# Deaths during or following police contact annual report

## Guidance

**Last updated: January 2018**

## Contents



*For copies of the annual death report and other studies, please visit the IOPC website at www.policeconduct.gov.uk.*

*This is a working document and the research team will review where necessary the data collection and analysis process to increase the level of detail reported on in the annual death report*

# 1. Introduction

***Becoming the Independent Office for Police Conduct (IOPC)***

On 8 January 2018, the IPCC became the IOPC, as set out in the Policing and Crime Act 2017. The Act introduces several changes that we asked for – both to the police complaints system and to the structure and powers of the IPCC.

Since 2013, we have doubled in size and are taking on nearly six times as many independent investigations. Given this level of growth, we asked the Government for a new structure that is better suited to our much expanded organisation. The new structure will have a Director General at its head, supported by two deputies, and a network of regional directors and a director for Wales. As it will no longer be a 'commission', we are taking on a new name.

It's important to note that while our name will change, our role, purpose and independence will not. The IOPC will continue to oversee the complaints system as a whole, to provide an independent appeal mechanism for some complaint investigations carried out by the police, and to carry out our own independent investigations into serious and sensitive cases. We will continue to use what we learn through our work to improve policing.

**Reference to the IOPC in this document, also covers the processes and policies that were in practice when we were operating under the name IPCC from 1 April 2004 to 7 January 2018.**

This document provides detailed information on how the IOPC (and previously the IPCC) collates and categorises deaths for inclusion in the annual death report. It also provides more detailed information on the definitions on the death categories and some aspects covered in the report. Further studies and related information can be found in section eight and contact details for the producers of the report are in section nine.

For details on our revisions policies, quality assurance, pre-release access and user engagement strategy in relation to the annual death report, please refer to the policies and statements document.

# 2. Data collection for the annual death report

***Referrals to the IOPC and previously the IPCC***

Under the Police Reform Act 2002, forces in England and Wales have a statutory duty to refer to the IOPC any complaint or incident involving a death which has occurred during or following police contact, and where there is an allegation or indication that the police contact, be it direct or indirect, contributed to the death[1]. The IOPC considers the circumstances of all the cases referred to it and decides how the case should be dealt with (see Box A for a description of types of investigation).

[1] Paragraph 4(1)(a), 13(1)(a), 14c(1). Schedule 3, Part 1, Police Reform Act 2002 as amended by the Serious Organised Crime and Police Act 2005, Schedule 12.

Since April 2006, the IPCC / IOPC has also received fatal cases mandatorily referred from Her Majesty's Revenue & Customs (HMRC)[2], the Serious Organised Crime Agency (SOCA) and since October 2013, SOCA's replacement, the National Crime Agency (NCA). It also received cases from the UK Border Agency (UKBA)[3] until March 2013, when its Executive Agency status was ended and its functions were brought back within the Home Office as: UK Visas and Immigration (UKVI); UK Immigration Enforcement (UKIE); and UK Border Force (UKBF). The IOPC has continued to have jurisdiction over those officials and contractors and therefore, any deaths that have occurred during or following contact with these organisations or individuals will also be presented in this report.

*Box A* **Type of investigation**

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

**Managed investigations** are carried out by police Professional Standards Departments (PSDs), under the direction and control of the IPCC/IOPC.

**Supervised investigations** are carried out by police PSDs, under their own direction and control. The IPCC/IOPC will set the terms of reference for a supervised investigation and receive the investigation report when it is complete.

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

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

*For more details on IOPC investigations, see IOPC Statutory Guidance (2015) section 15*

### *Identifying death cases referred to the IPCC/IOPC for examination*

Any case involving a death is extracted from the IOPC's internal case management system (Perito) using a data warehouse tool and imported into Excel by the research team at the IOPC. This is done regularly throughout the year so that the cases can be checked against existing cases to ensure that all deaths are captured and that there is no duplication. The extraction of death cases from Perito is reliant on accurate identifiers having been selected on the case. A validation process undertaken at the end of the year ensures that any cases that do not have an identifier are captured prior to analysis.

### *Categorising death cases*

The research team examines the circumstances of all death cases identified to determine whether they meet the criteria for inclusion in the annual death report. Cases are categorised based on the information available from referral documents, investigation reports, post mortems and inquest verdicts. Where information is unknown or unclear from the data available to the research team, for example on cause of death, this will be sought from IOPC colleagues and police forces.

The annual statistics are based on deaths that meet the criteria for inclusion in one of the categories presented in Box B; detailed information on the definition of these categories can be found in section two.

*Box B* **Categories of death included in the annual death report**

- **Road traffic fatalities**

[2] Regulation 34 of the Revenue and Customs (Complaints and Misconduct) Regulations 2005.
[3] Regulation 25 of the UK Boarder Agency (Complaints and Misconduct) Regulations 2010.

- **Fatal shootings**
- **Deaths in or following police custody**
- **Apparent suicides following police custody**
- **Other deaths following police contact – *IPCC/IOPC independent investigations only***

All cases included in the report are validated with the relevant IPCC/IOPC investigator (where applicable), and police force or appropriate authority. The purpose of this is to provide missing data where possible and flag any cases that are not listed but are considered to meet the criteria for inclusion. These cases will then be checked by the research team.

The annual figures are based on deaths occurring within a financial year. The date of death is the reference point to determine what financial year the death will be included in and not the date of the incident. For example, if a person is injured in a police related road traffic incident in December 2010, but remains in a coma from that date until their life support machine is turned off in May 2011, the death would be included in the 2011/12 figures not 2010/11 when the incident occurred. This delay between incident and date of death can happen with any of the categories reported on.

## 3. Death category definitions

To produce the annual death statistics, the circumstances of all deaths referred to the IPCC/IOPC are examined to determine whether they meet the criteria for inclusion under one of the five categories listed below. In 2010/11, there was a change to the definition of the category *'other deaths in or following police contact'* to only include those cases that meet the specified criteria **and** are subject to an IPCC/IOPC independent investigation. There have been no changes to the definitions of the other reported categories since 2004/05 when the IPCC/IOPC has had responsibility for producing the annual statistics.

### Road traffic incidents (RTIs)

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

This ***includes:***

- **Pursuit-related incidents**: Incidents are classified as pursuit-related if they involved a pursuit or where the police are driving in the same direction as a suspect vehicle. Not all of these incidents will have entered an official pursuit phase as defined in the Authorised Professional Practice (APP) on police pursuit[4]. 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 are driving in the direction of a vehicle before obtaining permission to pursue are also included as pursuit-related. For example:

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

- Police officers witness a car being driven erratically and start to pursue the vehicle using blue lights and sirens. The driver of the pursued car goes off at speed and hits a wall; he is taken to hospital but dies on arrival from the injuries sustained.

- **Emergency response-related incidents**: This includes all incidents that involve a police vehicle responding to a request for emergency assistance. For example:
  - A police van with its lights and sirens activated is responding to an emergency call of a report of assault in a town centre, when it collides with a pedestrian who is crossing the road. The pedestrian receives fatal injuries and dies at the scene.
- **'Other' police traffic related incidents**: This includes RTIs that did not happen during pursuit-related or emergency response-related activity, but where incidents occur during standard police patrol or where drivers respond to seeing a police vehicle by fleeing the location and crashing (and there is no pursuit of the vehicle by police).
  - A pedestrian is attempting to cross a dual carriageway when she steps into the path of an unmarked police vehicle on general patrol duties. The woman receives multiple injuries and is taken to hospital where she dies two weeks later.
  - A vehicle pulls up alongside a police car at some traffic lights. The driver of the vehicle appears to react to the presence of the police by jumping the red light and driving off at speed. The vehicle has crashed across the lights into a lamppost and the driver of the vehicle dies at the scene. The police remain stationary and do not activate lights or sirens.

*This does **not** include:*

- Deaths that occur following a road traffic incident where the police attend immediately after the event as an emergency service.
- Cases where an off-duty police officer is involved in a road traffic incident where an associated person dies.

## Fatal shootings

**Includes fatalities where police officers fired the fatal shot using a conventional firearm.**

*For example:*

- Officers receive a call reporting a disturbance in a block of flats. Police patrol officers attend the scene and see a man in the landing of the flats apparently with a firearm. Armed response officers arrive and challenge the man on a number of occasions. He is then shot by an armed officer. An ambulance attends but the man is declared dead at the scene.

*This does **not** include:*

- Fatalities following the discharge of a less-lethal firearm, such as a Taser stun gun; these cases would be considered for inclusion under another category.

## Deaths in or following police custody

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

*This **includes** deaths that happen:*

- During or following police custody where **injuries** that contributed to the death were **sustained during the period of detention**. For example:

- A man is arrested for being abusive and assaulting a member of the public. During the arrest, there is a struggle and the man is restrained. The officers notice that the man then stops moving. First aid is provided and an ambulance is called but the individual is declared dead when paramedics arrive at the scene of arrest.
- A man is arrested for drink driving and taken into police custody. While in custody he falls over three times and on one occasion bangs his head on the floor. The deceased is released from custody but dies the following day; the cause of death is identified as being linked to the head injuries sustained during the time spent in custody.

- **In or on the way to hospital** (or other medical premises) following or during **transfer** from scene of arrest or police custody. For example:
  - Following his arrest during transportation to the police station, a man becomes ill in the police vehicle and starts to vomit. Officers re-route and take him directly to hospital where his condition continues to deteriorate. He dies in hospital a few days later.
  - Police are called to a hospital where an individual is 'agitated' and has hit a member of medical staff. The police arrive, arrest the man for assault, and proceed to escort him to the police station. Before the officers have left the hospital premises, the man stops breathing. He is immediately given first aid. A drugs package is removed from his throat but the incident has left the man in a coma; his life support machine is turned off three weeks later.
- From **injuries or other medical problems** that are **identified** or that **develop** while a person is in custody. For example:
  - During arrest and detention, the deceased is identified to be suffering from long-term alcoholism and associated health problems. While in the police cell, officers become concerned about the individual's condition as he is slumped on the floor. He is taken to hospital where he dies of natural causes related to long-term alcohol abuse five days later.
  - A man arrives at police custody following his arrest for possession of drugs. During the booking in process, the man collapses and an ambulance is called. He is taken to hospital but dies on arrival.
- While a person is in police custody having been detained under **Section 136 of the Mental Health Act 1983** or other legislation. For example:
  - A woman is acting erratically in a high street and shouting abuse at passers-by; the police detain her under Section 136 of the Mental Health Act and take her to police custody as a place of safety. During a check on the woman in her cell, she is noted to have collapsed. An ambulance is called but she is declared dead on arrival to hospital having died of natural causes.

*This does **not** **include**:*

- Suicides that occur after a person is released from police custody.
- Deaths that happen where the police are called to assist medical staff to restrain individuals who are at no point under arrest.
- Deaths of individuals who have been transferred to the care of another agency and subsequently die while in their care, of injuries or illness not identified or sustained while in police custody.

## Apparent suicides following police custody

**Includes apparent suicides that happen within two days of release from police custody. It 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.**

The term 'suicide' does not necessarily relate to a coroner's verdict as in most cases, inquest verdicts are still pending. In these instances, the case is only included if, after considering the nature of death, the circumstances suggest that death was the intended outcome of a self-inflicted act – for example a hanging, or where there was some evidence of 'suicidal ideation', such as a suicide note.

*This **includes**:*

- Apparent suicides that occur **within two days** of release from police custody. For example:
  - A man is arrested and taken into police custody. The day after release from custody, a friend finds the man hanging in his garage having apparently committed suicide.
  - A man is arrested and detained in police custody. He is charged the following day at court and conveyed to prison. Later that day, he is found dead in his prison cell with self-inflicted wounds.
- Apparent suicides that occur **longer then two days** after release if a possible causal link between the apparent suicide and the period of time spent in police custody has been identified. For example:
  - A woman is released from police custody but no pre-release risk assessment is conducted. The woman is vulnerable and has a known history of serious mental health issues and previous suicide attempts. The woman is found dead at home four days after release. The suicide note attributes the time spent in police custody and treatment received to be a factor in the reason she committed suicide.

*This does **not** include:*

- When the last contact with the police relates to an individual answering bail as this does not constitute being in 'custody'. If the deceased's last contact was when they were answering bail, and they then commit suicide (within or longer than two days), it would either be excluded from the annual statistics or if it is subject to an IOPC independent investigation it would be classified as an '*other death following police contact'*.

## Other deaths following police contact – *IPCC/IOPC independent investigations only*

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

**An independent investigation is determined by the IOPC (and previously when operating as IPCC) for the most serious and sensitive incidents that cause the greatest level of public concern, have the greatest potential to impact on communities, or that have serious implications for the reputation of the police service. Since 2010/11, this category has included only deaths that have been subject to an IPCC/IOPC independent investigation. This is to improve consistency in the reporting of these deaths.**

*This **may include** (when subject to an independent investigation):*

- Deaths that occur after the police are called to **attend a domestic incident** that results in a fatality. For example:
  - The police receive an emergency call from a woman stating her partner is being violent and threatening her life. The police have previously attended domestic incidents at this address. The call is not logged correctly and the incident goes unattended for several hours. When officers finally arrive, the woman is found with fatal stab wounds and her partner has apparently committed suicide. *Both deaths will be counted in the statistics*.
- Deaths that occur while a person is actively attempting to **avoid arrest/contact**; this includes instances where the death is self-inflicted. For example:
  - The police attend an address in a block of flats with the intention of speaking with the occupier who is wanted for breach of his bail order. There is no answer at the door but police can hear noises from inside. The police are radioed from an officer on the ground who states that a man has climbed out onto the balcony and has fallen to the ground. The man is identified as being the wanted individual and is pronounced dead at the scene.

- Deaths that occur when the police attend a **siege situation**, including where a person kills themselves or someone else. For example:
  - The police receive a call from a person who states that they can hear their neighbour shouting erratically and believe he may be armed. Police armed response arrive due to the mention of a possible firearm. There are lengthy negotiations between the police and the man inside the house before they hear a gun being fired. The police enter the house and find that the man has shot himself; there is no one else present.
- Deaths that occur after the police have been contacted following **concerns about a person's welfare** and there is concern about the nature of the police response (please see section three for further details on the different types of concern for welfare contact). For example:
  - A member of the public contacts the police to raise concerns about a man's health after he appears to be heavily intoxicated in a public place. The police attend, speak with the individual and decide to leave him there. Some hours later, another call to the police is made about the same man who remains where the police left him earlier that day. The police attend but the man is pronounced dead at the scene.
- Deaths that occur where the police are called to **help medical staff to restrain** individuals who are at no point under arrest:
  - A member of hospital staff contacts the police as one of their patients is acting aggressively towards staff. The police arrive and assist medical staff in restraining the individual in order to help control the situation, which includes the police using leg restraints. At no point is the man under arrest. After a few minutes, the police become concerned about the man's welfare. The restraints are removed and he receives medical treatment; however, he dies of a heart attack later that day.

**Deaths not reported on in the annual death report**

There are a number of death cases that are referred to the IPCC/IOPC but that fall outside the remit for inclusion in the annual statistics. These cases are not included as the circumstances do not meet the criteria for inclusion under each of the categories as set out above.

Cases **would not be included** where:

- The fatality occurs after there has been some form of *contact* with the police, either directly or indirectly, but the case is **not** subject to an IPCC/IOPC independent investigation. The circumstances of these cases could be similar to the descriptions presented above but it has not been designated as an independent investigation. An independent investigation is determined by the IPCC/IOPC when an incident could cause the greatest level of public concern, have the greatest potential to impact on communities, or have serious implications for the reputation of the police service.
- Following police *contact*, an individual apparently commits suicide and the case is **not** subject to an IPCC/IOPC independent investigation.
- Deaths that occur more than two days after release from police *custody* and there are no concerns regarding the period spent in custody.
- The case relates to the death of police personnel while on duty.
- A complaint relating to the way the police investigated a death; in these cases the research team will ensure that the death it is relating to has been considered for inclusion in the annual statistics if appropriate.

## 4. Other deaths following police contact: reason for contact

This relates to the **'*other deaths following police contact*'** death category. It describes the reason for contact between the police and the deceased prior to their death. The contact can be either directly or indirectly between the deceased and the police. The categories of contact are grouped between *'concern for welfare'* and *'other contact'*. All the cases included in this category of death are **subject to an IPCC/IOPC independent investigation**. This suggests that the incident causes the greatest level of public concern, has the greatest potential to impact on communities, or has serious implications for the reputation of the police service.

### Reason for contact: 'Concern for welfare'

In these cases, the main reason for contact between the police and the deceased is related to a concern for welfare. This could be raised in relation to a number of different themes regarding an individual's safety or wellbeing. The concern may be raised by the person themselves or by a third party.

- **Domestic related**

This often includes cases involving a history of domestic violence that the police are already aware of. Threats may be made directly or indirectly against the deceased and/or associated family members and the deceased or a third party has reported this or raised concerns about their safety to the police. In the majority of instances, these deaths will be alleged murders committed by an interested party in the case who is the deceased's partner, ex-partner, sibling, parent, or an extended family member. Any apparent suicides of the perpetrator that follows an alleged or attempted murder are also included in the statistics within this category.

- The deceased has a history of being a victim of domestic violence by her ex-partner and this is known to the police. The woman contacts the police to say that her ex-partner is in her garden, which is a breach of his bail conditions. She requests the police call her back in two hours as she is going out; this call was not made. Later that evening, the property's police-installed panic alarm was activated, the police attend and find the woman had been stabbed by her partner. She later dies of these injuries.

- **Self-harm / suicide risk / mental health**

The cases in this category include the police being contacted with concerns about an individual being at risk of self-harm or suicide, or about the state of their mental health. The deceased or a third party can raise the concern. The person is not reported or considered missing. For example:

- A woman receives a text message from a friend stating that he is going to kill himself. She contacts the police requesting assistance, stating the suspected location of her friend. No action is taken. The woman then contacts the police again reporting her continued concern. The police respond and find the man hanging in the location originally provided to the police.

- **Health / injuries / intoxicated / general**

In these cases it is often a third party who contacts the police to raise concern about an individual's health; observed injuries; their level of intoxication; or general concerns about their behaviour. In some instances, the deceased may have raised concerns directly with the police about their own welfare. The police can have direct or indirect contact with the deceased. Often in these cases, the cause of death is accidental or from natural causes. For example:

- A call is made to the police to report a man who appears to be heavily intoxicated and is entering a vehicle with the intention to drive. A PCSO who is already in the vicinity prepares

to approach the vehicle but is requested not to by other officers who say they already dealing with the incident. However, no action is taken and the man is allowed to drive away. A few minutes later he crashes into another vehicle and dies at the scene.

- **Missing person**

In these cases the contact with the police relates to the report of a missing person, these are sub-divided into two groups:

***Missing person AND suicide / self-harm risk***

The police are contacted with a report of a missing person AND there is some concern with regards to the person self-harming or potential suicide risk. For example:

- The police receive a call reporting concern for a man's welfare as he was suffering from depression and had recently made comments to a friend about self-harm. The man is treated as a missing person and classed as high risk due to the reports of self-harm. The man is found found dead in his garage having taken his own life.

***Missing person - non-suicide / self-harm risk related***

The police are contacted with a report of a missing person. There is no specific concern that the individual is at risk of self-harm or suicide. For example:

- A wife reports to the police that her husband is missing from home and was last seen the night before going out in their blue Golf car. A couple of hours later the wife reports to the police that a third party has seen a blue overturned car in a nearby field. The next day the wife contacts the police again stating the same blue car is still there. The police attend the location and find the missing person deceased in the car.

- **Threatening behaviour / harassment**

In these cases the deceased, or a third party, has raised concerns regarding threatening behaviour or harassment by another person that is non-domestic related.

- A man contacts the police to report that his neighbour has been threatening violence in their interactions and he is concerned what he may do to him. Two days later the man is allegedly found murdered by his neighbour.

- **Other concern for welfare**

In these cases, the police are contacted regarding other types of concern for welfare that are not captured within the above categories. It includes cases where the deceased or a third party contacts the police as they are concerned for their own safety from another person, which is non-domestic related. For example:

- A man makes a 999 call to the police. The man gives his address and the operator hears a loud noise in the background before being cut off. The call handler gives the wrong address to officers who find no concerns at the recorded address. Twenty minutes later a silent call is received from the same number. When the call handler re-checks the details the correct address is identified and officers are dispatched. On arrival, they discover that the occupier has been fatally stabbed.

## Reason for contact 'Other'

Under this category, the reason for contact between the deceased and the police is not initiated by a concern for welfare.

- **Siege**

A siege situation is defined when there is a period of interaction and negotiation between the police and another person both of whom are armed, or where the non-police person is

believed to be armed. The person is not under arrest. During the siege situation, the individual dies, usually having taken their own life.

- The police are called to a property where a man is reported to be armed with a gun. Armed units arrive and there is period of negotiation. After a few hours, the man exits the property apparently unarmed; he then takes a knife from his jacket and slits his throat. He is immediately taken to hospital but is pronounced dead on arrival.

- **Avoiding contact with the police / arrest**

The cases included in this category are those where an individual dies while attempting to avoid contact with the police or while evading arrest. This includes incidents where a person is fleeing the police or apparently swallows drugs to evade arrest. For example:

- The police stop a vehicle for driving erratically. The driver alights from the vehicle, followed by police officers and a foot chase commences. The driver of the vehicle jumps over a wall but falls down a 20-foot drop on the other side. The police call an ambulance and the man is taken to hospital but dies a week later.

- Police are informed that a man is apparently selling drugs and they approach the suspect. On sight of the officers, the man is seen to swallow a package and immediately begins to choke. Officers attempt to retrieve the package and provide first aid, however the man dies on arrival at hospital.

- **Assist medical staff**

This category includes instances where the police are called to assist medical staff in dealing with individuals who may be acting aggressively or erratically, or to assist in controlling them so first aid can be administered.

- The police are called to assist at a hospital as a patient is acting aggressively towards staff. The man dies shortly after being restrained by officers.

- **Attending a disturbance**

In these cases the police are called to a location where there are reports of a disturbance. It is likely that the police come into contact with the deceased, or the alleged perpetrator of an assault on the deceased. If the disturbance is linked to a domestic incident then the '*domestic related'* category should be considered.

- The police attend a pub after a call was made regarding a man behaving violently and smashing glasses. The man is restrained by the police but no arrest is made. Immediately after the man becomes unwell and is transported to hospital where he dies two days later.

- **Executing a search warrant / arrest / investigation enquiries**

This category includes incidents where the police come into contact with the deceased due to attending a property to conduct a search or for the purpose of issuing an arrest warrant or making enquiries relating to an investigation. No arrest is made but a person present at the address dies of an exsiting illness or injuries sustained before or during police attendance.

- The police attend an address for the purpose of searching it for drugs. The occupant of the address allows the police to enter the property. As the police start to perform the search, the occupant collapses and is taken to hospital where he dies of a pre-exsiting illness.

- **Other**

This group includes various types of contact, either directly or indirectly with the police prior to the person's death that do not fall under the other themes. For example:

- The police receive reports about the alleged breeding of dangerous dogs at a property; no action is taken. A young boy is attacked by a dog at the property and dies from his injuries.

## 5. Cause of death

The cause of death reported on in the annual report is taken from the post mortem or, if applicable, the cause of death as reported at inquest. In a minority of cases, a post mortem may not be conducted. In these instances, the cause of death will be taken from the records of the certifying doctor or in the absence of this, it will be recorded in the report as 'no post mortem'. If the cause of death is being formally disputed at the time of analysis, or if the post mortem has not taken place or the IOPC are not aware of the outcome at the time of analysis, the cause of death will be recorded as 'awaited'.

Prior to 2013/14, the report presented in a table the primary cause of death and where relevant, a secondary cause. Since then, any causes of death now included in the report will reflect the wording used in the pathologist's report (or inquest). However, in some cases, especially where the wording is more complex, it may be summarised and included as a footnote.

## 6. Use of force

Restraint is recorded as a factor if a person was physically restrained at some point between the initial contact with police and their death. Restraint is reported on in the report if it involved restraint by police officers or police staff and it will be detailed separately if restraint was by civilians only during police contact.

Restraint includes the manual restraint of the deceased or the use of restraint equipment such as leg restraints; it does not include handcuffs. Stating that a case involved restraint does not mean that the restraint was considered to be a contributory factor to the cause of death. Restraint can be recorded as a factor on deaths that occur in or following police custody or those that follow other police contact.

When the cause of death was presented in a table in the report, if the restraint was identified as being a contributory factor, as stated by the pathologist or at inquest, then the cause of death was listed as 'restraint-related' in the annual statistics. Restraint was either listed as a primary or secondary cause of death based on the findings of the pathologist. Since then, as noted above, cause of death is now written out in full as used in the post-mortem (or inquest) reports.

In 2011/12, we started routinely recording data relating to the use of Taser stun guns and incapacitant spray by the police on cases involving a death. Where applicable, more detailed data was also collected on the type and method of restraint.

In 2015/16, in addition to recording data on Taser stun guns and incapacitant spray, the we started documenting data relating to all types of force used by the police including the use of batons, conventional firearms and police dogs.

## 7. Mental health, alcohol and drug factor

For each case included in the annual report, it is noted whether mental health, alcohol, or drugs was identified as relevant to the individual who died. These factors would be selected if these are referenced in the case circumstances in the following ways:

**Mental health**

A common way in which individuals with mental disorder may have contact with the police is when they are in a public place and are believed to be in need of *'immediate care and control'*. In these circumstances, individuals can be detained by police officers for their own and others safety under Section 136 of the Mental Health Act 1983 and taken to a place of safety, defined as a '*hospital, police station, mental nursing home or residential home, or any other suitable place*'.

The mental health marker is selected on a case if the individual has been detained under the Mental Health Act, is a patient at a psychiatric hospital, or if the individual is reported as having current or historical mental health issues. If the person is known to have previously attempted suicide or is reported to be suffering from depression, the mental health factor would also be selected. Information on mental health may be drawn from; information received from the police force at the point of referral; self-reported information by the deceased; or evidence provided by the medical staff or close associates of the deceased.

**Alcohol**

The alcohol factor is marked if the deceased had recently consumed or was intoxicated with alcohol at the time of arrest or contact with the police. It will also be marked if the cause of death is linked to alcohol. The relevance of alcohol may be deemed from information on the referral form from the police force or from information that is identified during the investigation.

**Drugs**

The drugs factor is applied to cases where the deceased had recently consumed drugs, was under the influence of drugs, had a history of drug abuse, or was found to be in possession of illegal drugs at the time of arrest or contact with the police. It will also be selected if the cause of death is related to drugs (either illegal or prescription drugs), including long-term misuse, overdose or where drug packages may have burst or are lodged in airways. The prevalence of drugs may be identified from information on the referral form from the police force or from the case description and investigation.

## 8. Further studies and related information

Below are some suggested research reports (produced while operating as the IPCC), information, websites and research from other organisations, countries and literature sources. These lists are not exhaustive. Figures relating to deaths in or following police contact, custody, road traffic incidents, police shootings and suicides following police custody in England and Wales should always be taken from the IOPC's annual death report.

**IPCC / IOPC reports and other relevant research**

Some other IPCC / IOPC research reports that are relevant to the area of deaths in or following police contact.

- The IPCC published the findings from its research study into use of force by the police in March 2016. This study brought together an evidence base informed by: analysis of public complaints recorded by the police; cases that the IPCC had been involved with; and research into the perceptions and experiences of members of the public, police personnel and other stakeholders. The report also provides a detailed look

at the data collated in relation to people from black and minority ethnic groups, people with mental health concerns, children, and people in custody.

- The IPCC conducted a long-term study examining deaths in or following police custody over an 11-year period between 1998/99 to 2008/09. The report identifies trends in the data, examines the nature of the deaths and identifies lessons that can be learnt for policy and practice to prevent further deaths from occurring.
- The IPCC, in collaboration with the Metropolitan Police Service and Forensic Medical Examiners working in London, conducted a study looking at the prevalence of Near misses in police custody, exploring the circumstances and makes recommendations on custody practice to prevent deaths in custody occurring.
- Approximately half of all deaths in or following police custody involve detainees with some form of mental health problem. To provide a better insight into the issues concerning mental health and custody, the IPCC conducted some research that examined the extent and use of police stations as places of safety under section 136 of the Mental Health Act.
- Fatalities arising from a road traffic incident involving the police accounted for one of the highest categories of death when the IPCC was created. The IPCC felt that it was important to analyse these cases in more detail and conducted a study to examine a range of the most serious incidents to identify lessons for policy and practice. Police road traffic incidents: a study of cases involving serious and fatal injuries.

  Since the publication of the above study, the IPCC worked with the then Association of Chief Police Officers (ACPO)[5] and road safety campaign groups to improve police pursuit policy. Pursuit management guidelines for police forces were developed that have the force of law. These are now owned by the College of Policing as Authorised Professional Practice on police pursuit.
- The IOPC has a statutory duty to secure and maintain public confidence in the police complaints system in England and Wales. The Statutory Guidance is one of the ways in which the IOPC assists local policing bodies to comply with their legal obligations and achieve high standards in the handling of complaints, conduct and death and serious injury (DSI) matters.
- The IPCC has also published many of the reports resulting from its independent investigations and IOPC will continue to do so.
- Previous IPCC and future IOPC Annual Reports and corporate plans are available on our website.
- Records of the IPCCs and IOPC's recent and archived press releases are also available.

**Other research, jurisdictions and countries**

*Note that the data produced by other jurisdictions may not be comparable to the data the IOPC releases on deaths in or following police contact.*

- The Independent Advisory Panel (IAP) on deaths in custody produces an annual report presenting figures on recorded deaths of individuals detained in state custody.
- Guidance on The safer detention and handling of persons in police custody 2nd edition (2012), produced on behalf of ACPO by the National Policing Improvement Agency (NPIA)

[5] ACPO has now been replaced by the National Police Chiefs' Council (NPCC).

- INQUEST is a charity that provides a free advice service to bereaved people on contentious deaths and their investigation, with a particular focus on deaths in custody (police, prison, immigration detention and deaths of detained patients)
- Prison and Probations Ombudsman for England and Wales are responsible for investigating deaths of prisoners, residents of probation service approved premises, and those held in immigration removal centres
- Police Ombudsman for Northern Ireland (PONI) does not routinely produce any annual statistics on deaths in custody or following police contact. However, they do monitor these internally and can produce figures on request
- Police Complaints Commission for Scotland (PCCS)
- Australia – The National deaths in custody program run by the Australian institute of Criminology examines the circumstances of deaths in prison, police custody and juvenile detention around Australia since 1992.
- Heide, S., Kleiber, M., Hanke, S, and Stiller, D. (2009) Deaths in German police custody European Journal of Public Health Vol.19, No.6, 597-601
- Police custody deaths in Mauritius (2005), Clinical Knowledge, Vol.15, No.1

**Some relevant literature**

Some suggested further reading around deaths in police custody or contact and associated themes, this list is not exhaustive.


- Association of Chief Police Officers (ACPO) (2009), *Guidance on the use of limb restraints*, London: ACPO and the Self-Defence, Arrest & Restraint Working Group of the Uniformed Operations Business Area
- Bradley, K. (2009), *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system,* London: Department of Health
- Di Maio, T. and Di Maio, V. (2005), *Excited delirium syndrome: cause of death and prevention*, Boca Raton: CRC Press
- Griesbach, D., Lardner, C. and Russell, P. (2009), *Summary of findings and recommendations from a research study on managing the needs of drunk and incapable people in Scotland: a literature review and needs assessment*, Scottish Government Social Research: www.scotland.gov.uk/socialresearch
- Home Office (2000), *Detainee risk assessment and revised prisoner escort record form*, Home Office Police Leadership and Powers Unit. August 2000. Home Office: London
- Journal of the Royal Society of Medicine, Vol. 92: 110-113
- James, D.S. (2009), *Pathological aspects of sudden restraint deaths associated with struggle against restraint*, Pathology Report on Baha Mousa. Baha Mousa Public Inquiry
- Karch, S.B. and Stephens, B.G. (1999), *Drug Abusers who Die during Arrest or in Custody*
- Man, L.H., Best, D., Marshall, J., Godfrey, C. and Budd, T. (2002), *Dealing with alcohol-related detainees in the custody suite*, Home Office Findings 178. London: Home Office
- Norfolk, G., Stark, M. and Travis, M. (2010), Acute Behavioural Disturbance: Guidelines on Management in Police Custody, produced by the Academic Committee of the Faculty of Forensic and Legal Medicine, September 2010

- Otahbachi, M., Cevik, C., Bagdure, S. and Nugent, K. (2010), *Excited delirium, restraints, and unexpected death: a review of pathogenesis*, February 2010
- Payne-James, J., Green, P. G., Green, N., McLachlan, G. M. C., Munro, M. H. W. M. and Moore, T. C. B. (2010) *Healthcare Issues of Detainees in Police Custody in London, UK*, Journal of Forensic and Legal Medicine, Vol. 17, Issue 1: 11-17
- Police and Criminal Evidence Act (PACE) (2008), *Codes of practice C*, revised edition London: The Stationery Office

## 9. Contact details

All of the annual death reports are free and available to download from the IOPC website in a PDF format. If you have any questions or comments regarding the annual death report you can contact the Research Team directly on research@policeconduct.gov.uk.

Alternatively and for all other IOPC enquiries, contact the switchboard helpdesk on 0300 020 0096, or enquiries@policeconduct.gov.uk, or see other contact methods.