IOPC Independent Office for Police Conduct

Deaths during or following police contact:

Statistics for England and Wales 2020/21

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National statistics

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

This designation means that the statistics:

> meet identified user needs

> are well explained and readily accessible

> are produced according to sound methods

> are managed impartially and objectively in the public interest

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

Contents

List of tables and figures

1

Introduction

This report presents figures on deaths during or following police contact that happened between 1 April 2020 and 31 March 2021. 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 seventeenth in a series of statistical reports on this subject, published annually by the IOPC, formerly the Independent Police Complaints Commission (IPCC). On 8 January 2018, the IPCC became the IOPC. This change was set out in the *Policing and Crime Act 2017*[1].

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

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

Box A on page 2 provides a definition for each of these categories.

For more detailed definitions please see the guidance document on the IOPC website.

Further supporting information about the report can be found in the background note.

1 Find out more about becoming the IOPC at policeconduct.gov.uk.

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

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

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

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

This does not include:

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

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

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

This includes deaths that happen:

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

This does not include:

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

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

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

This may include deaths that happen:

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

2

Overall findings

During 2020/21, in each category there were:

- **25** road traffic fatalities
- **one** fatal police shooting
- **19** deaths in or following police custody
- **54** apparent suicides following police custody
- **92** other deaths following police contact that were independently investigated by the IOPC

Demographic information about those who died is presented in the following chapters, along with details about the circumstances of the deaths and a summary of trend data. The appendix contains additional information, such as the age, gender and ethnicity of those who died, and information about the police force or appropriate authority[2] involved.

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

For a large portion of 2020/21, England and Wales were in lockdown owing to the coronavirus pandemic. 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 years.

Investigations

When we are told about a fatality, we consider the circumstances of the case and decide whether to investigate independently, or to direct an investigation[3]. In some circumstances, we decide that the local police force professional standards department (PSD)[4] or other equivalent department is best placed to investigate a case[5]. Box B on page 6 includes a description of each type of investigation.

2 The appropriate authority is usually a police force's chief officer or police and crime commissioner.
3 From February 2020 supervised and managed investigations are no longer available as a mode of investigation. A new mode – 'directed investigation' – has been created. These take place under IOPC direction and control, but using police resources.
4 Each force has a professional standards department, which oversees complaint handling and certain conduct matters.
5 In these circumstances the force must send the investigation report to the IOPC for review.

Table 2.1 shows the type of investigation at the time of analysis for all incidents involving a fatality recorded in 2020/21. The figures show the number of incidents; an incident leading to a single investigation can involve more than one death and so the totals for some categories may be lower than the total fatalities presented above. In total the IOPC independently investigated 129 incidents.

As all the fatalities in this report happened from April 2020 onwards, Table 2.1 no longer includes figures for supervised and managed investigations. Across all death categories no incidents were subject to directed investigation.

Table 2.1 Incidents by type of death and investigation type, 2020/21

Type of investigation	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Independent	19	1	16	2	91
Directed	0	0	0	0	0
Local	0	0	3	21	0
Back to force	1	0	0	31	0
Total incidents	20	1	19	54	91

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

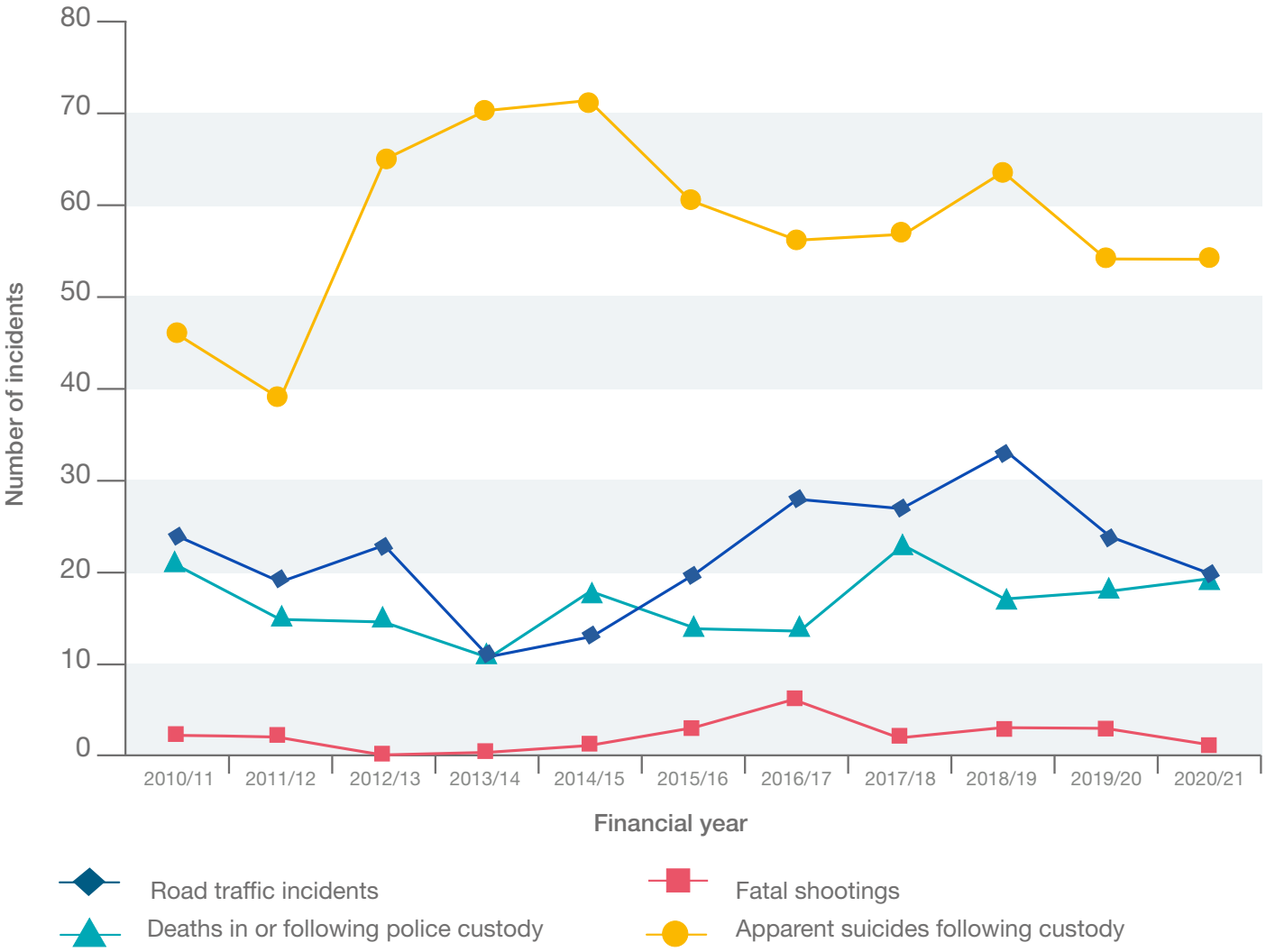
The figures in Table 2.2 show the number of fatalities across the different categories since 2010/11. It would not be meaningful to produce trend analysis across all five categories. This is because of the wide variation in the circumstances and changes to how the category of 'other deaths following police contact' is defined.

Table 2.2 Fatalities by type of death and financial year, 2010/11 to 2020/21

Fatalities											
	Financial year										
Category	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Road traffic fatalities	26	19	31	12	14	21	32	29	42	24	25
Fatal shootings	2	2	0	0	1	3	6	4	3	3	1
Deaths in or following police custody	21	15	15	11	18	14	14	23	17	18	19
Apparent suicides following custody	46	39	65	70	71	61~	56~	57	63	54	54
Other deaths following police contact*	57*	47	22	44	43	106~**	131~	177~	156~	107	92

* Change in definition of 'other deaths following contact' in 2010/11 to include only cases subject to an independent investigation.
** Expansion of IOPC investigative resource and capacity to carry out more independent investigations into serious and sensitive matters – this has a direct impact on the number of deaths reported in this category.
~ This table presents the most up-to-date set of figures for these categories; any changes to previously published data are indicated.

Figure 2.1 Incidents by type of death and financial year, 2010/11 to 2020/21



The number of fatal **road traffic incidents** (RTIs) has decreased this year from 24 to 20. This is the fifth lowest number recorded over the 17-year period since 2004/05 when these statistics were first published. It is the lowest number of incidents since 2015/16, when there were 20 RTIs. These figures are subject to fluctuation and, therefore, year-on year comparisons should be approached with caution.

This year there was one fatal **police shooting**, compared to three recorded last year. This is the lowest figure recorded since 2014/15. The number of **deaths in or following police custody** has increased slightly over the last year from 18 to 19. Over time, there have been some fluctuations in this category, with notable increases recorded in 2010/11, 2014/15 and 2017/18. The 2020/21 figure remains broadly in-line with the average over the 11-year period.

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

The category of '**other deaths following police contact**' is not included in Figure 2.1. The inclusion of a death in this category depends on whether we decide to open an independent investigation into the circumstances surrounding it. The criteria for making this decision may vary over time – for example, in response to public and community concerns. In addition, our capacity to carry out independent investigations increased in 2015/16, which had a direct impact on the number of deaths reported on in this category[6]. This means that trend analysis of deaths recorded in this category would not be meaningful.

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

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

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. In an independent investigation, IOPC investigators have all the powers of the police.

Directed investigations are IOPC investigations that are carried out using police resources. The IOPC sets the terms of reference for the investigation and directs the course of enquiries. At the end of the investigation the police investigator submits a report to the IOPC in order for decisions to be made about the outcome of the investigation.

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

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.

6 See our Corporate Plan 2015-18 and Strategic Plan 2018-22 for more information.

3

Road traffic fatalities

Demographics

In 2020/21, there were 20 fatal police-related road traffic incidents (RTIs), resulting in 25 fatalities. Of those who died, 21 were men and four were women. Eighteen people were reported to be White. Three were Asian, two people were Black. The ethnicity of two people was not known at the time of publication.

Five of the people who died were under 18 years old. The youngest was aged 16. A further 13 people were aged between 18 and 30 years and one person was aged over 60 years. The eldest was 83 years old. The average age was 28 years old. The average age decreases to 23 years if the deceased was the driver or passenger in a pursued or fleeing vehicle. It increases to 46 years if the deceased was a pedestrian, cyclist or a driver or passenger in a vehicle hit by either the police or the pursued or fleeing vehicle.

Circumstances of death

Incidents are classified as 'pursuit related' if they involved a pursuit, or if they involved the police driving in the same direction as a suspect vehicle. Not all these incidents will have entered an official pursuit phase as defined in the Authorised Professional Practice (APP) on police pursuits[7].

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

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

Pursuit-related

There were 15 police pursuit-related incidents, which resulted in 20 fatalities. Of these fatalities:

- nine people were the driver of a vehicle being pursued by the police when it crashed
- seven people were passengers in the car being pursued by the police
- three people were pedestrians who were hit by the pursued or suspect vehicle
- one person was a passenger of an unrelated vehicle, which was hit by the pursued car

The IOPC independently investigated all 15 pursuit-related incidents.

Emergency response related

This category includes all incidents that involve a police vehicle responding to a request for emergency assistance. One emergency response-related incident occurred in 2020/21 resulting in one fatality. The fatality involved a police vehicle colliding with a pedestrian while responding to a call about a domestic incident. This incident is being investigated independently.

This number has more than halved from three incidents and three fatalities recorded last year. The figures for this year show the lowest number of incidents and fatalities since 2016/17, when there were zero.

Other police traffic activity

This category includes RTIs that did not happen during pursuit-related activity or an emergency response. There were four incidents in 2020/21 resulting in four fatalities. Three incidents are being investigated independently. The remaining incident is being dealt with locally by the police force involved.

Of these four incidents, two happened when a vehicle responded to the presence of the police:

- An officer in a marked police vehicle was responding to an emergency incident with the vehicle's blue lights and sirens activated. The officer noticed that a motor scooter was being ridden in front of him. The scooter appeared to respond to the presence of the police vehicle and made off at speed. The officer informed the control room about the scooter but did not attempt to pursue it. The officer lost sight of the scooter and continued along the road where, shortly after, a member of the public waved him down. The scooter had collided with a tree and the rider died at the scene. This incident was subject to independent investigation.
- Officers on patrol in a marked police vehicle saw a car pull out of a car park. The car narrowly avoided a collision with two pedestrians before driving off in the opposite direction from the police vehicle. The police turned their car around, by which point they had lost sight of the vehicle. The officers drove in the general direction they believed the vehicle had travelled, and discovered it had crashed. The occupants of the car were taken to hospital, where one of the passengers later died. The incident was subject to independent investigation.

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

- Officers in a marked police van were responding to a non-emergency request for assistance. Emergency equipment was not used. They came to a stop at a traffic light controlled pedestrian crossing. As the traffic lights changed to green the police van pulled off from the lights. Around the same time a pedestrian, aged 83, started to cross the road when they were hit by the driver's side of the police vehicle, causing

them to fall over. Officers provided first aid at the scene. The pedestrian was taken to hospital where they died. The incident was independently investigated.

- Officers were dealing with an incident when they reported seeing a motorbike travelling at speed. CCTV showed that one officer, who was on foot, waved their arms up and down, apparently to indicate that the rider should slow down. The officer stated that the rider acknowledged them by flashing their indicators and continued down the road. Shortly afterwards the motorcycle rider was found having crashed. They were taken to hospital where they later died. After considering a referral, we returned the case to the force to address as it saw fit.

Trends

This year, 25 people died in 20 separate incidents. There was a rise in fatalities this year from 24 to 25. This is the sixth lowest figure recorded over the 17 years since we first published these statistics. The annual figures fluctuate, and year-on-year comparisons should be approached with caution.

Tables 3.1 and 3.2 set out of the type of road traffic fatalities and incidents over the past 11 years[8]. The tables show the incidents in the three categories previously described: pursuit related, emergency response related, and other police traffic activity.

This year there was a decrease in the number of pursuit-related incidents. The number of pursuit-related incidents is in line with the average seen over the past 11 years.

However, there was a slight increase in the number of pursuit-related fatalities this year. There was also an increase in the number of pursuit-related incidents that resulted in multiple fatalities. Three of these incidents accounted for eight fatalities. Although there has been an increase in the number of pursuit-related fatalities this year, it remains in line with the average seen over previous years.

This year has seen a reduction in the number of emergency response-related incidents. The data shows the lowest number of emergency response-related incidents and fatalities recorded since 2016/17, when there were zero.

The number of incidents resulting from other police traffic activity has doubled compared to the previous year. However, it is the third lowest number recorded in the past 11 years and less than a third of the number recorded in 2004/05.

8 Information on fatalities and incidents from 2004/05 is available in the time series tables at policeconduct.gov.uk.

Table 3.1 Type of road traffic fatality, 2010/11 to 2020/21

Fatalities											
	Financial year										
Road traffic incident type	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Pursuit-related	13	12	27	10	7	13	28	17	30	19	20
Emergency response-related	4	2	2	0	0	2	0	8	5	3	1
Other	9	5	2	2	7	6	4	4	7	2	4
Total fatalities	26	19	31	12	14	21	32	29	42	24	25

Table 3.2 Type of road traffic incident, 2010/11 to 2020/21

Incidents											
	Financial year										
Road traffic incident type	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Pursuit-related	13	12	19	9	6	12	24	17	21	19	15
Emergency response-related	3	2	2	0	0	2	0	7	5	3	1
Other	8	5	2	2	7	6	4	3	7	2	4
Total incidents	24	19	23	11	13	20	28	27	33	24	20

4

Fatal shootings

This year, there was one fatal shooting by police. This is the lowest figure since 2014/15. The circumstances of the fatal shooting are described below. The incident is subject to an ongoing independent investigation.

An armed officer from Wiltshire police responded to reports of a fight in the street between two men. Body worn video showed that one of the men, a White man aged 57, was stood outside of his property with what appeared to be a firearm. The armed officer instructed the man to put down his firearm, but he did not comply. The officer then fired a single shot, which hit the man in the chest. He received medical attention from officers and ambulance staff but died at the scene. A long-barrelled air rifle with a scope attached was recovered from the scene.

5

Deaths in or following police custody

Demographics

In 2020/21, 19 people died in or following police custody – 17 men and two women. Their ages ranged from 24 to 85 years. Seventeen were White and two were Black.

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

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

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

Seven people were arrested for an alleged assault. One of these was also arrested for criminal damage and another person was also arrested for false imprisonment. A further five people were arrested for theft/burglary. Two of these were arrested for other offences – one person was also arrested for recall to prison and another man was also arrested for breach of a criminal behavioural order and driving offences.

Two people were detained under the *Mental Health Act 1983*[9]. Other reasons for detention included possession of drugs, breach of the peace, possession of a weapon, blackmail and false imprisonment and failure to appear in court.

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

Table 5.1 Deaths in or following police custody: reason for detention, 2020/21

Reason for detention	Number of fatalities
Violence-related (non-sexual or murder)	7*
Theft / burglary	5**
Mental Health Act 1983	2
Drug / alcohol-related (excluding drink driving)	1
Failure to appear in court	1
Breach of the peace / anti-social behaviour	1
Possession of a weapon	1
Blackmail and false imprisonment	1
Total fatalities	19

* One person was also arrested for criminal damage and another person was also arrested for false imprisonment.
** One person was also arrested for recall to prison and another person was also arrested for breach of a criminal behavioural order and driving offences.

The data shows that 12 of the 19 people who died had some force used against them either by officers or members of the public before their deaths. It is important to note that the use of restraint, or other types of force, did not necessarily contribute to the deaths.

All 12 people were physically restrained[10] by the police or non-police, such as members of the public. One was restrained only by people who were not police.

Of the people who were physically restrained, 11 were White and one was Black. Seven incidents involved the use of leg restraints.[11] Of these seven incidents two involved use of a baton press[12], with one of these also involving use of a flexible lift and carry system.[13]

In addition to the seven incidents that involved the use of leg restraints, two other incidents included these methods of force:

- spit hood
- emergency response belt and fast straps[14]

10 The term 'restraint' refers to a range of actions, including physical holds and pressure compliance. It does not include the routine use of handcuffs, unless another form of restraint was also used.
11 This device is used to restrict the movement of limbs. Its application should prevent a person from kicking and punching, and allow the person to be transported safely.
12 This is where a baton is used in the restraint for example, e.g. to pin down someone's limbs.
13 This is a manual handling piece of equipment.
14 An emergency response belt is a soft style restraining belt made from strengthened fabric and straps secured with Velcro. Its intended purpose is to provide a protective and restraining device to handle, control, restrain, and move violent or injured subjects. It is intended to be used on the legs and arms. A fast strap is a device designed and used to restrict the movements of limbs. Its application should prevent a person from kicking and punching and allow for safe transportation of the person.

Circumstances of death

Cause of death according to the pathologist's report following a post-mortem[15] is reported for 16 of those who died. At an inquest, the cause of death is determined formally and may change from the cause of death listed in a pathologist's report. The IOPC is independently investigating 16 of the 19 deaths.

Seven people were taken ill or were identified as being **unwell in a police cell**. Four were taken to hospital where they died on arrival, or sometime later. Three people died in a police cell.

These seven cases are outlined below.

> A man was arrested following a domestic incident at his home and taken into custody. During a routine check he was found unresponsive in his cell. First aid was administered, and an ambulance was called. Paramedics arrived and provided medical assistance, but the man died shortly after. His cause of death was reported as *1a) Ischaemic heart disease 1b) Severe coronary artery atherosclerosis 2) Left ventricular hypertrophy.*

> One man was arrested on a no bail warrant[16] for failing to appear at court. When he was being booked into custody, he disclosed that he was alcohol dependent. During the man's detention he was seen by healthcare professionals[17] for drug and alcohol withdrawal and provided with medication. He was also subject to regular checks. During a check the man was found unresponsive in his cell. First aid was provided and the man was taken to hospital in an ambulance where he died shortly after arrival. His cause of death was reported as *cardiorespiratory arrest and seizure during acute alcohol withdrawal.*

> Police were called to reports of theft of a vehicle. When officers arrived, the vehicle that had allegedly been stolen had been stopped and a man was on the floor after apparently being restrained by two members of the public. The police handcuffed the man on the floor, arrested him, and transported him to custody. On arrival at custody the man disclosed that he had several medical conditions and that he was in pain.

  Later that day the man was assessed by a healthcare professional. He was given pain relief and taken to hospital by officers, where he remained under police guard. The man alleged he had been assaulted while being taken out of the vehicle and he was found to have multiple injuries. The man's condition deteriorated while in hospital and he died several days later. His cause of death was reported as *1a Tension pneumothorax 1b multiple rib fractures*.

> One man was arrested and transported to custody. The custody sergeant recorded that the man appeared to be intoxicated and that the man stated that he had taken drugs. He also recorded that the man initially refused to see a healthcare professional. The arresting officers also told the custody sergeant the man had a heart problem. The man was strip-searched and it was recorded that no items were found. The man was placed in a cell and subject to regular checks. For the first several hours of his detention, this involved rousing him owing to his apparent intoxication.

  The man saw a healthcare professional twice during his detention and was provided with medication. During a routine check the man was discovered to be unresponsive. First aid was provided by officers and staff,

15 In a minority of cases, a post-mortem may not be carried out. In these situations, 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'.

16 if a defendant fails to appear at court, a warrant may be issued for their arrest. The warrant may be issued with or without bail. If issued without bail, the defendant will be kept in police custody having been arrested until the next available court date.

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

and an ambulance was called. Ambulance staff took over medical treatment, but the man died shortly afterwards. The pathologist recorded the man's death, on the balance of probabilities, as *Sudden unexplained death in epilepsy.*

- One woman stated on arrival at custody that she was dependent on drugs. A strip search was carried out and did not find any drugs. The woman was placed in a cell monitored by CCTV, and subject to regular checks. A few hours into her detention officers noticed on the CCTV that the woman appeared to be having a seizure in her cell. First aid was administered, and the woman was taken to hospital in an ambulance. While in hospital overnight, medical staff found what appeared to be an unsealed package of drugs concealed in the woman's vagina. The woman died at hospital later the next day. Her cause of death was reported as *1a) Cardiovascular instability with resultant hypoxic ischaemic brain injury and secondary bronchopneumonia 1b) Cocaine intoxication*.
- One man was arrested for assault. The custody sergeant stated that while being booked into custody the man disclosed he was alcohol dependent and had experienced chest pains on and off for the past two years, for which he had sought medical advice. The man was placed on regular observations and seen by a healthcare professional who advised he should be observed for signs of alcohol withdrawal. During one observation the man was found unresponsive. An ambulance was called, and the man was provided with medical treatment before being taken to hospital, where he was de-arrested. The man remained in hospital where he died six days later. His cause of death was reported as *1a. Hypoxic Brain Injury 1b Cardiac Arrest 1c Myocardial Infarction 2 Ischaemic Heart Disease.* This case was subject to a local investigation.
- Police approached a group of people who appeared to have breached COVID-19 social distancing guidance. One of the officers requested an ambulance as they believed one of the men may have taken drugs. The man was identified as being wanted for an assault. The ambulance was cancelled, and the man was arrested and transported to custody. CCTV showed while in custody the man head-butted a wall. He was restrained and taken to a cell. He was then restrained as a search was carried out. Healthcare professionals went to the cell but were unable to assess the man due to his behaviour. When officers left the cell, the man head-butted the cell wall. He was restrained again and placed in handcuffs and leg restraints. He was then left in the cell and placed on constant observations. It was noted on the custody record the man was under the influence of drugs and/or alcohol.

  Approximately an hour later, the man was found unresponsive. The man's handcuffs and restraints were removed, and first aid was given while paramedics were on the way. A short time later paramedics arrived. The man was pronounced dead soon afterwards. His cause of death was reported as *i. Cardiorespiratory arrest ii. Cocaine, 4F MDMB-BINCA and MDMB-4en-PINACA (synthetic cannabinoids), heroin, pregabalin, gabapentin and dihydrocodeine toxicity (with associated acute behavioural disturbance), ischaemic heart disease and upper airway obstruction.*

Ten people were taken ill at the **scene of arrest**. Eight were taken to hospital where they died on arrival, or some time later. Two people died at the scene. These ten cases are outlined below.

- Officers went to an address to arrest a man and a woman for actual bodily harm. Body worn video showed the woman was searched and then lost her balance and fell backwards. The footage shows one officer

removed her handcuffs, and another called for an ambulance. Paramedics arrived and provided medical treatment. The woman was taken to hospital where she died three days later. Her cause of death was reported as *1a) Spontaneous subarachnoid haemorrhage 1b) Ruptured developmental aneurysm of the left posterior communicating artery*. This case was dealt with locally by the police force.

- Police were called to reports of a man on a roof. The report indicated the man had fallen or jumped off a roof and appeared to have injured himself. When officers arrived, the man appeared to be in pain and agitated. Officers stated that he became more agitated and started to resist their contact so he was taken to the ground and handcuffs and limb restraints were applied so he could be searched and receive medical attention. The man was arrested for attempted burglary and paramedics arrived and administered medical care to the man. The man was taken to hospital in an ambulance accompanied by police officers. On the journey to hospital the man became unwell. He was left in the care of the hospital and de-arrested. The man's condition deteriorated and he died the next day. His cause of death was reported as *1a Toxic effects of cocaine and cocaine-related acute behavioural disturbance associated with a prolonged physical struggle against restraint*.
- Police were called to a report of a man who appeared to have shot himself in the head at his home. When the police arrived, the man had an obvious facial injury and was still conscious and able to speak. The man received medical treatment at the scene and was placed into an ambulance and taken to hospital. While in the ambulance the man was arrested for being in possession of a firearm. The man died the next day while still under arrest. His cause of death was reported as *1a) Traumatic brain injury 1b) Gunshot wound 2) Pancreatic carcinoma with jaundice*.
- Police were called to a report of a domestic disturbance. Officers arrived and arrested a man for assault. The man was handcuffed and then moved to the floor where a baton was used to pin his legs down and leg restraints were applied. The man appeared to be under the effects of drugs and alcohol and an ambulance was called. The man continued to be handcuffed and restrained in leg restraints while officers waited for the paramedics. The man was transported to hospital by ambulance accompanied by officers. During the journey the man became unresponsive, and died in hospital later that day. His cause of death is awaited.
- Police went to an address to support paramedics who had been called by a man in need of medical assistance. Officers arrived and discovered the man was wanted for outstanding offences and recall to prison. He was arrested. The officers believed the man was trying to escape and he was taken to the floor and handcuffs were applied. Paramedics assessed the man and advised that he should be checked at hospital. The man was taken to hospital where he remained under police guard. During this time the man became unresponsive. Officers provided first aid and assisted medical staff with treatment, but the man died a short time later. His cause of death was reported as *1a Sepsis due to 1b Cellulitis and lung abscess due to 1c Complications of intravenous drug abuse*.
- Officers came across a man in a street who was acting erratically. A Taser was drawn and the man was 'red dotted'.[18] The Taser was not discharged. More officers and paramedics arrived at the scene. The man lunged towards officers and was then restrained and handcuffed. He was placed onto an ambulance bed, where chest and leg restraints were applied. The man was detained under section 136 of the *Mental Health Act* and transported to hospital. The

18 'Red dotting' is where a Taser is pointed at a person using the laser sight red-dot

man remained in the care of the police while at the hospital. Whilst under police guard, the man backed himself out a hospital room window. The man received medical attention, but later died. His cause of death was reported as *multiple injuries*.

> Officers responded to a call about a man who needed assistance in the street. Officers detained the man under Section 136 of the *Mental Health Act* and called an ambulance. The man was restrained on the floor and officers applied fast straps to the man's legs. An ambulance arrived and an emergency response belt was placed around his hips. The man was then placed on a stretcher and carried into the ambulance. The man was taken to hospital accompanied by officers.

  During the journey to hospital the man became unresponsive. The man died in hospital the next day. His cause of death was reported as *1a. Multi-organ failure 1b. Hyperthermia and Rhabdomyolysis 1c. Complications arising during restraint of a man with acute behavioural disturbance and amphetamine intoxication following a period of physical activity*.

> Police were called to reports of a man who appeared to be intoxicated and walking in front of cars. An ambulance was also requested. The man appeared to be under the influence of drugs. He was moved to a grass verge and placed on his front. An officer handcuffed the man while a member of the public restrained him on the floor. Another officer restrained the man's legs. The officers then started to apply leg restraints. The man's condition appeared to deteriorate, and officers stopped applying the leg restraints and rolled him onto his side. The man was arrested for possession of drugs and his handcuffs were removed. The man then became unwell and officers provided CPR. Paramedics arrived and provided first aid, but the man died at the scene. His cause of death was reported as 1*a. Complications arising during restraint of a man with acute cocaine intoxication following a period of physical activity*.

> Police responded to reports of a man causing a disturbance at a hotel. When police arrived, the man was leaning on a car that had stopped in the road. The officers attempted to move the man out of the road and tried to speak with him, however the man did not appear to engage with their attempts to communicate and pulled away from them. Body worn video shows the man then struck one of the officers and then appeared to stumble to the floor as an officer held his arm. The man was arrested for assaulting an emergency worker. Handcuffs and leg restraints were applied. Shortly after he became unresponsive. The handcuffs and restraints were removed and officers gave first aid. An ambulance attended and medical assistance was provided, but the man died at the scene. His cause of death was reported as *Ia. Cardiorespiratory collapse occurring during restraint of a man with acute behavioural disturbance and cocaine intoxication following a period of physical activity II. Cardiomegaly*.

> Police attended a report of a domestic assault. One man was arrested, and it was identified he had taken a quantity of medication. The man was taken to hospital and kept under arrest and police guard. Later that day the man was medically discharged into the care of police to be taken to custody.

  After he was discharged and still on hospital grounds an incident led to him being restrained on the floor by officers and hospital staff. Officers applied leg restraints and handcuffs, the man's arms were restrained, and a baton was used by one officer to pin the man's legs down. The officers called for support and a police van arrived at the hospital with three additional officers. The man was transported into the van using a flexible lift and carry system (FLACS). Upon being placed into the van officers noticed that the man was

unresponsive. The man was removed from the van, the FLACS and his handcuffs were taken off, and officers provided first aid. The man was taken back to the hospital for medical assistance where he was de-arrested and died six days later. His cause of death is awaited.

Two people died following **release from police custody**:

- A man was arrested for attempted burglary. During his arrest he was restrained. While the man was in custody police were told he had a brain injury and had been discharged from hospital that morning. A custody sergeant stated the man was transported under Section 136 of the *Mental Health Act* to a place of safety unit due to his behaviour. A doctor at the unit stated the man should be taken to hospital for a medical assessment. The man was taken to hospital by officers. Prior to transporting the man, he allegedly became aggressive and was handcuffed and arrested for breach of the peace. On arrival at the hospital the man was de-arrested and his handcuffs removed. An officer stated the man entered the accident and emergency department. The officers left, and CCTV footage shows the man left the hospital.

  Approximately two hours later police were called to reports of a man who had apparently been struck by a train. His cause of death was reported as *1a traumatic head injury and haemorrhage from chest, abdominal and limb injuries*. It is unclear how the man came to be on the train tracks and whether this is related to the behaviour displayed while the man was detained by police. This case was investigated locally by the police force.

- Police responded to a report of a fight at an address. A man was arrested for breach of the peace. During the arrest the man was restrained. The man was taken to custody where there was another period of restraint. The man was released from custody and died later that day. His cause of death is awaited. This incident is subject to an ongoing independent investigation.

Trends

Between 2004/05 and 2008/09, there was a year-on-year reduction in the number of deaths in or following police custody. These deaths reduced from 36 in 2004/05 to 15 deaths in 2008/09. Over the next two years, the number of deaths in custody increased to 21 in 2010/11, before reducing to 15 in 2011/12 and 2012/13. There was a further reduction in 2013/14 to 11.

In 2014/15, the number rose again to 18 and then declined and remained stable at 14 in 2015/16 and 2016/17. In 2017/18 there were 23 fatalities, the highest number recorded for ten years. This number fell to 17 fatalities in 2018/19 and increased slightly to 18 in 2019/20. This year the number increased slightly again to 19 but remains broadly in line with average figures for the 11-year period.

This year, no one died after making an apparent suicide attempt while in a police custody suite.[19] The last incident of this kind was in 2016/17. Before that, there was one incident in 2014/15 and one in 2008/09. Since 2004/05, a total of seven people are known to have died as a result of self-inflicted acts while in a police cell.

This year three people were pronounced dead in a police cell. In 2019/20 one person died in a police cell. In 2018/19 no-one died in a police cell and in 2017/18 there were three such deaths.

19 This year, there was one death after a self-inflicted act. However, this happened before the person was arrested and they were not taken into a custody suite.

6

Apparent suicides following police custody

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

The term 'suicide' does not necessarily relate to a coroner's verdict because, in most cases, verdicts are still pending. 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 54 apparent suicides following police custody in 2020/21 – 49 men and five women. The average age of those who died was 41 years. The most common age was between 41 and 50 years (15 people), followed by 31 to 40 years (13 people). The youngest person was 18 years. Fifty of those who died were reported to be White. Two people were Black and two people were from a Mixed ethnic group.

Over two thirds of the people (38) had known mental health concerns. Of these, three had been detained under Section 136 of the *Mental Health Act 1983.* Other mental health concerns included depression, emotional personality disorder, bipolar, psychosis, previous thoughts or incidents of suicide attempts and self-harm.

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). 17 related to alcohol and 17 to drugs.

Circumstances of death

Twelve apparent suicides happened the same day the person was released from police custody. Twenty-two happened one day after release, and 20 happened two days after release. There were no cases where the apparent suicide took place more than two days after release.

Table 6.1 shows the reasons why these people were detained by the police. Twenty–six of those who died had been arrested for a sexual offence. Of these, 21 related to sexual offences or indecent images involving children. Eight detentions were for violence-related offences. Eight detentions were for harassment and threatening behaviour. Other common reasons for detention were driving offences (five), drug/drink-related offences (four), criminal damage (three), under the provisions of the *Mental Health Act 1983* (three) or possession of a weapon (three).

Table 6.1 Apparent suicides following police custody: reason for detention, 2020/21

Reason for detention	Number of detentions
Sexual offences	26
Violence related (non-sexual or murder)	8
Threatening behaviour / harassment	8
Driving offences (including drink / drug driving)	5
Drug / drink related	4
Criminal damage	3
Mental Health Act 1983	3
Possession of a weapon	3
Theft / burglary	2
Trespassing on the railway	2
Failure to appear in court / breach of bail / recall to prison	1
Preventing a lawful and decent burial	1
Murder	1
Breach of the peace	1
Total number of reasons for detention	68
Total fatalities	54

This table counts the number of different reasons for detention. Each person was detained for at least one reason. Some people may have been detained for more than one reason.

Nine people were detained for multiple reasons compared with 17 last year. Four people who were arrested for violence-related offences were also arrested for other reasons.

The majority of recorded apparent suicides following police custody were dealt with locally by the police force involved (52). Two are being investigated independently. In these cases, the matters being considered by the investigations include:

- the police action and decision making in respect of risk assessments and safeguarding
- the steps the police took to protect someone's welfare, including a consideration of their mental health

Trends

The number of apparent suicides following time in police custody has remained the same this year. This is the sixth lowest number recorded over the 17-year period since 2004/05. Reporting of these deaths relies on police forces making the link between an apparent suicide and someone having spent time in custody recently. Increases in these deaths may therefore be influenced by improved identification and referral of such cases.

This year, for 48% of fatalities, the reason for detention related to alleged sexual offences. The proportion of sexual offences or indecent images involving children was 39%. These proportions are higher than the figures recorded last year (30% and 22% respectively) and higher than average figures. The average proportions for these alleged offences since 2004/05 are 34% and 27% respectively.

7

Other deaths following police contact: independent investigations only

In 2010/11, a change was made to the definition of this category. It now includes only those deaths following police contact that were investigated independently by the IOPC, previously the IPCC[20].

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

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

Thematic case selection involves independently investigating more cases where these themes may be a factor. This will enable us to develop a body of evidence for learning and prevention work. The move to thematic case selection may have an impact on the number and proportion of cases involving particular circumstances of death – such as concerns for welfare based on mental health, or domestic-related incidents.

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

Overall demographics

We independently investigated the deaths of 92 people who died during or following other contact with the police during 2020/21. Of these deaths:

- 52 were men and 40 were women
- 74 people were White, ten were Black, four were Asian. The ethnicity of four people was not known at the time of publishing
- Eight people were aged under 18 years, and 11 people were young adults aged between 18 and 24 years. The average age was 39 years old
- over half of those who died (48) were reported to be intoxicated by drugs and/ or alcohol at the time of the incident, or drugs and/ or alcohol featured heavily in their lifestyle. Over two-thirds of the people who died (62) were reported to have mental health concerns

Table 7.1 Other deaths following police contact: reason for contact, 2020/21

Reason for contact		Number of fatalities
Concern for welfare	Missing person	21
	Self-harm / suicide risk / mental health	26
	Health / injuries / intoxication / general	15
	Domestic related	21
	Threatening behaviour / harassment	3
	Subtotal	86
Other contact	Attending a disturbance	4
	Avoiding contact / arrest	2
	Subtotal	6
	Total fatalities	92

Circumstances of death

The deaths recorded in this category involve a range of circumstances. The police contact may not have been directly with the person who died, but with a third party, as illustrated by some of the case examples. Where we have included the cause of death, this is taken from the pathologist's report following a post-mortem[21].

As shown in Table 7.1, the most common reason for contact with the police related to a **concern for welfare**. 86 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 that relate to **other types of contact** with the police.

21 In a minority of cases, a post-mortem may not be carried out. In this situation, the cause of death is taken from the records of the doctor who certifies the death. If the cause of death is formally disputed at the time of the analysis, the cause of death will be recorded as 'awaited'.

A total of nine people who died following police contact had force used against them. Four people were White, three were Black and two were Asian. Eight were restrained by police officers or by members of the public. This does not necessarily mean that the force used contributed to the death. Seven people were known to have been restrained by police officers. Of these, one man also had leg restraints used on him and another man had a spit hood used. One person was restrained by members of the public only. In addition to the eight people who were physically restrained one person was Tasered.

Concern for welfare

Of the 86 fatalities that followed contact with the police about a concern for welfare, 21 people died following a report of a **missing person**. The police generally did not have direct contact with the deceased in these cases. Of these 21 people, 13 were also identified as being at risk of self-harm or suicide.

Of these thirteen:

- eight were men and five were women
- all were White
- the ages of those included in this category ranged from 14 to 68 years. The most common age group was 31 to 40 (five people). The average age was 35 years
- eight people were reported to be intoxicated by drugs and/or alcohol at the time of the incident, or drugs and/ or alcohol featured heavily in their lifestyle. All 13 people who died were known to have mental health concerns
- in twelve incidents, the person's death was caused by an apparent self-inflicted act

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

- four of those who died were men and four were women. Four were White, three were Black and one was Asian
- the ages of the people in this category ranged from one day old to 56 years. The average age was 35 years
- for one person, alcohol and/or drugs featured heavily in their lifestyle. Four people were known to have mental health concerns
- the classification of death for two of these people was alleged murder. Two deaths were caused by an apparently self-inflicted act and two deaths were from natural causes. Two classifications are not known at this time

Twenty-six fatalities related to a concern about a person's **risk of self-harm, risk of suicide, or their mental health**. In such cases, the concerns are usually raised with the police by a third party, about a person with known mental health concerns. For example, the person may have failed to attend an appointment or welfare check, or show signs of being at risk of self-harm or suicide. The person is not reported or considered missing. Of these:

- 17 people were men and nine were women
- 25 were White and one was Asian
- the ages of the people ranged from 17 to 81 years. The majority were aged between 41 and 50 years (12 people). The average age was 43 years
- death by self-inflicted means was the most common classification (21 people)
- 15 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

Two incidents involved use of force:

- Police were called to a concern for welfare for a man who had tested positive for COVID-19 and was in isolation. An officer attended the property and the man jumped from a first-

floor window. An ambulance was requested. The man was handcuffed. Paramedics arrived and attempted to place a mask and visor on the man because he was spitting. The man, who continued to be restrained on the floor, apparently shook these off and was moved to an ambulance to be taken to hospital. There was a reported delay in entering the hospital owing to a backlog of ambulances. While in the ambulance an officer placed a spit hood over the man. The man then became unresponsive. He was taken into hospital where he died shortly afterwards. His cause of death is awaited.

- A man made several calls to police, reporting that there was someone outside his property. Officers attended his address and found the man lying on the floor, in an apparently distressed state and shaking. The man was handcuffed and at various points officers held the man's arms, handcuffs, and legs. An ambulance was called, and one officer sat over his legs. The ambulance arrived and the man's handcuffs were removed. The man's condition deteriorated whilst being transported to hospital and he died shortly after arrival. His cause of death was reported as *cocaine, heroin and ethanol use*.

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

- eleven people were men and four were women
- 11 were White, two were Black, one was Asian and the ethnicity of one person was unknown
- the majority of people (ten) were aged under 50 years. The average age was 41 years old
- two thirds of those who died (ten) were reported to be under the influence of alcohol and/or drugs at the time of the incident, or these featured heavily in their lifestyle
- the most common form of death classification was accidental overdose (five people). Three deaths were deemed to be due to natural causes
- three incidents involved use of force
- Police responded to an emergency call about a man who was having a seizure. Ambulance staff were also alerted to the incident. When officers arrived, the man appeared to be agitated and distressed. The man apparently tried to run away, and two officers took hold of the man's arms whilst stood up, one arm each, to restrain him. The man was also handcuffed. An ambulance arrived and the man was walked to and then carried into the ambulance. The man was strapped into a stretcher and his handcuffs unlocked. He then became unwell and his handcuffs were removed. Ambulance staff and officers provided medical treatment, and the man was taken to hospital. He died shortly after arrival. His cause of death was reported as *1a) left hemothorax and inhalation of blood, 1b) broncho-pulmonary fistula, 1c) ascending aortic aneurysm*.
- Officers arrived at a property following a report of a concern for welfare. Shortly after arriving, officers called for an ambulance as there were concerns regarding the wellbeing of a man in the property. The man was handcuffed and leg restraints were applied. The man's condition deteriorated during this time and the handcuffs were removed. Paramedics arrived and provided medical treatment prior to moving him to an ambulance. The man was taken to hospital where he died shortly after arrival. His cause of death is awaited.
- Police were called by the fire service to a report of a man in possession of a knife. Officers arrived and began searching for the man. Body worn video shows that when the man was found he was inflicting wounds to himself with a knife. The man's relative

had also arrived at the scene and tried to get the knife from him. One officer then twice discharged a Taser in an attempt to stop him inflicting further injury to himself. The first discharge failed due to a cartridge fault. The second discharge worked, and the Taser barbs connected with the man's back. Officers, paramedics and the fire service provided first aid to the man, but he died at the scene. His cause of death was reported as *incised wound to the neck*.

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

- 17 of those who died were women and four were men. Women were a higher proportion in this category than in all the other independently investigated deaths following police contact.
- 15 people were White, four were Black and the ethnicity of two people was not known at the time of publication.
- the most common age range was 21 to 30 years (six people). The average age was 33 years. The youngest was one year.
- in 18 instances, the deaths were classified as alleged murder. All but four of those who were allegedly murdered were women. One death was self-inflicted, one was from natural causes, and one was accidental.
- One incident involved use of force, by members of the public only. A woman phoned the police to report that her ex-partner had attended her property, assaulted a child and was now being restrained by another adult. Officers were dispatched to attend but went to the wrong address. A further call was made to police reporting that the man was being restrained inside the property. Officers arrived and discovered the man was not breathing and they provided first aid. An ambulance arrived and paramedics took over treatment and transported him to hospital. The man died two days later. His cause of death was reported as *1a) Hypoxic ischaemic brain injury 1b) compression of the neck*.

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

- two were men and one was a woman. Two people were White. The ethnicity of one person was unknown. All people were over 50 years
- in all three incidents the classification of death was alleged murder

Other contact

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

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

- a 49-year-old White man called police in the early hours of the morning to report that another man was refusing to leave his home. Police called back a short while later and the man stated that he was fine. That afternoon a member of the public called police reporting that shouting and banging was coming from their upstairs neighbour and he believed that two other people were in the property. A little while later the neighbour made a further call to report ongoing fighting at the same address. The police arrived at the address approximately an hour after this call and found that the occupier had died. His cause of death was reported as *1a. Traumatic Subarachnoid Haemorrhage 1b. Left Vertebral Artery Dissection 2. Acute Alcohol Intoxication*

- A 26-year-old Asian man was involved in a road traffic collision. A passing police officer saw the collision and stopped to help. He was told members of the public had detained the man a short distance from the scene of the collision. The officer drove to where the man was being restrained on the floor by members of the public. The members of the public and the officer continued to restrain the man while the officer handcuffed him. The man was left lying on the ground and became unresponsive. Other officers arrived at the scene and the man's handcuffs were removed and first aid given. An ambulance was requested and attended to provide first aid, but the man died at the scene. His cause of death was reported as *Consequences of cocaine toxicity and coronary artery atheroma in temporal association to restraint due to agitation*.
- a 48-year-old White man called the police because he wanted another man to leave his house. The caller alleged the other man had assaulted him. Police officers attended the address and the other man was transported to hospital, as he said he had lost his medication. Later that evening police were called to reports that the 48-year-old man had been stabbed by the other man, who had returned to the address. His cause of death is awaited.
- A member of the public called police to report a disturbance involving several men outside their property. The caller stated the men were threatening violence to each other. A short while later police were called to reports that a man had been stabbed in the street. This related to the earlier incident that the police received a call for. The man, who was White and aged 45, died at the scene. His cause of death was reported as *stab wound to the chest*.

Two men died in incidents where they attempted to avoid **police contact or arrest**.

- Police officers were on duty patrolling a towpath on bicycles. The officers saw a group of four men on bicycles and electric scooters making their way up the towpath and decided to approach them. One, a 23-year-old Black man, cycled towards a lock with an officer in pursuit. The man apparently fell from his bicycle and a struggle ensued with the officer. The officer believed the man had a weapon and released him. Shortly after, the man entered the lock. The officer entered the water to try to find the man and a wider search was undertaken without success. The man's body was found in the lock the next day. His cause of death was reported as *drowning*.
- Two police officers were travelling in a police vehicle that had an Automatic Number Plate Recognition (ANPR) camera system. Officers reported the ANPR system was triggered by a car that had been reported as stolen. The police vehicle caught up with the car and indicated that it should stop. The car pulled over and a 56-year-old White man got out of the car. An officer took hold of his arm and a struggle began. A second officer reported the man put an item in his mouth.

  The officers stated that they continued to struggle with the man, and during this struggle the man ended up on the ground. He was handcuffed and officers reported he then became unresponsive. They removed his handcuffs, and the officers gave the man first aid and requested an ambulance. The man was taken to an ambulance where a package was removed from his airway. He was taken to hospital where he died shortly after arrival. 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 makes it difficult to identify a specific set of events that accounts for changes in the number of fatalities. The overall proportion of cases relating to a concern for welfare made up 94% of the deaths following police contact that were independently investigated – in 2019/20, the proportion was 86%.

During 2020/21, just over a quarter of investigations into deaths following police contact related to incidents where someone had reported being concerned about a person's risk of self-harm, risk of suicide, or mental health. Just over a fifth of the deaths following police contact were domestic-related. These types of concern for welfare both link to current areas of thematic work for the IOPC. This may result in the number of these types of investigations increasing and/or forming a larger proportion of the 'other contact' deaths that the IOPC investigates independently.

It is also possible that the coronavirus lockdowns had an impact on the number and types of contact that the police had with the public.

8

Background note

Background note

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

2 Since April 2006, the IOPC, previously the IPCC, has also received mandatory referrals for cases where someone has died during or following contact with Her Majesty's Revenue and Customs (HMRC)[22]; the Gangmasters and Labour Abuse Authority (GLAA)[23], and the Serious Organised Crime Agency (SOCA).

Since October 2013, we have also received mandatory referrals from SOCA's replacement, the National Crime Agency (NCA). Up until March 2013, we received cases from the UK Border Agency (UKBA)[24], when UKBA's executive agency status was ended and its functions were brought back into the Home Office as UK Visas and Immigration (UKVI); UK Immigration Enforcement (UKIE); and UK Border Force (UKBF). The IOPC continues to have jurisdiction over these officials and contractors. Therefore, this report includes deaths during or following contact with staff from these organisations.

3 In January 2018, we became the IOPC. This change was set out in the Policing and Crime Act 2017. Before this, we were the IPCC.

22 Regulation 34 of the Revenue and Customs (Complaints and Misconduct) Regulations 2005. 19 Regulation 36 of the Gangmasters and Labour Abuse

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

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

Changes and revisions

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

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

6 This report presents the most up-to-date set of figures for each death category. In this release, no fatalities have been added to previous year's figures. However, the following adjustments have been made to the trend figures:

- For 2015/16, one fatality has been added to the 'other deaths following police contact' figure and another fatality has been added to the 'apparent suicides following police custody' figure.
- For 2016/17, one fatality has been removed from the 'other deaths following police contact' figure and another fatality has been removed from the 'apparent suicides following police custody' figure.
- For 2017/18 one fatality has been added to the 'other deaths following police contact' figure.
- For 2018/19 one fatality has been removed from the 'other deaths following police contact' figure.

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

7 Table 6.1 sets out the reasons for detention for apparent suicides following police custody. In previous years, this table has shown the number of fatalities with footnotes to highlight where there were additional reasons for detention. Due to the high volume of fatalities with multiple reasons for detention in 2020/21, the figures shown in Table 6.1 are the total number of different reasons for detention. We also took this approach in our 2018/19 and 2019/20 reports.

Methods and definitions

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

Policies and statements

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

- confidentiality and security of data
- statement of administrative sources
- revisions policies
- announcing changes to methods
- quality assurance

- > pre-release access
- > user engagement strategy
- > pricing policy

Users, uses and engagement

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

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

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

13 Users of these statistics should 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 has been published. Read our revision policies for information about how we manage routine amendments and errors to published data.

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

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

Further information

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

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

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

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

19 If you have any questions or comments about our annual death reports, please email research@policeconduct.gov.uk.

20 Estimated publication date for our next report covering data for 2021/22: July/August 2022.

Appendix A: additional tables

Table A1 Incidents by type of death and financial year, 2010/11 to 2020/21

	Incidents										
	Financial year										
Category	10/11	11/12	12/13	13/14	14/15	15/16	16/17	17/18	18/19	19/20	20/21
Road traffic incident	24	19	23	11	13	20	28	27	33	24	20
Fatal shootings	2	2	0	0	1	3	6	2	3	3	1
Deaths in or following police custody	21	15	15	11	18	14	14	23	17	18	19
Apparent suicides following custody^	46	39	65	70	71	61~	56~	57	63	54	54
Other deaths following police contact*	49*	37	20	41	43	103~**	128~	171~	151~	104	91

^ 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, 2020/21

Gender	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Male	21	1	17	49	52
Female	4	0	2	5	40
Total fatalities	25	1	19	54	92

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

Table A3 Type of death by age group, 2020/21

Age group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Under 18	5	0	0	0	8
18 - 20	5	0	0	3	2
21 - 30	8	0	3	11	18
31 - 40	3	0	6	13	16
41 - 50	3	0	7	15	26
51 - 60	0	1	2	8	14
61 and over	1	0	1	4	7
Total fatalities	25	1	19	54	92**

* This category includes only cases subject to an independent investigation
** The age group of one person was unknown at the time of analysis.

Table A4 Type of death by ethnicity, 2020/21

Ethnicity group	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
White	18	1	17	50	74
Black	2	0	2	2	10
Asian^	3	0	0	0	4
Mixed	0	0	0	2	0
Other	0	0	0	0	0
Not known	2	0	0	0	4
Total fatalities	25	1	19	54	92

* 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, 2020/21

**Appropriate authority	Road traffic incident	Fatal shootings	Deaths in or following police custody	Apparent suicides following custody	Other deaths following police contact*
Avon & Somerset	0	0	0	0	2
Bedfordshire	0	0	0	2	1
Cambridgeshire	0	0	1	1	1
Cheshire	1	0	0	2	1
City of London	0	0	0	0	0
Cleveland	0	0	0	2	0
Cumbria	0	0	0	2	1
Derbyshire	0	0	2	1	0
Devon & Cornwall	1	0	3	2	3
Dorset	0	0	0	0	0
Durham	0	0	0	0	0
Dyfed Powys	0	0	0	1	0
Essex	0	0	1	0	3
Gloucestershire	0	0	0	0	0
Greater Manchester	3	0	0	1	7
Gwent	0	0	0	1	1
Hampshire	1	0	1	2	1
Hertfordshire	0	0	0	0	3
Humberside	0	0	0	0	1
Kent	1	0	0	2	3
Lancashire	0	0	0	0	4
Leicestershire	0	0	1	2	0
Lincolnshire	0	0	0	1	2
Merseyside	0	0	1	1	3
Metropolitan	4	0	2	6	16
Norfolk	0	0	2	1	0
North Wales	1	0	0	0	1
North Yorkshire	0	0	0	0	3
Northamptonshire	0	0	0	0	0
Northumbria	0	0	0	1	2
Nottinghamshire	1	0	0	1	0
South Wales	0	0	1	0	3
South Yorkshire	0	0	2	0	3
Staffordshire	0	0	0	0	1
Suffolk	0	0	0	1	1
Surrey	0	0	0	3	1
Sussex	0	0	0	2	2
Thames Valley	2	0	2	4	1
Warwickshire	0	0	0	1	1
West Mercia	2	0	0	0	1
West Midlands	5	0	0	0	8
West Yorkshire	3	0	0	5	5
Wiltshire	0	1	0	3	1
Metropolitan and Surrey	0	0	0	0	1
Metropolitan and Thames Valley	0	0	0	0	1
Northumbria and Metropolitan	0	0	0	0	1
Thames Valley and West Midlands	0	0	0	0	1
British Transport Police and Nottinghamshire	0	0	0	1	0
British Transport Police and Metropolitan Police	0	0	0	0	1
British Transport Police	0	0	0	2	0
Home Office~	0	0	0	0	0
Her Majesty's Revenue and Customs	0	0	0	0	0
Ministry of Defence	0	0	0	0	0
National Crime Agency	0	0	0	0	0
Total fatalities	25	1	19	54	92

* This category includes only cases subject to an independent investigation.
** Most cases involve one appropriate authority, where two are involved these are shown in the table on a separate line to the main counts for those approporiate authorities.
~ This includes UKBF, UKIE and UKVI.

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We welcome telephone calls in Welsh

Rydym yn croesawu galwadau ffôn yn y Gymraeg

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