ipcc
independent
police complaints
commission

Deaths in or following police custody:

Appendices

Maria Hannan, Ian Hearnden,
Kerry Grace and Tom Bucke
IPCC Research Series Paper: 17

Contents

Appendix A: Additional tables 1

Appendix B: Thoroughness of the investigation report for deaths in police custody 7

Appendix C: Logistic regression analysis – use of restraint 10

List of tables

Table A.1: Deaths in custody broken down by financial year and police force **2**

Table A.2: Deaths in custody by police force and rate of deaths per 100,000 notifiable arrests **3**

Table A.3: Deaths and cases in which restraint was used at any point by police force **4**

Table A.4: Investigation type in cases involving restraint at any point **5**

Table A.5: Cause of death for 'alcohol-only' cases **5**

Table A.6: Cause of death for 'drug-only' cases **6**

Table A.7: Cause of death for 'alcohol and drug' cases **6**

Table B.1: Investigation reports receiving a poor rating in terms of content **7**

Table B.2: Investigation reports receiving a high rating in terms of content **8**

Table C.1: Predicting restraint is a factor on a case **10**

Statistical note
In the percentage column presented in the tables, '-' denotes zero and '0' denotes less than 0.5%. Some percentages may add up to more or less than 100% due to rounding.

Appendix A: Additional tables

This Appendix provides some additional tables and analysis on some of the data provided within the main body of the report. Table A.1 provides further information on the number of deaths in custody by financial year and police force. Table A.2 shows the number of deaths by police force and a rate per 100,000 notifiable arrests (a more detailed version of Table 2.2).

Of the 87 cases involving restraint on arrest, during transportation or in custody or hospital, 33 occurred in the MPS area. This equates to 38% which, as Table A.3 shows, is a much higher percentage than is comprised by MPS cases in the whole sample (22%; 73 out of 333). Table A.2 shows that, including the MPS, the proportion of cases making up the restraint total of 87 was higher than the proportion of cases in the entire sample of 333 in nine police forces. These were: the MPS, Cheshire, Thames Valley, Essex, Hertfordshire, Humberside, Cleveland, Nottinghamshire, Staffordshire and West Mercia. However, the small numbers involved mean it is difficult to draw any conclusions from these figures for individual forces.

Table A.4 shows the investigation type in all 87 cases involving restraint. PCA supervised cases made up most (49) of these.

Tables A.5, A.6 and A.7 provide the cause of death for 'alcohol only', 'drug only', and 'alcohol and drugs' cases respectively. The tables provide both the primary and (where applicable) secondary cause.

Table A.1 Deaths in custody broken down by financial year and police force

Police force	1998/99	1999/00	2000/01	2001/02	2002/03	2003/04	2004/05	2005/06	2006/07	2007/08	2008/09	Total	%
Avon and Somerset	0	1	1	0	1	0	4	1	0	0	1	**9**	**3**
Bedfordshire	0	0	0	1	1	0	0	0	1	0	0	**3**	**1**
Cambridgeshire	1	0	0	1	0	0	0	0	0	0	0	**2**	**1**
Cheshire	0	1	0	2	1	0	1	0	0	2	1	**8**	**2**
City of London	0	0	0	0	0	0	0	0	0	0	0	**0**	**-**
Cleveland	0	1	1	0	0	0	1	0	0	1	0	**4**	**1**
Cumbria	2	0	0	1	0	0	0	0	0	0	0	**3**	**1**
Derbyshire	0	0	0	0	0	2	2	1	2	0	1	**8**	**2**
Devon and Cornwall	2	1	0	3	0	0	1	3	0	0	0	**10**	**3**
Dorset	0	0	2	0	0	2	1	0	0	0	0	**5**	**2**
Durham	0	0	0	0	0	0	0	0	0	0	0	**0**	**-**
Dyfed-Powys	0	2	0	1	0	0	0	0	1	0	0	**4**	**1**
Essex	1	2	0	0	1	0	0	3	1	0	0	**8**	**2**
Gloucestershire	1	0	0	0	0	0	1	0	0	0	0	**2**	**1**
Greater Manchester	2	2	0	1	2	2	3	2	2	3	1	**20**	**6**
Gwent	1	0	0	0	0	0	0	0	1	0	1	**3**	**1**
Hampshire	1	1	2	0	1	0	0	0	0	1	0	**6**	**2**
Hertfordshire	2	0	2	0	0	0	1	0	0	0	0	**5**	**2**
Humberside	2	0	1	3	0	1	0	0	0	0	0	**7**	**2**
Kent	0	1	0	0	0	1	1	1	1	1	0	**6**	**2**
Lancashire	3	1	0	1	1	2	0	1	1	2	0	**12**	**4**
Leicestershire	0	0	1	0	0	0	0	0	0	0	0	**1**	**0**
Lincolnshire	1	0	0	0	1	1	1	0	1	1	0	**6**	**2**
Merseyside	2	0	2	1	1	0	1	0	0	1	1	**9**	**3**
Metropolitan	9	12	4	5	9	7	5	6	4	5	7	**73**	**22**
Norfolk	1	0	0	0	0	1	1	0	1	0	0	**4**	**1**
North Wales	1	0	0	2	0	1	0	1	1	0	0	**6**	**2**
North Yorkshire	0	0	0	0	2	0	0	0	0	0	0	**2**	**1**
Northamptonshire	1	0	0	0	1	2	0	0	0	0	0	**4**	**1**
Northumbria	3	0	2	0	2	3	1	1	1	1	0	**14**	**4**
Nottinghamshire	0	0	0	0	0	2	0	0	1	0	0	**3**	**1**
South Wales	2	0	1	1	1	0	4	0	3	1	0	**13**	**4**
South Yorkshire	1	0	2	0	0	0	2	2	0	0	0	**7**	**2**
Staffordshire	0	0	0	1	0	0	0	1	0	0	0	**2**	**1**
Suffolk	0	0	1	1	1	0	0	1	1	0	0	**5**	**2**
Surrey	1	0	0	0	0	0	0	0	0	1	0	**2**	**1**
Sussex	2	0	1	0	3	0	0	2	0	0	0	**8**	**2**
Thames Valley	1	0	4	0	3	1	1	1	0	0	0	**11**	**3**
Warwickshire	0	1	0	0	0	0	1	0	0	0	1	**3**	**1**
West Mercia	0	1	0	0	0	2	0	0	0	1	0	**4**	**1**
West Midlands	2	2	1	0	3	2	0	1	2	0	0	**13**	**4**
West Yorkshire	4	2	2	1	0	0	3	0	2	0	1	**15**	**5**
Wiltshire	0	0	0	0	0	1	0	0	0	0	0	**1**	**0**
British Transport	0	0	0	1	0	0	0	0	0	0	0	**1**	**0**
HMRC	0	0	0	0	0	0	0	0	0	1	0	**1**	**0**
Total	**49**	**31**	**30**	**27**	**35**	**33**	**36**	**28**	**27**	**22**	**15**	**333**	**100**

Table A.2 Deaths in custody by police force and rate of deaths per 100,000 notifiable arrests

Police force	Total number of deaths 1998/99 - 2008/09	Percentage of deaths 1998/99 - 2008/09	Total number of notifiable arrests 1999/00 - 2008/09	Total number of deaths 1999/00 - 2008/09	Total number of deaths per 100,000 notifiable arrests 1999/00 - 2008/09
Avon and Somerset	9	3	282,422	9	**3.2**
Bedfordshire	3	1	145,542	3	**2.1**
Cambridgeshire	2	1	154,620	1	**0.6**
Cheshire	8	2	186,672	8	**4.3**
City of London	0	-	38,453	0	**-**
Cleveland	4	1	212,959	4	**1.9**
Cumbria	3	1	134,479	1	**0.7**
Derbyshire	8	2	212,234	8	**3.8**
Devon and Cornwall	10	3	279,283	8	**2.9**
Dorset	5	2	143,970	5	**3.5**
Durham	0	-	122,666	0	**-**
Dyfed-Powys	4	1	127,864	4	**3.1**
Essex	8	2	328,940	7	**2.1**
Gloucestershire	2	1	130,241	1	**0.8**
Greater Manchester	20	6	786,454	18	**2.3**
Gwent	3	1	155,266	2	**1.3**
Hampshire	6	2	430,396	5	**1.2**
Hertfordshire	5	2	191,462	3	**1.6**
Humberside	7	2	227,526	5	**2.2**
Kent	6	2	374,030	6	**1.6**
Lancashire	12	4	445,793	9	**2.0**
Leicestershire	1	0	204,336	1	**0.5**
Lincolnshire	6	2	187,572	5	**2.7**
Merseyside	9	3	421,183	7	**1.7**
Metropolitan	73	22	1,988,762	64	**3.2**
Norfolk	4	1	164,961	3	**1.8**
North Wales	6	2	184,347	5	**2.7**
North Yorkshire	2	1	202,593	2	**1.0**
Northamptonshire	4	1	135,273	3	**2.2**
Northumbria	14	4	494,720	11	**2.2**
Nottinghamshire	3	1	340,673	3	**0.9**
South Wales	13	4	323,377	11	**3.4**
South Yorkshire	7	2	366,348	6	**1.6**
Staffordshire	2	1	156,432	2	**1.3**
Suffolk	5	2	122,861	5	**4.1**
Surrey	2	1	164,009	1	**0.6**
Sussex	8	2	341,527	6	**1.8**
Thames Valley	11	3	535,125	10	**1.9**
Warwickshire	3	1	90,556	3	**3.3**
West Mercia	4	1	230,151	4	**1.7**
West Midlands	13	4	716,337	11	**1.5**
West Yorkshire	15	5	730,286	11	**1.5**
Wiltshire	1	0	92,124	1	**1.1**
British Transport	1	0	Not available	1	**Not available**
HMRC	1	0	Not available	1	**Not available**
Total England and Wales	**333**	**100**	**13,304,825**	**282^**	**2.1**

Source: figures are taken from notifiable arrest data published by the Home Office and the Ministry of Justice.
Some of the figures on notifiable arrests were estimates or were based on incomplete data when originally published. Other figures were revised in subsequent publications. Where revised figures were available the most up-to-date data was used.
Some figures for individual forces for some of the earlier years were not available in the original publications and have therefore been estimated by calculating the average for the force based on the data for the known years.
^This is the total number of deaths excluding deaths from 1998/99 and deaths from British Transport Police and HMRC, because data is not available for notifiable arrests for this year or for these organisations.

Table A.3 Deaths and cases in which restraint was used at any point by police force

Police force	Cases in sample		Cases in which restraint was used	
	N	%	N	%
Avon and Somerset	9	3	2	2
Bedfordshire	3	1	0	-
Cambridgeshire	2	1	1	1
Cheshire	8	2	4	5
City of London	0	-	0	-
Cleveland	4	1	2	2
Cumbria	3	1	0	-
Derbyshire	8	2	0	-
Devon and Cornwall	10	3	1	1
Dorset	5	2	1	1
Durham	0	-	0	-
Dyfed Powys	4	1	0	-
Essex	8	2	3	3
Gloucestershire	2	1	0	-
Greater Manchester	20	6	3	3
Gwent	3	1	0	-
Hampshire	6	2	1	1
Hertfordshire	5	2	3	3
Humberside	7	2	3	3
Kent	6	2	1	1
Lancashire	12	4	3	3
Leicestershire	1	0	0	-
Lincolnshire	6	2	0	-
Merseyside	9	3	2	2
Metropolitan	73	22	33	38
Norfolk	4	1	0	-
North Wales	6	2	2	2
North Yorkshire	2	1	0	-
Northamptonshire	4	1	1	1
Northumbria	14	4	3	3
Nottinghamshire	3	1	2	2
South Wales	13	4	1	1
South Yorkshire	7	2	0	-
Staffordshire	2	1	2	2
Suffolk	5	2	1	1
Surrey	2	1	0	-
Sussex	8	2	0	-
Thames Valley	11	3	4	5
Warwickshire	3	1	0	-
West Mercia	4	1	2	2
West Midlands	13	4	3	3
West Yorkshire	15	5	3	3
Wiltshire	1	0	0	-
BTP	1	0	0	-
HMRC	1	0	0	-
Total	**333**	**100**	**87**	**100**

Table A.4 Investigation type in cases involving restraint at any point

	N	%
Independent	15	17
IPCC managed	8	9
IPCC supervised	10	11
PCA supervised	49	56
Local	5	6
All investigations	**87**	**100**

Cases supervised and managed by the IPCC and the PCA involved an external police force conducting the investigation.

Table A.5 Cause of death for 'alcohol-only' cases

Primary cause \ Secondary cause	No second cause	Alcohol related	Airway obsruction	Natural causes	Head injury	Other	**Total people**
Natural causes	30	14	0	3	0	0	**47**
Alcohol related	17	0	2	0	0	0	**19**
Injuries prior to custody	0	0	0	0	22	4	**26**
Injuries during custody	0	0	0	1	3	0	**4**
Suicide	6	0	0	0	0	1	**7**
Hypothermia	0	3	0	1	0	0	**4**
Other	3	1	0	0	1	0	**5**
Unascertained	8	0	0	0	0	0	**8**
Total people	**64**	**18**	**2**	**5**	**26**	**5**	**120**

Table A.6 Cause of death for 'drug-only' cases

Primary cause \ Secondary cause	No secondary cause	Drug related	Natural causes	Restraint related	Airway obstruction	Head injury	**Total people**
Overdose accidental - drugs related	22	0	5	2	1	0	**30**
Airway obstruction	0	7	0	0	0	0	**7**
Natural causes	3	3	0	0	0	0	**6**
Drug related	4	0	0	0	0	0	**4**
Suicide - hanging	4	0	0	0	0	0	**4**
Overdose intentionality unknown	0	1	0	0	0	0	**1**
Injuries received prior to detention	0	0	0	0	0	1	**1**
Hypothermia	1	0	0	0	0	0	**1**
Unascertained/ inconclusive	0	1	0	1	0	0	**2**
Total people	**34**	**12**	**5**	**3**	**1**	**1**	**56**

Table A.7 Cause of death for 'alcohol and drug' cases

Primary cause \ Secondary cause	No secondary cause	Alcohol and/ or drug related	Natural causes	Restraint related	Postional asphyxia	**Total people**
Overdose accidental	26	0	3	1	0	**30**
Natural causes	6	4	1	0	0	**11**
Alcohol and/or drug related	6	0	0	0	0	**6**
Suicide	3	3	0	0	0	**6**
Airway obstruction	0	3	0	0	0	**3**
Overdose intentionality unknown	0	2	0	0	0	**2**
Restraint related	0	0	0	0	1	**1**
Unascertained/ inconclusive	4	1	0	0	0	**5**
Total people	**45**	**13**	**4**	**1**	**1**	**64**

Appendix B: Thoroughness of the investigation report for deaths in police custody

Previous research (Leigh et al, 1998) noted that investigators' reports on deaths in or following police custody varied considerably in content and detail. They recommended that 'minimum standards' for such reports be introduced, along with guidance on content, to ensure sufficient scrutiny of such deaths.

In this study, we attempted to assess the thoroughness of investigation reports by examining case files for evidence of the views of the Police Complaints Authority (PCA) and Independent Police Complaints Commission (IPCC) caseworkers and commissioners on investigators' decisions and recommendations. However, these were only found in a minority of cases. We therefore undertook an exercise aimed at gauging the completeness of each investigation report. This involved an assessment of each report which examined whether the following key information was available:

- Information on the deceased and the officers involved.
- Information on key decisions taken by professionals, in relation both to the incident and its subsequent investigation.
- Whether or not the terms of reference appeared to be met.
- Whether or not the conclusions and recommendations appeared supportable[1] .

There is some evidence that the quality of investigation reports has improved during the period covered by the study. We identified 29 cases (9% of the whole sample) where the investigator's report was found to be in need of improvement. However, 17 of these occurred in the first three years covered by the data collection period. Conversely, only one occurred in the final three years. Table B1 shows that most of the 29 cases needing improvement were supervised by the PCA (22) and that 13% of all cases supervised by the PCA were classed as poor quality.

Table B.1 Investigation reports receiving a poor rating in terms of content

	Number of cases	Cases as a proportion of all such investigation types
Local	1	1/52 = 2%
PCA supervised	22	22/163 = 13%
PCA supervised external force	1	1/13 = 8%
IPCC supervised	2	2/26 = 8%
IPCC managed	2	2/31 = 6%
IPCC managed external force	0	0/5 = 0%
Independent	1	1/43 = 2%
All modes of investigation	**29**	**29/333 = 9%**

Caution should be exercised when interpreting these findings, as some types of investigation contain low numbers in the whole sample.

1 Such views were necessarily subjective; however, care was taken to ensure consistency between research team members when arriving at a judgment on the thoroughness of each case.

In all, 19 investigations (6% of the whole sample) were rated by the research team or by PCA and IPCC caseworkers and commissioners as being of particularly high quality. These contained all the features described above. Compared with the 29 poor quality cases, the distribution of these across the 11 years was much more even. Nine occurred in the five years from 2004/05, and ten occurred in the six years to 2003/04. As Table B2 shows, five of the 19 high-quality investigations were independently investigated; 12% of all independently investigated cases were classed as high quality, as were two of the 13 cases supervised by the PCA and conducted by an external force.

Table B.2 Investigation reports receiving a high rating in terms of content

	Number of cases	Cases as a proportion of all such investigation types
Local	3	3/52 = 6%
PCA supervised	6	6/163 = 4%
PCA supervised external force	2	2/13 = 15%
IPCC supervised	1	1/26 = 4%
IPCC managed	2	2/31 = 6%
IPCC managed external force	0	0/5 = 0%
Independent	5	5/43 = 12%
All modes of investigation	**19**	**19/333 = 6%**

Caution should be exercised when interpreting these findings, as some types of investigation contain low numbers in the whole sample.

Checklist of information to be included in investigators' reports

There was much variation between the investigation reports examined for this study. On occasion, case files noted the comments of caseworkers and commissioners regarding the way investigators had gathered and presented evidence. On other occasions, information which we regard as important was not stated. While the numbers in each year were sometimes low, the proportion of cases each year with information not stated could be considerable, and often exceeded 20%. This issue has not always improved over time or according to the type of investigation.

The IPCC is currently assessing the quality of final reports written by investigators, in order to establish a standard in terms of content, style and quality. Based on the findings of this study and on our own observations of the reports, this section suggests eight broad ways in which investigators' reports can achieve consistency in the future.

The checklist is not exhaustive, as the content of reports will vary depending on the circumstances of each case. However, the suggestions below represent the minimum considerations that should be taken into account when conducting an investigation and compiling a report.

- Provide more detailed information. For a number of issues, a large amount of information was "not stated" at various points in the 11 year period covered by the study. For some of these issues, this situation has not improved over time. The following is a list of issues for which at least 20% of information was not stated between 2005/06 and 2008/09, the final three years covered by the study.

Carrying out an investigation
- The extent to which force policy and procedure on custody matters was followed.
- The identification of similar incidents previously occurring in the same force.

Risk assessment
- Details of the type of search of detainees conducted on arrival in custody.
- Details of items of property removed from detainees.
- Information on whether it was intended to rouse detainees while in custody.
- Adequacy of staffing levels in the custody area while detainees were held there.
- Briefings given to incoming custody officers and staff about detainees and their needs when arriving for duty.
- The training of the Forensic Physican or other healthcare professional that assessed the detainee and any issues around this e.g. a lack of specialist training.

Restraint
- Use of handcuffs on detainees during arrest.
- Use of handcuffs on detainees in custody or hospital.

- Draw on a thorough investigation process which includes location of information, and location and detailed interviewing of witnesses.

- Make clear and consistent reference to dates and times of incidents.

- Structure the report clearly: set out key events chronologically, link recommendations clearly to conclusions and base conclusions clearly on the evidence presented.

- Be prepared to offer recommendations when the reported circumstances of a case contain evidence that it is appropriate.

- Make conclusions and recommendations prominent.

- Provide relevant statements and information to the commissioner involved on action taken in the case during the investigation, rather than first raising this issue in the final report.

- Ensure that the wording of written warnings is drafted to reflect precisely the nature of the disciplinary action taken.

- Information on the outcome of any misconduct/disciplinary proceedings and/or prosecution is unlikely to be available at the time the investigation report is completed – however this information should be recorded in a central place for any analysis at a later date.

Appendix C: Logistic regression analysis – use of restraint

In chapter 3 we described the findings from a piece of logistic regression focusing on the use of restraint in our sample. Box C1 lists the factors in the model in order of strongest prediction for a case to have restraint used. After taking account of other variables in the model, being arrested for public order offences was the strongest predictor, increasing the odds of being restrained by five. Being arrested for a drug offence increased one's odds of being restrained by almost four. Being from a BME group increased the odds by three and being aged 17 to 34 years old increased one's odds of being restrained by two.

Table C.1 **Predicting restraint is a factor on a case**

Predictor	Sig.	Exp (B)
Arrested for public order offences	0.000	4.38
Arrested for drug offences	0.001	3.98
Being from a BME ethnic group	0.005	3.02
Being aged 17 to 34 years	0.019	2.12

Independent Police
Complaints Commission
90 High Holborn
London
WC1V 6BH

www.ipcc.gov.uk
Tel: 08453 002 002
Email: enquiries@ipcc.gsi.gov.uk

December 2010
Reference POL/30A

Published by the Independent Police Complaints Commission (IPCC).

© Independent Police Complaints Commission (IPCC) 2010.