IOPC Independent Office for Police Conduct

Deaths during or following police contact

Statistics for England and Wales 2022/23

Acknowledgements

Rachael Toon led the production and analysis of this report, with support from Melanie O'Connor, Allison Hall and Ed Stevens in the research team at the Independent Office for Police Conduct (IOPC). Our thanks go to IOPC colleagues who helped to gather and check the information in this report or to support its release. We would also like to thank officers and staff at police forces across England and Wales who provided information and responded to our enquiries.

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National statistics

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

This designation means that the statistics:

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

When statistics are designated as National Statistics it is a statutory requirement that the Code of Practice is followed.

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1 Introduction

This report presents figures on deaths during or following police contact that happened between 1 April 2022 and 31 March 2023. 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 nineteenth in a series of statistical reports on this subject, published annually by the IOPC.

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

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

Box A on page 5 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 32.

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

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

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

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

This does not include:

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

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

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

This includes deaths that happen:

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

This does not include:

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

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

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

This may include deaths that happen:

- after the police are called to attend a domestic incident that results in a fatality
- while a person is actively attempting to avoid arrest; this includes instances where the death is self-inflicted
- when the police attend a siege situation, including where a person kills 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 2022/23, there were:

- 28 road traffic fatalities
- three fatal police shootings
- 23 deaths in or following police custody
- 52 apparent suicides following police custody
- 90 other deaths following police contact that were independently investigated by the IOPC

Demographic information about those who died is presented in the following chapters, along with details about the circumstances of their death and a summary of trend data. The appendix contains more information, such as the age, gender and ethnicity of those who died, and information about the police force or appropriate authority involved. (The appropriate authority is usually a police force's 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 portion of 2020/21. At this stage, it is not possible to say with certainty what impact this had on the number or types of interactions that members of the public had with the police. Caution should be taken when comparing data from 2020/21 with previous and subsequent years.

Investigations

When we are told about a fatality, we consider the circumstances of the case and decide whether to investigate independently, or to direct an investigation.

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

In some circumstances, we decide that the local police force professional standards department (PSD) or other equivalent department is best placed to investigate a case. Each force has a PSD, which oversees complaint handling and certain conduct matters. When a police force or an equivalent department investigates a death or serious injury case, it must send the investigation report to the IOPC for review.

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 2022/23. The figures show the number of incidents. An incident leading to a single investigation can involve more than one death and so the totals for some categories may be lower than the total fatalities presented above. In total, the IOPC independently investigated 129 incidents.

Table 2.1 no longer includes figures for supervised and managed investigations as all the fatalities in this report happened from April 2022 onwards.

No incidents were dealt with by directed investigation across all death categories.

Table 2.1 Incidents by type of death and investigation type, 2022/23

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	20	3	20	1	85
Directed	0	0	0	0	0
Local	1	0	1	15	0
Back to force	5	0	2	36	0
Total incidents	26	3	23	52	85

Note: The type of investigation is shown as recorded on the IOPC case system at the time of analysis.

* The category 'other deaths following police contact' includes only cases dealt with by independent investigation.

Trends

The figures in Table 2.2 show the number of fatalities across the different categories since 2012/13. 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, 2012/13 to 2022/23

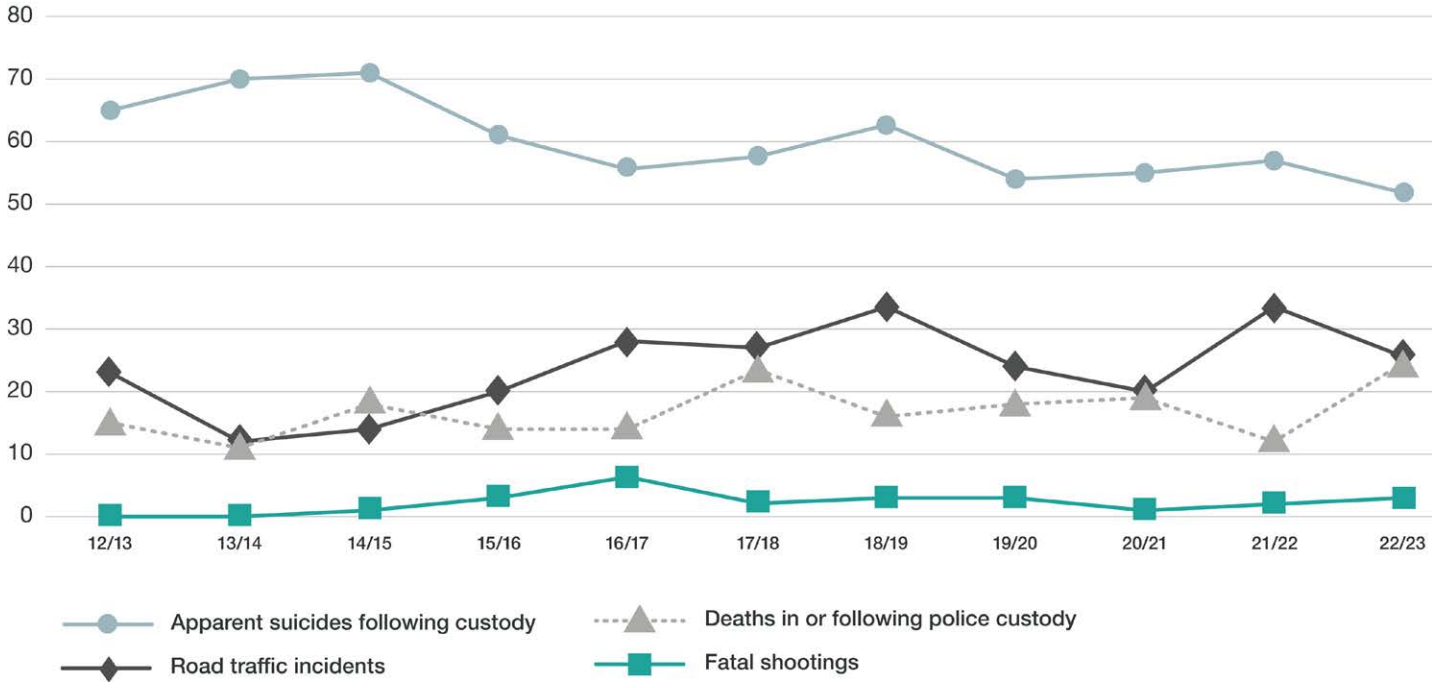
	Fatalities										
	Financial year										
Category	**12/13**	**13/14**	**14/15**	**15/16**	**16/17**	**17/18**	**18/19**	**19/20**	**20/21**	**21/22**	**22/23**
Road traffic fatalities	31	12	14	21	32	29	42	24	25	40~	28
Fatal shootings	0	0	1	3	6	4	3	3	1	2	3
Deaths in or following police custody	15	11	18	14	14	23	17	18	19	11	23
Apparent suicides following custody	65	70	71	61	56	57	63	54	55	57~	52
Other deaths following police contact*	22	44	43	106**	131	178	156	107	97~	111~	90

*There was a change in definition for the category 'other deaths following police contact' in 2010/11 to include only cases dealt with by an independent investigation.

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

~ 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, 2012/13 to 2022/23



The number of **fatal road traffic incidents (RTIs)** has decreased this year from 33 to 26. This is in line with the average recorded over the 19-year period since 2004/05 when these statistics were first published. It is the lowest number of incidents since 2020/21, when there were 20 RTIs. These figures are subject to fluctuation and, therefore, year-on-year comparisons should be approached with caution.

This year there were three **fatal police shootings**, compared to two recorded last year. This is in line with the average recorded since 2004/05. The number of **deaths in or following police custody** has increased notably over the last year from 11 to 23. Over time, there have been some fluctuations in this category, with notable increases recorded in 2010/11, 2014/15 and 2017/18. The 2022/23 figure is higher than the average over the 11-year period and is the highest figure since 2017/18 when there were 23 deaths.

The number of recorded **apparent suicides following custody** was 52, lower than the 57 fatalities recorded last year. The number of deaths in this category remains higher than the average number recorded over the years before 2012/13, when there was a notable increase. Reporting of these deaths relies on police forces making the link between someone's apparent suicide and them having been in custody recently. The overall increase in these deaths over the period since may be influenced by improved identification and referral of such cases.

The category of **'other deaths following police contact'** is not included in Figure 2.1. The inclusion of a death in this category depends on whether we decide to open an independent investigation into the circumstances surrounding it. The criteria for making this decision may vary over time – for example, in response to public and community concerns. In addition, our capacity to carry out independent investigations increased in 2015/16, which had a direct impact on the number of deaths reported on in this category. (See our Corporate plan 2015-18 and Strategic plan 2018-22 for more information.) This means trend analysis of deaths recorded in this category would not be meaningful.

Figures on all fatal incidents (as distinct from fatalities) are provided in Table A1 in the appendix. The appendix also includes data on:

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

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

Box B Types of investigation

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

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

Local investigations are carried out by police officers when the IOPC decides that the force has the necessary resources and experience to carry out an investigation. In death and serious injury cases the force sends the report to the IOPC for review at the end of the investigation.

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

3 Road traffic fatalities

Demographics

In 2022/23, there were 26 fatal police-related road traffic incidents (RTIs), resulting in 28 fatalities. Of those who died, 22 were men and six were women. Twenty-two people were White, five were Asian and one person was of an Other ethnicity.

Nineteen of the people who died were aged between 18 and 30 years, and the eldest person was 74 years old. The average age was 31 years old. The average age decreases to 28 years if the deceased was the driver or passenger in a pursued or fleeing vehicle. It increases to 37 years if the deceased was a pedestrian, cyclist or a driver or passenger in a vehicle hit by either the police or the pursued or fleeing vehicle.

Circumstances of death

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

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

Pursuit-related

There were 18 police pursuit-related incidents, which resulted in 20 fatalities. Of these fatalities:

- five people were the driver of a vehicle being pursued by the police when it crashed
- seven people were passengers in the car being pursued by the police
- five people were drivers or passengers of an unrelated vehicle, which was hit by the pursued car
- one person was a pedestrian who was hit by the car being pursued by the police
- one person was hit by a police vehicle when fleeing a pursuit on foot. It was suspected that they were the driver of the pursued vehicle
- one person was in a vehicle being pursued by the police when it crashed, but we have not been able to confirm whether they were the driver or the passenger

The IOPC independently investigated 15 of the pursuit-related incidents. One was investigated locally by the police and the other two were returned to the force to address as they saw fit.

Emergency response related

This category includes all incidents that involve a police vehicle responding to a request for emergency assistance. Two emergency response-related incidents occurred in 2022/23 resulting in two fatalities. Both incidents are being investigated independently.

This number has decreased from the three incidents and three fatalities recorded last year. The figures for this year are in line with the average number of incidents and fatalities since 2004/05.

One fatality happened when a police vehicle responding to an emergency call collided with a motorcycle. The police were responding to a request from ambulance services for assistance with a concern for safety.

The other fatality involved a police vehicle colliding with a pedestrian while responding to an emergency call. The incident the police were responding to was a domestic incident.

Other police traffic activity

This category includes RTIs that did not happen during pursuit-related activity or an emergency response. There were six incidents in 2022/23 resulting in six fatalities. Three incidents are being investigated independently. The remaining three incidents are being dealt with locally by the police force involved.

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

- Officers on patrol in an unmarked police vehicle observed a car driving over the speed limit which then turned into a petrol station. The police vehicle turned into the petrol station and pulled up behind the stationary vehicle at the petrol pump. The police vehicle activated its blue lights to indicate the police's presence. Upon seeing the police vehicle, the car swerved right and exited the petrol station. It drove the wrong way up a slip road before apparently driving off at speed. The police did not try to pursue the vehicle. A couple of minutes later the officers heard radio reports of a collision a short distance away. They attended an RTI involving this car. The driver died at the scene. The incident is being independently investigated.
- Officers on patrol in a marked police van saw a car pull out of a car park. The driver appeared to respond to the presence of the police van by braking. The police turned their van around, by which point the car had begun travelling off at speed. Officers could see the car in the distance and activated their blue lights to make the driver aware of their presence. They activated their sirens as they approached the car at the traffic lights. The driver made an immediate right turn and the officers lost sight of the car. The officers stopped their vehicle and updated the force control room. Several minutes later they continued along the road where they found the car had collided into a tree. The driver died at the scene. The incident is being independently investigated.
- Two officers were patrolling in a marked police vehicle when they saw a car that was described as 'driving erratically'. The officers tried to stop the car by activating their lights to signal that the driver should pull over. The car continued to drive at speed before stopping at traffic lights. One officer got out of his vehicle and walked to the car. As he approached the driver's side window, the car drove off at speed. The police did not try to pursue the car as the driver was not pursuit-trained. The officers drove in the general direction they believed the car had travelled and discovered it had collided with a vehicle. The officers gave first aid at the scene. The driver of the vehicle that was hit by the fleeing vehicle was taken to hospital but later died. We returned the case to the force to address as it saw fit.
- Officers in a marked police car were stopped at traffic lights when they noticed a vehicle travelling at speed. They followed the vehicle and signalled for it to stop using their blue lights. The vehicle pulled up to the side of the road and the marked police car pulled up behind it. An officer got out of the police car and tapped on the passenger side window of the vehicle the police had stopped. There was

no response so the officer tried to open the passenger side door. The vehicle pulled away at speed. Information about the vehicle was circulated, and the police car remained where it was. Shortly after the vehicle was involved in a collision with another car. The passenger in that car died at the scene. We returned the case to the force to address as it saw fit.

- Officers in a marked police vehicle signalled for a car to stop using the police vehicle's blue lights. The car initially stopped, and the police vehicle stopped behind it. An officer got out of the police vehicle and began to approach the car, which then drove off. The police vehicle continued along the road and reported that the car had failed to stop, and that they were unable to pursue it. Further down the road a member of the public indicated for the police vehicle to stop. The member of the public reported that there had been a collision further along the road. The officers continued down the road and discovered the car that they had signalled to stop. The car had collided with another vehicle, and then had collided with roadside furniture. The car was damaged but contained no occupants. One of the occupants was found a short distance from the car. Paramedics attended but the man was pronounced deceased at the scene. This incident was independently investigated.
- Officers in an unmarked police vehicle noticed a car being driven in the opposite direction. The officers appear to have decided to turn their vehicle around to obtain the registration number of the car. The police vehicle did not activate lights or sirens. The driver of the car appeared to react to the police vehicle by driving off at speed. The car lost control on a bend, and then went through a barrier before it entered a river. Emergency services arrived and the driver was rescued from the car. Medical treatment was provided but he died at the scene. We returned the case to the force to address as it saw fit.

Trends

This year, 28 people died in 26 separate incidents. There was a decrease in fatalities this year from 40 to 28. This is in line with the average recorded over the 19 years since we first published these statistics. The annual figures fluctuate, and year-on-year comparisons should 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 pursuit-related incidents is in line with the average seen over the past 11 years.

There was also a notable decrease in the number of pursuit-related fatalities this year, from 34 to 20. This year saw a decrease in the number of pursuit-related incidents that resulted in multiple fatalities. One incident accounted for three fatalities. This is the lowest number of pursuit-related incidents that resulted in multiple fatalities since 2019/20, which saw no such incidents. The number of pursuit-related fatalities this year has reduced to the number seen in 2020/21 (20).

This year has seen a decrease in the number of emergency response-related incidents and fatalities, although the figures for this year are in line with the average number of incidents and fatalities since 2004/05.

The number of incidents resulting from other police traffic activity has doubled compared to the previous year. It is slightly higher than the average over the past 11 years, but just over a third of the number recorded in 2004/05.

Table 3.1 Type of road traffic fatality, 2012/13 to 2022/23

RTI type	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
Pursuit-related	27	10	7	13	28	17	30	19	20	34	20
Emergency response-related	2	0	0	2	0	8	5	3	1	3	2
Other	2	2	7	6	4	4	7	2	4	3	6
Total fatalities	**31**	**12**	**14**	**21**	**32**	**29**	**42**	**24**	**25**	**40**	**28**

Table 3.2 Type of road traffic incident, 2012/13 to 2022/23

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

4

Fatal shootings

This year, there were three fatal shootings by police. This is an increase on the two incidents recorded last year, but in line with the average figure recorded since 2004/05. The circumstances of the fatal shootings are described below. One is subject to an ongoing independent investigation and the other two are complete.

- Cumbria Police were called to an address where a man had reportedly been drinking and was threatening to kill people. Officers entered the address where they stated they observed a man holding a knife to the throat of a young child. This observation was supported by body worn video footage. The man, who was 40 years old and of White ethnicity, did not comply with the officers' requests to put the knife down. One of the officers used his Taser to 'red dot' the man. He was repeatedly instructed to drop the knife, but did not. The officers requested the assistance of firearms trained officers. Armed officers were deployed to the scene and ordered the man to drop the knife, which he was still holding at the throat of the child. The man did not comply and he was shot seven times before the child was led away. Officers provided first aid before paramedics arrived. The man died at the scene.
- Officers from the Metropolitan Police Service spotted a vehicle that was believed to be linked to a firearms incident which took place the previous day. They began following the vehicle and circulated this via police airwaves. Officers continued to follow the vehicle, intending to use an 'enforced stop extraction'. The vehicle turned into a road where a marked police armed response vehicle was present. Once the vehicle had turned, officers decided to perform an 'inline extraction'. Armed officers exited their vehicles and approached the car. Evidence suggests that contact was made between the car and the police vehicles. A single shot was fired by an officer standing in front of the vehicle. This shot pierced the front windscreen and struck the driver, a 24-year-old man of Black ethnicity. Officers at the scene provided cardiopulmonary resuscitation (emergency treatment involving chest compressions) to the man before he was taken to hospital, where he died.
- A report was received about a man with a knife who had gained access to a Derbyshire Constabulary police station secure car park. The man who was 35 years old and of White ethnicity was reported to be smashing the glass in the entrance door and windows around it. Officers were deployed and tried to speak with him from behind the closed doors, repeatedly instructing the man to put the knife down. Three officers drew their Taser devices and aimed them at the man. CCTV footage showed the man leaving the main entrance and walking towards the

pedestrian gate, where an officer confronted him and discharged their Taser device. This was ineffective. Firearms trained officers were deployed to the scene arriving shortly after. Officers gave verbal commands to the man to drop the knife and attempts were made to stop him, including the use of a multi-bang stun grenade, the discharging of a baton round and a Taser. Body worn video shows that the man walked towards a firearms officer with the knife raised above his head. He then changed pace and ran directly at the firearms officer, still with the knife raised. As the man got nearer to the firearms officer, and once the distance between them was just over arms-length, the firearms officer discharged his firearm into the abdomen of the man. The man fell to the floor just in front of the firearms officer. Immediate fast aid was provided by officers at the scene before paramedics took over. The man was taken to hospital where he died shortly after arrival.

5

Deaths in or following police custody

Demographics

In 2022/23, 23 people died in or following police custody – 22 men and one woman. Their ages ranged from 20 to 93 years. Nineteen people were White, two people were Black, one person was of Mixed ethnicity and one person was Asian.

Thirteen people had mental health concerns. The types of mental health concerns included depression, psychosis, anxiety, post traumatic stress disorder, bipolar, borderline personality disorder and self-harm. Four people had been detained under section 136 of the *Mental Health Act 1983*.

Twenty-one people were known to have a link to alcohol and/or drugs. This meant that at the time of their arrest they had recently consumed, were intoxicated by, in possession of, or had known issues with alcohol and/or drugs. Where cause of death is reported, a pathologist recorded that alcohol or drug toxicity, or long-term abuse, was likely to be a contributing factor in the deaths of eight people.

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

Table 5.1 Deaths in or following police custody: reason for detention, 2022/23

Reason for detention	Number of fatalities
Speeding/driving offences	5
Mental Health Act 1983	4
Violence-related (non-sexual or murder)	4
Attempted murder	2~
Drug/alcohol-related (excluding drink driving)	2
Theft	2
Threatening behaviour/harassment	1**
Failure to appear in court	1
Breach of the peace/anti-social behaviour	1*
Criminal damage	1^
Total fatalities	**23**

* This person was also arrested for assault and criminal damage

** This person was also arrested for driving offences

~ One of these people was also arrested for possession of an offensive weapon and the other person was also arrested for assault

^ This person was also arrested for assault and possession of a bladed article

The data shows that 11 of the 23 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 11 people were physically restrained by the police or members of the public. The term 'restraint' refers to a range of actions, including physical holds and pressure compliance. It does not include the routine use of handcuffs, unless another form of restraint was also used. Of the 11 people that had force used on them, eight were White, one was Black, one was of Mixed ethnicity and one person was Asian.

Four of the 11 incidents involving use of force included use of leg restraints. One involved use of leg restraints alone, one incident involved leg restraints along with 'red-dotting' the individual with a Taser, another involved leg restraints along with distraction strikes (this is a personal safety technique designed to weaken a person's resistance by changing their thought process and aiding with balance displacement and motor dysfunction) and use of a spit hood, and the other incident involved leg restraints alongside use of distraction strikes and PAVA incapacitant spray.

Three of the 11 incidents involving use of force included discharge of Taser devices. All three incidents where Taser was discharged involved other uses of force. One incident involved use of PAVA spray and baton in addition to discharge of Taser, and the other two involved use of restraint in addition to discharge of Taser.

Circumstances of death

Cause of death according to the pathologist's report following a post-mortem examination is reported for eleven of those who died. In a minority of cases, a post-mortem examination may not be carried out. In these cases, the cause of death is taken from the records of the doctor who certifies the death. If the cause of death is formally disputed at the time of the analysis, the cause of death will be recorded as 'awaited'. At an inquest, the cause of death is determined formally and may change from the cause of death listed in a pathologist's report. The IOPC is independently investigating 20 of the 23 deaths.

Eight people were taken ill or were identified as being unwell **in a police cell**. Five were taken to hospital where they later died. Three people died in a police cell.

These eight cases are outlined below.

- A man was arrested and taken into custody. It was noted he was intoxicated and the man said he had consumed alcohol and did not feel well. The man began vomiting while being booked into custody. He was placed in a cell on constant observations. A short time later he was seen by the custody nurse and an ambulance was called, which took the man to hospital. On arrival at hospital, the man disclosed that he had taken medication with the intention of ending his life. The man died in hospital two days after his arrest. His cause of death is awaited.
- A woman was arrested for driving while unfit through alcohol. She was placed in a CCTV monitored cell and put on 30-minute rousing checks due to being intoxicated. The woman's observation level was changed after a couple of hours and she no longer had to be roused. The next morning an ambulance was called as the woman appeared to be having seizures. Custody staff provided emergency first aid before the arrival of paramedics, who pronounced the woman dead shortly after their arrival. Her cause of death was reported as *1a) Left haemothorax, 1b) ruptured aneurysm of thoracic aorta with dissection*.
- A man went to Accident & Emergency after taking an overdose of prescription medication. He was later released into the care of his family. Later that evening police were called and the man was arrested for affray. He was taken to custody where he was seen by a healthcare professional to make sure he was medically fit to detain. In the morning he was medically assessed by another healthcare professional. He was also assessed by the mental health team. The man voluntarily

agreed to be admitted to mental healthcare for assessment and later that afternoon he was taken from his cell to the custody desk to be released. The man became unwell at the desk. Medical aid was provided. Paramedics attended and took over treatment, but the man was pronounced dead. His cause of death was reported as *1a Venlafaxine overdose, 2 Severe ventricular hypertrophy*.

- A vehicle was stopped after the driver and passenger were observed taking part in a suspected drug deal. The driver, passenger and vehicle were searched. The driver was taken to a police station to be strip searched. The strip search did not find any drugs and the man was arrested for conspiracy to supply class A drugs. The man was taken to a custody unit. Early the next morning the man became unwell in his cell. Custody staff and a healthcare professional provided medical assistance. The man's condition appeared to improve, but he became unwell a second time and an ambulance was called. An air ambulance followed soon after, but the man was pronounced dead a short time later. His cause of death is awaited.
- A man was arrested and remanded into police custody before appearing at court the following day. The man disclosed a history of drug use and was strip searched and seen on two occasions by a healthcare professional, one of whom provided medication for withdrawal symptoms. The next afternoon the man was found unresponsive in his cell. Medical aid was provided by custody staff and a healthcare professional before paramedics arrived and took over treatment. The man was taken to hospital where he died shortly after arrival. His cause of death is awaited.
- A man was arrested for a drug-related offence. During his arrest the man was restrained. The man was taken into custody, searched and placed on a rest period until the next morning due to his apparent intoxication. The next morning, the man was seen by a healthcare professional who noted that the man was intoxicated and that the level of intoxication would indicate that he had taken substances while in custody. The man was strip searched and placed on a further rest period. After the rest period, the man was interviewed for the drug-related offence. Later that day, the man was found unresponsive during a routine cell check. A healthcare professional provided medical aid and an ambulance was called. The man was taken to hospital where he died shortly after arrival. His cause of death is awaited.
- Officers attended reports of a road traffic collision involving a heavy goods lorry. The lorry had left the road, driven through a hedge, and came to a stop in a field. The driver of the lorry did not report any injuries and there was minimal damage to the lorry. The driver was breathalysed at the scene, which found that he was over the prescribed legal drink driving limit. The driver was arrested and transported to custody. He had a medical episode in the custody suite shortly after arrival. Officers and a healthcare professional administered medical aid until the arrival of paramedics. The man was taken to hospital where he died later that evening. His cause of death was reported as *Ia Abdominal haemorrhage sustained in a road traffic collision, II Intoxication with alcohol*.
- A man was arrested for drink driving following a road traffic collision. The officers that attended the incident stated that there was no concern over any injury to the man. An off-duty paramedic was also present at the scene. The man was taken to custody, where he waited in the holding area for just under two hours before being booked in to custody. During the booking in procedure the man appeared to have a seizure. Medical aid was provided by a healthcare professional before the man was taken to hospital by ambulance. He died nine days later. His cause of death was recorded as *1a: Multi-Organ Failure 1b: Advanced Alcoholic Liver Disease with Liver Failure and Seizure 2: Road Traffic Accident with Subdural Haematoma.* After considering a referral, we returned the case to the force to address as it saw fit.

Twelve people were taken ill at the **scene of arrest**. Eight people were taken to hospital, where they later died. Four people died at the scene.

- Police in a marked police van responded to a call about a man reported to be behaving erratically on a street. The man voluntarily sat in the police van with officers. He tried to push his way out of the van. He was restrained on the ground and handcuffed. Further officers arrived to assist. The man became unwell, and an ambulance was called. The man was detained under Section 136 of the *Mental Health Act 1983* while waiting for the ambulance. He was taken to hospital where he died later that day. His cause of death was reported as *the effects of cocaine*.
- Police attended a road traffic collision. The driver of the vehicle that crashed was arrested for driving a motor vehicle while unfit through drink or drugs. The man complained of aches and pains but reportedly had no visible injuries aside from a small cut. An ambulance arrived and the man was removed from the car and placed in the ambulance. The man's condition deteriorated while in the ambulance and he was taken to hospital. He became more unwell during the journey and the ambulance stopped while CPR was given. The ambulance continued to the hospital where the man died a short while later. His cause of death is awaited. After considering a referral, we returned the case to the force to address as it saw fit.
- Officers were called to an incident at a house. They entered the house and started speaking to a man who was lying on the floor. An ambulance was requested due to the man's physical condition. The man was arrested in connection with an alleged assault and placed in handcuffs. He complained of pain after being handcuffed and was placed from his back onto his side. His health significantly deteriorated while waiting for the ambulance. Officers removed the man's handcuffs and provided medical aid until the ambulance arrived. The man was taken to hospital where he died shortly after arrival. His cause of death was reported as *blunt force trauma to the stomach*.
- Officers were called to reports of a vehicle being driven erratically. When officers arrived, the vehicle had come to a stop and the male driver had been detained by members of the public. Officer body-worn camera footage showed the man was distressed, confused and non-compliant. One officer drew his Taser and red-dotted the man. He then put it away. The man was arrested on suspicion of driving while unfit through drink or drugs. Officers restrained him prone on the ground, handcuffed him and applied two sets of leg restraints. The man remained on the ground and for short periods was in the prone position. An ambulance was called as it was believed the man had acute behavioural disturbance. A police van was requested to attend for the man to be placed into due to the extremely hot weather. When it arrived, he was searched and placed into the rear of it. Paramedics arrived shortly after this and provided medical treatment before taking the man to hospital. He died the next day. His cause of death was reported as *multi-organ dysfunction due to acute cocaine toxicity*.
- Officers came across a man behaving erratically. When officers tried to speak to the man he ran off. Officers found him some minutes later in a residential garden further down the road. The officers talked to the man who moved towards them, and the main road which they were on. The officers used PAVA incapacitant spray twice on the man, before he ran away through a fence to a member of the public's back garden. The officers followed him and administered distraction strikes before restraining the man and detaining him under Section 136 of the *Mental Health Act 1983*. The man was handcuffed, and a leg restraint was applied. While being restrained the man appeared to have trouble breathing. He became unconscious, and officers removed the handcuff and restraint and provided medical aid until an ambulance arrived. The man died at the scene. His cause of death cannot be reported at this time.

- A man was reported to have seriously assaulted another man. Police located the man who was alleged to have carried out the assault and, after a foot pursuit, detained him. While attempting to restrain the man, it was reported that he punched one of the officers in the face. The man was placed on his side on the ground and handcuffed. He was then arrested. Within minutes of being placed on the ground, the man said that he had breathing difficulties. He then became unresponsive, and an ambulance was called. An officer removed the man's handcuffs and provided medical aid. Paramedics arrived and took over treatment before the man was pronounced deceased. His cause of death is awaited.
- Police were called to reports of a disturbance in a premises. When the officers arrived, a man was being restrained by members of the public on the floor in a prone position. With assistance from the public, officers applied handcuffs and rolled the man onto his side. Leg restraints were then applied. Officers arrested the man and called an ambulance because they suspected he was suffering from acute behavioural disturbance. The man was kept restrained on his side while waiting for the ambulance. The man's condition appeared to deteriorate, and the officers decided to transport him to hospital themselves. The man died the next day. His cause of death was reported as *Ia Multiorgan failure and rhabdomyolysis Ib Complications arising following cocaine use which involved physical exertion and prone restraint*.
- Police received notification of a concern for welfare for a man who had failed to attend court. Officers went to an address believed to be the man's home, however, this was later revealed to be the wrong address and they did not find the man. The next day officers went to the correct address. The man was found and arrested for the outstanding warrant. The man appeared to be unwell and an ambulance was called. The man was taken to hospital accompanied by officers. The man died in hospital the day after he was admitted. His cause of death is awaited.
- Police were called to reports of a disturbance in a flat. Two officers armed with Tasers went to the address and spoke with a man and his partner in the corridor of the flats. It is reported that the man then pushed and assaulted one of the officers and went back inside his flat. Officers followed the man inside the flat where they tried to restrain him. One officer discharged their Taser twice at the man, who fell to the floor. The second officer physically restrained the man on the floor and tried to place handcuffs on him. A struggle ensued during which the first officer re-energised the discharged Taser on several occasions. Other officers arrived at the scene and the man was handcuffed. The man was arrested for assault on an emergency worker and an ambulance was requested. Paramedics arrived and provided treatment, but the man's condition deteriorated, and he died at the scene. His cause of death is awaited.
- Police were called to a care home where an older resident had armed himself with a cutlery knife and was reportedly becoming threatening towards care workers. Officers arrived and were directed to the older resident's room. The resident, who was an amputee and in a wheelchair, failed to put down the knife. The officers used PAVA spray, a baton strike and finally a Taser to disarm the man. He was then handcuffed, and an officer updated the control room to confirm the man had been detained. Once disarmed, the man was taken to hospital by ambulance. He remained in hospital where he died 21 days later. His cause of death was reported as *Ia Ischaemic heart disease with bronchopneumonia*.
- Police officers on patrol on a bridge were alerted by a member of the public about an argument taking place between three men. The officers came across a man who stated that two men had tried to steal his bag. The officers located the two men, who were in the company of a woman. The woman made an allegation of theft against the man police had initially encountered. Body worn video shows that one of the officers returned to the initial man to discuss the allegations and while

standing along the river, the officer began to inform the man that he was under arrest. The man ran away from the officer toward the river. The officer ran after the man, who then entered the river and got into difficulty. More officers arrived and began to assist, and emergency services were called. A body was recovered from the water just over an hour later. The ambulance service provided treatment to the man, but he was pronounced deceased a short time later. His cause of death is awaited.

- Officers responded to a call from a taxi firm stating that one of their drivers was being attacked within their car by a passenger. Body worn video shows that on arrival officers found the passenger sat on the ground and they observed that he was struggling with his breathing. The officers requested an ambulance and reported they had found possible class A drugs on the ground. They suspected that the man had swallowed drugs. A knife was found in the back of the taxi where the man had been sitting. The man was handcuffed and arrested. He confirmed to the officers that he had swallowed a quantity of cocaine. The man's condition began to deteriorate. At one point he was restrained on the ground due to his behaviour. He was later moved to his side in the recovery position. Paramedics arrived and the man was placed on a stretcher and carried into the ambulance. He began to resist the crew and repeatedly tried to remove the oxygen mask placed over his face and other medical equipment resulting in the officers restraining him by the arms and handcuffing him again. He was taken to hospital, where he died 2 days later. His cause of death was reported as *1a. Hypoxic-ischaemic encephalopathy 1b. Out-of-hospital cardiac arrest 1c. Cocaine intoxication.*

One man was taken ill in a **police vehicle**. He was taken to hospital where he died.

- Police were called to a concern for a man's welfare. Officers arrived at the man's address and asked the man to go to hospital with them. The man left his address with the officers and got into a police car. The officers informed the control room that they were going to transport the man to hospital for a mental health assessment. While in the car, the man became agitated and was detained under Section 136 of the *Mental Health Act 1983*. The man resisted officers' attempts to detain him. Officers restrained the man and applied handcuffs and leg restraints. A police van arrived, and officers removed the man from the police car and placed him on the ground, before carrying him to the police van. While being carried, the man appeared to try to harm himself and three officers delivered distraction strikes to the man's arm and chest area. While being transported in the van, the man spat in an officer's face. Officers then applied a spit guard over the man's head. The man's condition deteriorated, and officers called an ambulance as they believed he was suffering from acute behavioural disorder. While waiting for the ambulance, officers continued to restrain the man for safety reasons. The man was placed in the recovery position and officers monitored his condition. The man was taken to hospital, where he died later that day. His cause of death was reported as *the physiological effects of exertion following a period of restraint, combined with cocaine and other substances.*

One man died after **leaving police detention**.

- A man was detained by police under section 136 of the *Mental Health Act*. He was taken to hospital by ambulance for a mental health assessment. Whilst at hospital there were significant delays of many hours in the man being assessed by an appropriate trained mental health practitioner. The man was described by officers as being calm and compliant during this time. During his time at the hospital the man had been for several smoke breaks in the company of officers. In the early hours of the next morning, on one of these smoke breaks, the man ran away from the officers. The officers pursued the man, first on foot, and then in a police vehicle. The man was seen to jump over a fence. The officers stated that despite

searching for the man they could not see him. Further searches were undertaken, and the man was declared a high-risk missing person and missing person enquiries were carried out. He was found dead later that day. His cause of death is awaited. This death was subject to local investigation.

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

- Police responded to a report of concern for safety due to a man's behaviour. The man was reported to have been banging on neighbouring doors and threatening the occupants, and a police officer stated he was in possession of a weapon. The man was Tasered, then restrained and arrested by officers before being taken to custody. In custody, the man was strip searched and seen by a healthcare professional. The man was later seen by a healthcare professional for a second time. He had an injury to his foot and stated that he wanted to kill himself. He was seen by a mental health practitioner and was charged and remanded in custody to appear in court the next day. The man was remanded into custody by the court and on the way to prison, he was taken to hospital for his foot injury. At the hospital, the man swallowed a bag of white powder and became unwell. Medical treatment was provided, but the man died shortly after. His cause of death is awaited. The independent investigation into this incident considered the contact the police had with the man while he was in custody, including risk assessments and searches.

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 again to 18 and then declined and remained stable at 14 in 2015/16 and 2016/17. In 2017/18 there were 23 fatalities, the highest number recorded for ten years. This number fell to 17 fatalities in 2018/19 and increased slightly to 18 in 2019/20. In 2020/21 the number increased slightly again to 19, and then fell notably to 11 in 2021/22. This year, the number of deaths in or following police custody increased again, to 23. This is double the figure recorded the previous year, and slightly higher than the average recorded since figures began in 2004/05.

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

This year three people were pronounced dead in a police cell, the same figure as in 2021/22 and 2020/21. In 2019/20, one person died in a police cell. In 2018/19, no one died in a police cell and 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 happen within two days of the person's release from custody. They are also included if experiences in custody may have been relevant to the death, and the death was referred to the IOPC. The police may not always be told about an apparent suicide that happens after time in custody as the association may not be clear. Therefore, there may be more deaths in these circumstances than are reported here.

The term 'suicide' does not necessarily relate to a coroner's verdict. Verdicts are still pending in most cases. We include these cases only after considering the nature of death and whether the circumstances suggest that it was an intentional, self-inflicted act. For example, a hanging, or where there was some evidence of 'suicidal ideation', such as a suicide note.

Demographics

There were 52 apparent suicides following police custody in 2022/23 – 49 men and three women. The average age of those who died was 43 years. The most common age was between 31 and 40 years (16 people), followed by 51 to 60 years (14 people). The youngest person was 19 years (two people). Forty-eight of those who died were White. One person was from a Mixed ethnic group, one person was Black and two people were Asian.

Seventy-five percent of the people (39) had known mental health concerns. Of these, one was detained under Section 136 of the *Mental Health Act 1983*. Other mental health concerns included depression, bipolar, psychosis, schizophrenia, post-traumatic stress disorder, anxiety, previous thoughts or incidents of suicide attempts, and self-harm.

Just under a half of the people (20) 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). Fourteen deaths related to alcohol and 13 to drugs.

Circumstances of death

Twelve apparent suicides happened the same day the person was released from police custody. Twenty-five happened one day after release, and 15 happened two days after release. There were no cases where the apparent suicide took place more than two days after release.

Table 6.1 shows the reasons why these people were placed into custody by the police. Twenty-six of those who died had been arrested for a sexual offence. Of these, 24 related to sexual offences or indecent images involving children. Eleven were for violence-related offences. Other common reasons were criminal damage (7), threatening behaviour and harassment (6) driving offences (4), possession of a weapon (4), theft/burglary (4), failure to appear in court (2) and drug/drink related (2).

Table 6.1 Apparent suicides following police custody: reason for detention, 2022/23

Reason for detention	Number of detentions
Sexual offences	26
Violence related (non-sexual or murder)	11
Criminal damage	7
Threatening behaviour/harassment	6
Driving offences (including drink/drug driving)	4
Possession of a weapon	4
Theft/burglary	4
Failure to appear in court	2
Drug/drink related	2
Mental Health Act 1983	1
Murder	1
Outraging public decency	1
Administering a substance with intent	1
Total number of reasons for detention	**70**
Total fatalities	**52**

Eighteen people were detained for multiple reasons. This compares with 20 last year.

The majority of recorded apparent suicides following police custody were dealt with locally by the police force involved (51). One is being investigated independently. In this case, the matters being considered by the investigation include the time the man spent in custody, including observations, medical assessment, risk assessments, and care post-release from custody.

This year, for 50% of fatalities, the reason for custody related to alleged sexual offences. The proportion of sexual offences or indecent images involving children was 46%. These proportions are lower than the figures recorded last year (53% and 47% respectively) but higher than average figures. The average proportions for these alleged offences since 2004/05 are 35% and 29% respectively.

Trends

The number of apparent suicides following time in police custody is lower than the 57 recorded in 2021/22. It is the sixth lowest number recorded over the 19-year period since 2004/05. 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.

7

Other deaths following police contact: independent investigations only

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

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

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

In 2018/19, the IOPC began a phased move to thematic case selection. The thematic areas include domestic abuse, road traffic incidents, abuse of authority for sexual or financial gain, mental health and discrimination. Thematic case selection involves independently investigating more cases where these themes may be a factor. This enables us to develop a body of evidence for learning and prevention work. The move to thematic case selection may have an impact on the number and proportion of cases involving particular circumstances of death – such as concerns for welfare based on mental health, or domestic-related incidents.

Overall demographics

We independently investigated the deaths of 90 people who died during or following other contact with the police during 2022/23. Of these deaths:

- Fifty-nine were men and 31 were women.
- Seventy-five people were White, four were Black, five were Asian, three people were Mixed ethnicity and one person was from an Other ethnic group. The ethnicity of two people was not known at the time of publication.
- Six people were aged under 18 years, and 21 people were young adults aged between 18 and 30 years. Eight people were aged over 60. The average age was 40 years old.
- Almost two thirds of those who died (55) were reported to be intoxicated by drugs and/or alcohol at the time of the incident, or drugs and/or alcohol featured heavily in their lifestyle. A similar proportion of the people who died (57) were reported to have mental health concerns.

Table 7.1 Other deaths following police contact: reason for contact, 2022/23

Reason for contact		Number of fatalities
Concern for welfare	Missing person	20
	Health/injuries/intoxication/general	30
	Self-harm/suicide risk/mental health	16
	Domestic related	15
	Threatening behaviour/harassment	1
	Other	3
Other contact	**Subtotal**	**85**
	Assisting medical staff	1
	Avoiding contact/arrest	1
	Attending a disturbance	1
	Other	2
	Subtotal	**5**
	Total fatalities	**90**

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 shown by some of the case examples. Where we have included the cause of death, this is taken from the pathologist's report following a post-mortem examination.

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

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

A total of six people who died following police contact had force used against them. Four people were White, and two were Black. Five were restrained by police officers or by members of the public. This does not necessarily mean that the force used contributed to the death. One man had leg restraints and a spit hood used on him. One man was subject to discharge of a Taser.

Concern for welfare

Of the 85 fatalities that followed contact with the police because of a concern for welfare, 20 people who died had been **reported missing**. The police generally did not have direct contact with the person who died in these cases. Of these 21 people, 12 were also identified as being at risk of self-harm or suicide.

Of these 12:

- Ten were men and two were women.
- All twelve were White.
- The ages of those included in this category ranged from 15 to 58. The most common age group was 21 to 30 (six people). The average age was 31 years.
- 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. All 12 people who died had mental health concerns.
- In ten incidents, the person's death was caused by an apparent self-inflicted act.

There were no specific risks of self-harm or suicide for the remaining eight people reported missing to the police. In these cases:

- Five of those who died were men and three were women.

- Five were White, two people were of Mixed ethnicity and one person was Black.
- The ages of the people in this category ranged from 21 to 62. The average age was 38.
- Seven 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. Six people had mental health concerns.
- Three deaths were caused by an apparently self-inflicted act, three were accidental and two were an accidental overdose.

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

- Twenty-one people were men and nine were women.
- Twenty-five were White, one was Black, one was of Mixed ethnicity, two were Asian and the ethnicity of one person was unknown.
- The majority of people (9) were aged between 41 and 50. The average age was 41.
- Almost a quarter of those who died (22) were reported to be under the influence of alcohol and/or drugs at the time of the incident, or these featured heavily in their lifestyle.
- The most common form of death classification was accidental overdose (nine people). Eight deaths were accidental.

Four incidents involved **use of force**:

- Police were called to reports of a man acting aggressively and 'smashing up' his flat. Upon arrival officers tried to engage with the man, who was now out in the street, but this was not successful. Officers and family members tried to calm the man. He was handcuffed at the back and restrained on the floor in the recovery position. The man become unresponsive while waiting for the ambulance, and medical aid was given by officers until the paramedics arrived. The man was taken to hospital where he died later that day. His cause of death was reported as *1a Cardiac arrest during a period of restraint whilst intoxicated with cocaine. 2 Cardiac hypertrophy and coronary artery disease*.
- Police were called to reports of a potential burglary, where initial information indicated there may be firearms at the address. Officers attended and spoke to one of the occupants of the address, who said their family member was having a mental breakdown and had an axe. Officers tried to engage with the man, who was still in the house. A short time later, the man opened a bedroom window and fell from the window into the garden. The man was restrained by officers and the family member, and he was placed in handcuffs. The officers suspected the man was experiencing acute behavioural disturbance and requested an ambulance. The man's condition started to deteriorate, and he was placed in the recovery position. Officers noticed the man had stopped breathing, so they removed his handcuffs and provided cardiopulmonary resuscitation (CPR) until an ambulance arrived. The man was taken to hospital where he died later that day. His cause of death was reported as *1a Haemothorax with hypoxic-ischaemic brain damage, 1b Cardiopulmonary resuscitation, 1c out of hospital cardiac in the context of drug induced psychosis caused by cocaine.*
- A member of staff in a residential care home called police to report that a man had broken in and was covered in blood and shouting. The man could be heard shouting in the background throughout the call. By the time the first officer arrived on the scene, the man had locked himself in a toilet. Officers gained entry to the toilet, restrained the man and handcuffed him. The man became unresponsive. Officers removed the handcuffs and gave medical aid. Paramedics arrived and provided medical treatment. The man died at the scene. His cause of death is awaited.
- Police went to a reported assault in a pub car park. Officers found a man in the car park with a head wound. An ambulance arrived and decided the man needed to go to hospital.

The man was agitated when he was examined by paramedics, so officers agreed to go with them to the hospital. The man continued to be agitated at the hospital so further police units were called. Officers restrained the man and he received medical treatment. The man's condition deteriorated and he died two days later. His cause of death was reported as *head injury*.

Sixteen fatalities related to a **concern about a person's risk of self-harm, risk of suicide, or their mental health**. In such cases, 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 showed signs of being at risk of self-harm or suicide. The person is not reported or considered missing. Of these:

- Twelve people were men and four were women.
- Twelve were White, two were Asian and and one person was of Other ethnicity. The ethnicity of one person was not known.
- The ages of the people ranged from 30 to 75. The majority were aged between 41 and 50 (seven people). The average age was 46.
- Death by self-inflicted means was the most common classification (14 people).
- Ten 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.

Fifteen fatalities were **domestic-related**. This means 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:

- Eleven of those who died were women and four were men. Women were a higher proportion in this category than in all the other independently investigated deaths following police contact.
- Fourteen people were White and one person was Asian.
- The average age was 42. The youngest person was two and the eldest was 84.
- the deaths were classified as alleged murder in 11 instances. All but three of those who were allegedly murdered were women. Four deaths were self-inflicted.

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

- A man had an ongoing neighbour dispute with another man. One of the men was reported to police as a missing person. He was subsequently found, and a note was recovered from his home. In the note, he threatened to kill the second man. He was arrested and interviewed. There were concerns about the man's mental health. The man was released, and a risk management plan was created, and support was put in place for his mental health. Roughly a week later, the man who made the threats said he was being harassed by the second man. Police started an investigation and began the process of arranging a housing move. They advised the two men to stay away from each other, but the second man refused. Approximately two weeks later police received reports of two neighbours arguing and that one was attacking the other. Officers attended and found the second man had been stabbed by the man who had threatened to kill him. The second man's cause of death was reported as *Multiple sharp force injuries*.

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

- Police received calls from members of the public to report that a stationary car was in the live lane of an A road. Approximately 15 minutes after the first call, a police unit on the other side of the carriage way noted that the

stationary car was on fire and there had been a road traffic collision. Two people died as a result of the collision.

- Police received a call that reported concern for the safety of a man. Information shared with the police indicated that the man had been kidnapped. The man was found at an address later that day, and a person at the address was arrested on suspicion of murder. The man's cause of death is awaited.

Other contact

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

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

- Police received a non-emergency call asking for assistance to detain a woman under the provisions of Section 2 of the *Mental Health Act 1983* after she refused to leave her address. Police went to the address, placed the woman in handcuffs and put her into a transport ambulance. The woman was left in the care of mental health nurses and officers left the address. The woman became unresponsive inside the transport ambulance. She was taken to hospital where she died shortly after arrival. Her cause of death was reported as *bilateral pulmonary thromboembolism*.

One man died in an attempt to **avoid police contact or arrest**:

- Officers witnessed a suspected drugs transaction between a man and a woman. Officers made efforts to detain the man, who was riding a pedal cycle. Several officers pursued the man on foot, whilst other officers followed in unmarked vehicles. A police officer used a baton to stop and detain the man, who was then restrained on the floor. The man would not open his mouth and there was a suspicion that he may have swallowed drugs. One officer slapped the man in an action that was described as a 'distraction slap' to encourage the man to open his mouth. Another officer held the man's chin in an attempt to prevent him from swallowing drugs. The man was searched, and due to concerns that he may have concealed drugs, he was taken to a local police station for a strip search. The man denied that he had swallowed drugs. The man stated that he was in pain and stated that his ribs were sore. An officer also discovered a bruise to the man's leg. A strip search was conducted, and the man wasn't found to be carrying or concealing any drugs. He was taken back to his home address. Officers stated that the man refused offers to seek medical attention. The man died at his home address five days later. His cause of death was reported as *Ia) Mixed drug use (heroin, diazepam and cocaine) with pneumonia II Multiple fractures (ribs, larynx and fibula).*

One man died after police officers attended a **report of a disturbance**:

- Members of the public called police stating there a man was on a bridge shouting religious remarks holding a screwdriver or knife. Officers went to the bridge and engaged with the man. He was Tasered multiple times, before he entered the river. He was rescued by the Royal National Lifeboat Institution and was taken to hospital where he died later that day. The object in the man's possession was later found to be a plastic and metal firelighter. His cause of death cannot be reported at this time.

Two men died **following other contact with the police**:

- Police carried out a pre-planned firearms operation at an address. Firearms officers arrived at the scene and surrounded a property. Approximately 35 minutes later, a noise described as a bang was heard from inside the property. An hour and a half after the noise, officers entered the property where they found a man dead from an apparently self-inflicted gunshot wound to the head. His cause of death was reported as *shotgun wound to the head*.
- Police received a call from an employee at a fast-food restaurant who believed that the

occupants of a van at the 'drive-thru' may be intoxicated. The male driver was arrested on suspicion of driving whilst unfit to drive through drink. The second man was left with the keys of the vehicle, whilst the driver was escorted away by the police to the station. No checks were conducted by the police and the man that was left with the keys was disqualified from driving at the time. A short while later police received a report of a road traffic incident involving the van. The driver, the man who had been left with the keys, died at the scene.

Trends

In 2010/11, a change was made to the definition of this category. It now includes only those deaths following other police contact that were investigated independently by the IOPC, formerly the IPCC. The number of cases recorded in this category is directly linked to the number of cases independently investigated. It would not be meaningful to provide any trend analysis for this category. The deaths included in this category happen in a range of circumstances, which makes it difficult to identify a specific set of events that accounts for changes in the number of fatalities. The overall proportion of cases relating to a concern for welfare made up 94% of the deaths following police contact that were independently investigated – a slightly higher proportion than in 2021/22.

During 2022/23, 18% of investigations into deaths following police contact related to reports of concerns about a person's risk of self-harm, risk of suicide, or mental health. Seventeen percent of the deaths following police contact were domestic-related. These types of concern for welfare link to current areas of thematic work for the IOPC. This may result in the number of these types of investigations increasing and/or forming a larger proportion of the 'other contact' deaths that the IOPC investigates independently.

8 Background note

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

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:
   - Her 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*).
   - Serious Organised Crime Agency known as SOCA.

   Since October 2013, we have also received mandatory referrals from SOCA's replacement, the National Crime Agency (NCA). Up until March 2013, we received cases from the UK Border Agency (UKBA) (Regulation 25 of the *UK Border Agency (Complaints and Misconduct) Regulations 2010*). At this time UKBA's executive agency status was ended. Its functions were brought back into the Home Office as UK Visas and Immigration (UKVI); UK Immigration Enforcement (UKIE); and UK Border Force (UKBF). The IOPC continues to have jurisdiction over these officials and contractors. Therefore, this report includes deaths during or following contact with staff from these organisations.

3. We became the IOPC in January 2018. This change was set out in the *Policing and Crime Act 2017*. We were the IPCC before this.

Changes and revisions

4. In 2010/11, a change was made to the definition of the 'other deaths following police contact' category. It now includes only those deaths following police contact that were investigated independently by the IOPC (or previously by the IPCC). As a result, we have changed the approach to how this category is presented in this report. You can find out more in our guidance document. No other changes have been made to the definitions of the death categories.

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

spent in custody and their death.

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

   - For 2020/21, two deaths have been added to the 'other deaths following police contact' figure.
   - For 2021/22, two deaths have been added to the 'other deaths following police contact' figure, one death has been added to the road traffic incident figure and one death has been added to the apparent suicides following police custody figure.

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

7. Table 6.1 sets out the reasons for detention for apparent suicides following police custody. In previous years, this table showed the number of fatalities with footnotes to highlight where there were additional reasons for detention. Due to the high volume of fatalities with multiple reasons for detention in 2022/23, the figures shown in Table 6.1 are the total number of different reasons for detention. We have taken this approach since our 2018/19 report.

Methods and definitions

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

Policies and statements

9. We produce a number of policies and statements in connection with this report. These are available on our website. They include information about:

   - confidentiality and security of data
   - statement of administrative sources
   - revisions policies
   - announcing changes to methods
   - quality assurance
   - pre-release access
   - user engagement strategy
   - pricing policy

Users, uses and engagement

10. Information about key users of the data contained in this report, and how it was used, can be found in the user engagement feedback document. It also summarises any feedback received on the annual deaths report, our response to it, and any impact this may have on either the information contained in the report or the data collection process.

11. This report provides data and information about a highly sensitive topic area. It is used to promote and inform debate and discussion among police forces and other stakeholders and interested parties. It provides users with an opportunity to learn from the cases that appear in the report and to identify, take action, and/or review policy to help prevent such deaths from happening again where possible.

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

13. Users of these statistics should take care when looking at the time series of the data. There may be discontinuities owing to changes in category definition and the varied nature of the circumstances of the cases. The small numbers involved also mean readers should be cautious about drawing conclusions from trend analysis as variances can be large.

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

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

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

Further information

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

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

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

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

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

20. Estimated publication date for our next report covering data for 2023/24 is July 2024.

Appendix A: additional tables

Table A1 Incidents by type of death and financial year, 2012/13 to 2022/23

Incidents											
	Financial year										
Category	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21	21/22	22/23
Road traffic incident	23	11	13	20	28	27	33	24	20	33~	26
Fatal shootings	0	0	1	3	6	2	3	3	1	2	3
Deaths in or following police custody	15	11	18	14	14	23	17	18	19	11	23
Apparent suicides following custody^	65	70	71	61	56	57	63	54	55	57~	52
Other deaths following police contact*	20	41	43	103**	128	172	151	104	96~	104~	85

^ 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, 2022/23

Gender	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Male	22	3	22	49	59
Female	6	0	1	3	31
Total fatalities	28	3	23	52	90

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

Table A3 Type of death by age group, 2022/23

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	6
18 - 20	6	0	1	2	1
21 - 30	13	1	5	9	20
31 - 40	3	2	9	16	17
41 - 50	4	0	2	6	20
51 - 60	1	0	5	14	18
61 and over	1	0	1	5	8
Total fatalities	28	3	23	52	90

Table A4 Type of death by ethnicity, 2022/23

Ethnicity group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
White	22	2	19	48	75
Black	0	1	2	1	4
Asian^	5	0	1	2	5
Mixed	0	0	1	1	3
Other	1	0	0	0	1
Not known	0	0	0	0	2
Total fatalities	**28**	**3**	**23**	**52**	**90**

* 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, 2022/23

Appropriate authority**	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Avon & Somerset	1	0	1	1	3
Bedfordshire	0	0	0	1	1
Cambridgeshire	0	0	1	0	0
Cheshire	0	0	0	0	0
City of London	0	0	0	0	0
Cleveland	0	0	2	2	1
Cumbria	1	1	0	0	3
Derbyshire	0	1	0	3	1
Devon & Cornwall	0	0	0	4	3
Dorset	0	0	0	0	1
Durham	1	0	0	0	2
Dyfed-Powys	0	0	0	1	0
Essex	1	0	2	2	0
Gloucestershire	0	0	0	1	2
Greater Manchester	3	0	1	0	12
Gwent	0	0	1	0	0
Hampshire	0	0	1	4	0
Hertfordshire	0	0	1	1	0
Humberside	1	0	0	1	4
Kent	1	0	0	3	2
Lancashire	1	0	1	0	2
Leicestershire	1	0	0	0	2
Lincolnshire	0	0	1	0	1
Merseyside	1	0	1	0	2
Metropolitan	2	1	2	3	9
Norfolk	1	0	1	1	0
North Wales	0	0	0	0	0
North Yorkshire	0	0	0	2	3
Northamptonshire	0	0	0	1	6
Northumbria	1	0	2	5	2
Nottinghamshire	1	0	1	0	2
South Wales	1	0	1	0	2
South Yorkshire	0	0	0	3	1
Staffordshire	0	0	0	3	2
Suffolk	0	0	0	0	1
Surrey	1	0	0	1	0
Sussex	1	0	1	1	1
Thames Valley	0	0	0	0	0
Warwickshire	0	0	0	0	2
West Mercia	0	0	0	2	5
West Midlands	3	0	1	1	6
West Yorkshire	5	0	1	3	2
Wiltshire	0	0	0	0	0
Gwent Police & South Wales Police	0	0	0	0	3
Northamptonshire & Derbyshire	0	0	0	0	1
Hertfordshire & Essex Police	0	0	0	1	0
British Transport Police	0	0	0	0	0
Home Office ~	0	0	0	0	0
Her Majesty's Revenue and Customs	0	0	0	0	0
Ministry of Defence	0	0	0	0	0
National Crime Agency	0	0	0	1	0
Total fatalities	**28**	**3**	**23**	**52**	**90**

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

** 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.

~ This includes UKBF, UKIE and UKVI

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

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

July 2023

ISBN 978-1-7394778-0-6