when there was a notable increase. The number is higher than the average of 59 deaths reported over the 11-year period. Reporting of these deaths relies on police forces making the link between a person's apparent suicide and them being recently in custody. The overall increase in these deaths over the period since 2014/15, 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 conduct 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 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 deal with as it considers appropriate.

3 Road traffic fatalities

Demographics

In 2025/26, there were 15 fatal police-related road traffic incidents (RTIs), resulting in 15 fatalities. Of those who died, 12 were men and 3 were women. Eleven people were White, one person was Black, two people were of mixed ethnicity, and one person was from an other ethnic group.

No-one was under 18 years old. Four people who died were aged between 18 and 30 years, and the eldest person was 84 years old. The average age was 41 years old. The average age decreases to 36 years if the deceased was the driver or passenger in a pursued or fleeing vehicle. It increases to 54 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 would 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 eleven police pursuit-related incidents, which resulted in eleven fatalities. Of these fatalities:

- Six people were the driver of a vehicle being pursued by the police when it crashed.
- Two people were passengers in the car being pursued by the police.
- One person was a rider of an unrelated moped, which was hit by the pursued car.
- Two people were pedestrians who were hit by the car being pursued by the police.

The IOPC independently investigated ten of the pursuit-related incidents. The remaining incident was referred back to the relevant police force to deal with as it saw fit.

Emergency response-related

This category includes all incidents that involve a police vehicle responding to a request for emergency assistance. Two emergency response-related incidents occurred in 2025/26 resulting in two fatalities. These incidents are both being investigated independently.

This number has decreased from the five incidents and five fatalities recorded last year. The figures for this year are below the average of three emergency-response related incidents and fatalities recorded over the 11-year-period since 2015/16.

These two fatalities involved police vehicles colliding with pedestrians whilst using emergency warning equipment. The circumstances of these two incidents were:

- Officers in a marked police car collided with a pedestrian whilst responding to an ongoing emergency call about a domestic incident.
- A marked police van carrying several officers collided with a pedestrian. The officers had been assigned to attend a public order incident.

Other police traffic activity

This category includes RTIs that did not happen during pursuit-related activity or an emergency response. There were two incidents in 2025/26 resulting in two fatalities. Both incidents were referred back to the relevant police force to deal with as it saw fit.

Of these two incidents, both happened when a vehicle appeared to respond to the presence of the police:

- An officer in a marked vehicle with blue lights and sirens activated was responding to a report of a disturbance. The officer observed a motorcycle ahead increase speed and overtake other vehicles. The officer contacted the force control room and reported that they believed the rider thought they were being instructed to stop and, as a result, drove off and failed to stop. The officer advised they would not pursue the motorcycle and continued to the original incident. They remained some distance behind the motorcycle and lost sight of it soon after. A short time later, police received a report of a collision involving a motorcycle and a stationary vehicle at a nearby location. It was later confirmed that this was the same motorcycle. The rider was taken to hospital where they later died. We returned the case to the force to deal with as it saw fit.
- Officers on patrol in a marked police vehicle saw a car in the distance that was reportedly driving erratically. The officers increased their speed to obtain the registration number of the car. Shortly afterwards, the vehicle mounted a kerb and hit a bollard. Officers activated their blue lights and sirens to signal for the driver to stop. The driver failed to stop and drove away at speed. Officers de-activated their blue lights and sirens and slowed down. As the officers were not pursuit-trained, they did not pursue the vehicle. Officers informed the control room that a car failed to stop following a collision, and they suspected the driver may have been under the influence. The officers then continued at normal speed, losing sight of the vehicle shortly afterwards. The vehicle was found in a ditch approximately 15 minutes later. The driver was taken to hospital where he died almost three weeks later. We returned the case to the force to deal with as it saw fit.

Trends

This year, 15 people died in 15 separate incidents. There was a decrease in fatalities this year from 26 to 15. This is below the average of 29 road traffic incident fatalities recorded over the 11-year period since 2015/16. 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 a decrease in the number of pursuit-related incidents. The number of eleven is below the average of 19 incidents seen over the past 11 years.

There was a decrease in the number of pursuit-related fatalities this year, from 18 to eleven. There were no pursuit-related incidents that resulted in multiple fatalities. Prior to 2025/26, the last time

that there were no pursuit-related incidents that resulted in multiple fatalities was in 2019/20. The number of pursuit-related fatalities this year is lower than the average of 21 fatalities recorded over the 11-year period since 2015/16.

This year has seen a notable decrease in the number of emergency response-related incidents and fatalities. The figure of two incidents and two fatalities for this year is lower than the average of three incidents and three fatalities since 2015/16.

The number of incidents resulting from other police traffic activity has decreased to two from three the previous year, with the number of fatalities also decreasing to two from three. It is lower than the average of four incidents and four fatalities over the past 11 years, and a decrease of over 80% compared to the number of incidents recorded in 2004/05.

Table 3.1 Type of road traffic fatality, 2015/16 to 2025/26

RTI type	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Pursuit-related	13	28	17	30	19	20	36~	20	24	18	11
Emergency response-related	2	0	8	5	3	1	3	2	1	5	2
Other	6	4	4	7	2	4	3	6	7	3	2
Total fatalities	**21**	**32**	**29**	**42**	**24**	**25**	**42~**	**28**	**32**	**26**	**15**

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

Table 3.2 Type of road traffic incident, 2015/16 to 2025/26

RTI type	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Pursuit-related	12	24	17	21	19	15	28~	18	22	17	11
Emergency response-related	2	0	7	5	3	1	3	2	1	5	2
Other	6	4	3	7	2	4	3	6	6	3	2
Total incidents	**20**	**28**	**27**	**33**	**24**	**20**	**34~**	**26**	**29**	**25**	**15**

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

4

Fatal shootings

There were four fatal police shootings in 2025/26 which occurred in three separate incidents. This represents an increase compared to the two fatal police shootings and two incidents recorded last year. The circumstances of the four fatal shootings are summarised below. Two incidents are subject to ongoing independent investigations, while one is complete.

- Thames Valley Police received a call to report a man with a gun at a railway station. Firearms officers were sent to the station. Officers from an armed response vehicle were first on the scene. As the officers exited the armed response vehicle, a 38-year-old White man walked at speed towards both officers with a knife in his right hand. The officers challenged the man, instructing him to stay still and put the knife down. Body worn video shows that the man ran towards both officers with the knife. One officer then discharged a single shot which hit the man in his abdomen, causing him to fall to the ground. Officers provided first aid before paramedics arrived and took over medical care. The man died at the scene.
- Greater Manchester Police received a call from a member of the public reporting a man had driven at and stabbed multiple people at a synagogue, while wearing what appeared to be an improvised explosive device (IED).

  Firearms officers arrived at the synagogue, where a number of people had already been injured in the terror attack. One member of the public later passed away. The man, who was aged 35 and Asian, was standing outside the front of the building, holding a knife. The officers moved towards the man and gave him verbal directions. The man moved towards the officers with the knife and officers then discharged their weapons several times. The man died at the scene.

  Two other men were injured during the incident. Both were inside the synagogue at the time. Initial examination appeared to show these injuries were caused by a police-issue firearm. One of the men, a 53-year-old White man, died at the scene.
- Norfolk Constabulary received reports of a road traffic collision. It was reported that one of the drivers involved was seen with what appeared to be a handgun, who then left the scene. Firearms officers found the 61-year-old White man lying on a raised verge on the side of the road. The man was ordered by officers to drop his weapon. Two officers fired a single shot at the man, hitting him in the chest and abdomen. First aid was provided by the armed officers and ambulance crews. However, the man died at the scene. What appeared to be a non-police issue gas-powered air gun was recovered from the scene.

5

Deaths in or following police custody

Demographics

In 2025/26, 27 people died in or following police custody – 24 were men and three were women. Their ages ranged from 18 to 65 years. Twenty-three people were White, three people were Asian and one person was of a mixed ethnicity.

Eighteen people had mental health concerns. The types of mental health concerns included depression, anxiety, bipolar disorder, self-harm, PTSD (post-traumatic stress disorder), paranoid psychosis and emotionally unstable personality disorder. Two people had been detained under section 136 of the *Mental Health Act 1983*.

Twenty-two 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. Eight people had links to alcohol and twenty had links to 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 seven people.

Table 5.1 on page 16 shows the reasons why people were arrested or detained by the police.

Table 5.1 Deaths in or following police custody: reason for detention, 2025/26

Reason for detention	Number of fatalities
Violence-related	6*
Theft / burglary / shoplifting	5**
Criminal damage	3
Harassment / threatening behaviour	3***
Driving offences (including drink / drug driving)	3^
Drug / drink-related	2^^
Mental Health Act 1983	2^^^
Breach of the peace	1
Possession of a weapon	1
Other	1
Total fatalities	**27**

* Four of these people were also arrested for other offences. Two people were arrested for drug/drink-related offences. Of these two, one was further arrested for criminal damage. Another person was arrested for criminal damage, and another person for harassment/threatening behaviour.

** One person was also arrested for recall to prison.

*** One person was also arrested for false imprisonment.

^ One person was also arrested for possession of a weapon.

^^ Both these people were arrested for other offences. One was arrested for breach of a Community Protection Notice and the other person was arrested for shoplifting.

^^^One person was also arrested for theft.

The data shows that 12 of the 27 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.

Ten of the twelve people who had force used against them were physically restrained by the police. One of these ten deaths also involved use of force by security staff in addition to the police. In addition to the ten deaths where it is known that police used physical restraint, for one death, leg restraints were applied but it is not possible from the available evidence to know if these were applied by the police or by medical staff. Another death involved restraint by members of the public only. 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 twelve people who were physically restrained, ten were White and two were Asian.

Five of the twelve incidents involving use of force also included use of leg restraints. One involved use of PAVA incapacitant spray in addition to physical restraint, and in another incident, two officers also discharged a Taser.

Circumstances of death

Cause of death according to the pathologist's report following a post-mortem examination is reported for 10 of the 27 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 medical 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 25 of the 27 deaths. The remaining two deaths are being investigated locally by the police force involved.

Sixteen people became ill or were identified as being unwell **in police custody.** Nine were taken to hospital where they later died. Six people died

in a police cell. One person was pronounced deceased in an ambulance that was in the custody suite car park.

These 16 cases are outlined below.

- A man was arrested for a drug-related offence and for breaching a Community Protection Notice. He was taken into custody and placed in a cell, with observations every 30 minutes. The next day the man was remanded to appear at court. He was later assessed by a healthcare professional and kept on 30-minute checks. Two days after the man's arrival in custody, he was found unresponsive during a welfare check. Custody staff performed cardiopulmonary resuscitation (CPR) and an ambulance was called. Paramedics attended, but the man died shortly after. His cause of death is currently *unascertained*.
- A woman was arrested and was taken into custody. While in custody, the woman disclosed that she was dependent on alcohol and drugs, and that she experienced symptoms upon alcohol withdrawal. She tested positive for drugs. She was assessed by a healthcare professional and provided medication for drug withdrawal. The woman was placed on 30-minute observations. Later the same day, the woman was transferred to a different custody suite, in a different police force. During the journey the woman was sick. During the booking in process at the second custody suite the woman also disclosed that she was dependent on alcohol, and drugs, and that she experienced symptoms on alcohol withdrawal. The woman remained on 30-minute observations. She was again assessed by a healthcare professional and continued to receive treatment for drug withdrawal. She was remanded in custody to appear at court the next day. During her time in custody, the woman reported feeling sick and also vomited two further times. Two days after the woman's initial arrest, during a routine check, the woman was found unresponsive in her cell. Medical assistance was provided by a healthcare professional and paramedics attended, but the woman was pronounced dead a short time later. Her cause of death was reported as *1a. Alcohol misuse with alcohol-related cardiomyopathy complicated by alcohol withdrawal and terminal withdrawal seizure 2. Brainstem encephalitis.*
- A man was arrested for recall to prison and taken into custody. The day after the man's arrest, custody staff entered the cell to provide him with food and found the man lying face down on the floor. Paramedics attended and the man was pronounced dead a short time later. His cause of death was reported as *1a. Unascertained.*
- Police responded to a report of a man who had smashed a car window and who was running in and out of traffic. On arrival, officers suspected that the man was under the influence of drugs or alcohol. Officers restrained the man and applied leg restraints. The man was arrested. He was placed in the rear of a police van and taken to custody. The man was later transported to hospital in the police van. On arrival at hospital, it was noted that the man was unresponsive. The man was taken out of the van and his handcuffs were removed. Officers provided first aid alongside hospital medical staff. The man was taken into hospital but died shortly after. His cause of death cannot be reported at this time.
- Police were called to reports of a 'drunk' man running into traffic. Police officers arrived and security staff on the scene informed them that the man, who they had restrained on the floor, had assaulted them. Officers restrained the man as they applied handcuffs, and he was arrested for assault, criminal damage and being drunk and disorderly. The man was carried into a police van and taken to custody, where he was initially placed in a holding cell. While in the cell the man vomited several times. The man was placed in a CCTV monitored cell on 30-minute rousing checks. Shortly after, the man was seen by a healthcare professional and was deemed to be 'intoxicated'. Later that evening, five minutes after a routine check, custody staff became concerned about the man's welfare and re-entered his cell. The man

was unresponsive and first aid was provided, including CPR, by officers and a healthcare professional. Paramedics attended, but the man was pronounced dead a short time later. His cause of death was reported as *Ia Acute myocardial infarction.*

- A man was arrested for assault and a drug-related offence. While being searched, the man was asked by officers if he had something in his mouth and he said no. The man was taken to custody in a police van. During the booking in procedure, the man said he had taken ketamine. The man was searched and placed in a cell on 30-minute observations. During a routine check a few hours later, a detention officer found the man lying on the floor of the cell with a cut to his head. A healthcare professional attended and an ambulance was called, with officers suspecting the man had had a seizure. The man began to have seizures as paramedics attended to him, and ambulance staff requested leg restraints which were applied. The man was taken to hospital by ambulance. During transportation to hospital, the man had a cardiac arrest. He remained in hospital, where he died two days later. While in hospital, a medical procedure found a number of empty snap bags in the man's stomach. His cause of death cannot be reported at this time.
- A man was arrested for driving offences. He was asked to provide a breath sample and was searched at the roadside, both with a negative result. The man was taken to custody. During the booking in procedure, the man said that he was receiving support for a drug dependency. The man was searched and then placed on 30-minute observations. Several hours later, a detention officer noticed that the man appeared to be unwell. Custody staff and a healthcare professional provided medical assistance and an ambulance was called. Paramedics arrived and attended to the man, who appeared to be having seizures. He was taken to hospital by ambulance. He died later that day. The man's cause of death was reported as *I (a) Acute cocaine toxicity*.
- A man was arrested for stalking and controlling and coercive behaviour and taken into custody. During the initial risk assessment, the man disclosed that he had taken an overdose of prescription medication earlier that day, with the intention of ending his life. He also stated that he intended to take his own life when released from custody. The man was assessed by a custody healthcare professional, who recorded that his blood pressure was extremely low and advised that he required hospital treatment. An ambulance was called and the man was taken to hospital under police escort, while still under arrest. The man refused medical treatment and died in hospital two days later. His cause of death is awaited.
- Officers arrested a man at his home address. PAVA incapacitant spray was used and the man was physically restrained and handcuffed to the rear. He was placed in the back of a police van and taken to custody. On arrival at custody, the man was carried into the building and placed in a holding cell. Officers then left the cell. Approximately five minutes later, officers entered the holding cell and found the man unresponsive. Officers gave CPR and an ambulance was called. The man was taken to hospital, where he died later that day. His cause of death is awaited.
- A man was arrested for theft and taken into custody. During the arrest he was restrained. While being booked into custody the man disclosed that he had consumed alcohol and drugs. The man was then placed on 30-minute rousing checks. While in custody, the man twice requested to see a healthcare professional. A healthcare professional was consulted, but did not attend. Later that evening, the man was found unresponsive in his cell by a detention officer. Officers performed CPR until paramedics arrived. The man was taken to hospital where he died three days later. His cause of death cannot be reported at this time.
- An officer approached a man who was refuelling his car at a petrol station and detained him for a search, after conducting an

intelligence check on the car. As a result of the search, the man was arrested for possession of a weapon and taken into custody. The man was placed on 30-minute observations. A couple of hours after arriving in custody, the man was found unresponsive in his cell during a routine check. Custody staff called for assistance and began CPR. Paramedics attended shortly afterwards, but the man was pronounced dead. His cause of death was reported as *Ia. Cocaine Toxicity II. Coronary artery atheroma and cardiomegaly*.

- A man was arrested for burglary and taken into custody. In the course of his arrest, the man was handcuffed and restrained, including use of leg restraints. During the booking-in procedure, the man was taken to a cell where he was searched and seen by a healthcare professional due to the custody officer noting that the man was possibly suffering from 'acute behavioural disturbance'. An ambulance was called due to the way the man was presenting. An officer observed the man through the cell door window and raised a concern that the man had stopped breathing. Officers and the healthcare professional gave the man CPR and used a defibrillator. Officers called the ambulance service again. Paramedics attended and placed the man in an ambulance. The man died a short time later. His cause of death is awaited.
- Police received a concern for welfare call about a man. The man was located, arrested, and transported to custody. Some hours later, the man experienced a medical episode in custody. An ambulance was called and the man was taken to hospital where he was pronounced dead shortly after arrival. His cause of death is awaited.
- A woman was arrested for shoplifting and possession of Class B drugs and taken into custody. A strip search was carried out. During the search, drugs were found in her clothing. The woman was placed in a CCTV-monitored cell and put on 60-minute observations. She later tested positive for Class A drugs. Shortly afterwards, she was seen by a healthcare professional and assessed as fit for detention and interview. In the early hours of the following morning, custody staff heard the woman vomiting in her cell. When spoken to, she reportedly stated that she was withdrawing. She was later seen again by a healthcare professional who provided medication for withdrawal and assessed her as fit for interview. The woman was subsequently interviewed and returned to her cell. Approximately two hours after her interview, the woman was found unresponsive in her cell. Custody staff and healthcare professionals attended and provided medical assistance. During treatment, a small amount of a substance believed by officers to be drugs, was found on the woman. The woman died a short time later. Her cause of death is awaited.
- A man was arrested for assault and a public order offence and taken into custody. Whilst being booked into custody the man was restrained so he could be searched. He was assessed by a healthcare professional. The custody record noted that the man was intoxicated and was dependent on alcohol. The man was released on bail. A few hours later, the man was re-arrested for harassment after breaching his bail conditions. During his second period in custody, the man complained of arm pain. Early the next day, he was seen by a healthcare professional who advised that he be monitored for alcohol withdrawal. Later that evening the man was charged and remanded in custody. During his second period in custody, the man was seen by a healthcare professional and twice provided with medication for alcohol withdrawal. The following morning, two days after the man was arrested, the man was found unresponsive and an ambulance was called. Officers gave CPR to the man, with support from a healthcare professional. The man was taken to hospital, where he died shortly after arrival. His cause of death is awaited.
- Police received a report of a man driving erratically. Police arrived at the scene. It was noted the man was unsteady, and he reported

having a chest infection. The man was breath tested, but was unable to provide enough breath to complete the test. The man failed to complete the Field Impairment Test (this is a series of tests, for example, asking someone to walk in a straight line). He was arrested for driving while impaired by drink and/or drugs and taken to custody. Due to his apparent confused state, he was seen by a healthcare professional. It was noted that his heart rate was raised and he had a high temperature. The custody sergeant authorised the man to be released from custody as his unfitness to drive was due to a medical episode. An ambulance was called and the healthcare professional fitted the man with an oxygen mask. The man was taken to hospital. The man died in hospital several days later. His cause of death is awaited. This death was investigated locally by the police force.

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

- Police were called to reports of a man running along the street shouting and causing damage to properties. On arrival, officers located the man, who appeared to be attempting to enter a house. The man was taken to the ground and handcuffed. An officer informed the force control room that they believed the man was suffering from acute behavioural disturbance, and an ambulance was requested. Officers moved the man into an upright position and in response to questioning, he told them he had consumed alcohol and drugs. The man was arrested on suspicion of criminal damage. Five minutes after police arrived, the man became unresponsive and his handcuffs were removed. Officers placed him in the recovery position and provided first aid, including CPR, until paramedics arrived and took over treatment. The man was taken to hospital, where he died later that day. His cause of death was reported as *1 (a) MDMA toxicity associated with Acute Behavioural Disturbance*.

- Police were called to reports of a man who was refusing to leave a business premises and who appeared to be under the influence of drink and/or drugs. On arrival officers described the man as under the influence of an unknown substance, sweating and paranoid. Officers handcuffed and searched the man, who was detained under Section 136 of the *Mental Health Act 1983*. The man was taken to hospital but was later returned to a marked police van in the hospital car park due to concerns about his behaviour. Whilst in the van the man became quiet and officers requested assistance. Medical staff performed CPR, but the man died a short time later. His cause of death was reported as *1a Cocaine toxicity in the context of drug induced psychosis*.

- Police received calls about an incident where a person had been attacked, with one of the calls stating that the reported attacker was at the scene. Officers attended and were directed to a man on the floor. The officers pulled the man from behind a parked car and placed him in handcuffs while he was lying on the ground. The man repeatedly told officers he had been stabbed and could not breathe. The man was arrested for assault. Shortly afterwards, he became unresponsive. The handcuffs were removed and CPR was given. Paramedics attended and provided medical treatment, however, the man was pronounced dead at the scene a short time later. He died as a result of stab wounds which had been inflicted prior to police arrival. A man has been convicted of his murder.

- Police received a call from a man who reported that he had breached his bail conditions. During the call he threatened to harm himself and others, police records also showed he was an outstanding suspect for the offence of criminal damage. Officers attended and found the man in a street harming himself. Both officers discharged their Taser, and the man was restrained and handcuffed. Further officers attended and he was arrested for criminal damage. An ambulance had been called and, shortly after it arrived, the man appeared to begin having seizures. The man was taken to hospital by ambulance, accompanied by police officers. While at hospital under police watch, officers

reported that the man became agitated. Body worn video shows that handcuffs were reapplied and the man was restrained by officers. A short time later leg restraints were also applied, and the man's handcuffs were removed again. An hour later, the man had multiple seizures and then went into cardiac arrest. Hospital staff performed CPR, but he died shortly after. His cause of death is awaited.

- Police responded to a call about a domestic incident. On arrival, the police forced entry to the property. Officers found a man sitting on the floor asking for help. He stated that he was having a seizure. The man was arrested for a breach of the peace and handcuffed. He told officers he had taken a quantity of medication and asked to be taken to hospital. As the man left the address, he appeared to have a seizure. Officers called an ambulance and provided medical assistance until paramedics arrived and took over care. The man was put into the ambulance, which remained at the scene, where he died shortly afterwards. His cause of death is awaited.
- Police received calls reporting a man running in and out of gardens and jumping on cars. A further call reported the man had entered a house. Callers reported that they thought the man might be under the influence of drugs. Officers attended and entered the house. The man was restrained on the floor, handcuffed, and arrested for burglary. The man was turned onto his side and an ambulance was requested, for 'possible acute behavioural disturbance'. Officers became concerned about the man's breathing, and a further call was made to the ambulance service. Paramedics arrived and the man disclosed that he had taken drugs. An officer applied leg restraints so paramedics could provide treatment while minimising risk to the man, police and paramedics. The man's condition deteriorated further and the leg restraints and handcuffs were removed. The man was taken to hospital where he died a short time later. His cause of death was reported as *1a) Cocaine Toxicity with Acute Behavioural Disturbance*.
- Police received a call from a man requesting the police. He stated that his drink had been 'spiked'. Officers attended the address and identified him as being wanted for theft offences. He was arrested and handcuffed. The man told officers he believed his drink had been spiked and that he had drugs on him. A search was carried out, but no drugs were found. Due to concerns about the man's health, officers took him to hospital in a police van. During the journey, officers described the man as appearing agitated. On arrival at the hospital the man was taken out of the van, and restrained on the ground as officers were concerned that he was trying to run away. The man was de-arrested for theft and detained under Section 136 of the *Mental Health Act 1983*. The man was placed back in the van. Body worn video showed him shouting, kicking, and banging in the van. During this time, officers contacted the Mental Health Liaison Team and sought advice from a consultant at the hospital who came to the van. Just over an hour later, while still in the van, the man's condition appeared to deteriorate. Officers flagged down a doctor who reviewed him. The doctor did not identify any immediate concerns, but stated they would locate the consultant who had previously seen him. Shortly afterwards, the man became unresponsive. Officers provided CPR until medical staff took over. The man was taken into the hospital but died a short time later. His cause of death is awaited.
- Police received a call to report a man had caused criminal damage to a vehicle. A further call was made from another person, reporting a concern for welfare for the man. Police arrived and gained entry to the man's house. The man was upstairs and officers informed him he was under arrest for criminal damage. It was identified that he had a weapon. Over the next several hours, officers engaged on-and-off with the man. A negotiator also arrived at the house. After a number of hours, the man was found dead within the house. The cause of death cannot be reported at this time.

- Police received several calls reporting concerns for a man. The callers said he appeared to be under the influence of drugs and to have injuries. Some people reported that he was forcing entry into their homes. Another call reported that the man was being restrained by residents. The man was known to have outstanding domestic abuse offences against him. Officers attended and found the man lying on the ground outside a house. He was with two members of the public who appeared to be trying to keep him still. The man appeared to be unresponsive. Police provided first aid until an ambulance arrived. After the man was moved into the ambulance, ambulance crews told an officer that they did not think his condition was life threatening or life changing, so the man was arrested for the outstanding offences. The man was taken to hospital, where his condition deteriorated. The man died a short time later. His cause of death was reported as *1a Acute cocaine toxicity 2 physical exertion during an ABD that involved a period of restraint, whilst exposed to the potential effects of ketamine and sertraline*. This death was investigated locally by the police force.

One person died after becoming ill during **transportation to custody in a police vehicle**.

- Officers stopped a van and because of checks on police systems decided to conduct searches under the *Misuse of Drugs Act 1971*. The driver was searched and nothing was found, but as a result of initial checks on police systems he was arrested on suspicion of driving whilst disqualified and placed into the rear of a police van in handcuffs. The van was also searched, and a large knife was found and opened beer containers. At the same time, the arresting officer had undertaken additional checks and confirmed the man was not disqualified from driving, despite the initial information provided. The man was therefore de-arrested on suspicion of driving whilst disqualified. However, he was arrested for possession of a bladed article. The man was asked to do a breath test which gave a negative result. While travelling to custody, officers became concerned when the man failed to respond to them. An officer opened the internal cage door, and the man appeared to be having a seizure. Officers assessed this as a medical emergency and diverted the van and drove the man to hospital, with lights and sirens on. Upon arrival, the man was taken from the van and his handcuffs were removed. A small package, containing a white powder, was found in his hand. The man died shortly after arrival at hospital. His cause of death cannot be reported at this time.

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

- A woman was arrested on suspicion of assault and taken into custody. It was noted by the custody sergeant that she suffered from several medical conditions, resulting in her having decreased mobility. She was examined by a healthcare professional, who assessed her as not fit for detention due to concerns about her mobility. The custody sergeant made the decision to release her from custody before interview. Arrangements were made for social services to attend her home address the following morning. She was taken home by police officers and entered her property while officers remained outside. Shortly after entering the property, officers heard screaming and then a thud. They entered to find the woman on the floor. Officers provided CPR and used a defibrillator. Paramedics arrived, but the woman died at the scene. Her cause of death is awaited.

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 and then to 19 in 2020/21. The number of deaths in or following police custody fell notably to 12 in 2021/22, before almost doubling to 23 in 2022/23. There was another slight increase in 2023/24 to 25 deaths, before a fall to 18 in 2024/25.

This year, the number of deaths in or following police custody has increased notably, to 27, the joint-third highest recorded since 2004/05. The average number of deaths in or following police custody recorded since figures began in 2004/05 is 20. The average recorded over the 11-year period since 2015/16 is 19. These trends are shown in the graph in figure 2.1 on page 9, and in the time series data tables available on our website.

This year, no people died after making an apparent suicide attempt while in a police custody suite. The last incident of this kind was in 2023/24. Before that, there was one incident in 2016/17, one 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. Three people died as a result of a self-inflicted act that happened prior to arrest.

This year, six people were pronounced dead in a police cell, double the figure of three recorded in 2024/25. In 2023/24, four people died in a police cell. In the years 2022/23, 2021/22 and 2020/21 three people were pronounced dead in a police cell. 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 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 67 apparent suicides following police custody in 2025/26 – 62 men and five women. The average age of those who died was 46 years. The most common age was between 51 to 60 years (22 people), followed by 31 to 40 years (16 people). The youngest person was 19 years old. Sixty-three of those who died were White, and four people were Black.

Almost two-thirds of the people (43) had known mental health concerns. Of these, one person was detained under Section 136 of the *Mental Health Act 1983*. Other mental health concerns included depression, psychosis, bipolar disorder, anxiety, previous thoughts or incidents of suicide attempts, and self-harm.

Just under half of the people (29) 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. Eighteen deaths related to alcohol and sixteen to drugs.

Circumstances of death

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

Table 6.1 shows the reasons why these people were placed into custody by the police. Forty of those who died (60%) had been arrested for a sexual offence. Of these, 29 (43%) related to sexual offences or indecent images involving children. Twenty-one were for threatening behaviour and harassment; many of these people were arrested for controlling and coercive behaviour and/or stalking. Other common reasons were offences involving violence (11) and driving offences (6).

Twenty-one people (31%) were detained for multiple reasons. This compares to eleven last year (18%).

All but one of the recorded apparent suicides following police custody were dealt with locally by the police force involved. The remaining incident is being independently investigated by the IOPC.

Table 6.1 Apparent suicides following police custody: reason for detention, 2025/26

Reason for detention	Number of detentions
Sexual offences	40
Harassment / threatening behaviour	21
Violence-related (non-sexual or murder)	11
Driving offences (including drink / drug driving)	6
Drug / drink-related	3
Criminal damage	2
Possession of a weapon	2
Theft / burglary / shoplifting	2
False imprisonment	2
Breach of the peace	1
Mental Health Act 1983	1
Terrorism-related	1
Child neglect	1
Sending indecent communications using a public network	1
Obstructing a police officer	1
Total number of reasons for detention	**95**
Total fatalities	**67**

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

Trends

The number of apparent suicides following time in police custody of 67 is higher than the 61 recorded in 2024/25. It is higher than the average of 59 recorded over the 11-year period from 2015/16. 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 60% of fatalities, the reason for custody was for alleged sexual offences. The proportion of sexual offences or indecent images involving children was 43%. These proportions are in line with the figures recorded last year (62% and 44% respectively), but higher than average figures. The average proportions for these alleged offences since 2004/05 are 38% 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 that 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.

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

Overall demographics

We independently investigated the deaths of 63 people who died during or following other contact with the police during 2025/26. Of these deaths:

- Thirty-eight were men and 25 were women.
- Forty-six people were White, two people were Black, eight were Asian, three people were of a mixed ethnicity, two people were of an other ethnicity, and the ethnicity of two people was not known.
- Four people were aged under 18 years, and 18 people were young adults aged between 18 and 30 years. Six people were aged over 60. The average age was 38 years old.
- Over half of those who died (37) 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 (43) were reported to have mental health concerns.

Table 7.1 Other deaths following police contact: reason for contact, 2025/26

Reason for contact		Number of fatalities
Concern for welfare	Domestic related	16
	Health / injuries / intoxication / general	13
	Self-harm / suicide risk / mental health	12
	Missing person	6
	Threatening behaviour / harassment	2
	Concern for welfare - other	2
	Subtotal	**51**
Other contact	Avoiding contact / arrest	3
	Attending a disturbance	3
	Executing a search warrant / arrest / conducting investigation enquires	3
	Assisting medical staff	2
	Other	1
	Subtotal	**12**
	Total fatalities	**63**

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. The cause of death, where shown, 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 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 twelve fatalities were recorded for other types of contact with the police.

A total of twelve people who died following police contact had force used against them. Eight people were White, one person was Black, one person was Asian, one person was of mixed ethnicity, and one person was of other ethnicity.

Eleven people were restrained by police officers. Of these eleven deaths:

- Six people had leg restraints applied by police officers.
- Three deaths also involved restraint by members of the public.
- One death involved use of other equipment, namely a bite guard. This death also involved use of PAVA incapacitant spray.

In addition to the eleven people who were restrained, one incident also involved discharge of a Taser.

The use of force does not necessarily mean that the force used contributed to the death.

Concern for welfare

Of the 51 fatalities that followed contact with the police because of a concern for welfare, thirteen 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 their concern. In this category:

- Nine people were men and four were women.
- Twelve people were White and one person was of an other ethnicity.

- The most common ages were 21-30 and 31-40, with four people in each of these age groups. The average age was 43.
- The majority 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 forms of death classification were natural causes, accidental, and accidental overdose (three people in each classification). Two were self-inflicted, one was an alleged murder, and the classification of one death is not known at this time.

One incident involved **use of force**:

- Police were contacted with reports of concern for a man. Officers reported that they believed he was suffering from acute behavioural disturbance and an ambulance was requested. The officers held on to the man's arms and as they did so, the man gradually slipped down some steps on to the floor. When on the floor, an officer determined the man needed to be further restrained. He was handcuffed, then laid on his side and his legs were restrained. A short time later, leg restraints were also applied. Further requests were made for the ambulance service to attend urgently. While waiting for the ambulance, the leg restraints were removed. An ambulance arrived and the man was taken to hospital, where he died three days later. His cause of death is awaited.

Twelve 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 have shown signs of being at risk of self-harm or suicide. Of these:

- Ten people were men and two were women.
- Eight people were White, two were Asian and one person was of mixed ethnicity. The ethnicity of one person is not known at this time.
- The ages of the people ranged from 22 to 68. The majority were aged between 41 and 50 (five people). The average age was 41.
- The most common death classification was self-inflicted (eight people). Three people died as a result of an accidental overdose. One death was restraint-related.
- Nine 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.

Three incidents involved **use of force**:

- Police responded to calls of concern for a man who was reportedly having a mental health episode and under the influence of drugs. Officers arrived at the property where the man was found, and body worn video shows that he appears to be in distress and behaving erratically. An officer used physical restraint to control the man's arm and put him inside the van, assisted by a member of the public. An ambulance was called by a member of the public who was present, and a police officer informed the ambulance service of 'suspected acute behavioural disturbance'. Shortly after, the man became unresponsive. The man was removed from the van, and CPR was given until the ambulance arrived. A defibrillator was also used by officers and paramedics. The man was taken to hospital where he died the next day. His cause of death cannot be reported at this time.
- Police responded to reports of a man causing a disturbance to his neighbours. The callers reported that he appeared to be experiencing a mental health episode. Officers attended and found the man on the ground in the front garden of a house. Officers began to restrain the man which they reported was done in order to stop him harming himself. They identified that they believed the man was experiencing acute behavioural disturbance and requested an ambulance. While waiting for the ambulance, officers applied handcuffs and leg restraints as a further measure to keep the man safe. Officers continued to restrain the man while he was in

the ambulance. Once inside the hospital, the leg restraints were removed and officers stepped away from the man. The man died the next day. His cause of death was reported as *Ia. Multi-organ failure Ib. Cardiac arrests Ic. Acute cocaine toxicity.*

- Police received a report of a man reportedly experiencing a mental health episode and assaulting family members. It was stated that he was being restrained by family members. When officers arrived, the man could be seen assaulting a family member. Officers restrained the man. He was taken to the floor and handcuffed. The man was turned onto his side. Officers were concerned about the man's breathing and contacted the ambulance service. A few minutes later, an officer stated that they could not hear the man breathing. Officers removed the handcuffs and began CPR. Paramedics arrived and took over treatment. However, the man died at the scene. His cause of death was reported as *1a) Cocaine intoxication with Acute Behavioural Disturbance in Temporal Association with Restraint.*

Sixteen 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:

- Fifteen of those who died were women and one was a man.
- Ten of the people were White, three were Asian, two were of mixed ethnicity and the ethnicity of one person is not known at this time.
- The average age was 36. The youngest person was two and the eldest was 85.
- The deaths were classified as alleged murder in ten instances. Six deaths were self-inflicted.

Six people who died were **reported missing**:

- Four of those who died were men and two were women.
- Four of the people were White and two were Asian.
- The average age was 34. The youngest person was 13 and the eldest was 51.
- Two deaths were self-inflicted.
- Four people were known to have a specific risk of suicide or self-harm.

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

- Both people were men.
- Both people were White.
- Both classifications of death were alleged murder.

Two people died following **other types of concerns for welfare**:

- Police received an automated phone call reporting that a car had been involved in a road traffic collision. Police called the number back but there was no response. The location of the incident was near a border with another force and fell into that second force's jurisdiction. The incident was passed to this second force within a few minutes. A call handler from the second force attempted twice to call the number back, with no answer. The log was closed a short time later. The next morning, a call was made to police. The caller reported that they had found a car crashed into a hedge. The driver of the car was pronounced dead at the scene. Her cause of death was reported as *1a. Head injury due to 1b. Road traffic collision*.
- Police received multiple automated calls of a car being involved in a collision. This included an iPhone crash detection call, as well as a call from the vehicle itself after the vehicle telematics detected a collision. Both calls provided the location of the crash. Officers were sent to the vicinity, but reported there were no signs of a collision. A further call was received later that day from telematics monitoring reporting that they had been

notified of a vehicle involved in a crash. Officers were again deployed to the vicinity, but reported no signs of a collision. Two days after the initial report, police received a call from the ambulance service to report that they had been notified of a car on its roof, found in a field. The driver of the car was pronounced dead at the scene. His cause of death was reported as *1a Traumatic head injury*.

Other contact

The twelve deaths recorded for other types of contact took place in the following circumstances.

Two people died after contact with the police who were **assisting medical staff**:

- The ambulance service contacted police to request assistance with a man they were struggling to contain. When officers arrived, they were informed by ambulance crew that the man was in a crisis, had possibly taken drugs, and was vomiting blood. Paramedics were trying to get the man into an ambulance but had struggled to do so. The man agreed to get into the ambulance, but once inside he tried to leave. Officers restrained the man to control him and used leg restraints. They continued to restrain the man during the journey to hospital. Officers also accompanied the man into hospital, applying restraint at various points. The man died shortly after arrival at hospital. His cause of death was reported as *Ia Caffeine toxicity*.
- An ambulance crew was transporting a man to hospital. The ambulance pulled onto the hard shoulder of a motorway due to concerns the paramedics had about welfare. The man then got out of the ambulance and ran on to the motorway. Ambulance crew called for assistance from the police and an officer arrived soon after. The officer tried to interact with the man on the motorway. He then discharged his Taser, which made contact with the man. The man fell into one of the motorway lanes, where he was hit by a car. The officer moved the man into the central reservation where paramedics provided medical assistance. However, the man died at the scene. His cause of death is awaited.

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

- Police received calls to report that a resident of a hostel was reportedly shouting and screaming and had smashed a window in his room. It was reported that he likely had mental health concerns. A call handler contacted the ambulance service about the incident. Officers attended the incident and upon entering the man's room, found him lying on the floor. The room was filled with smoke, and the floor was covered in water. The officers removed the man from the room, placed him on his side, and applied handcuffs. An officer provided an update stating that they suspected the man had acute behavioural disturbance and asked for the incident to be treated as a medical emergency. While awaiting the ambulance, officers restrained the man and used leg restraints. Paramedics arrived and officers carried the man out of the building and onto a stretcher. The man's handcuffs and leg restraints were removed, and he was taken to hospital. The man died the next day. His cause of death is awaited.
- Officers responded to reports of a disturbance at a residential address. During the police response, PAVA incapacitant spray was used on several occasions. The man was also restrained and handcuffed, leg restraints were applied and a bite guard was used. An ambulance was called as the police believed the man was displaying symptoms relating to acute behavioural disturbance. The ambulance service reported a delay in attendance and officers decided to transport the man the short distance to hospital. After placing the man in the police vehicle, they noticed he was unresponsive and began CPR. Officers continued the journey to hospital, but the man died shortly after arrival. His cause of death is awaited.
- Officers attended a report of individuals fighting on the road outside a block of flats. Officers arrived and went into one of the flats where they found a woman being restrained on the floor by another woman. Shortly

after their arrival, the officers requested an ambulance, telling the control room that a woman was experiencing a drug-induced, psychotic episode. When waiting for the ambulance, the officers physically restrained the woman and applied leg restraints. Officers thought the woman may be suffering with acute behavioural disturbance and the ambulance service was contacted again and an ambulance arrived shortly afterwards. The woman was taken to hospital accompanied by an officer who continued to restrain her. The woman died shortly after arrival at hospital. Her cause of death was reported as *1a. The effects of cocaine.*

Three men died after **avoiding police contact or arrest**:

- Officers approached a man on the driveway of a house. Having identified themselves as police officers the man appeared to remove an item from his clothes with his hand and raised the same hand towards his mouth. An officer requested the man to spit out what he had in his mouth. The officer attempted to detain the man and they both fell to the ground, resulting in a struggle. The man then appeared to be struggling to breathe, and officers immediately changed from restraining the man to assisting and providing medical attention. Officers gave CPR and an ambulance was called. Paramedics arrived and continued treatment. The man was taken to hospital where he died shortly after arrival. His cause of death is awaited.
- Two officers in a police vehicle spoke to a man on the street. While speaking to the officers the man took a package from his mouth, which he said contained drugs. An officer left the vehicle to conduct a drugs search of the man. The officer described that the man appeared to throw something, and the man said he had thrown away the drugs. The package was not found during the search, and the man was taken to a friend's house. Officers continued to search the area, but no drugs were found. About an hour after officers let the man go, they called him, and he maintained that he had not swallowed the drugs and had thrown them away. Officers returned the next morning to continue the search in daylight, where they found the man collapsed but responsive. First aid was provided and the man was taken to hospital, where he died later that morning. His cause of death was reported as *1a) Principally cocaine related mixed drug toxicity (cocaine, methadone, heroin and pregabalin)*.
- Officers observed what they believed to be a drugs transaction taking place between two men on a street. In the area was an unmarked police car and a police van. As officers approached the men, one of them, who was on an e-bike, rode away from them. Officers approached and tried to engage with the man on the e-bike during which the man fell from the bike, slid along the road, and made contact with the stationary police van. The man got to his feet. Officers took him to the floor, restrained him, and applied handcuffs. Officers sat the man up and attempted to get him to his feet. The man became unresponsive. Officers laid him on the floor, removed the handcuffs, and gave him CPR. An ambulance was called and when paramedics attended, they removed a package from the man's throat. The man was taken to hospital where he died shortly after arrival. His cause of death is awaited.

Three people died after contact with police who were **executing a search, arrest warrant or other investigation enquiries:**

- A man in a shop was detained by officers for a stop and search. He was handcuffed and escorted out of the shop. During the search, the man appeared to reach into his pocket and put something into his mouth. A struggle ensued as officers reportedly tried to remove the item from the man's mouth. The man was taken to the ground by officers and an ambulance was requested. Shortly after, officers noticed that the man appeared to be having a medical episode. Officers removed his handcuffs and gave him CPR. An ambulance arrived and the man was taken to hospital, where he died shortly after arrival. His cause of death was reported as *I (a) Cocaine toxicity*.

- Police attended a man's home address in response to reports of someone uploading indecent images of children to the internet. The man consented to having his computer and phone examined. Officers said that while the man's devices were being searched, he stabbed himself in the neck. More officers and the ambulance service were called. First aid was provided by officers and paramedics attended, but the man was pronounced dead a short time later.
- Officers attended a flat in relation to a theft investigation. Four people were present in the flat, one man was subsequently arrested for the theft. While searching the flat for evidence, one officer found a significant amount of a white substance believed to be drugs, and drug-related equipment. The officer placed the items on a table in the room where the other three people were sitting. The officer left the room to continue the search. The other two officers present also turned away from the room shortly after. When the officers returned to the room, the white substance was gone. The officers searched the three people, but the drugs were not found. One of the people told another man that he needed to go to hospital, which he denied. The officers asked the man why he would need to go to hospital and it was reported that he said he didn't need to go. The officers left the flat with the man they had arrested for the theft. Early the next morning, the ambulance service attended the same flat where a man disclosed that he had swallowed a quantity of drugs. Later that morning the man was taken to hospital, where he died a short time after. His cause of death is awaited.

One death occurred following **other contact** with the police:

- Police received reports of a group of teenagers with knives and possibly a machete, who were surrounding other children in a park. Officers were sent to the area, stopped a child, and carried out a search, which did not find anything. Approximately an hour later, another two officers talked to a group of children in the same park. Shortly after the officers' interaction with the children, a boy was stabbed in an area close to the park. The boy died later that evening.

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 make it difficult to identify a specific set of events that account for changes in the number of fatalities. The overall proportion of cases about a concern for welfare made up 81% of the deaths following police contact that were independently investigated, compared to 89% in 2024/25.

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 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.

   From 1 May 2024, we have received mandatory referrals from the Independent Commission for Reconciliation and Information Recovery (ICRIR). 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*.

4. From 1 May 2025, we have received mandatory referrals from the National Food Crime Unit within the Food Standards Agency (the Food Crime Officers (Complaints and Misconduct) Regulations 2025).

Changes and revisions

5. In 2010/11, a change was made to the definition of the 'other deaths following police contact' category. It now includes only those deaths following police contact that were investigated independently by the IOPC (or previously by the IPCC). As a result, we changed the way 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.

6. In 2007, the IPCC issued an operational advice note to forces to address inconsistencies in the referral of 'apparent suicides following release from police custody'. Forces were asked to refer any suicides that happened within two days of release from police custody, or apparent suicides that happened more than two days after release, but where there was a possible link between the time the person spent in custody and their death.

7. This report presents the most up-to-date set of figures for each death category. In this release, five fatalities have been added to previous year's figures. The following adjustments have been made to the trend figures:

   - For 2024/25, one death was added to the 'deaths in or following police custody' figure, three deaths were added to the 'other deaths during or following police contact' figure and one death was added to the 'apparent suicides following police custody' figure.
   - For 2023/24 one death was added to the the 'other deaths during or following police contact' figure.
   - For 2022/23, one death was added to the 'other deaths during or following police contact' figure.
   - For 2021/22, two deaths were added to the 'road traffic fatalities' figure and one death was added to the 'deaths in or following police custody' figure.

   Where cases have been added, this is because they were either not subject to an independent investigation or had not been referred to us when the report for that financial year was released, or because the organisation has subsequently received information that means the death now meets the definition for the relevant category within the report. In line with our revisions policy, in these instances, the figures for the published annual report were not amended.

8. 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 2025/26, the figures shown in Table 6.1 are the total number of different reasons for detention. We have used this approach since our 2018/19 report.

Methods and definitions

9. 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

10. 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

11. 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.

12. 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.

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

14. Users of these statistics should take care when looking at the time series data tables. There may be discontinuities (such as jumps, gaps or another abrupt change in data) 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.

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

Further information

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

17. 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.

18. 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.

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

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

21. Estimated publication date for our next report covering data for 2026/27 is summer 2027.

Appendix A: additional tables

Table A1 Incidents by type of death and financial year, 2015/16 to 2025/26

Incidents											
	Financial year										
Category	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23	23/24	24/25	25/26
Road traffic incident	20	28	27	33	24	20	34~	26	29	25	15
Fatal shootings	3	6	2	3	3	1	2	3	2	2	3
Deaths in or following police custody	14	14	23	17	18	19	12~	23	25	18~	27
Apparent suicides following custody^	61	56	57	63	54	55	57	54	68	61~	67
Other deaths following police contact*	103**	128	172	151	104	96	106	87~	61~	51~	62

^ 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, 2025/26

Gender	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Male	12	4	24	62	38
Female	3	0	3	5	25
Total fatalities	**15**	**4**	**27**	**67**	**63**

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

Table A3 Type of death by age group, 2025/26

Age group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Under 18	0	0	0	0	4
18 - 20	1	0	1	2	3
21 - 30	3	0	7	6	15
31 - 40	6	2	7	16	17
41 - 50	0	0	8	13	11
51 - 60	2	1	1	22	7
61 and over	3	1	3	8	6
Total fatalities	**15**	**4**	**27**	**67**	**63**

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

Table A4 Type of death by ethnicity, 2025/26

Ethnicity group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
White	11	3	23	63	46
Black	1	0	0	4	2
Asian^	0	1	3	0	8
Mixed	2	0	1	0	3
Other	1	0	0	0	2
Not known	0	0	0	0	2
Total fatalities	**15**	**4**	**27**	**67**	**63**

* 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, 2025/26

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	4	5
Bedfordshire	0	0	0	0	0
Cambridgeshire	0	0	0	0	1
Cheshire	0	0	0	0	3
City of London	0	0	0	0	0
Cleveland	0	0	0	1	0
Cumbria	0	0	0	0	0
Derbyshire	0	0	0	3	1
Devon & Cornwall	1	0	1	1	1
Dorset	0	0	1	0	1
Durham	0	0	1	2	3
Dyfed-Powys	0	0	1	3	0
Essex	1	0	0	2	1
Gloucestershire	0	0	0	1	0
Greater Manchester	0	2	5	2	4
Gwent	0	0	0	1	1
Hampshire	0	0	3	1	5
Hertfordshire	1	0	0	1	0
Humberside	0	0	0	1	0
Kent	1	0	1	2	0
Lancashire	1	0	2	4	0
Leicestershire	0	0	1	0	3
Lincolnshire	0	0	1	1	0
Merseyside	0	0	3	1	5
Metropolitan	6	0	1	4	5
Norfolk	0	1	0	1	0
North Wales	0	0	0	1	0
North Yorkshire	0	0	1	1	0
Northamptonshire	0	0	0	1	0
Northumbria	1	0	1	8	2
Nottinghamshire	0	0	0	0	3
South Wales	0	0	0	0	0
South Yorkshire	0	0	0	6	1
Staffordshire	0	0	1	0	2
Suffolk	0	0	0	0	0
Surrey	0	0	0	1	1
Sussex	0	0	0	1	1
Thames Valley	0	1	1	3	2
Warwickshire	0	0	0	2	1
West Mercia	0	0	0	1	3
West Midlands	2	0	2	1	0
West Yorkshire	0	0	0	1	3
Wiltshire	0	0	0	1	2
Metropolitan Police & Thames Valley Police	0	0	0	1	0
Greater Manchester Police & Lancashire Constabulary	0	0	0	1	0
West Yorkshire & British Transport Police	1	0	0	0	0
Bedfordshire & Hertfordshire	0	0	0	0	1
Nottinghamshire & Lincolnshire	0	0	0	0	1
Lancashire & West Yorkshire	0	0	0	1	0
British Transport Police	0	0	0	0	1
Home Office ~	0	0	0	0	0
His 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	**15**	**4**	**27**	**67**	**63**

* 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:

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

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