Government Statistical Service

National Statistician's Review of IPCC statistics on deaths during or following police contact

March 2012

The National Statistician

The National Statistician – a statutory office holder – is also the Chief Executive of the UK Statistics Authority Board and the Board's principal adviser on:

- the quality of official statistics
- good practice in relation to official statistics, and
- the comprehensiveness of official statistics.

She is also the Head of the Government Statistical Service (GSS) which is a network of professional statisticians and their staff operating both within the Office for National Statistics and across more than 30 other government departments and agencies.

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Executive Summary

The Independent Police Complaints Commission (IPCC) produces statistics on deaths during or following police contact. The purpose of this review was to gain a full understanding of the factors that led to public criticism of the statistics on or around 31 January 2012 and establish what basis in fact those concerns have. We conclude that both publications have been collated conscientiously with a consistent process that is followed routinely for the annual statistics. However, there are a number of changes that could be implemented to avoid any misunderstanding on the part of users and enhance public confidence. We have concluded that the four specific cases criticised as being incorrectly classified have been correctly classified and presented in the publications where appropriate by the research team. This report makes recommendations to address the concerns raised by users of the statistics and assist the producers to take actions that will bolster public confidence in the statistics.

The full Terms of Reference for this review are set out in **Annex A**.

Background

A File on Four programme, *Police restraint*, broadcast on BBC Radio 4 on 31 January 2012, criticised the IPCC's statistics on restraint related deaths in police custody. There were also news articles in The Independent newspaper, on the Bureau of Investigative Journalism website and on the BBC news website. There were two specific criticisms made against the IPCC:

- Some specific, high profile cases are not properly classified in the figures as deaths in custody
- The figures involving police restraint are incorrect

Links to the Radio 4 programme and news articles are listed in **Annex B**.
Jane Furniss, Chief Executive of IPCC, wrote to Jil Matheson, the National Statistician, on 2 February inviting her to carry out an independent review of the statistics produced by IPCC on deaths following police contact.

This review considered two publications produced by the IPCC:

- An annual set of official statistics: *Deaths during or following police contact*[1], (herein after referred to as 'the annual statistics'). The publication presents figures on deaths occurring between 1 April and 31 March each year that fall into one of five categories and an overview of the nature and circumstances in which these deaths occurred.
- A one off study: *Deaths in or following police custody: an examination of the cases 1998/99 – 2008/09* [2], (herein after referred to as 'the one off study'). The publication presents figures on deaths that fall into the category 'deaths in or following police custody' and an overview of the nature and circumstances in which these deaths occurred. The publication also identifies trends in the data and lessons that can be learned for policy and practice to prevent future deaths from occurring.

[1] http://www.ipcc.gov.uk/en/Pages/reports_polcustody.aspx

[2] http://www.ipcc.gov.uk/en/Pages/deathscustodystudy.aspx

Collation and production of the annual set of official statistics: "Deaths during or following police contact: Statistics for England and Wales 20XX/YY (financial year)"

Under the Police Reform Act 2002, there is a statutory duty to refer to the IPCC any complaint where there is an allegation that the conduct complained of has resulted in death or serious injury or any recordable conduct matter that alleges that the police failed to take action which could have prevented someone's death. Where there has been no complaint or recordable conduct matter, a death should also be referred if at or before the time of death the person had contact with the police or there is an indication that police contact directly or indirectly caused or contributed to the death. The IPCC considers the circumstances of all the deaths referred to it and annually reports on those deaths which meet these statutory criteria. There are ten categories of deaths during or following police contact plus one 'not included elsewhere' category.

Annual statistics are produced on deaths occurring within a financial year that fall into the following five categories:

- Road traffic incidents
- Fatal shootings
- Deaths in or following police custody
- Deaths during or following other police contact
- Suicide following custody (within 48h of release from custody or more than 48h after release where the period spent in custody may be relevant to the subsequent death)

Cases that fall into the remaining categories of deaths are not included in the publication as there is no evidence to suggest that deaths in these categories are directly related to the police contact. Detailed definitions for all of the categories and further information on definitions used in the publications and what each category does and does not include are listed in **Annex C**.

The annual statistics also include information on 'cause of death'. This is distinct from 'category of death' and is an extensive list – the statistics include any cause of death reported in the post mortem or certified by the attending doctor that occurred during that year. 'Restraint related' is a listed cause of death in the annual statistics and one off study, meaning that it has been identified as having been a factor in the death and is undisputed by the certifying doctor, pathologists conducting the post mortem and during any inquest. If restraint directly results in death it is listed as a primary cause of death; if it is deemed relevant it is listed as a secondary cause of death in the one off study. The annual statistics do not provide this degree of detail and only have one level for cause of death.

Any cases involving a death are extracted from a case tracking management system using a data warehouse tool and imported into excel - this is done regularly throughout the year so that cases extracted are checked against existing cases to ensure that all death cases are captured and that there is no duplication.

Circumstances of all deaths referred to the IPCC are examined to determine which of the above categories the case falls into and whether they fall into any of the five categories reported in the annual statistics. Cases are categorised based on the information available from investigation reports, referral documents, post mortems and information from caseworkers and the police forces themselves. Where information extracted from the case tracking management system is unclear or unavailable (e.g. circumstance of death, whether there was intent to arrest or detain the individual) further advice is sought from the caseworker, investigator or police force. Cases are categorised by

one person and then rechecked by another member of the research team. Cases are also checked against a master dataset containing all deaths since 2004 (when the IPCC was established) throughout the year as more information about a case becomes available to ensure no data are missing. Once classified, cases are sent out to IPCC investigators, the press team, caseworkers and commissioners and to the respective police forces for validation – to confirm that each case has been put into the correct category and that there are no cases missing or cases included that should not have been classified into one of the five categories reported in the statistics. The dataset containing all cases that fall within the five categories for a financial year is then finalised – it will include information on; circumstance of death; cause of death; reasons for detention (if in custody); demographics. Cause of death is only included once a post mortem has been carried out or the death has been certified by the attending doctor. For any cases where restraint being a cause of death is officially disputed, restraint is not listed as a cause of death. Cases without a cause of death yet are not listed under a specific cause of death category but are listed under the category 'Awaited'. Cases where cause of death could not be determined from a post mortem or inquest are listed under 'Unknown'.

A report is written presenting and summarising the statistics and key findings for each of the five categories of death included in the publication. This is then discussed at an IPCC management board and the report is sent to commissioners for comment before a final draft of the report is produced. A final draft is then sent to the Chief Executive to quality assure. An embargoed version of the final report is sent to key stakeholders and the police forces to allow them to prepare for the release. The annual statistics contain the definitions for the categories of death included in the report and some examples of each scenario.

Collation and production of the one off study: "Deaths in or following police custody: an examination of the cases 1998/99 – 2008/09"

The one off study only reports and analyses cases that fall into the category of death 'death in or following police custody'. This is the third police contact category of five that appears in the annual statistics as described above. Deaths that fall into any of the other categories of death are not included in the study. The reasons for focussing solely on this category of death are explained in the Introduction to the publication. It was felt that there was a need for a more thorough insight into deaths of this nature. The research team set up a user group to consult on all aspects of the production of the one off study. The content of the publication was discussed with this user group at the onset of the study. The group comprised experts and interested parties from a range of organisations.

Chapter 3 in the one off study examines deaths in police custody involving police restraint in detail. However, as this study only examines deaths in or following police custody it will not include any individuals where restraint was a primary or secondary cause of death but the individual was not in police custody, as they had not been arrested or detained under Section 136 of the Mental Health Act 1983. IPCC sought information on cases pre 2004 (when the organisation was formed) from the Home Office, Police Complaints Authority archives and direct from police forces. For cases from 2004 onwards the study was only based on those cases that had been included in the yearly statistical publications on deaths during or following police contact within the category 'deaths in or following police custody'. This included some cases where the individual had been restrained and had been arrested/detained already or there was intent to arrest/detain. Cases where restraint was involved but the individual had not already been arrested/detained and there was no intent to arrest/detain are not included in this study as they do not fall into the category 'deaths in or following police custody'. This is not explicitly highlighted in the report for the one off study.

Further information about the collation and production of the two publications is available in **Annex D**.

During the course of this review we found that processes for collating and classifying cases and producing statistics and reports were well documented and readily to hand, but that such documentation has not been published and so is not available to users of the outputs.
We conclude that both publications have been collated conscientiously with a consistent process that is followed routinely for the annual statistics. However, there are a number of changes that could be implemented to avoid any misunderstanding on the part of users and aid public confidence.

Examination of the criticisms made of specific cases

The BBC File on Four programme made a number of criticisms which have been examined in detail:

1. Criticism: There are figures available on the number of deaths in police custody since 1998/99 but there is no equivalent figure available on the number of restraint related deaths for the same period.

The one off study on deaths in police custody examined custody deaths which occurred during the period between 1998/99 and 2008/09 and included a chapter which looked specifically at restraint related custody deaths. The IPCC has not produced a report that focuses solely on all deaths where restraint has been a factor. However, figures relating to cause of death (including whether restraint caused or was directly related to the death) are published in the annual statistics, but only where it is the primary cause of death.

2. Criticism: If an individual comes into contact with the police and is not arrested or detained, but is restrained and dies, this individual will not be included in the deaths in police custody figures.

The statement is factually correct, however such cases are outside the scope of the one off study. These individuals are included in another category of death: 'Deaths during or following other police contact', which includes deaths where the fatality follows contact with the police that did not involve arrest or other detention'. This category is not included in the one off study, but is included in figures given in the annual statistics publication. Restraint would only be shown as a cause of death where it is the primary cause of death.

3. Criticism: there are some cases where the individual was restrained by the police but the case is not recognised in the figures as a restraint related death.

A cause of death is only recorded in the figures where the cause of death is conclusive following a post mortem, inquest or as certified by the attending doctor. Where a cause of death, including restraint, is disputed or inconclusive, it is not listed in a specific category in the statistics but is listed in the category 'Unknown'. There are some cases where the individual was restrained but it was not concluded collectively that restraint was a factor which either directly resulted in death (primary cause of death) or is relevant to the death (secondary). These cases would therefore not have restraint listed as a cause of death in the figures. Decisions on cause of death and whether there was intent to arrest/detain are not made by researchers who produced the one off study and who produce the annual statistics – cause of death is determined only by a post mortem, doctor's report or the verdict of an inquest.

4. Criticism: How are the figures collated by the IPCC and what care has gone into ensuring that they are properly representative of the cases and the investigations that they have been directly involved in?

A description of how the figures are collated has been outlined. A full explanation can be found in **Annex D.**

5. Criticism: Four specific high profile cases were not included in the one off study with a cause of death listed as restraint related.

IPCC researchers make a judgment on how to classify the cases into a specific category of death, but the decision on how to classify each case depends on information from the inquest, post mortem or attending doctors' reports, pathologists' verdicts and information from investigators/police forces – researchers who produce the statistical publications are bound by the verdicts and information available from these sources. The four cases have been examined and details of how they have been classified and justifications for this are set out for each case below.

Cases 1, 2 and 3

- Deaths occurred prior to the inception of the IPCC in 2004.
- All fall into the category 'deaths in or following police custody' – the individuals were arrested/detained or there was intent to arrest/detain. All three cases feature in the one off study. There are no annual statistics available for the years in which the individuals died.
- The deaths were not reported as restraint related in the publication as either:
    - an open verdict for cause of death was recorded by a High Court judge.
    - The primary cause of death was agreed but the underlying/contributing factor of restraint was disputed by pathologists
    - the cause of death was recorded as inconclusive following two post mortems.

  The one off study does state that "It should be noted that it is not always clear whether or not the death was related to the restraint because there may be a disagreement between medical practitioners over the cause of death, or they may find it impossible to determine the precise cause. There may therefore be some additional cases where the restraint may have contributed to the death but it is not clear from the medical evidence."

Case 4

- Death occurred after the IPCC's inception. The IPCC conducted an independent investigation.
- Falls into the category 'deaths during or following other police contact' - there was no intent by officers to arrest/detain so the individual is not included in the category 'deaths in or following police custody'. The individual therefore is not included in the one off study on deaths in or following police custody but is included in the annual statistics for 2008/09 on deaths during or following police contact.
- The cause of death is recorded in the annual statistics as 'Awaited' as the inquest into the death was ongoing at the time of publication of the statistics. At the inquest the jury returned a narrative verdict.

We have concluded that the four cases where the classification was queried have been correctly classified and presented in the publications where appropriate by the research team. However, the annual statistics and one off study should be more explicit that causes of death are only listed in the

publications when they are conclusive and undisputed by pathologists, the certifying doctor, or after the conclusion of an inquest.

Overall conclusions

We conclude that some confusion may have been caused as users, including the media reports did not appreciate that the one off study only included individuals who had died in or following police custody and did not include any individuals who had died during or following police contact but had not been arrested or detained. It also may not have been apparent that these cases are included in the annual statistics under the category 'deaths during or following police contact'.

The two publications are produced using a rigorous process and we have found no evidence that the figures are incorrect or that cases that should have been included in either publication have not been. During the course of this investigation we were readily able to obtain internal documentation from the IPCC research team which fully described the processes for classifying and processing all deaths following police contact cases and for the procedures used to compile the annual statistics and one off study. However, the producers could do more to improve users' understanding of the differences between the two publications, how deaths are classified and cause of death is determined, and the process for producing the statistics. For the sake of transparency all relevant internal documentation should be published and care should be taken to ensure that explanatory commentary is prominently placed in both the annual statistics and any one off studies.

The research team should consider putting the annual statistics forward for an assessment by the UK Statistics Authority against the Code of Practice for Official Statistics. An Assessment is an end to end process which determines whether the statistics are fully compliant with the Code of Practice for Official Statistics and thus appropriate to be designated as National Statistics. Producers of the statistics are required to submit information on users/suppliers of the statistics as well as detailed written evidence on the production of the statistics for analysis by the Assessment team. Findings from Assessments are included in a published report which provides a considered assessment of the strengths and weaknesses of the statistical activities being assessed and covers all aspects of the work leading to the statistical output/publication and its dissemination. Achieving National Statistics status would safeguard the quality of the statistics and help the producers enhance the quality of the statistical service over time. It would enhance public trust in the statistics by demonstrating that they meet the required quality. A National Statistics Assessment would not prevent IPCC from maintaining its independence from the Home Office. Due to the current Assessment timetable within UK Statistics Authority, it is likely that the annual statistics would be assessed in time for the 2012/13 publication in July 2013.

We conclude that the criticisms made about the publications, that some specific, high profile cases are not properly classified in the figures as deaths in custody and that the figures involved police restraint are incorrect, are unsupported and may have been due to a misunderstanding about the scope of the definition 'deaths in or following police custody' and how causes of death are recorded in the publications.

Recommendations

- **Make clear from the outset where future research studies are one off publications and how they relate to the regular statistical publications**. Describe any differences in coverage early on in the executive summary or introduction so that users fully understand the information

presented. Ensure that front covers of regular statistics and one off studies cannot easily be confused. Cross reference one off studies to regular statistics produced to ensure users are clear from the outset that they are separate publications.

- **Provide users with more information on the process for compiling the statistics – to improve trust in the statistics and how they are produced.** Any useful information should be published as a standalone document alongside the publications on the IPCC website. The following would be useful to users:
    - Information on the process for collating the statistics.
    - Further information on how each case is classified.
    - Information on cause of death and how this is determined.
    - Information relating to restrictions on releasing names of individuals included in the publications.
- **Consider including in the annual statistics more detail on cause of death, including figures for secondary cause of death.**
- **Consider putting the annual statistics forward for an assessment by the UK Statistics Authority against the Code of Practice for Official Statistics.**
- **The research team should also further develop its working relationship with the Home Office Head of Profession for Statistics**, **whilst being mindful of the IPCC's independence from the Home Office.** On professional statistical matters, the Home Office Head of Profession reports to the National Statistician rather than to the Home Office. He has a broad range of experience in producing National Statistics in the criminal justice field and could offer advice on how to improve and maintain public confidence in the statistics, provide advice on following the Code of Practice for Official Statistics, and help safeguard the professional integrity of the statistics.

Annex A

Terms of Reference

Aim of the review

- Conduct an independent statistical review into the collation, analysis and presentation of IPCC official statistics on deaths during or following police contact and the ten year study of deaths in police custody.
- Ascertain if the statistics accurately reflect the totality of all deaths during or following police contact.
- Gain a full understanding of the factors that led to public criticism of the statistics, on and around 31 January 2012 and what basis in fact those concerns have.
- Make recommendations which address the concerns of the users of the statistics and assist the producers to take actions that address concerns in public confidence in the statistics.
- Complete the review by 31 March 2012.
- Publish a report on the National Statistician's pages of the UK Statistics Authority website and on the IPCC website.

Background

- A number of media organisations presented news items on Tuesday 31 January which were critical of IPCC figures on deaths following police contact, and in particular figures on cases involving the use of restraint by police officers.
- Two specific criticisms are made against the IPCC:
    - Some specific, high profile cases are not properly classified in the figures as deaths in custody
    - The figures involving police restraint are incorrect
- The review will examine statistical releases and analytical reports in the public domain, public statements made by IPCC officials, the views of concerned users of the statistics and the relationship between the IPCC statisticians and the Home Office Head of Profession for statistics. The scope of the review may be extended if initial investigations deem it necessary.
- This independent National Statistician's review was initiated by Jil Matheson at the request of the Chief Executive of the IPCC.
- The review will be conducted by Tim Andrews of the National Statistician's Office, assisted by Claire Bradshaw.

Annex B

- **BBC Radio 4 File on Four programme**, *Police restraint*, broadcast on 31 January 2012

  http://www.bbc.co.uk/programmes/b01bb703
  Transcript from the programme (the section of the programme specifically on the IPCC statistics start at the end of page 15):
  http://news.bbc.co.uk/1/shared/bsp/hi/pdfs/31_01_12_fo4_policerestraints.pdf

- **BBC news article,** *Deaths in police custody figures 'understated'*, published on 31 January 2012

  http://www.bbc.co.uk/news/uk-16678970

- **Bureau of Investigative Journalism article,** *How many have died after police restraint? MP calls for inquiry*, published on 31 January 2012

  http://www.thebureauinvestigates.com/2012/01/31/how-many-have-died-after-police-restraint-mp-calls-for-inquiry/

- **Independent article**, *Rate of deaths in custody is higher than officials admit*, published on 31 January 2012

  http://www.independent.co.uk/news/uk/crime/rate-of-deaths-in-custody-is-higher-than-officials-admit-6297270.html

Annex C

Terminology

- **Deaths in or following police custody –** deaths of individuals who have been arrested or otherwise detained by the police. It includes deaths that occur while a person is being arrested or taken into detention or where there was intention to arrest.
- **Cause of death –** a factor which directly results in death (primary cause of death) or is relevant to the death (secondary).
- **Circumstance of death –** the situation the individual was in that resulted in death.
- **Reasons for detention –** the reasons that led to the individual being arrested or detained by the police.
- **Deaths during or following police contact –** deaths where the fatality follows contact with the police that did not involve arrest or other detention. The definition for this category changed in 2010/11 – so there are some cases that used to be included in this category but are not included from 2010/11. From 2010/11, only deaths subject to an independent investigation are included in this category. The reasons for this are explained in the publication for 2010/11 and further analysis presented shows what the figures for this category may have been under the old definition.

Death Category Definitions

These category definitions used from 2010/11 onwards. In that year there was a change to the definition of *category 4* deaths (other deaths in or following contact). There have been *no changes* to reported categories 1, 2, 3 or 5.

Category 1; Road Traffic Incidents

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

For example:

- A police van, with its lights activated, was responding to an emergency call when it collided with a pedestrian who was crossing the road. The pedestrian received fatal injuries and died at the scene.

- The deceased, a pedestrian, was attempting to cross a dual carriageway when she stepped into the path of an unmarked police vehicle. The woman received multiple injuries and was taken to hospital where she died of her injuries four weeks later.

- Police officers witnessed a car allegedly driven erratically and started to pursue the vehicle using sirens and blue lights. The driver of the pursued car hit a wall and died at the scene.

This would **not include**

- Deaths following a road traffic incident where the police have attended immediately after the event as an emergency service.

Category 2; Fatal shootings

Includes fatalities where police officers fire the fatal shots.

For example:

- Officers received a call reporting a disturbance in a block of flats. Police patrol officers attended the scene and saw the deceased in the landing of the flats, apparently armed with a firearm and a sword-like weapon. Armed response officers arrived and allegedly challenged the deceased on a number of occasions. He was then shot by an armed officer whilst standing at the first floor landing window. An ambulance was called but he was declared dead at the scene.

Category 3; Deaths in or following police custody

Includes deaths of persons who have been arrested or otherwise detained by the police. It includes deaths that occur while a person is being arrested or taken into detention. The death may have taken place on police, private or medical premises, in a public place or in a police or other vehicle.

This would **include** the following:

- Deaths which occur during or following police custody where **injuries** which contributed to the death were **sustained during the period of detention**. For example:
    - A man, who had allegedly been abusive and had assaulted a police officer, was arrested in the street by officers. During the arrest a struggle took place and the man collapsed. He was declared dead at the scene.
    - The deceased was arrested for drink driving. Whilst in custody he fell over three times and on one occasion banged his head on the floor. The deceased died two days after being released from injuries sustained during the time spent in custody.

- Deaths which occur **in or on the way to hospital** (or other medical premises) following or during **transfer** from police custody. For example:
    - Following his arrest, and while being transported to the police station, the deceased became ill in the police van. Officers took him to hospital where his condition continued to deteriorate. He died in hospital two weeks later.

- Deaths which occur as a result of **injuries or other medical problems** which are **identified** or **develop** while a person is in custody. For example:
    - During his arrest and detention, the deceased was identified as being intoxicated. While in custody, officers became concerned about his condition and he was taken to hospital where he died of related illnesses five days later.

- Deaths which occur while a person is in police custody having been detained under **Section 136** [*place of safety*] of the Mental Health Act 1983 or other legislation. For example:
    - On arrival at the police station, a Forensic Medical Examiner (FME) was called to check the deceased but was unable to see him due to the detainee's erratic behaviour. When the FME did eventually enter the cell the man had collapsed and efforts to revive him failed. An ambulance was called but he was declared dead in the cell.

This would **not include**:

- Suicides which occur after a person has been released from police custody.
- Deaths of individuals who have been transferred to the care of another agency and subsequently die whilst in their care.

Category 4; Deaths during or following other police contact

Includes deaths where the fatality follows contact with the police that did not involve arrest or other detention. The contact does not have to be directly with the deceased but may be with a third party. From 2010/11, only deaths subject to an independent investigation, which are carried out by the IPCC's own investigators, are included in this category.

Examples of the type of contact include:

- Deaths which occur after the police are called to attend a domestic incident which results in a fatality.
- Deaths which occur while a person is actively attempting to evade arrest. This includes instances where the death is self-inflicted.
- Deaths which occur when the police are in attendance at a siege situation, including where a person kills himself or someone else.
- Deaths which occur after the police have been contacted following concerns regarding a person's welfare and there is some concern about the nature of the police response.

Category 5; Suicide following custody

Includes all apparent suicides that occur within two days of release from police custody. It also includes apparent suicides which occur beyond two days of release from custody, where the period spent in custody may be relevant to the subsequent death.

(A) Apparent suicides that occur ***within 48 hours*** following release from police custody (excluding those following transfer to a prison or other secure setting, unless meet B criteria). For example:

- The deceased was arrested, taken to custody and detained. A risk assessment was carried out by the custody officer, who concluded that the deceased was fit for detention and did not require any medical attention. Later the same day, the deceased was released from custody. The following day he was found hanging in his hotel room.

(B) Apparent suicides which occur ***longer than 48 hours*** after release (including those following transfer to a prison or other secure setting) if a possible causal link between the apparent suicide and the period of time spent in police custody has been identified. For example:

- The deceased was arrested and detained for burglary offences. He was remanded to police cells by Magistrates and charged with additional offences. The deceased was conveyed to Prison and was found dead two days after being transferred there. Officers had assessed him to be a medium suicide risk; however, this information was not referred to on the Prisoner Escort Record form that accompanied the deceased to prison.

NB: Answering bail does not constitute 'custody'. If the deceased's last contact was when they were answering bail, and they then commit suicide, it can either be a Cat 4 (if an independent investigation) or a Cat 7.

Category 6; Suicide following custody (not included)

Includes deaths where the person took his/her own life more than two days after release and there are no concerns (i.e., raised by friends, family, or mention of police officers/custody in a suicide note) regarding the period spent in custody or officers' contact.

For example:

- The deceased was arrested for drink driving. He was bailed for attendance to Court at the end of the month. During his time in custody it was noted that the deceased appeared very down and so he was monitored via CCTV and placed on 30 minutes observation. He was released into the care of his wife and four days after being released, the deceased was found hanging at his home address.

Category 7; Suicide following contact

Includes deaths where the person took his or her own life after police contact and is NOT subject to an INDEPENDENT investigation.

Situation could include:

- Officers responded to a call from a woman who was concerned for her estranged boyfriend. The deceased was found by officers to be drunk and upset at the break up of their relationship. He was

left in the company of the former partner and two other friends who stated they would take the deceased home with them, or stop with him for the night to ensure his safety. The following day police officers responded again to the deceased's former girlfriend concerns as she was unable to contact him. Officers gained entry to the property and found the deceased hanging.

Category 8; Suicide prior to / during contact

Includes deaths where the police attended a suicide attempt already in progress and is NOT subject to an INDEPENDENT investigation.

Situation could include:

- Police were called to a male standing on the wall of a car park's top floor and threatening to jump. On arrival one officer asked the deceased to stand back away from the edge, and two other officers started to climb the stairs to approach him. The deceased fell from the wall onto the road below whilst officers were still going up the stairs.

Category 9; 'Other' following custody

Includes deaths where the person dies after being released from custody and the cause of death was

(a) not self inflicted [if suicide use Cat 5 or 6]; or

(b) not related to an injury/ condition that can be related to the time spent in custody.

For example:

- The deceased was arrested on suspicion of fraud. He was bailed, and was due to attend the police station again a week later. Three days after his release, having been out walking for the day, the deceased returned home and subsequently had a cardiac arrest from which he died.

Category 10; 'Other' following contact

Includes deaths where the fatality occurred after there had been some contact with police officers, not necessarily with the deceased person and is NOT subject to an INDEPENDENT investigation.

Situation could include:

- Police officers attended a call to assist the deceased who did not want to be removed from the hospital where he received treatment. Officers assisted the deceased to a flat across the road from the hospital and left him in the property with a friend. The following morning the lifeless body of the deceased was found in the flat to which he had been taken, apparently dying as a result of an accidental drug overdose.

Category – other; Not included

This category is used for any deaths that do not fit into one of the ten previously discussed categories.

For example:

- If officers were in close **proximity to a road traffic incident** but they were not involved in the events leading to the incident.
- If it is likely that the person was **already dead** when officers responded to a call.
- If the deceased's family complains about the way a **death investigation** was conducted.
- The death of **police personnel**.
- A **complaint** relating to the way the police investigated a death (even if this is an independent investigation). *Please check though that the death the complaint is related to has been previously captured/looked at (probably on death referrals) if necessary.*

Custody or contact

Here are some examples of when the case involves both custody and contact to help assist with the categorisation.

Example A – Cat.5 or 4
The individual has been arrested and commits suicide on the second day from release (cat.5). However, a few hours before the suicide he has 'contact' with police officers. If there;

a) is no concern regarding that contact i.e. the contact is coincidental and it is not an independent investigation – remains Cat.5.
b) is some concern regarding the contact i.e. during the interaction the individual is distressed but the police offer no assistance/ he is reported missing and the investigation is independent – change to a Cat.4.

If there has been no contact with the police after release from custody and the individual commits suicide within two days and is subject to an independent investigation – this is still a Cat.5

Annex D

Collation and production of the annual set of official statistics: "Deaths during or following police contact: Statistics for England and Wales 20XX/YY (financial year)"

Under the Police Reform Act 2002, there is a statutory duty to refer to the IPCC any complaint where there is an allegation that the conduct complained of has resulted in death or serious injury or any recordable conduct matter that alleges that the police failed to take action which could have prevented someone's death. Where there has been no complaint or recordable conduct matter, a death should also be referred if at or before the time of death the person had contact with the police or there is an indication that police contact directly or indirectly caused or contributed to the death. When cases are referred to IPCC they are input by case workers/administrators into a case tracking management system. There are ten categories of deaths during or following police contact plus one 'not included elsewhere' category. Yearly statistics are produced on deaths occurring within a financial year that fall into the following five categories:

- Road traffic incidents
- Fatal shootings
- Deaths in or following police custody
- Deaths during or following other police contact
- Suicide following custody (within 48h of release from custody or more than 48h after release where the period spent in custody may be relevant to the subsequent death)

There are also 6 other categories of deaths that are not included in the publications:

- Suicide following custody (not included – more than 48h after release and there are no concern regarding period spent in custody)
- Suicide following police contact
- Suicide prior to/during police contact
- 'Other' following custody
- 'Other' following contact
- Not included – any deaths that do not fit into one of the previous ten categories.

Cases that fall into the remaining categories of deaths are not included in the publication as deaths in these categories did not occur as a direct result of police contact.

The annual statistics also include information on 'cause of death'. This is distinct from 'category of death' and is an extensive list – the statistics include any cause of death reported in the post mortem or certified by the attending doctor that occurred during that year.

Any cases involving a death are extracted from the case tracking management system using a data warehouse tool and imported into excel - this is done regularly throughout the year so that cases extracted are checked against existing cases to ensure that all death cases are captured and that there is no duplication.

Circumstances of all deaths referred to the IPCC are examined to determine which of the above categories the case falls into and whether they fall into any of the five categories reported in the annual statistics. Cases are categorised based on the information available from investigation reports, referral documents, post mortems and information from casework colleagues and the police forces

themselves. Where information extracted from the case tracking management system is unclear or unavailable (e.g. circumstance of death, whether there was intent to arrest or detain the individual) further advice is sought from the caseworker or police force. It is worth pointing out that not all cases referred to IPCC are investigated. There are also different modes of investigation – there are independent investigations conducted by IPCC, as well as managed, supervised and local investigations which have varying degrees of collaboration between the police force and IPCC (except for local investigations which are conducted solely by the police force).

There is detailed information on what each category of death includes and does not include. Cases are categorised by one person and then rechecked by another member of the research team. Cases are also checked against a master dataset containing all deaths since 2004 (when the IPCC was established) throughout the year as more information about a case becomes available to ensure no data are missing. Once classified, cases are sent out to IPCC investigators, caseworkers and commissions and to the respective police forces for validation – to confirm that each case has been put into the correct category and that there are no cases missing or cases included that should not have been. The dataset containing all cases that fall within the five categories for a financial year is then finalised – it will include information on; circumstance of death; cause of death; reasons for detention (if in custody); demographics. SPSS is used to provide this information collectively for each category as well as the number of fatalities. Cause of death is only included once a post mortem has been carried out or a cause of death has been determined by an attending doctor without a post mortem. All cases investigated have a post mortem conducted or a cause of death certified by an attending doctor. A post mortem is conducted if a death has been referred to a coroner who feels a post mortem is necessary to determine the cause of death. The decision of whether or not a post mortem is conducted is a judicial one and is taken by a coroner. Only once the post mortem has concluded will a cause of death be listed unless it has already been decided by an attending doctor without the need for a post mortem. If there is a dispute over a particular aspect relating to the cause of death this aspect will not be listed as a cause of death. For any cases where restraint as a cause of death is disputed, restraint is not listed as a cause of death. Some cases also have an inquest following a post mortem which may result in the cause of death changing. As inquests and post mortems can take considerable amounts of time, the report uses the best information available at the time on cause of death. Cases without a cause of death yet agreed are not listed under a specific cause of death category.

A report is written presenting and summarising the statistics and key findings for each of the five categories of death included in the publication. This is then discussed at an IPCC management board and the report is sent to Commissioners for comment before a final draft of the report is produced. A final draft is then sent to the Chief Executive and Office to quality assure. An embargoed version of the final report is sent to key stakeholders and the police forces to allow them to prepare for the release.

Other information

The reports previously included raw text descriptions of each death in an annex. It was decided to stop including this as the descriptions were taken directly from the investigation report at the point the investigation was referred – some descriptions are subsequently disputed during the investigation. For cases where there has been an inquest, names of individuals who have died will be in the public domain. But for cases where there was no inquest, names will not necessarily be in the public domain, unless the death was report in the press. IPCC does not routinely release names of every individual included in the statistics.

The definitions for categories 1-4 were inherited in 2004 from the Home Office, who had up until then produced the statistics for deaths during or following police contact. From 2004 onwards other categories were expanded.

Collation and production of the one off study: "Deaths in or following police custody: an examination of the cases 1998/99 – 2008/09"

The ten year study is a one off research study that only reports and analyses cases that fall into the category of death 'death in or following police custody'. Deaths that fall into any of the other categories of death are not included in the study. The reasons for focussing solely on this category of death are explained in the Introduction of the publication (page 8): "The other categories of death are quite different [to the category 'deaths in police custody'] in nature and circumstance and the decision was therefore taken to focus only on deaths in or following police custody, where a duty of care is owed by the police to the individuals once they are detained, as they fall within their jurisdiction and control. Past IPCC research has examined police-related road traffic incidents which resulted in death or serious injury, and future research may look at some of the other categories of death".
IPCC sought information on cases pre 2004 (when the organisation was formed) from the Home Office, Police Complaints Authority archives and direct from police forces. There were data quality issues relating to the amount of information available for each case, for example inconsistent referral practices and missing information – however all cases were sifted to ensure they met the criteria for being in the category 'deaths in or following policy custody'. For cases from 2004 onwards the study was only based on those cases that had been included in the yearly statistical publications on deaths during or following police contact within the category 'deaths in or following police custody'. This included some cases where the individual had been restrained and had been arrested/detained already or there was intent to restrain. Cases where restraint was involved but the individual had not already been arrested/detained and there was no intent to restrain are not included in this study as they do not fall into the category 'deaths in or following police custody'.