
IOPC Independent Office for Police Conduct

# Deaths during or following police contact

## Statistics for England and Wales 2024/25

# Acknowledgements

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


## Contact details

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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

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# 1 Introduction

This report presents figures on deaths during or following police contact that happened between 1 April 2024 and 31 March 2025. 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-first in a series of statistical reports on this subject, 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 29.

## 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 29 for more information. Deaths of police personnel or incidents involving off-duty police personnel are not included in the statistics in this report.

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

This does not include:

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

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

**Deaths in or following police custody** include deaths that happen while a person is being arrested or taken into detention.

It includes deaths of people who have been arrested or detained by police under the *Mental Health Act 1983*. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

This includes deaths that happen:

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

This does not include:

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

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

**Other deaths following police contact** include deaths that follow contact with the police, either directly or indirectly, that did not involve arrest or detention under the *Mental Health Act 1983* and were subject to an independent investigation.

An independent investigation is determined by the IOPC for the most serious incidents that cause the highest level of public concern, have the greatest potential to impact on communities, or have serious implications for the reputation of the police service. Since 2010/11, this category has only included deaths where there has been an independent investigation, or where one is ongoing. This is to improve consistency in the reporting of these deaths.

This may include deaths that happen:

- after the police are called to attend a domestic incident that results in a fatality
- while a person is actively attempting to avoid arrest, including instances where the death is self-inflicted
- when the police attend a siege situation, including where a person kills themself or someone else
- after the police were contacted about concerns for a person's welfare and there is concern about the nature of the police response

# 2 Overall findings

During 2024/25, there were:

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

Demographic information about those 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 determine that the case should be investigated locally by the police force.

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

Since February 2020, supervised and managed investigations are no longer available as a mode of investigation. A new type – 'directed investigation' – was created. These 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 2024/25. 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 presented above. In 2024/25, the IOPC independently investigated 86 incidents.

Table 2.1 no longer includes figures for supervised and managed investigations as all the fatalities in this report happened from April 2024 onwards. There were no directed investigations in any of the death categories.

**Table 2.1 Incidents by type of death and investigation type, 2024/25**

| 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** | 21 | 2 | 15 | 0 | 48 |
| **Directed** | 0 | 0 | 0 | 0 | 0 |
| **Local** | 1 | 0 | 2 | 14 | 0 |
| **Back to force** | 3 | 0 | 0 | 46 | 0 |
| **Total incidents** | 25 | 2 | 17 | 60 | 48 |

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 2014/15. 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, 2014/15 to 2024/25**

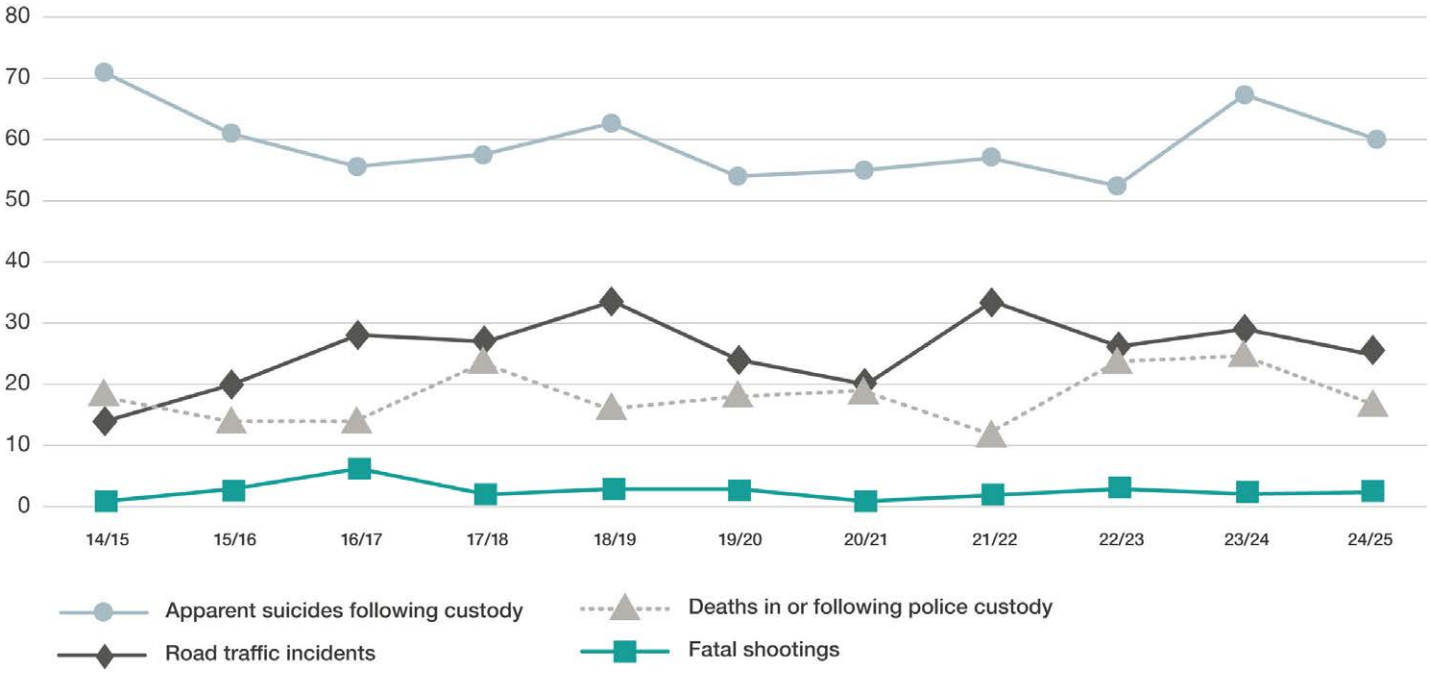
| | Fatalities | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial year | | | | | | | | | | |
| **Category** | **14/15** | **15/16** | **16/17** | **17/18** | **18/19** | **19/20** | **20/21** | **21/22** | **22/23** | **23/24** | **24/25** |
| **Road traffic fatalities** | 14 | 21 | 32 | 29 | 42 | 24 | 25 | 40 | 28 | 32 | 26 |
| **Fatal shootings** | 1 | 3 | 6 | 4 | 3 | 3 | 1 | 2 | 3 | 2 | 2 |
| **Deaths in or following police custody** | 18 | 14 | 14 | 23 | 17 | 18 | 19 | 11 | 23 | 25 ~ | 17 |
| **Apparent suicides following custody** | 71 | 61 | 56 | 57 | 63 | 54 | 55 | 57 | 54 | 68 | 60 |
| **Other deaths following police contact*** | 43 | 106** | 131 | 178 | 156 | 107 | 97 | 113 ~ | 91 | 62 ~ | 50 |

* 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, 2014/15 to 2024/25**




The number of **fatal road traffic incidents (RTIs)** has decreased this year, with 25 incidents, compared to 29 last year. This is in-line with the average of 25 incidents recorded over the 11-year period since 2014/15. These figures are subject to fluctuation and, therefore, year-on-year comparisons should be approached with caution.

This year there were two **fatal police shootings**, compared to two recorded last year. This is below the average of three fatal shootings recorded since 2014/15.

The number of **deaths in or following police custody** has decreased over the last year from 25 to 17. Over time, there have been some fluctuations in this category, with notable increases recorded in 2014/15, 2017/18 and 2022/23. The 2024/25 figure is lower than the average of 18 deaths over the 11-year period.

The number of recorded **apparent suicides following custody** was 60, notably lower than the 68 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. However, the number is line with the average of 60 deaths reported over the 11-year period. Reporting of these deaths relies on police forces making the link between someone'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 open an independent investigation into the circumstances surrounding it. The criteria for making this decision may vary over time – for example, in response to public and community concerns. In 2015/16 our capacity to carry out independent investigations increased, which had a direct impact on the number of deaths reported in this category (See our Corporate plan 2015-18 and Strategic plan 2018-22 for more information.) This means trend analysis of deaths recorded in this category would not be meaningful.

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

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

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

## Box B Types of investigation

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

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

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

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

# 3

# Road traffic fatalities

## Demographics

In 2024/25, there were 25 fatal police-related road traffic incidents (RTIs), resulting in 26 fatalities. Of those who died, 20 were men and six were women. Seventeen people were White, five were Asian, three were Black and one person was of mixed ethnicity.

Four of the people were under 18 years old. A further ten people who died were aged between 18 and 30 years, and the eldest person was 84 years old. The average age was 36 years old. The average age decreases to 25 years if the deceased was the driver or passenger in a pursued or fleeing vehicle. It increases to 52 years if the deceased was a pedestrian, cyclist, or a driver or passenger in a vehicle hit by either the police or the pursued or fleeing vehicle.

## Circumstances of death

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

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

### Pursuit-related

There were 17 police pursuit-related incidents, which resulted in 18 fatalities. Of these fatalities:

- Ten people were the driver of a vehicle being pursued by the police when it crashed.
- Four people were passengers in the car being pursued by the police.
- Three 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.

The IOPC independently investigated 14 of the pursuit-related incidents. One incident was investigated locally by the police and 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. Five emergency response-related incidents occurred in 2024/25 resulting in five fatalities. These incidents are being investigated independently.

This number has increased from the one incident and one fatality recorded last year. The figures for this year show the highest number of incidents and fatalities since 2018/19, when there were five.

Three fatalities happened when police vehicles that were responding to emergencies collided with another vehicle. The type of incidents the police were responding to included:

- a separate police pursuit of a vehicle
- intercepting the suspect of a crime
- a report of an injured person in the road

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

- a report of a man with a knife
- a report of a group of men with weapons who were fighting in the street

### Other police traffic activity

This category includes RTIs that did not happen during pursuit-related activity or an emergency response. There were three incidents in 2024/25 resulting in three fatalities. Two incidents are being investigated independently. We referred one incident back to the relevant police force to address as it saw fit.

Of these three incidents, one happened when a vehicle responded to the presence of the police:

- An officer on patrol saw a vehicle that had been added the previous day to a police 'hotlist' of vehicles of interest. The car was travelling in the opposite direction, and upon seeing the police vehicle, the officer reported it was driving off at high speed. The officer turned their vehicle around and drove in the same direction, but by that point had lost sight of the car. The police vehicle briefly activated its blue lights to pass another vehicle in front, then de-activated the blue lights and continued in the same direction. Seconds later, the car had crashed. The passenger of the car died at the scene. We returned the case to the force to address as they saw fit.

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

- An officer on patrol in an unmarked police vehicle noticed a car travelling past him at speed. The officer attempted to stop the car by activating his blue lights to signal the driver to stop. The officer reported that the car had failed to stop and stated that at this point, they also lost sight of the car. The police vehicle continued along the road in the same direction as the car. Further down the road, the car had collided into a tree on the opposite side of the road. The driver was thrown from the car and was given medical treatment. Emergency services attended but the man died at the scene. This incident is being independently investigated.
- Officers on patrol in a marked police vehicle noticed a car travelling at speed. The police vehicle attempted to catch up with the car. As they approached a junction, the police vehicle collided with a motorcycle. Officers and paramedics provided first aid, but the rider of the motorcycle later died at the scene. This incident is being independently investigated.

## Trends

This year, 26 people died in 25 separate incidents. There was a decrease in fatalities this year from 32 to 26. This is below the average of 28 road traffic incident fatalities recorded over the 11-year period since 2014/15. 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 17 is below the average of 18 incidents seen over the past 11 years.

There was a decrease in the number of pursuit-related fatalities this year, from 24 to 18. There was also a decrease in the number of pursuit-related incidents that resulted in multiple fatalities. One incident accounted for two fatalities. The number of pursuit-related fatalities this year is lower than the average of 21 fatalities recorded over the 11-year period since 2014/15.

This year has seen a notable increase in the number of emergency response-related incidents and fatalities. The figures of five incidents and five fatalities for this year are higher than the average of three incidents and three fatalities since 2014/15.

The number of incidents resulting from other police traffic activity has halved to three from six the previous year, with the number of fatalities decreasing from seven to three. It is lower than the average of five incidents and five fatalities over the past 11 years, and a fifth of the number of incidents recorded in 2004/05.

**Table 3.1 Type of road traffic fatality, 2014/15 to 2024/25**

| RTI type | 14/15 | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pursuit-related** | 7 | 13 | 28 | 17 | 30 | 19 | 20 | 34 | 20 | 24 | 18 |
| **Emergency response-related** | 0 | 2 | 0 | 8 | 5 | 3 | 1 | 3 | 2 | 1 | 5 |
| **Other** | 7 | 6 | 4 | 4 | 7 | 2 | 4 | 3 | 6 | 7 | 3 |
| **Total fatalities** | **14** | **21** | **32** | **29** | **42** | **24** | **25** | **40** | **28** | **32** | **26** |

**Table 3.2 Type of road traffic incident, 2014/15 to 2024/25**

| RTI type | 14/15 | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Pursuit-related** | 6 | 12 | 24 | 17 | 21 | 19 | 15 | 27 | 18 | 22 | 17 |
| **Emergency response-related** | 0 | 2 | 0 | 7 | 5 | 3 | 1 | 3 | 2 | 1 | 5 |
| **Other** | 7 | 6 | 4 | 3 | 7 | 2 | 4 | 3 | 6 | 6 | 3 |
| **Total incidents** | **13** | **20** | **28** | **27** | **33** | **24** | **20** | **33** | **26** | **29** | **25** |

# 4

# Fatal shootings

There were two fatal police shootings in 2024/25 compared to the two incidents recorded last year. The circumstances of the two fatal shootings are summarised below. Both incidents are subject to ongoing independent investigation.

- West Mercia police were called by the ambulance service to concerns for the welfare of a man. The 39-year-old Black man was in possession of a knife at an address. Police attempted to negotiate with the man for several hours. Firearms officers were deployed and forced entry into the address. Body-worn video showed the man holding a knife and advancing towards the officers. At least one Taser was then discharged, and a firearms officer fired a single shot which hit the man in the chest. Officers attempted immediate first aid but the man died at the scene.
- Surrey Police were called by a member of the public to a report of a 29-year-old White man having a verbal altercation with someone outside of a property. The man was reported to be carrying a firearm. Firearms offices arrived, approached the address, and contained it. A firearms officer instructed occupants of the property to come to the front door with nothing in their hands. The man opened the door and appeared to point a weapon in the officers' direction. One firearms officer then discharged a single round from their firearm, which hit the man in his abdomen, and another officer discharged a 'baton round'. Officers then removed the man from the property and began first aid. An ambulance was requested, and shortly after paramedics arrived and took over medical care. The man was taken to hospital where he died four days later. A non-police issue weapon was located at the scene.

# 5

# Deaths in or following police custody

## Demographics

In 2024/25, 17 people died in or following police custody – 14 were men and three were women. Their ages ranged from 17 to 76 years. Fifteen people were White, two people were Black.

Nine people had mental health concerns. The types of mental health concerns included depression, anxiety, bipolar disorder and self-harm. No one had been detained under section 136 of the *Mental Health Act 1983*, however, one person was detained using powers under the *Mental Capacity Act 2005.*

Fifteen people were known to have a link to alcohol and/or drugs. This meant that at the time of their arrest they had recently consumed, were intoxicated by, in possession of, or had known issues with alcohol and/or drugs. Where cause of death was reported, a pathologist recorded that alcohol or drug toxicity, or long-term abuse, was likely to be a contributing factor in the deaths of four 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, 2024/25**

| Reason for detention | Number of fatalities |
|---|---|
| Violence-related (non-sexual or murder) | 5* |
| Speeding / driving offences | 3 |
| Failure to appear in court / recall to prison | 2** |
| Theft / burglary | 2 |
| Sexual offences | 1 |
| Threatening behaviour / harassment | 1 |
| Breach of the peace / anti-social behaviour | 1 |
| Drug / drink-related | 1 |
| *Mental Capacity Act 2005* | 1 |
| **Total fatalities** | **17** |

* One of these people was also arrested for criminal damage
** One of these people was also arrested for drug/drink offences

The data shows that five of the 17 people who died had some force used against them by officers or members of the public before their deaths. It is important to note that the use of restraint, or other types of force, did not necessarily contribute to the deaths.

All five of the 17 people who had force used against them were physically restrained by the police. One death also involved use of force by security officers. 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 five people that were physically restrained, three were White and two were Black.

Three of the five incidents involving use of force also included use of leg restraints.

## Circumstances of death

Cause of death according to the pathologist's report following a post-mortem examination is reported for eight of the 17 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 15 of the 17 deaths.

Eight people became 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 for failing to appear in court and was taken into custody. During the man's initial risk assessment, he disclosed that he was drug dependent. He was placed on 30-minute checks. The man arrived in custody on a Saturday evening and was held in custody over the weekend while awaiting a court appearance on the Monday. While in custody, the man was seen on three occasions by a healthcare professional who provided medication for drug withdrawal symptoms. A healthcare professional attended his cell in the early hours of Monday morning to administer medication and the man was found unresponsive. An ambulance was called, and custody staff performed cardiopulmonary resuscitation until paramedics arrived and took over. The man was taken to hospital by ambulance where he died shortly after. His cause of death was reported as

*I(a) Chronic obstructive pulmonary disease with myocardial fibrosis and cirrhosis of the liver*

- A woman was arrested for theft and was taken into custody. While being booked into custody, the woman asked to see a nurse, stating that she was suffering from alcohol and drug withdrawal. Late the next day, the woman was seen by a healthcare professional and was provided with medication for drug withdrawal. Shortly after, during a routine cell check, a detention officer found the woman unresponsive. Custody staff and the healthcare professional attended the cell to provide medical assistance and an ambulance was called. An air ambulance also attended, but the woman was pronounced dead a short time later. Her cause of death was reported as *1a) unascertained*. The IOPC's independent investigation involved a medical expert who found that the woman's death could be accounted for by a sudden onset fatal cardiac arrythmia.
- A man was arrested for being in charge of a motor vehicle while unfit through alcohol. He was taken into custody and initially placed on 30-minute rousing checks due to being intoxicated. Later that day, the man's observation level was changed. He still had to be checked every 30 mins but no longer had to be roused. While in custody, the man was seen on seven occasions by a healthcare professional for the monitoring and treatment of his alcohol levels. The day after the man's arrival in custody, during a routine check, the detention officer noticed the man did not respond and raised a medical emergency. Cardiopulmonary resuscitation was performed by custody staff, and an ambulance and the air ambulance followed soon after. The man was pronounced dead shortly after their arrival. His cause of death was reported as *1a Sudden unexpected death in alcohol misuse (SUDAM) in a patient with clinically diagnosed heart failure and fatty liver disease with possible Wernicke's encephalopathy, a potential element of alcohol withdrawal and recent amphetamine use*.
- A woman was arrested for a recall to prison and further arrested for drug related offences, and then taken into custody. During the woman's initial risk assessment, she disclosed that she was drug dependent. A care plan was put in place, and she was placed on general observations in a CCTV monitored cell. The next day, the woman was seen by a healthcare professional after custody staff reported that she was vomiting and feeling drowsy. The custody staff informed the woman that she was unfit for transporting to prison and would remain in custody. Shortly after, the woman was found unresponsive in her cell. Officers performed cardiopulmonary resuscitation until paramedics arrived. An air ambulance also attended. The woman was pronounced dead shortly after the arrival of paramedics. Her cause of death was reported as *1(a) Complications of chronic drug abuse (heroin and cocaine) with cardiomegaly.*
- Officers attended a report that a car had collided with a stationary vehicle. The driver was arrested on suspicion of driving while under the influence of alcohol and he was taken into custody. The man failed to provide a breath sample and was placed in a cell with checks to take place every 30 minutes. Shortly after, during a routine check, the detention officer found the man on the floor, showing signs of a suspected stroke. The detention officer called for assistance, the healthcare professional examined the man in his cell, and an ambulance was called. Paramedics arrived and the man was taken to hospital by ambulance. He remained in hospital where he died four days later. His cause of death was reported as *1a) Brainstem haemorrhage following thrombolysis for ischemic stroke*.
- A man was arrested for a sexual offence and taken into custody. A risk assessment was conducted, and the man was placed on 30-minute observations. Shortly after, the man was seen by a healthcare professional and assessed as being fit for detention and interview. The next day, during a routine check, custody staff found the man lying on his back on the cell floor with a pool of blood around

him. Medical aid was provided by custody staff until paramedics attended and took over the treatment. The man was taken to hospital by an ambulance where he died the next day. His cause of death is awaited.

- A man was arrested for assault. It was noted that the man was intoxicated and had self-inflicted injuries. The man was taken to hospital and was further arrested for public order offences. Later that evening, the man was discharged from hospital and taken to custody where he was put on 30-minute rousing checks due to being intoxicated. After a couple of hours, the man's observation level changed. He still had to be checked every 30 minutes, but no longer had to be roused. During the man's detention, he was seen by a healthcare professional on several occasions. The man was known to be alcohol dependent and was given medication on one occasion. Approximately 30 hours after the man's arrival in custody, the custody sergeant went to the cell and found the man unresponsive. A defibrillator was used and custody staff provided cardiopulmonary resuscitation until an ambulance arrived. Paramedics took over and the man was taken to hospital where he died three days later. His cause of death was reported as *1a) Hypoxic-ischaemic brain injury 1b) Cardiac arrest 1c) Alcohol withdrawal seizure*.
- A man was arrested for assault and taken into custody. Officers noted that the man appeared to be intoxicated and he was put on 30-minute rousing checks. A few hours later the man's observation level changed. He still had to be checked every 30 minutes, but no longer had to be roused. Minutes later, a detention officer became concerned about the man's mental health. He was seen by a mental health practitioner and later assessed by a custody nurse who deemed him fit for police interview. He was interviewed and returned to his cell where he suddenly became unwell. A detention officer became concerned by how the man appeared on CCTV, entered the cell and found the man unresponsive. An ambulance was called and custody staff performed cardiopulmonary resuscitation until paramedics arrived and took over. He was taken to hospital where he died eight days later. His cause of death is awaited. This death was subject to local investigation.

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

- Officers stopped a man on suspicion of committing a road traffic offence. He was asked to provide a breath sample, which tested positive for drugs. Officers arrested the man, placed him in handcuffs and escorted him to the police vehicle. While the man was standing beside the police vehicle, waiting to be placed inside it, the officer leant into the back of the police vehicle. At this point, the man ran into a live lane of traffic and was hit by another vehicle. Officers performed cardiopulmonary resuscitation. Paramedics arrived and took over treatment before the man was pronounced dead. His cause of death was reported as *1a: Head injury. 1b: Road traffic collision (pedestrian)*.
- Police were called to reports of a man acting aggressively. When officers arrived, the man was arrested for common assault. Officers restrained the man prone on a mattress and handcuffed his hands behind his back. The officers stated that they believed the man was suffering from Acute Behavioural Disturbance. Additional officers attended to assist at the scene, and an ambulance was called. Whilst awaiting the ambulance the man remained restrained by officers, who periodically moved him onto his side. The ambulance service arrived and the police agreed with paramedics to carry the man outside the building to the ambulance. At this point, leg restraints were applied to the man. A few minutes later it was identified that the man had become unresponsive and cardiopulmonary resuscitation was performed by paramedics in the ambulance. He was taken to hospital where he died shortly after arrival. His cause of death is awaited.
- Police were contacted with a concern for welfare of a man. The police log noted that the

man was wanted for an alleged assault. Police attended the man's reported location. They recorded on the incident log that he appeared to be suffering from a mental health episode and had reported that he had taken drugs. The man was arrested and restrained on the floor. He was placed in the back of the van to be taken to hospital. During the journey he was observed hitting various parts of his body against the van. Officers pulled over to apply leg restraints. Upon arrival at the hospital a spit hood was placed on the man. The officers continued to restrain the man until he was sedated and the man's condition deteriorated. The officers left the room and the man was placed into an induced coma. The man died 12 days later. His cause of death is awaited.

- Police were called to a report of a man standing on the wrong side of the railings of a bridge over an A road. Once the man was on the right side of the railings officers detained the man under the *Mental Capacity Act 2005*. The man was handcuffed with his hands behind his back and officers took hold of his arm and walked him to the rear of a police van, sitting him down with the back doors open. The man expressed discomfort, stating the handcuffs were too tight. One of the officers removed the handcuffs, and the man sat back down on the bench in the cage of the rear of the police van. Soon after, the man exited the van and was seen to run and jump over the bridge railings onto the road below. Officers provided cardiopulmonary resuscitation and a doctor attended, but the man died at the scene. His cause of death was reported as *1a) Blunt Force Chest Injuries*.
- Police responded to a report of a man in distress at a supermarket. Upon arrival, officers found the man being restrained on the ground by two security officers. The man was arrested for a public order offence and handcuffed to the rear. The incident log noted that the officers were querying whether the man was suffering from acute behavioural disturbance and requested an ambulance. After approximately 20 minutes, a further call to the ambulance service was requested, noting that the male was sweating and had laboured breathing. Paramedics arrived and requested that the man's handcuffs were moved to the front of his body. The paramedics noted that it was 'likely' Acute Behavioural Disturbance so the man was taken to hospital accompanied by officers. His condition deteriorated and he died later that evening. His cause of death is awaited.
- Police responded to reports of a man in a residential street who appeared to be suffering from a mental health episode. The man had entered properties on the road. Officers located the man, he was taken to the ground and restrained. During the initial restraint, the man was arrested for burglary. Further officers arrived to assist and moved the man onto his back, applying handcuffs and leg restraints. Officers stated that they believed the man could be suffering from acute behavioural disturbance. Body Worn Video shows that officers made a consistent effort to put him on his side and back and put a first aid bag under his head. Officers made a number of efforts to request ambulance attendance. An ambulance arrived and the man was taken to hospital where he died a few days later. His cause of death is not available at this time.

One child died during **transportation to custody in a police vehicle**.

- A female child was arrested for assault and criminal damage. She was placed in the rear passenger side of a marked police car and handcuffed with her hands positioned in front. An officer was seated next to her during transport. While on her way to custody, the child managed to remove her handcuffs, climb into the front passenger seat, access the front passenger door and get out of the moving car. The child ran across the road and was struck by a vehicle being driven by a member of the public, on the opposite carriageway. The child died at the scene. Her cause of death is awaited.

One man was **taken ill during detention by the Border Force**.

- Border force officers arrested a man at an airport on suspicion of exportation of a

controlled drug. A package in his possession was tested and found to be cocaine. Arrangements were made for the man to attend hospital for an X-ray. While being held at the airport, prior to transportation to hospital, the man stated that he felt unwell. The man then disclosed he had, in fact, concealed packages internally. Shortly after, the man's condition deteriorated and paramedics were called. Paramedics arrived and asked for the officers' assistance as the man began to fit. A defibrillator and a mechanical chest compression device were used by paramedics. The man was taken to hospital where he was pronounced dead shortly after arrival. His cause of death is awaited.

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

- Police were called to a report of an assault at a house. Officers arrived at the address and arrested a man. As the officers attempted to apply handcuffs, the man reportedly became resistant and was taken to the ground. During the arrest the man sustained facial injuries. The man was taken to hospital where it was confirmed that he had fractured his shoulder. He was discharged from hospital later that evening and the police returned him to custody. The next day, the man was released from custody. Three days after his release from custody, the man was found dead at his home. His cause of death is awaited.

  At this time, it is not possible to rule out whether the injuries sustained during his arrest were a causal or contributory factor in the man's death. This case is subject to local investigation by the police force.

# 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 11 in 2021/22, before more than doubling to 23 in 2022/23. There was another slight increase in 2023/24 to 25 deaths. This year, the number of deaths in or following police custody has decreased notably, to 17. The average number of deaths in or following police custody recorded since figures began in 2004/05 is 19. Visualisation of these trends can be found in the graph in figure 2.1 on page 9, and in the time series data 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.

This year three people were pronounced dead in a police cell, one fewer than in 2023/24, and the same figure as in 2022/23, 2021/22 and 2020/21. In 2019/20, one person died in a police cell. In 2018/19, no one died in a police cell. In 2017/18 there were three such deaths.

# 6

# Apparent suicides following police custody

Apparent suicides following time in police custody are included in these statistics if they occur within two days of the person's release from custody. They are also included if experiences in custody may have been relevant to the death, and the death was referred to the IOPC. The police may not always be told about an apparent suicide that happens after time in custody as the association may not be clear. Therefore, there may be more deaths in these circumstances than are reported here.

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

## Demographics

There were 60 apparent suicides following police custody in 2024/25 – 56 men and four women. The average age of those who died was 43 years. The most common age was between 21 to 30 years (14 people), followed by 41 to 50 years (13 people). The youngest person was sixteen years old. Fifty-seven of those who died were White, two people were Asian and one person was of mixed ethnicity.

Sixty-two percent of the people (37) 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, schizophrenia, paranoid delusion, borderline personality disorder, anxiety, previous thoughts or incidents of suicide attempts, and self-harm.

Just under half of the people (28) were reported to be intoxicated with drugs and/or alcohol at the time of their arrest, or drugs and/or alcohol featured heavily in their lifestyle. Twenty-three deaths related to alcohol and thirteen to drugs.

## Circumstances of death

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

Table 6.1 shows the reasons why these people were placed into custody by the police. Thirty-eight of those who died had been arrested for a sexual offence. Of these, 27 related to sexual offences or indecent images involving children. Ten were for violence-related offences. Other common reasons were threatening behaviour and harassment (9), driving offences (4), criminal damage (2), and failure to appear in court / breach of court order (2).

**Table 6.1 Apparent suicides following police custody: reason for detention, 2024/25**

| Reason for detention | Number of detentions |
|---|---|
| Sexual offences | 38 |
| Violence-related (non-sexual or murder) | 10 |
| Threatening behaviour / harassment | 9 |
| Driving offences (including drink / drug driving) | 4 |
| Criminal damage | 2 |
| Failure to appear in court / breach of court order | 2 |
| Possession of a weapon | 1 |
| Theft / burglary | 1 |
| Drug / drink related | 1 |
| *Mental Health Act 1983* | 1 |
| Fraud | 1 |
| Attempted murder | 1 |
| **Total number of reasons for detention** | **71** |
| **Total fatalities** | **60** |

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

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

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

# Trends

The number of apparent suicides following time in police custody is lower than the 68 recorded in 2023/24. It is in line with the average of 60 recorded over the 11-year period from 2014/15. 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 63% of fatalities, the reason for custody related to alleged sexual offences. The proportion of sexual offences or indecent images involving children was 45%. These proportions are higher than the figures recorded last year (46% and 38% respectively) and higher than average figures. The average proportions for these alleged offences since 2004/05 are 37% 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.

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

## Overall demographics

We independently investigated the deaths of 50 people who died during or following other contact with the police during 2024/25. Of these deaths:

- 33 were men and 17 were women.
- 43 people were White, two were Black and five were Asian.
- Three people were aged under 18 years, and 10 people were young adults aged between 18 and 30 years. Three people were aged over 60. The average age was 39 years old.
- Over half of those who died (29) were reported to be intoxicated by drugs and/or alcohol at the time of the incident, or drugs and/or alcohol featured heavily in their lifestyle. A similar proportion of the people who died (32) were reported to have mental health concerns.

**Table 7.1 Other deaths following police contact: reason for contact, 2024/25**

| Reason for contact | | Number of fatalities |
|---|---|---|
| Concern for welfare | Domestic related | 16 |
| | Self-harm / suicide risk / mental health | 13 |
| | Health / injuries / intoxication / general | 10 |
| | Threatening behaviour / harassment | 3 |
| | Missing person | 2 |
| | **Subtotal** | **44** |
| Other contact | Assisting medical staff | 2 |
| | Attending a disturbance | 2 |
| | Executing a search warrant / arrest / conducting investigation enquiries | 1 |
| | Siege | 1 |
| | **Subtotal** | **6** |
| | **Total fatalities** | **50** |

## Circumstances of death

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

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

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

A total of seven people who died following police contact had force used against them. All seven people were White.

Five people were restrained by police officers. Of these five deaths:

- Four people were physically restrained by the police and one person had leg restraints applied by police officers.
- Three also involved restraint by non-police (one involved physical restraint by prison officers, one physical restraint by security guards, and one the application of leg restraints by paramedics).
- Three involved use of other equipment. One incident involved a spit hood, one incident involved leg restraints and another incident involved leg restraints and cross body restraints.

Two deaths involved other use of force. One death involved use of a police dog and in another incident, officers used CS gas canisters and stun grenades.

This does not necessarily mean that the force used contributed to the death.

## Concern for welfare

Of the 44 fatalities that followed contact with the police because of a concern for welfare, ten 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:

- All ten people were men.
- Nine people were White and one was Asian.
- The most common ages were 31 to 40, with

three people in this age group. The average age was 47.

- Over three-quarters of those who died (8) were reported to be under the influence of alcohol and/or drugs at the time of the incident, or these featured heavily in their lifestyle.
- The most common form of death classification was accidental (four people). Three deaths were from natural causes, one was the result of an accidental overdose and the classification of two deaths is not known at this time.

Two incidents involved **use of force**:

- Officers were called to a concern for welfare for a man following a disturbance in the street. Police found the man on the floor in the front garden of a house. Officers moved the man and applied handcuffs, briefly using their hands to hold the man on the floor in what they stated was an attempt to stop the man from harming himself. An ambulance was called and officers stated that they suspected that the man was under the influence of drugs, and that he was suffering from Acute Behavioural Disturbance. Officers placed the man in the recovery position, at which point they noticed the man had become unresponsive. The police removed the handcuffs and gave cardiopulmonary resuscitation. Paramedics arrived and provided medical treatment, but the man died at the scene. His cause of death is awaited.
- Police conducted a stop and search of a man who had been travelling in a vehicle, as they suspected that he had drugs concealed on him. The officers believed the man had something concealed in his mouth and asked him to spit it out. An officer took hold of the man's neck, in what was stated to be an attempt to prevent the man from swallowing what was in his mouth. The man was handcuffed and physically restrained by officers. An officer also performed back slaps. The man was transported to a police station for a strip search to be conducted. On the way to the police station the man advised officers that he had swallowed an empty wrapper of drugs having taken its contents. The strip search did not find any drugs and the man was released. Later that day, the man became unwell and was taken to hospital where he died. His cause of death was reported as *I(a) Cocaine toxicity*.

Thirteen 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 three were women.
- Twelve people were White and one was Asian.
- The ages of the people ranged from 16 to 58. The majority were aged between 31 and 40 (four people). The average age was 37.
- Death by self-inflicted means was the most common classification (ten 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.

One incident involved **use of force**:

- Police were called to a report of a man causing damage at a hotel. The man had also said that he was going to take his own life. The man left the hotel, and police received a further call from a member of the public about his welfare. The man attempted to gain entry to a bar and became involved in a physical altercation with security guards. The man was restrained on the floor by security guards and subsequently police officers, who arrived whilst the man was being restrained. Police officers applied handcuffs and a spit hood. Paramedics arrived, and following concerns for the man's wellbeing, cardiopulmonary resuscitation was provided by police officers and ambulance staff. The man

was taken to hospital where he died just over two weeks later. His cause of death is awaited.

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:

- Thirteen of those who died were women and three were men.
- Eleven of the people were White, two were Black and three were Asian.
- The average age was 39. The youngest person was 19 and the eldest was 76.
- The deaths were classified as alleged murder in 12 instances. Four deaths were self-inflicted.

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

- Two people were men. One was a woman.
- Three people were White.
- All three classifications of death were alleged murder.

Two people who died had been **reported missing**:

- Both people who were reported missing were under 18.
- Both people were male, and both were White.
- One person was known to have a specific risk of suicide or self-harm.

## Other contact

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

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

- Police received an emergency call from a healthcare professional asking for assistance with a prisoner who was reportedly assaulting hospital staff members and prison staff after being transported to hospital. Upon the arrival of police officers at the hospital, the man was being restrained by three prison officers on the floor. Police officers then applied leg restraints to the man. Shortly after, it was noted that the man was unresponsive. Medical staff provided cardiopulmonary resuscitation, and the handcuffs and leg restraints were removed. The man was pronounced dead a short time later. His cause of death is awaited.
- Police received a call from the ambulance service requesting police assistance as a man was having a “psychotic episode” and had “assaulted the ambulance crew”. On arrival officers assisted the ambulance crew by restraining the man’s arms, wrists and ankles whilst paramedics attended to him. Paramedics applied leg restraints and cross body restraints to the man. The man then had an apparent seizure, and the ambulance crew noted that the man was suffering with acute behavioural disturbance. The officers released their hold of the man. Shortly after, a paramedic declared the man was in cardiac arrest. He was placed in an ambulance, where paramedics attempted resuscitation, however, the man was pronounced dead. His cause of death was reported as *Cocaine cardiotoxicity*.

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

- Officers were called to a report of a public order incident involving a group of people fighting in the street. When officers arrived, they entered a house where a number of people were present. Police officers dispersed the people from the house. Outside the house a man told officers that he had been assaulted and named the person who he said had assaulted him. Police officers did not take action to arrest the man who had been named. A couple of hours later, police received a report of an incident involving the man who stated that he had been assaulted and another man, who had been inside the house when police

had attended the disturbance. One of the men died a short time later. His cause of death is awaited.

- Police received an anonymous call to a residential address reporting that a man had been heard shouting "call the police". An officer attended and spoke to the man outside of the property who said he lived at the address but refused to allow the officer inside. Just over three weeks later, police received anonymous information about a dead body in the same address that the officer had attended. The information suggested the man had been murdered two or three weeks before. Enquiries were carried out, but police were unable to locate a body. Several arrests were made, including the man who lived at the address that was initially visited by the police officer. A short time after the arrests a body of a man was found.

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

- Officers on patrol stopped a vehicle as it was believed it contained a man who was wanted. After officers approached the car, the man picked up a glass bottle, hit it against the dashboard several times and then repeatedly smashed it against his own head. Officers tried to open the passenger door, but it was locked. The man was instructed to drop the bottle, but when he failed to comply, a police dog was deployed into the vehicle. The dog bit the man on the right side of his lower back. Officers removed the man from the vehicle, applied handcuffs, and requested an ambulance for the man due to facial and head injuries and a dog bite. The man's condition appeared to deteriorate rapidly, and he disclosed to the officers that he had taken a significant quantity of drugs. Paramedics arrived, took over the man's medical care, and transported him to hospital. While in the ambulance, the man went into cardiac arrest and cardiopulmonary resuscitation was given. He died shortly after arriving at the hospital. His cause of death was reported as *1a) Cocaine toxicity*.

One person died in one incident during a **siege situation** with the police:

- Officers were called to an address following a domestic incident. On arrival, the man would not let officers enter the property. It was reported that the man was in possession of a firearm and had made threats to harm himself. Armed officers and police negotiators were deployed to the scene. After several hours of speaking with the negotiators, the man withdrew from engaging with them. Officers forced entry into the property. An armed officer fired two CS gas cartridges into the house from outside. As additional armed officers entered the property, at least two separate officers each threw a stun grenade. No conventional police firearms were discharged during the incident. The man was found inside the house and had an apparent gunshot wound to his head, alongside what appeared to be a non-police issue firearm positioned next to him. The man received immediate first aid and was taken to hospital where he died a short time later. His cause of death is awaited.

## Trends

In 2010/11, a change was made to the definition of this category. It now includes only those deaths following other police contact that were investigated independently by the IOPC, formerly the IPCC. The number of cases recorded in this category is directly linked to the number of cases independently investigated. It would not be meaningful to provide any trend analysis for this category. The deaths included in this category happen in a range of circumstances, which make it difficult to identify a specific set of events that account for changes in the number of fatalities. The overall proportion of cases relating to a concern for welfare made up 88% of the deaths following police contact that were independently investigated, compared to 85% in in 2023/24.

During 2024/25, 32% percent of the deaths following police contact were domestic-related. Violence against women and girls is a current thematic area for the IOPC. This may result in the number of these types of investigations

increasing and/or forming a larger proportion of the ‘other contact’ deaths that the IOPC investigates independently.

# 8 Background note

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

2. Since April 2006, the IOPC, previously the IPCC, has also received mandatory referrals for cases where someone has died during or following contact with:

- His Majesty's Revenue and Customs known as HMRC (Regulation 34 of the *Revenue and Customs (Complaints and Misconduct) Regulations 2005*).
- The Gangmasters and Labour Abuse Authority known as the GLAA (Regulation 36 of the *Gangmasters and Labour Abuse Authority (Complaints and Misconduct) Regulations 2017*).
- The Serious Organised Crime Agency (later replaced by the National Crime Agency). Since October 2013, we have also received mandatory referrals from the National Crime Agency (NCA). Up until March 2013, we received cases from the UK Border Agency (UKBA) (Regulation 25 of the *UK Border Agency (Complaints and Misconduct) Regulations 2010*). At this time UKBA's executive agency status was ended. Its functions were brought back into the Home Office as UK Visas and Immigration (UKVI); UK Immigration Enforcement (UKIE); and UK Border Force (UKBF). The IOPC continues to have jurisdiction over these officials and contractors.
- 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). The IOPC's remit was extended after the time period considered within this report, but future reports will include any deaths during or following contact with staff from this organisation.

## 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 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.

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 2023/24, one death has been added to the 'deaths in or following police custody' figure and two deaths have been added to the 'other deaths during or following police contact' figure.
- For 2021/22, two deaths have been added to the 'other deaths during or following police contact' figure.

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.

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 2024/25, 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

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 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.

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 2025/26 is summer 2026.

# Appendix A: additional tables

### Table A1 Incidents by type of death and financial year, 2014/15 to 2024/25

| Incidents | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| | Financial year | | | | | | | | | | |
| Category | 14/15 | 15/16 | 16/17 | 17/18 | 18/19 | 19/20 | 20/21 | 21/22 | 22/23 | 23/24 | 24/25 |
| Road traffic incident | 13 | 20 | 28 | 27 | 33 | 24 | 20 | 33 | 26 | 29 | 25 |
| Fatal shootings | 1 | 3 | 6 | 2 | 3 | 3 | 1 | 2 | 3 | 2 | 2 |
| Deaths in or following police custody | 18 | 14 | 14 | 23 | 17 | 18 | 19 | 11 | 23 | 25~ | 17 |
| Apparent suicides following custody^ | 71 | 61 | 56 | 57 | 63 | 54 | 55 | 57 | 54 | 68 | 60 |
| Other deaths following police contact* | 43 | 103** | 128 | 172 | 151 | 104 | 96 | 106~ | 86 | 60~ | 48 |

^ 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, 2024/25

| Gender | Road traffic incident | Fatal shootings | Deaths in or following police custody | Apparent suicides following custody | Other deaths following police contact* |
|---|---|---|---|---|---|
| Male | 20 | 2 | 14 | 56 | 33 |
| Female | 6 | 0 | 3 | 4 | 17 |
| **Total fatalities** | **26** | **2** | **17** | **60** | **50** |

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

### Table A3 Type of death by age group, 2024/25

| Age group | Road traffic incident | Fatal shootings | Deaths in or following police custody | Apparent suicides following custody | Other deaths following police contact* |
|---|---|---|---|---|---|
| Under 18 | 4 | 0 | 1 | 1 | 3 |
| 18 - 20 | 5 | 0 | 0 | 1 | 2 |
| 21 - 30 | 5 | 1 | 2 | 14 | 8 |
| 31 - 40 | 2 | 1 | 5 | 12 | 15 |
| 41 - 50 | 2 | 0 | 5 | 13 | 11 |
| 51 - 60 | 4 | 0 | 0 | 10 | 8 |
| 61 and over | 4 | 0 | 4 | 9 | 3 |
| **Total fatalities** | **26** | **2** | **17** | **60** | **50** |

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

### Table A4 Type of death by ethnicity, 2024/25

| Ethnicity group | Road traffic incident | Fatal shootings | Deaths in or following police custody | Apparent suicides following custody | Other deaths following police contact* |
|---|---|---|---|---|---|
| White | 17 | 1 | 15 | 57 | 43 |
| Black | 3 | 1 | 2 | 0 | 2 |
| Asian^ | 5 | 0 | 0 | 2 | 5 |
| Mixed | 1 | 0 | 0 | 1 | 0 |
| Other | 0 | 0 | 0 | 0 | 0 |
| Not known | 0 | 0 | 0 | 0 | 0 |
| **Total fatalities** | **26** | **2** | **17** | **60** | **50** |

* 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, 2024/25

| 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 | 1 |
| Bedfordshire | 1 | 0 | 0 | 0 | 0 |
| Cambridgeshire | 0 | 0 | 0 | 1 | 0 |
| Cheshire | 0 | 0 | 0 | 1 | 0 |
| City of London | 0 | 0 | 0 | 0 | 0 |
| Cleveland | 0 | 0 | 0 | 0 | 0 |
| Cumbria | 1 | 0 | 0 | 0 | 0 |
| Derbyshire | 0 | 0 | 0 | 1 | 0 |
| Devon & Cornwall | 0 | 0 | 0 | 4 | 1 |
| Dorset | 0 | 0 | 0 | 2 | 1 |
| Durham | 0 | 0 | 0 | 0 | 0 |
| Dyfed-Powys | 0 | 0 | 1 | 1 | 0 |
| Essex | 0 | 0 | 1 | 0 | 2 |
| Gloucestershire | 0 | 0 | 0 | 3 | 0 |
| Greater Manchester | 2 | 0 | 0 | 1 | 2 |
| Gwent | 0 | 0 | 0 | 1 | 1 |
| Hampshire | 1 | 0 | 0 | 3 | 2 |
| Hertfordshire | 0 | 0 | 0 | 0 | 1 |
| Humberside | 0 | 0 | 0 | 1 | 1 |
| Kent | 1 | 0 | 1 | 1 | 1 |
| Lancashire | 0 | 0 | 0 | 2 | 3 |
| Leicestershire | 0 | 0 | 0 | 0 | 1 |
| Lincolnshire | 0 | 0 | 0 | 2 | 0 |
| Merseyside | 0 | 0 | 2 | 1 | 3 |
| Metropolitan | 5 | 0 | 2 | 2 | 4 |
| Norfolk | 0 | 0 | 0 | 1 | 2 |
| North Wales | 1 | 0 | 1 | 2 | 0 |
| North Yorkshire | 1 | 0 | 0 | 1 | 3 |
| Northamptonshire | 0 | 0 | 0 | 3 | 1 |
| Northumbria | 1 | 0 | 0 | 2 | 0 |
| Nottinghamshire | 0 | 0 | 1 | 0 | 1 |
| South Wales | 0 | 0 | 0 | 2 | 3 |
| South Yorkshire | 1 | 0 | 0 | 2 | 2 |
| Staffordshire | 1 | 0 | 1 | 0 | 2 |
| Suffolk | 0 | 0 | 0 | 4 | 0 |
| Surrey | 0 | 1 | 1 | 2 | 2 |
| Sussex | 0 | 0 | 0 | 4 | 2 |
| Thames Valley | 0 | 0 | 0 | 1 | 0 |
| Warwickshire | 2 | 0 | 0 | 0 | 0 |
| West Mercia | 0 | 1 | 0 | 1 | 0 |
| West Midlands | 4 | 0 | 0 | 4 | 2 |
| West Yorkshire | 2 | 0 | 2 | 1 | 2 |
| Wiltshire | 0 | 0 | 1 | 2 | 1 |
| Gwent Police & South Wales Police | 1 | 0 | 0 | 0 | 0 |
| West Yorkshire Police and Greater Manchester Police | 0 | 0 | 0 | 0 | 1 |
| Essex & Suffolk Constabulary | 0 | 0 | 0 | 0 | 1 |
| South Wales & Staffordshire Police | 0 | 0 | 0 | 0 | 1 |
| Leicestershire Police & Warwickshire Police | 0 | 0 | 1 | 0 | 0 |
| British Transport Police | 0 | 0 | 0 | 0 | 0 |
| Home Office ~ | 0 | 0 | 1 | 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 fatalities** | **26** | **2** | **17** | **60** | **50** |

* 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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