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Deaths in or following police custody:

An examination of the cases 1998/99 – 2008/09

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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.

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Executive summary

Deaths in or following police custody are a controversial area of policing which has the potential to impact on trust and confidence in the police more broadly. This is particularly true in Black and minority ethnic (BME) communities where a number of high profile deaths have caused concern. The number of deaths in or following police custody is relatively small, but each death represents a tragedy. Despite the high profile nature of this area relatively little research has been conducted into it. Those studies that have been carried out are from some time ago. This study therefore examines deaths in or following custody over an 11 year period in order to identify trends in the data, examine the nature of the deaths, and most importantly identify lessons that can be learnt for policy and practice to prevent future deaths from occurring.

Prevalence of deaths in police custody and profile of deceased

Between 1998/99 and 2008/09 there were a total of 333 deaths in or following police custody.[1] However, these deaths were not distributed evenly across the time period, with a fall occurring over the 11 years. In 1998/99 there were 49 deaths and this had fallen to 15 in the final year of the study. Using notifiable arrest data we found that the rate of deaths varied from 3.6 per 100,000 notifiable arrests in 1998/99 to 1 per 100,000 in 2008/09. Rates for police forces varied from 3.8 deaths per 100,000 arrests to 0 per 100,000.

Ninety per cent of the deceased in our sample were male, 76% were White, 7% were Black, 5% were Asian, 2% were Mixed race, and 1% were Chinese/other ethnicity (the ethnicity of 9% of the sample was not stated). The ages of the deceased ranged from 14 to 77 years old with the average age being 39 years old. Sixty-eight per cent were arrested in a public place, and the most common reasons for arrest were being drunk and incapable/disorderly, public order offences, driving offences and drug offences. The most common causes of death were natural causes, overdoses, suicide and injuries received prior to detention. Most of the deceased were pronounced dead in hospital.

Deaths involving police restraint

Twenty-nine per cent of the sample were involved in a struggle or violence on arrest, or while in custody or hospital. Forty-two per cent were handcuffed either on arrest, or while in custody or hospital. Twenty-six per cent (87 people) were physically restrained by officers on arrest, during transportation or while in custody or hospital.

Of the 87 people who were physically restrained by officers, just under half were arrested for public order or drugs offences. People aged between 25 and 34 years old were significantly more likely to be restrained than other age groups, and people from BME groups were significantly more likely to be restrained than White people. The most common restraint technique was being held down by police officers, used on 54 occasions during arrest and 21 occasions in custody or hospital.

For 16 people (5%), cause of death was classed as restraint-related (either primary or secondary cause of death). Of these deaths 12 people were White, three were Black and one was Asian. For

1 See chapter two for full definition of deaths in or following police custody.

four of the 16 people, cause of death was also classed as positional asphyxia.

Risk assessment, care of detainees and medical provision

Of the 247 detainees who were booked into custody and liable for a risk assessment at the police station, just under half were actually risk assessed. When looked at over the time period there did seem to have been some improvement in more recent years, but any improvements were not consistent and there were still issues around this in more recent years. Different reasons were given for there being no risk assessment, but the detainee's level of intoxication was by far the most commonly given. This is important as previous research (Bucke et al, 2008) has highlighted the importance of risk assessing all detainees, regardless of whether or not they display any immediate signs of concern.

Of the 205 detainees who required checking while in police cells, a small number received constant supervision, but most were scheduled to receive checks every half an hour. However, several people did not receive checks as regularly as they should have, and as highlighted above this included people who were vulnerable due to their mental health and/or their level of intoxication. The most commonly used method to rouse someone was simply "going to the cell", i.e. not doing anything to proactively engage with the detainee such as asking them a question.

There was a high level of missing information (117 cases) on whether custody officers and staff were given a briefing on the detainees and their needs when arriving for duty. A forensic physician (FP) was called out in just under two-thirds of the applicable cases. Where the elapsed time was known, in over half of the cases FPs were called out either on the detainee's arrival at custody (32) or within an hour of arrival (37).

In fewer than one in five cases, at least one of the officers or members of staff dealing with the case was trained in first aid. In 13 cases (4%), at least one of the officers or members of staff dealing with the case had received refresher first aid training. This highlights a need for first aid training for custody officers and staff.

Deaths involving mental health and suicide

Seventeen people died after being detained under Section 136 of the Mental Health Act 1983 and being taken to a place of safety. Of these 17 individuals, nine were taken to police custody as a place of safety instead of hospital, despite guidance to the contrary. A further two people were detained under other sections of the Mental Health Act, and 39 additional people were identified either during the arrest or once in police custody as having possible mental health needs. A further 11 people were identified as being a possible suicide/self-harm risk. Finally, there were 26 individuals who were not identified as having any mental health needs or as being a possible suicide/self-harm risk, but who went on to commit suicide.

There were examples of people who had been identified as having mental health needs, or as being a potential suicide/self-harm risk, who were not checked on as frequently as they should have been following the risk assessment. In some cases the standard of care they received was questioned and criticised by the investigator[2] on the case.

Deaths involving alcohol and/or drugs

Nearly three quarters of people in the sample (72%) were linked to alcohol and/or drugs (i.e. they had either been arrested for offences related to alcohol and/or drugs, were intoxicated, or both, and/or this was related to the cause of death). A total of 120 were associated with alcohol either

2 This is either the investigator from the individual police force's professional standards department, or the IPCC investigator who investigated the death of the individual.

at arrest, on arrival at police custody or as the cause of death. People who had an alcohol factor (but not a drugs factor) tended to be older, with those aged between 55 and 64 years old being significantly more likely to have alcohol associated with their case than younger groups. They were also significantly more likely to be male and have no permanent address. The majority of these people seem to be arrested for reasons possibly related to alcohol such as being drunk and incapable/disorderly, driving offences, and public order offences.

Of the 87 arrests for being drunk and incapable or drunk and disorderly, 60 did not involve arrest for any other offences but led to the person being taken to custody (this included one person who was also being detained under Section 136 of the Mental Health Act).
This raises questions about whether people who are very inebriated and who are suspected of having committed such offences, or who are arrested due to their level of intoxication, should be taken to custody. The Association of Chief Police Officers (ACPO) Safer Detention Guidelines (2006) state that people detained for being drunk and incapable should be taken to alternative facilities, but this does not seem to be occurring.

The most common cause of death for those with an alcohol factor was natural causes, but just under a third of these deaths were also related to alcohol use. There were also several cases where the deceased had used alcohol and died from injuries received prior to or during detention – for example, falling and sustaining a head injury when intoxicated. Symptoms of head injuries were sometimes overlooked due to the intoxication of the deceased.

Fifty six people in the study had some link to drugs associated with their case. They were significantly more likely to be younger (aged 18-34 years) and a higher proportion were from BME groups. People with a drug factor were also significantly more likely to be restrained. For most of these people drugs were associated with the cause of death. There were a further 64 people who had a link to both alcohol and drugs in their case, and in the majority of these cases the cause of death related to drugs or alcohol (e.g. overdosing).

There were examples of individuals linked to alcohol, drugs or both who were not checked and/or roused as frequently as they should have been, and who were not adequately risk assessed because of their intoxication. This is outlined in more detail in the relevant section above.

Investigations and investigation outcomes

The investigator found that police force policy and procedure on custody matters was breached in 91 cases (27%). These breaches would not necessarily have impacted on the death. The most common recommendations for improving force policy centred on officer training in first aid and liaison with FPs (69 recommendations), and risk assessment of custody cells and detainees' property and clothing (58 recommendations). In 17 cases (5% of the sample) the investigator identified similar incidents which had previously occurred in the same force.

In 50 cases (15% of the sample) the investigator identified examples of good practice in the same force. Investigators made 510 general recommendations, not targeted at individual police officers. In the case of 28 (8%) of the deceased, recommendations had been implemented by the time the investigation report had been completed. On 38 separate occasions, investigators identified training needs for individual police officers. Misconduct/disciplinary charges were recommended on 78 separate occasions for police officers and on nine separate occasions for staff members – an average of one in every four cases.

Prosecutions were recommended against 13 police officers, who faced a total of 36 charges. None resulted in a guilty verdict (that we are aware of from the information available). Although making up 7% of all cases, the 22 cases involving Black

detainees accounted for seven of the 13 recommendations for prosecution of police officers. One police staff member was prosecuted for misconduct in a public office and was found guilty and sentenced to six months in prison, having resigned from the police prior to the prosecution. The acquittal rate of police officers and staff members is therefore very high despite, in some cases, there appearing to be relatively strong evidence of misconduct or neglect. This study was unable to examine why this might be, but it is something that future research could explore.

Recommendations

In addition to the recommendations made below, we would like to reiterate two recommendations we have made in our previous research on the use of police custody as a place of safety under Section 136 of the Mental Health Act (Docking et al, 2008). The first is in relation to the need for NHS commissioners to develop alternative places of safety (Docking et al, 2008: Recommendation 1) and the second is the need for police forces to ensure that sufficient numbers of FPs (or other healthcare professionals) are approved under Section 12 of the Mental Health Act 1983 to assess Section 136 detainees who are taken to police custody (Docking et al, 2008: Recommendation 12).

Recommendation 1: Police forces and local health service providers and commissioners should adopt the ACPO Safer Detention Guidelines (2006) and develop protocols on the care of drunken detainees. Given the strong link between alcohol and deaths in custody, the Home Office and Department of Health should pilot alternative facilities for intoxicated people with access to medical provision, with a view to developing a national scheme.

Restraint

Detailed recommendations by investigators in cases where restraint was used are set out in chapter seven. We have used these to formulate our own recommendations which we see as the key issues. In addition to these, we understand that the Police Federation is planning a strategy aimed at gaining the recognition of 'excited delirium' by the British medical profession[3], training for police officers and emergency medical staff and development of joint protocols between agencies. The evidence, from the USA in particular, suggests that this should be supported and we would suggest that it should also include training on the transportation of detainees suffering from 'excited delirium'.

Recommendation 2: ACPO should ensure that training manuals clearly state which restraint techniques are unauthorised, and which should only be used for a maximum length of time (for example, restraint in the prone position).

Recommendation 3: Control room staff should ask for details on the clinical condition of the detainee, and of other patients on the premises when police officers are called to restrain detainees at medical facilities. This will enable the officers on the ground to make a judgment on whether to exercise restraint and on how to do it safely.

Risk assessment, care of detainees and medical provision

Recommendation 4: Custody sergeants, as part of a risk assessment, should ask the arresting officer(s) whether they or any other person have used any restraint techniques on the detained person. This information should be shared with healthcare professionals attending to the detainee; any concerns should be noted on the custody record by the healthcare professional.

Recommendation 5: Police forces should emphasise to custody personnel the risks around head injuries being masked by intoxication, with a view to custody sergeants including this within the standard risk assessment. The Faculty of Forensic and Legal Medicine has issued useful

3 It is currently recognised by the Faculty of Forensic and Legal Medicine but not by accident and emergency staff or ambulance staff.

guidance for custody officers on head injuries which forces should circulate to custody officers and staff. The dangers around being complacent about the risk posed by someone regularly in police custody should also be reinforced by forces to officers and staff.

Recommendation 6: Custody officers and staff should ensure that colleagues are aware of the circumstances and needs of all detainees (including any risks and medical needs) as part of handing over custody duties at the end of a shift. This should be done verbally and in view of the CCTV in the custody suite (where available), in addition to a written acknowledgment that the custody officers/staff have been fully briefed on the risks and needs. If CCTV is not available this should be recorded on the custody record in addition to being communicated verbally.

Recommendation 7: Police forces should ensure that CCTV is available in at least one cell in the custody suite, to be used when a detainee is identified as being at risk, and where available that it is fully operational[4]. Independent custody visitors should check that CCTV is operational when carrying out their custody visits.

Recommendation 8: Police forces should ensure that custody officers and staff are clear about their individual roles and responsibilities in the custody suite, so that checks and information recorded on the custody record are completed accurately.

Recommendation 9: Police forces should adopt procedures to ensure that custody officers and staff adhere to PACE Code C with respect to risk assessing, checking and rousing. It should be emphasised that:

- Rousing involves the use of a stimulus designed to elicit a response from the detainee (as per PACE Code of Practice C Annex H).
- Cell visits and checks are completed and recorded in a timely and accurate manner.
- All detainees should be risk assessed on arrival to the custody suite and throughout their detention, regardless of their level of intoxication.
- A detainee's unwillingness or inability to participate in a risk assessment should be viewed as a possible warning of risk.

Recommendation 10: Healthcare professionals should ensure that their directions for custody staff on the frequency of checks required for a detainee are written in the custody record, in addition to being verbally passed on. The same applies to any recommendations on the rousing of a detainee.

4 CCTV is not a substitute for the necessary checks a vulnerable individual should receive but is an additional form of protection.

1.Introduction

Background

Deaths which occur in or following police custody are relatively small in number, but they remain a controversial area of policing which creates much public and media concern. In particular, a series of high-profile cases have focused attention on the police treatment of ethnic minority men and have involved long-term campaigns focusing on allegations of racism, neglect, ill-treatment and police misconduct (Bucke and Wadham, 2009).

This is not just an issue in England and Wales, but one which has caused concern in other jurisdictions such as Australia, South Africa and the USA. These cases also raise the issue of the right to life under Article 2 of the European Convention on Human Rights, because the jurisprudence of the European Court of Human Rights has taken the view that the state has a duty to protect life and to investigate deaths in state custody effectively.

Regardless of their outcome, these cases can have a large impact on public trust and confidence in the police, particularly among ethnic minority communities (Community-Police Consultative Group for Lambeth, 1996; Macpherson, 1999; Bowling and Philips, 2002). The IPCC has disseminated the findings from its investigations into deaths in custody via the Learning the Lessons bulletin and other methods. However, despite the high-profile nature of some individual cases, there has been no recent attempt to aggregate cases on the nature and circumstances of these deaths. This study into deaths in custody seeks to provide a thorough insight into the area and identify specific issues that emerge across the cases. An overview of some of the key literature is provided below, before setting out the research aims and methodology.

Being detained in police custody and processes which apply to detainees

A person may be taken into police custody following an arrest for a suspected offence or as a place of safety under Section 136 of the Mental Health Act 1983 (where the individual is deemed in need of immediate care or control). The Police and Criminal Evidence Act 1984 (PACE) sets out police powers of arrest and Section 117 of PACE allows the police to use reasonable force in the exercise of their powers. Section 30 of PACE requires the police to take a person arrested for an offence to a police station as soon as practicable after the arrest. Once the person arrives at the police station the custody officer should decide whether there is sufficient evidence to charge the individual for an offence under Section 37 of PACE. If detained under Section 136 of the Mental Health Act 1983, the custody officer should seek to arrange the mental health assessment as soon as possible.

Once detained in a police station, the detention is governed by PACE Code of Practice C. The Code of Practice has been amended several times (most recently in 2008), with the most significant changes occurring in 2003 when major changes were made to help strengthen the risk assessment of detainees. In addition to the statutory Code of Practice, ACPO issued guidance (2006) to officers to help ensure the safe detention and handling of people in police custody.

Finally, in relation to the use of police custody as a place of safety under Section 136 of the Mental Health Act 1983, there have been Home Office Circulars and Department of Health (2008) Codes of Practice which, since 1990, have stated that a place of safety should ideally be a hospital. More recently this has been strengthened to suggest that police custody should only be used as a place

of safety in exceptional circumstances.

Number and nature of deaths in or following police custody

Under the Police Reform Act 2002, there is a statutory duty to refer to the Independent Police Complaints Commission (IPCC) any incident that has resulted in death or serious injury arising from police contact[5]. Since April 2006, the IPCC has had responsibility for reporting on fatal cases referred from HMRC and SOCA. From April 2007, UKBA has also been subjected to the same statutory duty. The IPCC uses these referrals to compile annual statistics on deaths during or following police contact. Between 2004/05 and 2008/09 there were 128 deaths in or following police custody (IPCC, 2009). This includes deaths of those arrested or otherwise detained by the police and those which 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 car or other vehicle.

Leigh et al (1998) studied 227 deaths in

custody occurring between 1990 and 1996 and estimated that there were approximately 3.2 deaths per 100,000 arrests for notifiable offences. Since arrests for notifiable offences make up only part of those in custody, the number of deaths as a proportion of the total number of people passing through police custody would be lower (see chapter two for more detail on this and for a more recent estimate). Deaths in custody are therefore relatively rare events. However, it is difficult to overestimate the impact of these cases on the family members of the deceased, the police personnel linked to the cases and the wider community. In addition, Bucke et al (2008) found that there were a much larger number of 'near misses' in custody, with approximately 400 each year where death was thought to be very likely or fairly likely if action had not been taken. It is therefore very important that the lessons from these cases are learnt so that future deaths can be prevented.

5 Or a complaint alleging that police conduct has resulted in death or serious injury. Paragraph 4(1) (a) and 13(1) (a), Schedule 3, Part 1, Police Reform Act 2002. As amended by the Serious Organised Crime Agency (SOCA) and Police Act 2005 Schedule 12.

Leigh et al (1998) grouped the causes of death that they analysed into three categories:

- Those resulting from the deceased's own actions (63%).
- Those resulting from the deceased's medical condition (29%).
- Those in which "another person's actions may have been associated" with the death (8%).

In the 'deceased's own actions' group, deliberate self harm either in or before entering custody made up the largest group of deaths (34% of all deaths).

Ethnicity of the deceased

While the number of deaths may be relatively small, there have been numerous high-profile deaths involving ethnic minority men. Concern about these deaths is linked to wider debates and discussions about racism and the police (Bucke and Wadham, 2009). Similar debates have occurred in other Western countries. For example, in Australia a major public inquiry was established in response to public concern over Aboriginal deaths (Royal Commission into Aboriginal Deaths in Custody, 1991).

Previous research in England and Wales has analysed deaths in custody to establish whether there were any differences in the nature of deaths by the ethnicity of the detainees (Leigh et al, 1998). The numbers were too small to find any statistically significant differences but there were some differences which were noted:

- A larger proportion of White than Black detainees were arrested for alcohol-related offences.
- A larger proportion of Black than White detainees were arrested for drug-related offences.
- A greater proportion of White than Black detainees died from in-custody deliberate self harm or from medical conditions.
- Over one-third of cases in which a Black detainee died occurred in circumstances in which police actions may have been a factor (the proportion rises to almost one-half if the cases of accidental death where the police were present are added) – this compared with only 4% of cases where the detainee was White.

Some ethnic minority deaths in custody that have caused the most concern have involved the actions of the arresting police officers. Of particular concern has been officers' use of baton blows to the head, or restraint of an individual so that he or she has difficulty breathing during the arrest (these issues are highlighted below). Such cases include the deaths of Brian Douglas, Shiji Lapite, Wayne Douglas and Ibrahima Sey (PCA, 2002a). The Police Complaints Authority (PCA, 2002a) stated that "*...a disproportionate number of people who die in custody or specifically following restraint are from minority ethnic groups, which inevitably leads to allegations of racism*" (page 5).

Restraint, positional asphyxia, 'excited delirium' and possible police action

Police officers may physically restrain an individual if they are trying to resist or escape arrest, or if they become violent or attempt to self harm while in police custody. The restraint may involve manual restraint, batons, CS spray/PAVA[6], handcuffs and other equipment. There is a condition known as 'post exercise peril' where someone who has been exerting themselves physically and suddenly stops is at risk of cardiac problems in the minutes that follow (Dimsdale et al, 1984). It is possible that this could also play a part in some restraint deaths where the person has been very physically active to avoid detention. Detainees who have taken drugs and/or alcohol, or have some physical, medical or psychiatric condition, are more vulnerable to the impact of restraint than others, and in some cases the restraint can lead to a death in custody (Leigh et al, 1998: PCA, 2002a).

One of the most controversial conditions is 'positional asphyxia' – where the death results from a body position which restricts a person's ability to breathe. Some forms of police restraint may increase the risk of asphyxiation. The degree of risk associated with different holds is not clear, but neck holds have been strongly discouraged (PCA, 2002a). There is also the possibility of unlawful behaviour by the police in some of these cases, which can include assault and can result in the death of the individual. Leigh et al (1998) found that police actions may have been associated with the death in 6% of the cases they examined.

Another condition related to restraint deaths is 'acute behavioural disturbance', which incorporates 'excited delirium'. There are many possible causes including head injury, brain tumours, delirium from high temperature, heat exhaustion and endocrine disorder such as high blood sugar or low blood sugar and thyroid disease. Anti-psychotic and other drugs such as cocaine can also precipitate these episodes (PCA, 2002b). Someone suffering from this condition may ignore pain and continue to struggle against restraint beyond the normal point of exhaustion (PCA, 2002a). Police officers now receive training on positional asphyxia and excited delirium as part of their personal safety training.

Perhaps one of the most high-profile recent cases involving restraint is the death of Roger Sylvester, who died in 1999 after being restrained by officers from the Metropolitan Police Service, following his detention under Section 136 of the Mental Health Act 1983. Mr Sylvester was a young Black man, and as highlighted above there has been particular concern about deaths involving ethnic minority men and police restraint (PCA, 2002a). The PCA (1999) and Leigh et al (1998) recommended that safe restraint procedures and positions should be reinforced to officers in training. The ACPO Guidance on Safer Detention (2006) also sets out warning signs for physical violence, stressing the importance of monitoring the detainee and ensuring that the degree of restraint is reasonable, and describes the factors which can cause positional asphyxia.

Risk assessment, care of detainees, and medical provision

Bucke and Wadham (2009) suggest that another key area of concern is the care that detainees receive once they arrive at the police station, and possible issues of police neglect or failure to provide adequate care for the detainees. They highlight the case of Christopher Alder, a Black man who died in a police station in Hull in 1998, as an example of a case where the police have been criticised for inadequate care of a detainee.

6 A water-based alternative to CS.

Past work suggests that the majority of deaths in custody result from the deceased's own actions or from a medical condition (Leigh et al, 1998). This highlights the importance of properly risk assessing detainees upon arrival into custody, to identify people with possible mental or physical health issues and ensure they receive appropriate care and access to medical provision. This can include placing 'vulnerable' detainees in cells with CCTV and trying to ensure that the cell environment is as safe as possible. Some individuals may require medication or treatment in hospital and therefore need to be moved from custody as soon as possible, and should see a doctor at the earliest opportunity.

All detainees in custody should be regularly checked for their safety, but as highlighted above those with mental health needs and those who are intoxicated through alcohol or drugs need additional care (Home Office, 2003). The revised PACE Codes of Practice (Home Office, 2003) state that *"detainees should be visited at least every half an hour*[7]*...Those suspected of being intoxicated through drink or drugs or whose level of consciousness causes concern must, subject to any clinical directions given by the appropriate healthcare professional...*

- *be visited and roused at least every half hour,*
- *have their condition assessed as in Annex H* [of the Codes]*, and*
- *clinical treatment arranged if appropriate"* (Code C, 9.3).

It is important that custody officers and staff are appropriately trained on risks, risk assessments and in caring for vulnerable detainees (Bucke et al, 2008), and that these procedures and guidelines are adhered to.

Mental health and suicide

There has been concern among various organisations over vulnerable people being held in police custody and the deaths of some of these individuals. The IPCC has also raised concerns about some of these issues and in particular about police custody being used as a place of safety under the Mental Health Act 1983. The IPCC is concerned about the possibility that some of these detentions of vulnerable individuals may result in deaths in custody (Docking et al, 2008). People with mental health needs are likely to find the custody environment distressing and this can exacerbate their mental state and in some cases lead them to try to self harm or attempt to commit suicide. The importance of an adequate risk assessment to identify possible mental health problems and the risk of suicide is discussed below. In addition Bucke et al (2008) identified poor searching procedures and stressed the importance of adequately searching the detainees to help prevent suicide and self harm.

In order to help prevent suicide, the PCA (1999) recommended improving risk assessments when 'booking in' detainees and reducing the possibility of ligatures being used. It also suggested that *"CCTV coverage of custody suites should be expanded to include one or two observation cells for particularly vulnerable detainees"* (PCA, 2002a: page17; see also Leigh et al, 1998).

Alcohol and drugs

People who are intoxicated from alcohol and/or drugs pose a greater risk when in custody and need greater levels of care such as regular checks and rousing. The importance of adequately risk assessing detainees to identify such issues is looked at above, but there is a broader debate about whether intoxicated individuals should be in custody or whether they should be in a hospital or an alternative facility. For example, Leigh et al (1998) made recommendations on the use of detoxification and 'drying-out' facilities for intoxicated detainees rather than police custody. On drugs and alcohol misuse, the PCA (1999) recommended greater clarity and revisions in the PACE Codes of Practice to improve the rousing of intoxicated detainees (this has now occurred), improved training for forensic physicians (FPs)[8] and the use of a 'scale of consciousness' to aid decisions on detainees, and training for custody officers on intoxicated detainees.

7 With the proviso that if no reasonably foreseeable risk was identified in a risk assessment, there is no need to wake a sleeping detainee.

8 Forensic physicians are doctors contracted by police forces. Part of their role is to offer medical care to detainees and to advise whether they are well enough to be kept in police custody or interviewed by police officers.

From the available evidence it therefore appears that the use of drugs and alcohol is an important factor in deaths in custody (Community-Police Consultative group for Lambeth, 1996; Leigh et al, 1998; IPCC, 2008). Heavily intoxicated people may be found unconscious in their cells and declared dead on arrival at hospital; other detainees may swallow drugs on arrest which have then leaked from their wrappings or have caused the person to asphyxiate (Bucke and Wadham, 2009). Bucke et al (2008) identified poor checking and rousing procedures of detainees as an important problem. The issue of dual diagnosis, where a detainee may be intoxicated from alcohol and/or drugs but also have mental health needs, is also problematic, as some mental health facilities may be unwilling to take individuals who are intoxicated, so that they are taken to police custody (Docking et al 2008).

Research design

This remains an area where relatively little recent research has been conducted. It is therefore important to analyse these cases in more detail to further our knowledge and understanding and hopefully help to prevent future deaths in custody.

Aims and research questions

In order to have a large enough sample of cases to be able to draw meaningful conclusions from the data, this study examines deaths in custody[10] over an 11 year period[9]. The overall aim is:

> ***To examine all deaths in or following police custody over an 11 year period with regard to a series of specific issues and changes over time***.

This study looks at the key issues set out above and seeks to identify lessons which can be learnt for policy and practice. In order to do this, it tries to answer the specific research questions set out below:

1. Trends, characteristics of deceased and causes of deaths

- What is the extent of deaths in or following police custody over an 11 year period from 1998/99 to 2008/09? We have attempted to calculate a standardised mortality rate, i.e. the number of deaths in custody per year by the number of people entering police custody per year.
- How were the deaths spread across the different police forces in England and Wales over the 11 years?
- What are the characteristics of the deceased? For example, age, gender, ethnicity, mental health and arrest reason?
- What are the characteristics of the case? For example, why was the person in custody and what was the reason for arrest?
- How do the two above factors vary by cause of death?
- What are the causes of death[11]? For example, are the deaths due to the deceased's own actions, a pre-existing medical condition, or the actions or inactions of another individual?
- Are there any trends or patterns between the reasons for arrest, and the length of time in custody, and the cause of death?
- How have any of the above changed over time?
- Do there appear to be any links between improved service and reduction in deaths?

2. Location and timing of death, investigation and investigation outcomes

- Where did the deaths occur. For example, on the street, at the police station or in the hospital?
- How many deaths occurred before arrival at custody or following release from custody?
- If the death occurred in or following custody how long was the individual in custody before death, or how long after release did the death occur?
- How were the deaths investigated? For example, was it a local investigation or supervised/investigated by the PCA/IPCC?
- What were the recommendations and other outcomes of the investigation report?
- What lessons can be learnt from the incidents? Did individual police forces make improvements following any of these incidents?
- Were any specific issues identified about partnership working, both strategically and in

9 See 'Methodology' section for more information on why this time period was chosen.

10 We used the IPCC definition of 'deaths in or following police custody' (category 3 deaths) as set out in the IPCC (2009) *Annual Report and Statement of Accounts 2008/09*. IPCC, London: page 18.

11 For reasons of access the study focuses on the data contained in the investigation report rather than other sources such as coroner reports. However, the post mortem results were available, and in many cases so was the inquest verdict.

relation to the individual cases?
- Were training needs identified for arresting officers, custody officers and custody staff?
- What support if any was offered and given to officers and staff, and to family members?
- What were the inquest verdicts?
- Were there any misconduct or disciplinary proceedings? Where there any criminal charges arising from the incidents? If so, what were their outcomes?

3. Demographics of the deceased
- How, if at all, do the reasons for arrest vary by the ethnicity, age and gender of the deceased?
- How, if at all, does the use of force and restraint on detainees vary by the ethnicity, age or gender of the deceased?
- How, if at all, do the nature and circumstances of the deaths vary by the ethnicity, age or gender of the deceased? For example, did the death occur on a street or in a police station?
- Is there any difference in the cause of death in terms of the ethnicity, age or gender of the deceased?
- Is there any difference in the outcome of the investigation in terms of the ethnicity, age or gender of the deceased?
- Are there any other issues in terms of the ethnicity, age or gender of the deceased that arise from the data?

4. Restraint, positional asphyxia and 'excited delirium'
- To what extent did the deaths involve allegations of any struggle or violence, and at what stage did this occur?
- Were any of those who died restrained at any point? If so, did this contribute to the death?
- If restraint was used, why was it used, was it proportionate, what techniques did this involve and where did this occur?
- What was the reason for the arrest where restraint was used?
- To what extent did positional asphyxia or 'excited delirium' feature in the deaths?

5. Risk assessment, care of detainees and medical provision
- To what extent were those who died suffering from any physical injuries or other medical conditions pre- and post-custody?
- How frequently and thoroughly were risk assessments conducted in custody?
- What concerns, if any, were identified by the risk assessments? And what actions were taken in response to the risks identified?
- To what extent were FPs or other healthcare professionals called to examine those who died prior to the death occurring? Where issues of the quality of the examinations and/or the advice that was given are raised by the investigator[12] these will be examined[13].
- For the above questions, were there key points where an intervention could have been made which could have prevented the death but was missed[14]?
- Was information shared, where appropriate, between different agencies, i.e. health and police, police and prisons?
- What type of cells were used to hold those who died? For example, did the cell have CCTV, 'drying out' facilities or life monitoring technology?
- Were custody officers and staff trained in terms of detention handling and first aid?
- Was first aid given at the scene or in custody by officers and/or other staff?
- What was the ratio of custody officers/staff to detainees at the time of the incident?

6. Mental health and suicide
- What evidence was there (if any) that the person was mentally vulnerable?
- Was there any indication that such information would have been available to the police?
- To what extent did the police identify the risk?
- Were any of those who died being held in custody as a place of safety under Section 136 of the Mental Health Act 1983?
- To what extent did suicide and mental health issues feature in the deaths?
- Was medical assistance called for, and what was the outcome?

12 Meaning the investigator from the police force professional standards department or from the IPCC who investigated the death of the individual.

13 Information on the quality of the healthcare examinations and advice more generally is not normally provided in the investigation report, where it was not considered relevant to the death. It is therefore only possible to look at these issues where they have a potential impact on the individual concerned.

14 To do this we assessed the information that was available and the actions that were taken at the time, as well as the investigator's view as to whether things could have been done differently.

- For deaths following a suicide, could anything have prevented this? For example, removal of clothes, removal of ligature points or more frequent checks/observation?

7. Alcohol and/or drugs

- To what extent were issues of alcohol and/or drug use identified by the arresting officer, and by the risk assessment in custody?
- What evidence was there (if any) that the person was intoxicated through alcohol and/or drugs?
- Was there any indication that such information would have been available to the police?
- To what extent did the police identify the risk?
- To what extent did the use of alcohol and/or drugs feature in these deaths?
- What was the nature and frequency of checking and rousing that officers/staff conducted?
- Was medical assistance called for, and what was the outcome if so?
- For deaths related to the use of alcohol and/or drugs, is there anything that may have prevented the deaths? For example, more frequent checks/observation, assessment by doctor, transfer to hospital, CCTV or life monitoring?

Methodology

We used investigation reports[15] and inquest verdicts, as well as other information such as misconduct recommendations on completed cases, as the basis for collecting information on these incidents. These sources of information provide the most thorough and detailed evidence available on the deaths and bring together a wide range of information such as custody records, toxicology reports, and CCTV evidence. We designed a data collection sheet (proforma) on which to detail the nature of the deaths, which was then used to create a Statistical Package for the Social Sciences (SPSS) dataset. The study involved a detailed examination of these deaths and sought to address the aims, research questions and thematic issues set out above.

To consider the different factors in each death and conduct more meaningful analysis we needed to look at all deaths in or following police custody over a long period of time in order to have a large enough sample of cases. We also wanted to consider whether changes to policy and practice may have occurred over time and how this may have affected the possible risks of being held in custody. We have tried to consider data on legal and procedural changes (e.g. changes to PACE Code C) to see if this shows any correlation with changes in the numbers/causes of deaths in custody.

We were aware that there may have been problems in obtaining some older case files and that in the early-to-mid-1990s there was some inconsistency in referrals to the PCA from police forces. We therefore decided to look at deaths in or following police custody which have occurred over the 11 year period ending on 31 March 2009. We are aware that much will have changed in terms of policies and procedures over this time period and have sought to take this into account when examining the deaths. We collected data on these cases to allow us to identify completed investigation reports on each death. There were 333 cases which fell within this period. Some earlier cases had only very limited information available as the files had been destroyed, some had been locally investigated and no investigation report had been produced[16], and for the most recent cases the investigation report may have been partially complete (for example, missing the recommendations). However, in order to have a complete dataset we included all of the cases and used whatever information was available.

The evidence is considered within the context of the good practice set out in the ACPO Guidance on the Safer Detention and Handling of Persons in Police Custody, and the changes made to PACE Code C. If information is available in the investigation reports about the relevant police force policy in place at the time of the incident, this is also considered. To prevent any further distress to the families and friends of the deceased, as well as the officers and staff involved in the cases, the anonymity of those in the sample has been preserved.

15 All available investigation reports were used, including those supervised, managed or independently conducted by the IPCC, investigations supervised by the PCA, and investigations carried out locally by the individual police force.

16 In total there were ten cases from 1998/99 without an investigation report, three from 1999/00, two from 2000/01, three from 2002/03, one from 2003/04, one from 2006/07 and two from 2007/08.

Issues beyond the scope of the study

This study only looks at deaths in or following police custody (see chapter two for full definition) and therefore does not include other deaths following police contact such as police-related road traffic incidents, police shootings, other deaths following police contact, or suicides following release from police custody. These other deaths are collated in the IPCC annual statistics on deaths following police contact. The other categories of death are quite different 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 individual 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[17], and future research may look at some of the other categories of death.

We are aware that some police forces record 'near miss' incidents in custody and that this data might provide valuable information. However, this information is not recorded in a consistent or robust way by all police forces and it would therefore be difficult to collate and analyse[18]. Using this data is therefore beyond the scope of this project and such data has not been included. We also explored the possibility of obtaining coroners' reports; however, this posed numerous logistical problems which would have impacted significantly on the size and length of the project. We therefore decided not to collate this data, but have included inquest verdicts where available. Lessons may be mentioned in the reports and were therefore examined; however, unless the investigator actually commented on this we had no way of knowing whether these had led to changes in practice.

We are aware from previous research we have conducted, which also used completed investigation reports, that information on the training officers and police staff have received is often fairly limited. Therefore while we sought to gain information on training in relation to custody and first aid, we have not looked at wider training issues around identifying mental and physical health problems or specific training on restraint. Unless specifically mentioned in the investigation reports as being relevant to the individual cases we examined, we did not consider the following issues more generally:

- Custody management structures and the potential impact of additional responsibilities on custody officers and staff.
- Performance targets for officers.
- The layout and design of the custody suite and whether this has an impact on the role of The custody officers and staff.
- The availability of alternatives places of safety.
- Multi-agency agreements and relationships.
- Access to medical information.
- The training of FPs and other healthcare professionals, and contractual arrangements.

The next chapter looks at the prevalence of deaths in custody over the 11 year period as well as the characteristics of the deceased. The subsequent chapters then go on to look at a series of thematic issues arising from these cases such as restraint, risk assessment and medical provision, mental health and suicide, the use of alcohol and drugs, and investigations and their outcomes. The final chapter brings together all of the key findings to draw out the conclusions from the study and make recommendations for changes to policy and practice.

17 Docking, M., Bucke, T., Grace, K. and Dady, H. (2007): *Police road traffic incidents: A study of cases involving serious and fatal injuries*. IPCC Research and Statistics Series: Paper 7. IPCC: London.

18 For more information on near misses see Bucke et al (2008).

2. Prevalence of deaths in police custody and profile of deceased

There is very limited data on the number of deaths in or following police custody in recent years and much of the research in this area was conducted some time ago. This chapter therefore seeks to look at the overall figures and trends over an 11 year period from 1998/99 to 2008/09. It will look at the number of deaths, the demographics of the deceased, the reasons for their detention and cause of death. The chapter seeks to identify any patterns and trends in the data and attempt to explain these.

Definition of deaths in or following police custody

The Police Reform Act 2002 places a statutory duty on police forces to refer incidents of police contact involving death and serious injury to the IPCC[19]. The IPCC uses these referrals to produce annual statistics on deaths following police contact. There are four main categories of deaths which are reported on, one of which is 'deaths in or following police custody'. This is defined as:

> '*Deaths of persons who have been arrested or otherwise detained by the police. It includes deaths which occur whilst 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'* (IPCC, 2009: page 3).

The definition goes on to state that:

'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.*
- *Deaths which occur in or on the way to hospital (or other medical premises) following or during transfer from police custody.*
- *Deaths which occur as a result of injuries or other medical problems which are identified or develop while a person is in custody.*
- *Deaths which occur while a person is in police custody having been detained under Section 136 of the Mental Health Act 1983 or other legislation'.*

'This would not include the following:

- *Deaths (including suicides) which occur after a person has been released from police custody, except those that meet the criteria outlined above.*
- *Deaths of individuals who have been transferred to the care of another agency and subsequently die whilst in their care'.*

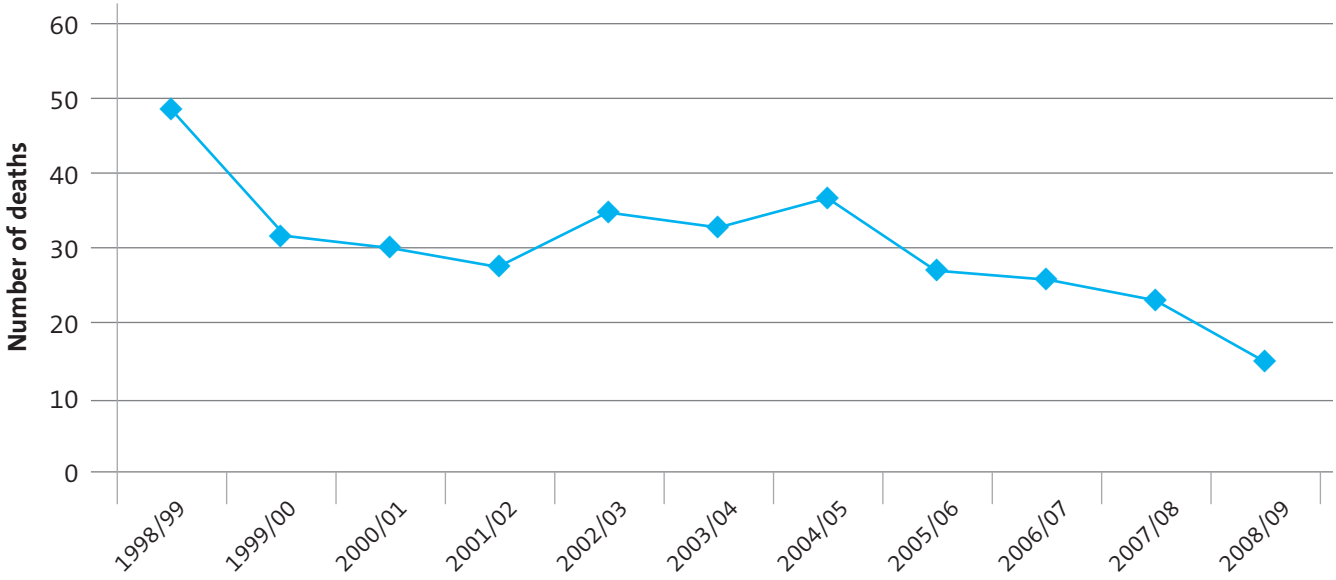
In order to be consistent with our published statistics we decided to use the same definition for cases to be included in this study. This means that there may be some discrepancies between older figures published by the IPCC's predecessor, the Police Complaints Authority (PCA), and the Home Office on deaths in or following police custody, and figures quoted in this report, as the PCA and the Home Office used different criteria. For ease of reference the terms 'deaths in or following police custody' and 'deaths in police custody' will be used interchangeably throughout this report.

Prevalence of deaths in or following police custody

Between 1998/99 and 2008/09 there were a total of 333 deaths. Figure 2.1 shows how the figures are broken down for each financial year (i.e. each

19 Since April 2006, the IPCC has had responsibility for reporting on fatal cases referred from HMRC and SOCA. From April 2007, UKBA has also been subjected to the same statutory duty.

Figure 2.1 **Total number of deaths in or following custody 1998/99 - 2008/09**



reporting year). A key finding is that there has been a major fall in deaths in police custody during the time period covered by this study. The figure shows that the number of deaths fell from 49 in 1998/99 to 31 in 1999/00 and then remained fairly stable from 1999/00 to 2001/02. Deaths increased again in 2002/03 to 35, and then remained relatively stable again until 2004/05, since when there appears to have been another gradual fall.

In order to provide some context to this study and provide some perspective on the number of deaths in custody, we wanted to calculate a rate of deaths compared to the number of people held in police custody. However, figures are not readily available on the total number of people held in police custody.

The closest available data are figures collected by the Home Office on how many arrests there were for 'notifiable offences' in England and Wales on an annual basis. This data underestimates the total number of people held in custody as it consists of offences which are indictable or triable either way, but excludes most summary offences (Povey et el, 2009). Offences which are not notifiable and are therefore not included in the 'notifiable offences' data include being drunk and disorderly, and failure to provide a specimen of breath. Detentions under Section 136 of the Mental Health Act are not 'notifiable offences' since they are not actually offences and so are also not included. Data collected from forces by the Department of Health and Home Office (2010) showed that there were around 2 million people detained in 2008/09, whereas the notifiable arrest data shows there were just under 1.5 million people detained. However, they still provide the best estimate available, so using the notifiable arrest data we were able to provide a rate of deaths in custody per 100,000 arrests.

Leigh et al (1998) used the same methodology in their study on deaths in custody between 1990 and 1996. They found a rate of 3.2 deaths per 100,000 arrests for notifiable offences over the seven year period. Table 2.1 shows that the rate of deaths in our study fell from 3.6 per 100,000 notifiable arrests in 1998/99 to 1.0 per 100,000 in 2008/09, with an overall rate of 2.2 deaths per 100,000 notifiable arrests across a ten year period. This will slightly overestimate the rate of deaths as the total number of people held in custody will be higher (as noted above), but it does clearly show a decrease in the rate of people dying in custody.

In a previous IPCC research study we estimated the total number of people held in police custody for

Table 2.1 **Number of deaths per year and rate of deaths per 100,000 notifiable arrests**

Financial year	Deaths in or following custody	Notifiable arrests	Rate of deaths per 100,000 notifiable arrests
1998/99	49	1,365,651*	3.6
1999/00	31	1,277,900	2.4
2000/01	30	1,264,200	2.4
2001/02	27	1,271,900	2.1
2002/03	35	1,313,100	2.7
2003/04	33	1,330,400	2.5
2004/05	36	1,353,400	2.7
2005/06	28	1,429,800	2.0
2006/07	27	1,482,200	1.8
2007/08	22	1,475,266	1.5
2008/09	15	1,458,347	1.0
Total	**333**	**15,022,164**	**2.2**

*1998/99 data not available. This is therefore an estimate based on the average number of notifiable arrests for the other years.

2005/06 using data that police forces had provided us (Docking et al, 2008). This suggests that the difference between the rate of deaths per 100,000 notifiable arrests and per 100,000 people held in custody is around 0.6. If we take this difference into account then the total rate of deaths in police custody across the 11 years may be closer to 1.6 per 100,000 people held in custody.

Police force comparisons

Table 2.2 shows how the deaths are broken down by police force, percentage of all deaths, and rate of deaths per 100,000 notifiable arrests for the last ten years of the study (notifiable offence data is not available for 1998/99).

The highest number of deaths – in the Metropolitan Police Service area (73 deaths – 22%) and the Greater Manchester area (20 deaths – 6%) can perhaps be explained by the fact that these large forces have the highest number of notifiable arrests. However, other forces had slightly more deaths than may have been expected for their size. For example, Northumbria had 14 deaths (4%) and South Wales had 13 deaths (4%). When looked at by the number of deaths per 100,000 notifiable arrests the forces with the highest rate of deaths in custody were:

- Derbyshire (3.8 deaths per 100,000 arrests).
- South Wales (3.4 deaths per 100,000 arrests).
- Dorset (3.5 deaths per 100,000 arrests).

Two forces did not have any reported deaths in custody over the time period – City of London and Durham. Of forces which had any deaths in custody, those with the lowest rates were:

- Cambridgeshire (0.6 deaths per 100,000 arrests).
- Cumbria (0.7 deaths per 100,000 arrests).
- Gloucestershire (0.8 deaths per 100,000 arrests).

Table 2.2 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 deaths per 100,000 notifiable arrests 1999/00 - 2008/09^
Avon and Somerset	9	3	3.2
Bedfordshire	3	1	2.1
Cambridgeshire	2	1	0.6
Cheshire	8	2	4.3
City of London	0	-	-
Cleveland	4	1	1.9
Cumbria	3	1	0.7
Derbyshire	8	2	3.8
Devon and Cornwall	10	3	2.9
Dorset	5	2	3.5
Durham	0	-	-
Dyfed-Powys	4	1	3.1
Essex	8	2	2.1
Gloucestershire	2	1	0.8
Greater Manchester	20	6	2.3
Gwent	3	1	1.3
Hampshire	6	2	1.2
Hertfordshire	5	2	1.6
Humberside	7	2	2.2
Kent	6	2	1.6
Lancashire	12	4	2.0
Leicestershire	1	0	0.5
Lincolnshire	6	2	2.7
Merseyside	9	3	1.7
Metropolitan	73	22	3.2
Norfolk	4	1	1.8
North Wales	6	2	2.7
North Yorkshire	2	1	1.0
Northamptonshire	4	1	2.2
Northumbria	14	4	2.2
Nottinghamshire	3	1	0.9
South Wales	13	4	3.4
South Yorkshire	7	2	1.6
Staffordshire	2	1	1.3
Suffolk	5	2	4.1
Surrey	2	1	0.6
Sussex	8	2	1.8
Thames Valley	11	3	1.9
Warwickshire	3	1	3.3
West Mercia	4	1	1.7
West Midlands	13	4	1.5
West Yorkshire	15	5	1.5
Wiltshire	1	0	1.1
British Transport	1	0	Not available
HMRC	1	0	Not available
Total England and Wales	**333**	**100**	**2.1^**

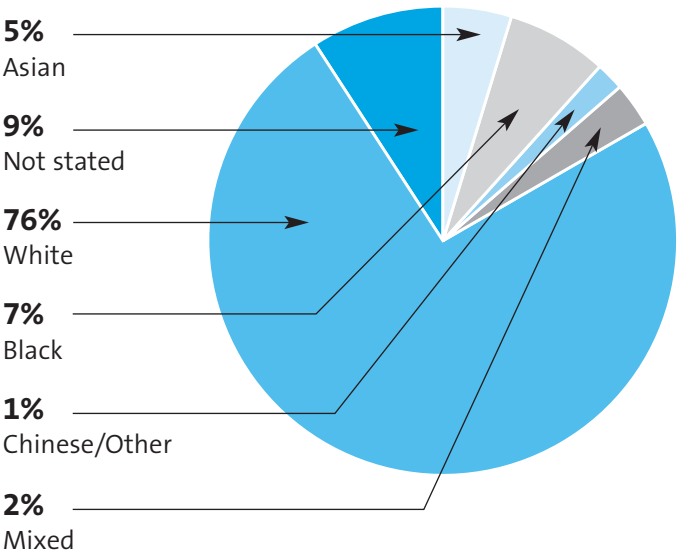
Source: figures were calculated using notifiable arrest data published annually by the Home Office and the Ministry of Justice (2009).
Some of the figures on notifiable arrests were estimates or were based on incomplete data when originally published. Other figures were revised in subsequent publications. 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.
^These figures are based on 282 deaths which occurred between 1999/00 and 2008/09. They exclude the two deaths from British Transport Police and HMRC because data is not available for notifiable arrests in 1998/99 or for these two organisations. A full version of this table with notifiable arrest figures and number of deaths for 1999/00-2008/09 can be found in Appendix A.

Characteristics of the deceased

Leigh et al (1998) found that in 92% of the deaths in custody they examined, the deceased was male. Of all notifiable arrests made in 2008/09, 83% were male and 17% were female (Povey et al, 2010). In comparison, in our study the vast majority of the deceased were men (299; 90%), with 34 (10%) involving women. This indicates that men might be slightly overrepresented in the number of deaths in police custody compared to women.

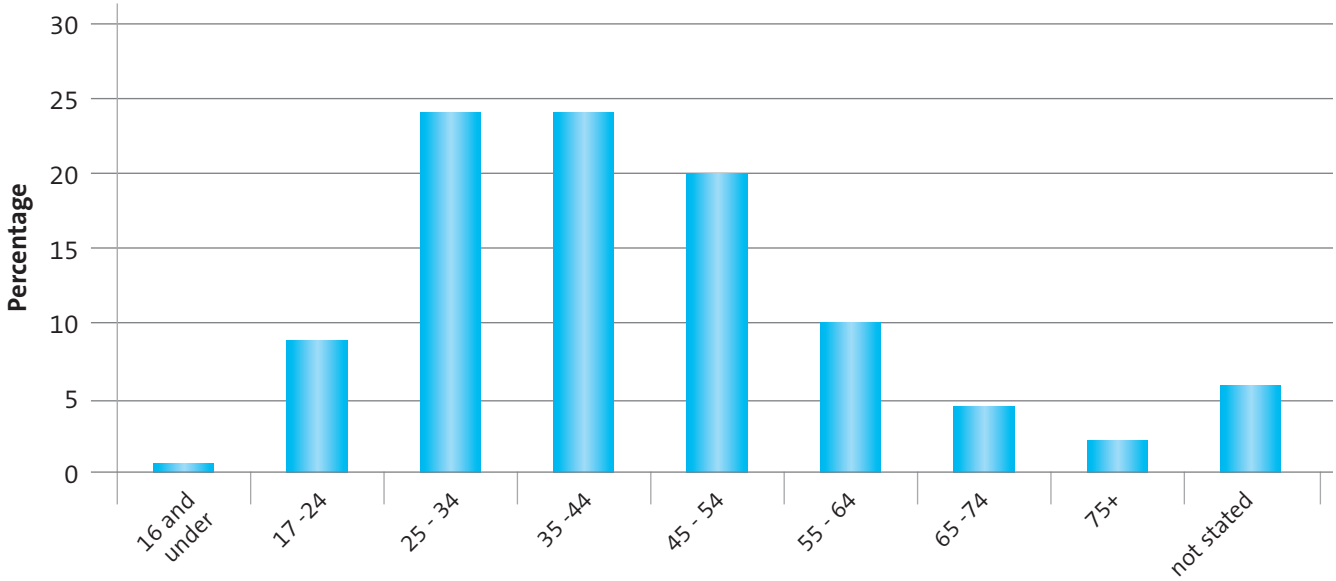
Seventy-six per cent of the deceased (253 people) were British and 9% (31 people) were foreign nationals. The nationality of 49 people (15%) was not stated. Leigh et al (1998) found that 87% of their sample of deaths in custody were White. Figure 2.2 shows that the majority of the deceased in our sample were White (76%, 253 people), 7% were Black (22 people), 5% were Asian (17 people), 2% were Mixed race (seven people) and 1% were Chinese/Other (three people). There were 31 people (9%) for whom ethnicity was not stated. In comparison White people made up 79% of notifiable arrests, Black people 7%, Asian people 5%, Mixed race people 3%, Chinese or other people 1% and the ethnicity of 4% of those arrested was not stated/unknown (Povey et al, 2009 – ethnic breakdown not available for 2008/09). The ethnic breakdown of deaths in custody appears therefore to be broadly in line with the make-up of detainees more generally.

Figure 2.2 **Ethnicity of deceased**



Seventy-six per cent of the deceased (252 people) had a permanent address and 16% had no fixed abode (52 people). It was not stated for 29 people (9%) whether or not they had a permanent address. The ages of the deceased ranged from 14 to 77 years old, with the average age across all the years being 39 years old. Figure 2.3 shows that

Figure 2.3 **Age ranges of deceased**



almost half of the deceased were between 25 and 44 years old (48%). The ages of those arrested for notifiable arrests are broken down differently and a comparison of the arrested population is therefore not possible (Povey et al, 2010).

Details of arrest

The majority of the deceased were arrested in a public place (68%), 20% were arrested in their own home, 5% in the home of a friend or family member, 2% at a police station, 1% in an 'other' place and for 4% the location of arrest was not stated. The time of arrest was distributed fairly evenly across the day with almost half of all arrests (48%) between 12:01 and 00:00. Only 8% of arrests took place between 03:01 and 09:00. However, this data should be treated with some caution, as for 25% of the arrests no time was stated.

Leigh et al (1998) found that most of the deaths in custody they looked at involved arrests for relatively minor offences such as theft, being drunk and incapable, drink driving or being in breach of the peace. The most common reason for arrest in our sample was being drunk and incapable/disorderly (22%), followed by public order offences (11%), driving offences (11%) and drug offences (10%). Table 2.3 shows all of the various reasons for arrest for the deceased in our study. Each person could have up to five reasons for their arrest, so there are a larger number of 'arrests' than deceased. The table shows that the majority of people in our sample were arrested for relatively minor offences with very few arrested for more serious offences such as serious violence and sexual offences. Many of these people would not be captured in the notifiable arrest data, as they comprise only summary offences such as drunk and incapable/disorderly. This underlines the need to view any rates as indicative rather than specific.

Table 2.3 **Reasons for arrest**

	N	%
Drunk and incapable/disorderly	87	22
Public order offences	45	11
Driving offences	43	11
Drug offences	38	10
Wanted on warrant/bail offences	34	9
Theft offences	31	8
Assault	25	6
Other	19	5
Burglary/robbery	16	4
Section 136 Mental Health Act	17	4
Criminal damage	12	3
Possession of offensive weapon	8	2
Sex offences	5	1
Threats to kill	3	1
More serious violence	3	1
Other mental health	2	1
Not stated	11	3
Total	**399**	**100**

Each person could have up to five reasons for their arrest.

There were some differences in the reasons for arrest by demographic groups. Those aged 25 to 34 years old made up 26% of all arrest reasons but significantly[20] more of the drug offences (46%)[21]. Older people were significantly overrepresented in arrests for drunk and incapable/disorderly; 45% of these arrests were people aged between 55 and 64 years old, despite them only making up 30% of all arrest reasons[22]. People without a permanent address were also significantly more likely to be arrested for being drunk and incapable/disorderly[23]. Those aged 65 years and over were significantly overrepresented in driving offences, making up 19% of the arrest reasons despite consisting of only 10% of the sample of arrest reasons[24]. There were also some differences in reasons for arrest by ethnicity; BME people made up 15% of the arrest reasons but were underrepresented in drunk and incapable/disorderly arrests (10%, not statistically significant) and overrepresented in arrest for public order offences (20%, not

20 Figures of note were tested for statistical significance. The objective of significance testing is to decide whether any difference between two or more figures is due to chance or whether it can be decided that there is a relationship between the data. For example, if such a test finds that there is less than a 5% probability that the difference is due to chance, then we can say that we are 95% confident that the difference is significant.

21 This finding is statistically significant at the 95% confidence level.

22 This finding is statistically significant at the 95% confidence level.

23 This finding is statistically significant at the 95% confidence level.

24 This finding is statistically significant at the 95% confidence level.

statistically significant) and significantly overrepresented in drug offences (36%)[25].

What happened following the arrest

Following the arrest 74% of the deceased were taken to a police station, 22% to hospital and 2% died at the scene of the arrest. For the remaining people information was not stated, or they were handled in another way[26]. All of the individuals who were identified as having head injuries[27] at the point of arrest were taken to custody as was an individual with a deep wound, and an individual who had collapsed. This is obviously of some concern as they were in need of medical treatment. Table 2.4 shows the reasons why individuals were taken to hospital on arrest, or after they may have initially been taken to custody but before they were booked in. When taken together, breathing problems, heart attacks, and swallowing a drugs package make up almost half of the reasons why the individuals were taken to hospital (45%).

If looked at by financial year the proportion of people who were taken to custody (as opposed to hospital/elsewhere) following the arrest ranged from 83% in 2004/05 to 60% in 2008/09. There is no clear pattern across the financial years, but in the three most recent years a higher proportion of people were taken straight to hospital or were initially taken to custody but transferred before they could be booked in. This may indicate an increasing awareness on the part of the arresting officers to identify possible illness and risk, and an increase in custody sergeants refusing to admit people into custody who appear unwell.

Of those who were transported somewhere following their arrest, 79% were transported using a police vehicle and 15% by ambulance. For the remaining people information was not stated or other means were used.

Table 2.4 **Reasons why the deceased were taken to hospital following the arrest**

	N	%
Breathing problems	16	19
Heart attack	12	14
Swallowed drugs package	11	13
Condition deteriorated	6	7
Stopped breathing/collapsed	6	7
Physical injuries	6	7
Section 136 Mental Health Act	6	7
Intoxication	5	6
Other	5	6
Other mental health issues	3	3
Medication/drugs overdose	3	3
Unconscious/unresponsive	3	3
Sprayed with CS spray	2	2
Stab wound	2	2
Total	**86**	**100**

Each person could have up to two reasons for being taken to hospital.

The time that the deceased arrived in custody or hospital (where applicable) was not stated in 32% of the cases. Where the time of arrival was stated it was fairly evenly distributed across the day, with fewer people arriving in custody or hospital between 03:01 and 09:00. Data collected by the Department of Health and Home Office (2010) from police forces for 2008/09 shows that the average length of detention in custody was nine hours. For those people in our study who were detained in custody or hospital the length of detention prior to death was unfortunately not stated in 37% of cases. Of the remainder, 27% were held for under three hours and 12% were held for three to six hours. Due to the high number of cases where the length of detention is not stated, once the data is broken down by reason for arrest and length of detention the numbers become very small. It is therefore not possible to say whether there appears to be any difference in the length of detention by reason for arrest.

25 This finding is statistically significant at the 95% confidence level.

26 The percentages are rounded and therefore do not add up to 100%.

27 One person with head injuries was initially taken to custody but transferred to hospital before they were booked in.

Cause of death

Using the post mortem findings as the primary source and other information in the investigator report to provide any additional information, we were able to group the deaths into different causes. Each death was given a 'primary' cause and some also had a 'secondary' cause. For example, the primary cause of death may be liver failure (natural causes) but this may be related to alcohol use which would then be the secondary cause of death. Figure 2.4 shows that the most common primary cause of death across all of the years was natural causes (104 deaths; 31%).

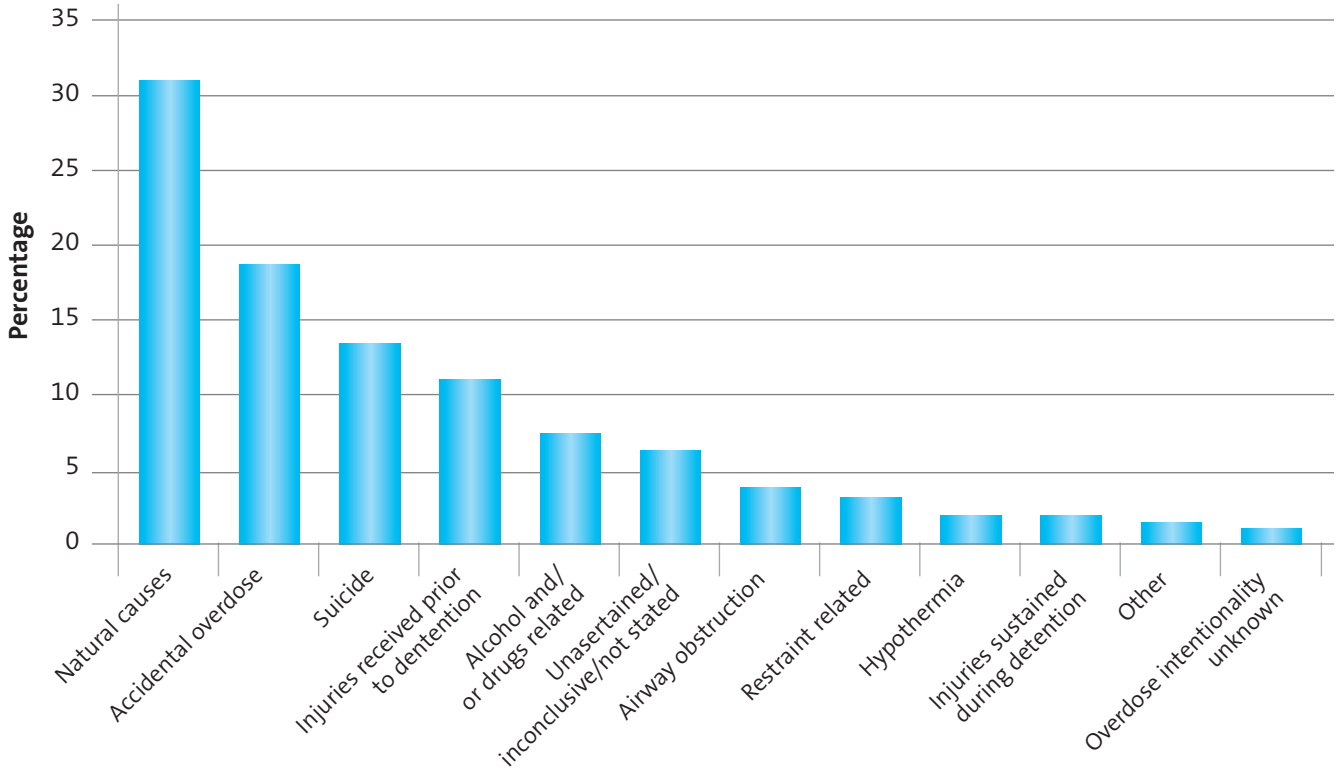
If we then look at the four largest primary causes of death by financial year (shown in figure 2.5) we can see that all four have fallen fairly consistently over the 11 year period, apart from the natural cause deaths which have shown no clear pattern. The numbers of deaths are small so the figures should be treated with some caution, but it does appear that suicides seem to have fallen the most dramatically.

Suicides can be looked at by type. Of the 44 suicides across the 11 years:

- 34 were hangings.
- Five were poisoning.
- Two were self-harm incidents.
- Three were intentional overdoses.

The majority were therefore hangings, and it is this cause of death that has changed over the time period – in 1998/99 there were 14 hangings, whereas most other years had between one and three hangings (2003/04 had six hangings). This would indicate an improvement in cell conditions and a removal of possible ligature points across the custody estate to make it a safer environment in line with ACPO Guidance (2006). Leigh et al (1998) found a higher rate of self-harm deaths in custody (28%), which would also indicate improvements since their study ended. Our figures also show the potential difficulty in preventing natural cause deaths as it may be more difficult to identify that the individual is potentially unwell.

Figure 2.4 **Primary cause of death**



In addition to the further detail provided above on suicides, more information is also available on the primary cause of deaths for some of the largest groups. Of the 104 natural cause deaths:

- 58 were heart related.
- 27 were brain related.
- Seven were liver related.
- Four were related to pneumonia.
- Eight were related to other natural causes such as multiple organ failure.

Of the 61 accidental overdoses:

- 49 were drug overdoses.
- One was an alcohol overdose.
- 11 were alcohol and drug overdoses.

Of the 25 alcohol and/or drug-related deaths:

- 15 were alcohol related.
- Six were drug related.
- Four were alcohol and drug related.

The secondary cause of death also provides additional information on the deaths. Table 2.5 shows the deaths which had a secondary cause related to them. Of all the natural cause deaths, 21 were also related to alcohol and/or drugs, five had additional natural causes (for example brain and heart related), and two were restraint related (the person may have had a heart attack to which the restraint may have contributed). Of the accidental overdoses, eight were related to natural causes, three were restraint related and one was related to an airway obstruction. Of the suicides, three were also related to drugs or alcohol and one was related to hypothermia. Of the injuries received prior to detention, 27 were head injuries and eight were related to other injuries – an example of this would be an individual who had sustained injuries in a road traffic incident before being arrested. Of the airway obstruction deaths, of which there were 11, most (nine) were drug-related (as opposed to cases related to alcohol). These occurred as a result of the person swallowing a drugs package. Of the restraint cases, five were related to natural causes (all heart related) and four to positional asphyxia. Three of the hypothermia deaths were related to alcohol and/or drugs, and one to natural causes.

What the secondary cause of death therefore shows is that an even greater number of deaths were related to alcohol and/or drugs in some way. This highlights the importance of recognising the

Figure 2.5 **Four main primary causes of death by year**

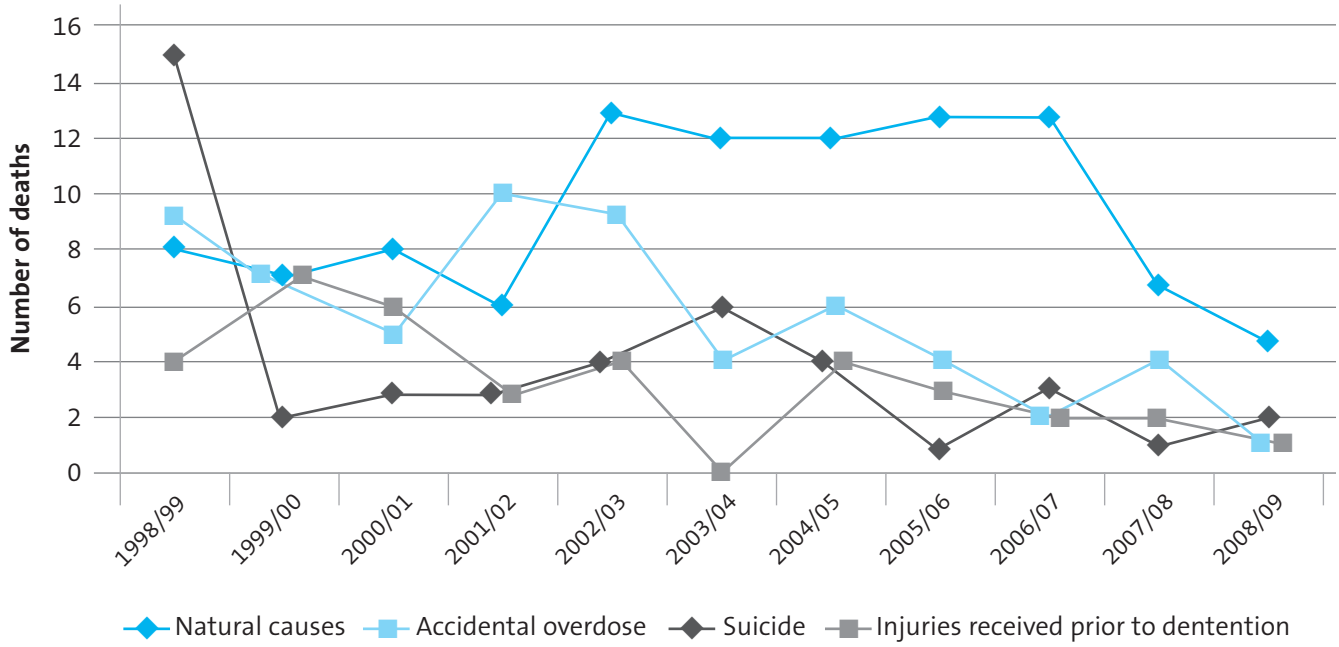


Table 2.5 **Deaths with a 'secondary' cause**

Secondary cause / Primary cause	Alcohol and/or drug related	Head injury	Natural causes	Other	Restraint related	Positional asphyxia	Airway obstruction	Hypo-thermia	**Total primary cause of death**
Natural causes	21	0	5	0	2	0	0	21	**104**
Accidental overdose	0	0	8	0	3	0	1	0	**61**
Suicides	3	0	0	0	0	0	0	3	**45**
Injuries received prior to detention	0	27	0	8	0	0	0	0	**36**
Alcohol and/or drug related	0	0	0	0	0	0	1	0	**25**
Unascertained/ inconclusive	4	0	0	0	1	0	0	4	**18**
Airway obstruction	11	0	0	0	0	0	0	11	**11**
Restraint related	0	0	5	0	0	4	0	0	**10**
Injuries sustained during detention	0	4	1	1	0	0	0	0	**6**
Hypothermia	3	0	1	0	0	0	0	3	**6**
Other	1	1	0	0	0	0	0	1	**5**
Overdose intentionality unknown	3	0	0	0	0	0	0	3	**3**
Not stated	0	0	0	0	0	0	0	0	**3**
Total secondary cause of death	**46**	**32**	**20**	**9**	**6**	**4**	**2**	**46**	**333**

vulnerability of these individuals once in police custody. The secondary cause also highlights a further six restraint-related cases.

There were some differences in the cause of death when comparing different demographic groups. Table 2.6 shows the percentage within each demographic group for the primary cause of death. It shows that in terms of gender, men were more likely to die from natural causes and suicide than women (not statistically significant), and women were significantly more likely to die from an overdose[28]. In terms of age, older people (55+ years) were significantly more likely to die of natural causes than younger people[29], and younger people (under 16-34 years old) were significantly more likely to die from an overdose or by committing suicide than those in older age groups[30]. The numbers broken down by ethnic group and then split by cause of death were very small, so the figures have been combined into BME and White to allow a more meaningful comparison. This shows that White people were more likely to die of natural causes (not statistically significant) and significantly more likely to commit suicide than people from BME groups[31], and people from BME groups were more likely to overdose (not statistically significant).

There were some notable differences in cause of death when examined by reason for arrest. Twenty-five per cent of people who were arrested

28 This finding is statistically significant at the 95% confidence level.

29 This finding is statistically significant at the 95% confidence level.

30 This finding is statistically significant at the 95% confidence level.

31 This finding is statistically significant at the 95% confidence level.

Table 2.6 **Percentage of cause of deaths within demographic groups**

	Male	Female	Under 24	25 - 34	35 - 44	45 - 54	55 - 64	65 - 74+	BME	White	Total % for cause of death
All natural causes	32	21	10	16	28	39	39	59	27	32	**31**
All overdoses	17	41	38	37	11	12	12	0	23	19	**19**
All suicides	14	9	28	23	10	9	9	0	4	16	**14**
Injuries received prior to detention	11	9	3	4	15	9	9	27	13	11	**11**
Alcohol and/or drug related	7	9	10	2	11	12	12	0	6	8	**8**
Airway obstruction	4	0	3	2	5	3	3	0	6	3	**5**
Restraint related	3	3	0	2	6	1	1	5	6	3	**3**
Injuries sustained during detention	2	3	0	0	2	3	3	0	2	2	**3**
Hypothermia	1	6	0	4	0	3	3	5	4	2	**2**
Other	2	0	0	1	2	1	1	0	2	1	**2**
Unascertained/ inconclusive	6	0	7	6	7	7	7	0	6	4	**2**
Not stated	1	0	0	1	1	0	0	5	2	0	**1**
Total percentage	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**	**100**
Total number of people	**299**	**34**	**29**	**81**	**81**	**67**	**34**	**22**	**49**	**253**	**333**

Not stated demographics not shown. Age of 19 people was not stated. Ethnicity of 31 people was not stated.

for being drunk and incapable/disorderly (22 people) died from injuries received prior to and during detention, which was significantly higher than for the total sample (14%) . Forty-two per cent of those arrested for public order offences (19 people, not statistically significant) and 51% of those arrested for driving offences (22 people, statistically significant) died of natural causes, compared to 31% of the total sample. Fifty-six per cent of those arrested for drug offences (22 people) overdosed compared to 19% of the total sample (statistically significant) . Fifteen per cent of those arrested for drug offences (six people) died from an airway obstruction (i.e., while swallowing a drugs package) compared to 3% of the total sample (statistically significant) .

Location of death

We felt it was important to examine where each of the deceased was pronounced dead. Leigh et al (1998) found that the location of where the deaths were certified in their sample was split almost evenly between the police station (46%) and hospital (47%). Table 2.7 shows where the detainees in our sample were pronounced dead. If these options are combined then 72% died in hospital and 21% in custody. The remainder died in a public place, on private premises or elsewhere. The percentage of people who died in hospital (at any stage of the detention) across the 11 years ranged from 53% to 82% and the percentage of those dying in custody ranged from 13% to 31%.

Table 2.7 **Where the deceased were pronounced dead**

	N	%
In hospital (from custody)	146	44
In custody	69	21
In hospital (from arrest)	68	20
In hospital (following release from custody)	9	3
In public place during arrest	6	2
At home following release	5	2
Other	3	1
In hospital (during arrest)	3	1
In hospital after attempt to take to custody	3	1
Public place following release	3	1
At home (during arrest)	2	1
On private property/home	2	1
In hospital from other	2	1
In ambulance on way to hospital	1	0
Not stated	11	3
Total	**333**	**100**

The lowest proportion of people to die in hospital and the highest proportion to die in custody were both towards the start of the time period we examined – 1998/99. Since 2003/04 the proportion of people dying in hospital has been consistently higher than the average for the whole period, and the proportion of people dying in custody has been consistently lower than the average for the whole period.

This change may have occurred for a number of reasons. For example, people who are unwell may be more likely to be taken straight to hospital rather than custody in more recent years. Custody officers may be more reluctant to accept the detention of someone who is unwell. Lastly, custody officers and staff may be quicker to pick up on signs of illness amongst their prisoners and seek suitable medical care.

There were some differences in terms of where someone was pronounced dead depending on the reasons for their arrest. Twenty-eight per cent of those arrested for being drunk and incapable/disorderly died in custody, as did 32% of those arrested for being wanted on warrant/bail offences, and 42% of those arrested for less serious theft offences, compared to 21% of the total sample. Eighty per cent of those arrested for public order offences, and 77% of those arrested for drug offences died in hospital, compared to 72% of the total sample.

Factors on the cases

As illustrated above many of the deaths were linked to alcohol and/or drugs. We therefore thought it would be useful to look at how many of the deceased had alcohol- or drug-related issues. Given the relatively high number of suicides we also looked at how many people had mental health issues associated with them. Using information that was identified by the arresting and custody officers, via the post mortem, the arrest reason and the cause of death (not for mental health), we placed a 'factor' on each relevant case for alcohol, drugs and mental health. Finally, due to the controversial nature of restraint deaths, we examined how many people were restrained at any point throughout their detention and put a factor on their case where appropriate.

The issues surrounding restraint, mental health, and alcohol and drugs are examined in detail in the subsequent chapters and will therefore not be touched upon in any depth here. However, the Venn diagrams below demonstrate the high numbers of people in our sample with one of these factors associated with their case, and the large overlaps between the factors. Figure 2.6 shows that of the 333 people in our sample, 184 had an alcohol factor, 120 a drugs factor and 58 a mental health factor. There were 64 people who had an alcohol and drugs factor (of whom 11 also had a mental health factor), 14 who had both an alcohol and a mental health factor, and ten people with both a drugs and mental health factor. Figure 2.7 shows that there were 87 people who were restrained (i.e. held down by the officers rather than just handcuffed) and of these over half (46) also had a drugs factor. Figure 2.8 shows that a further 14 people who were restrained had an alcohol factor. What this shows is the complexity

Figure 2.6 **Relationship between mental health, drugs and alcohol across cases**

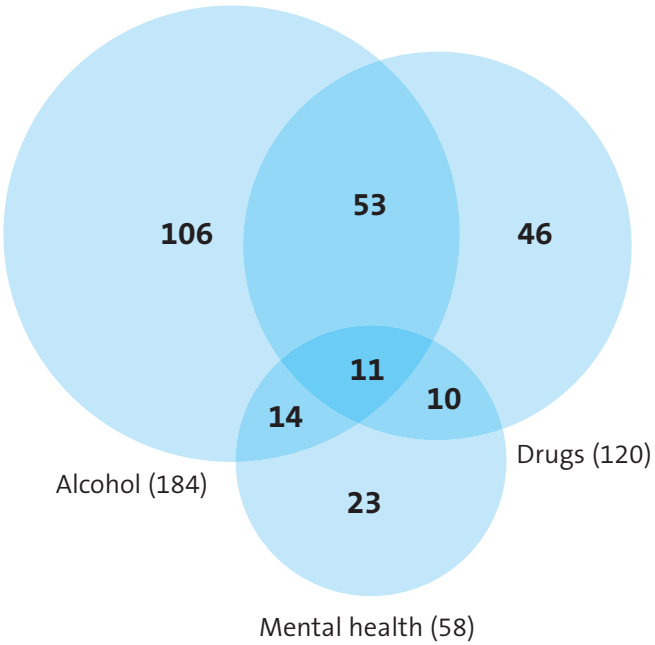
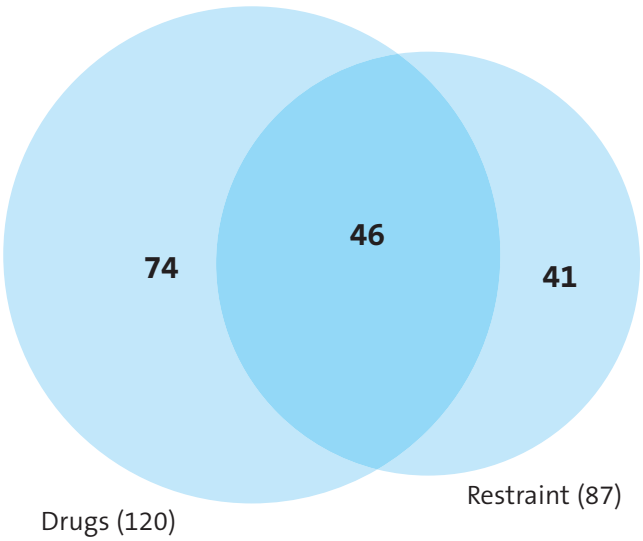


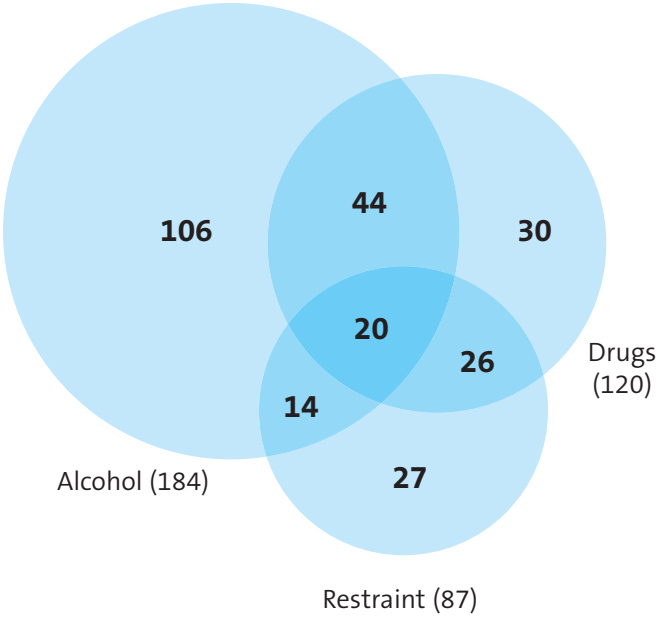
Figure 2.7 **Relationship between drugs and police use of restraint across cases**



of problems these individuals had, their vulnerability and the potential problems that officers dealing with them may face in terms of providing adequate care.

The next chapter looks at the use of restraint in our sample, restraint-related deaths and lessons that can be learnt from them. It also examines the previous literature in this area.

Figure 2.8 **Relationship between police use of restraint, drugs and alcohol across cases**



3. Deaths involving police restraint

The detention of a suspect by police officers will sometimes involve restraint techniques. The use of restraint may be of no significance to the death but on the other hand it may be a relevant or even a contributory factor. This chapter examines the extent to which restraint was a feature of the deaths in the sample.

It begins by briefly outlining what is known about restraint from previous research. This includes a focus on a number of causes of death which have been shown to feature in restraint-related cases. The chapter then explores the extent to which the deaths in the sample involved allegations of a struggle or violence, and the stages during arrest or detention at which this occurred. Similar information is then presented on the use of handcuffs, batons, CS/PAVA[32] spray, tasers and firearms.

The chapter then considers whether or not those who died were restrained at any point. This includes an assessment of whether the use of restraint varied according to the ethnicity, age or gender of the deceased, the reasons for arrest, and a breakdown of the stages of arrest or detention when restraint techniques were used. There is then a discussion of the reasons for using restraint action, the nature of the restraint techniques involved, and the extent to which the specific causes of death described earlier in the chapter featured in the deaths. The chapter then assesses whether the restraint action taken was proportionate to the situation, and whether it contributed to the death.

Previous findings on restraint-related deaths

Deaths during or following custody are relatively rare. However, although numbers may be small, deaths due to restraint are especially sensitive, and raise important issues concerning police conduct (PCA, 2000). Police officers may lawfully use reasonable force when restraining a person, during the course of arrest or detention (under Section 117 of PACE). Nevertheless, several concerns have been raised, over a number of years about restraint during or following police contact, both in England and Wales and elsewhere (see for example Cartwright, noted in Liebling, 1997; Pollanen et al, 1998; Postill and Rowan, 1998; PCA, 2002a; Inquest, 2004; O'Halloran and Frank, 2000; Forum for Preventing Deaths in Custody, 2007). A PCA report on the issue stated that *"safer restraint...must be placed at the forefront of any discussion about deaths in custody"* (PCA, 2002b). A multi-agency Independent Advisory Panel on Deaths in Custody (previously the Forum for Preventing Deaths in Custody) was set up in 2005. This followed the recommendation of a Parliamentary report into deaths in custody by the Joint Committee on Human Rights. The Panel's remit includes the sharing of best practice on restraint issues.

Recent work by the Offender Health Research Network (2009) has examined use of restraint in a number of institutional settings. The work makes clear that restraint-related deaths are not straightforward to identify. Leigh et al (1998), James (2009), Byard et al (2008; noted in OHRN, 2009) and others have noted that rather than restraint alone leading to death, it typically combines with other conditions and circumstances[33]. Detainees who have taken drugs or alcohol, or have some physical, medical or

32 A water-based alternative to CS.

33 In such cases, where cause of death can be difficult to identify, O' Halloran (2004) has suggested that re-enactment of the circumstances of the deaths associated with restraint can be helpful.

psychiatric condition[34], are more vulnerable to the impact of restraint than others. Combined with such conditions, detailed below, restraint can lead to a number of complications and may lead to death in custody.

Positional asphyxia

Positional asphyxia is a cause of death resulting from a body position which interferes with the victim's breathing. Some believe this is relevant to a range of restraint-related deaths, such as where an individual is held down or placed in a prone position and restricted in their movement. Some studies (Chan et al, 1997; Schmidt and Snowden, 1999) suggest that positional restraint should not present a risk of asphyxia for healthy individuals. Others, however, have found that some forms of police restraint may increase the risk of asphyxiation (PCA, 2002b). Neck holds and prone restraint have become particularly discredited (Davis, 1999). ACPO guidance (2006) makes clear that the prone position must be avoided if possible, and minimised if unavoidable, and that training for staff in custody *"must include tactical communications and the recognition and management of positional asphyxia and acute behavioural disturbance"*. The guidance adds that, once in a cell, a person's restraints should be removed *"as soon as it is considered safe to do so and care must be taken to prevent positional asphyxia"*.

Excited delirium

Excited delirium can be caused by drugs, alcohol, a psychiatric illness or a combination of these, and may lead a victim to struggle against restraint beyond the normal point of exhaustion. Features of excited delirium include agitation, excitability, paranoia, aggression, great strength, numbness to pain and elevated body temperature (Mash et al, 2009, noted in OHRN, 2009; Di Maio and Di Maio, 2005; Blaho et al, 2000). Deaths following excited delirium and restraint often involve incoherent mumbling, cessation of struggling, shallow and laboured breathing, and cardiopulmonary arrest (Paquette, 2003; Stratton et al, 2001, both noted in OHRN, 2009; Jauchem, 2010). Others have shown that excited delirium may be induced by even small amounts of illicit drugs (Karch and Stephens, 1999) and that restraining devices in such cases should only be used as a last resort (Parent, 2006). Recent research (Otahbachi et al, 2010) views positional asphyxia as one of the factors in the development of excited delirium.

Excited delirium has proved a contentious topic. Many contend that death in such cases is the result of confrontation, abuse and inappropriate use of force, rather than the effects of drugs. The psychological stress of being confronted with this aggression, they argue, results in further physiological reactions. It is only relatively recently that the existence of excited delirium has become more widely accepted in the USA. This followed a September 2009 report by the American College of Emergency Physicians (ACEP), which classified excited delirium as a syndrome in its own right. The Faculty of Forensic and Legal Medicine, which aims to develop and maintain the highest possible standards of competence and professional integrity amongst FPs, has now recognised excited delirium (as a form of acute behavioural disorder). The Faculty has issued guidelines on managing acute behavioural disturbance (and excited delirium) in police custody (Norfolk et al, 2010). However, Huish (2010) noted that there remains a lack of knowledge and acceptance of excited delirium within the wider British medical profession, and warned:

> *"There is no specific training for medical staff and therefore the rapid actions required to identify possible indicators and treatments aren't undertaken and post mortems do not look for any of the potential signs."*

Huish reports that for that reason, the Police Federation is planning a strategy aimed at the recognition of excited delirium by the British medical profession, training for police officers and emergency medical staff, and development of joint protocols between agencies. This is something

34 Guidance produced by ACPO (2006) lists a number of circumstances which can contribute towards a death during restraint. These are: body position obstructing an airway; pressure applied to the back of a person's neck, torso or abdomen when they are in the prone position; pressure on the shoulder girdle or accessory muscles of respiration when a person is lying down; a person's intoxication through drink or drugs; leaving a person in the prone position; a person's obesity; a person's heightened levels of stress; respiratory muscle failure after a person has been struggling; and application of bodyweight on a person's upper body to hold them down. The role of this last point, however, has been disputed (see Forensic Drug Abuse Advisor, 2000).

that the evidence, from the USA in particular, suggests should be supported.

Acute behavioural disturbance

The Home Office (2003) noted that:

> *"Those experiencing excited delirium are likely to show an acute behavioural disturbance... When confronted or frightened these individuals can become oppositional, defiant, angry, paranoid and aggressive...Attempting to restrain and control these individuals can be difficult because they frequently possess unusual strength, pain insensitivity and instinctive resistance to any use of force."*

In terms of its origins, the PCA (2002b) found that acute behavioural disturbance can occur following substance misuse, intoxication and withdrawal, physical illness (such as head injury) and psychiatric conditions (including psychotic and personality disorders). Guidelines on the management of people in police custody issued by the Faculty of Forensic and Legal Medicine (Norfolk et al, 2010) advises that *"ideally, individuals with acute behavioural disturbance should not be taken to a custody suite but directly to an emergency department"*.

Post-exercise peril

If a person who has been exerting themselves physically suddenly stops, they may be at risk of cardiac problems immediately afterwards (Dimsdale et al, 1984). Known as post-exercise peril, this can play a part in some deaths; for example, if a person attempts to run away or struggles with the police, and then stops due to being restrained.

Cases from our study which involved restraint

The next section focuses on cases within our sample which involved a struggle or violence prior to arrest, and goes on to explore whether restraint was used and the nature of this restraint. It looks at the characteristics of those who were restrained,

Case study 3.1

Cause of death: cardio-respiratory arrest with restraint role uncertain

The deceased, who had a long history of schizophrenia, was arrested at his home under Section 136 of the Mental Health Act. Considerable aggression from the individual took place on arrest, and continued to occur during transportation and at the police station. The deceased was restrained and handcuffed at all three points, and a specialist restraint device was used both on arrest and in custody.

No risk assessment was conducted in custody due to the deceased's level of aggression and his mental health issues. A FP examined the deceased soon after arrival and advised that he be taken to hospital. The man was then assessed under the Mental Health Act and seen by a Section 12 approved doctor and an approved mental health practitioner. He was then sectioned and taken to hospital, but died on arrival.

The deceased sustained bruising consistent with being in a struggle or restrained; however, the two Home Office pathologists who examined the case could not agree on cause of death. Both agreed that death was due to cardio-respiratory failure. One linked this to restraint. However, the other believed that the death occurred precisely because the deceased was not restrained, as this had given him the freedom to exhaust himself during periods of aggression.

The investigation report stated that there was evidence that, before the death, the force had taken every step it could to educate officers as to the causes of positional asphyxia and excited delirium. No disciplinary procedures were recommended or instigated against the officers involved, and no recommendations were made for force policy or practice.

considers whether the restraint was proportionate and examines the cause of death for individuals who were restrained. 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 study 3.1 indicates the difficulty that medical practitioners can have in agreeing the precise cause of death.

Cases involving a struggle or violence

Figure 3.1 shows the proportions of cases in which a struggle or violence took place on arrest and in custody or hospital. Of the 333 in the sample, 27% (91) were involved in a struggle on arrest, 59% (196) were not, and information was not stated for 14% (46). In custody or hospital, 8% (28) were involved in a struggle or violence, 72% (241) were not, information was not stated for 13% (42), and the question was not applicable for 7% (22).

Where the question was not applicable, this was commonly because the deceased had either died or become unconscious before arriving at custody or hospital.

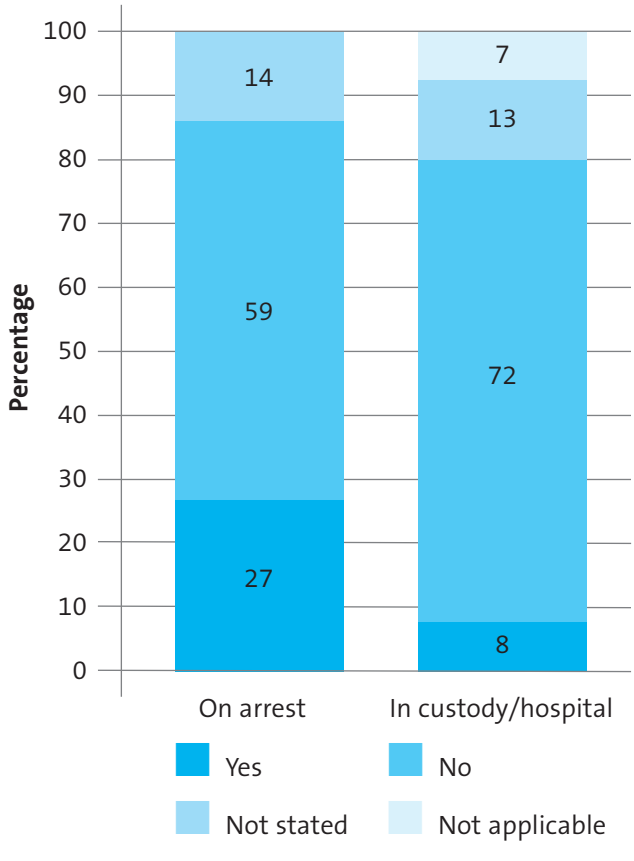
Seven of those involved in a struggle or violence when in custody or hospital were not among the 91 involved in a struggle or violence on arrest. Therefore a total of 98 people (29% of the total sample) were involved in a struggle or violence at some point during their contact with the police.

Use of handcuffs and other equipment

Police officers have a variety of means at their disposal for the purpose of restraining detainees. On occasion, this may involve the use of specialist equipment, as well as manual restraint. Use of such equipment on detainees has attracted criticism across jurisdictions (see Inquest, 1997; Strote and Hutson, 2006). Improper or unjustified use was highlighted by the PCA (2002b) during the period covered by the current study as an issue of particular concern. Findings on use of equipment are therefore included in this chapter[35].

During arrest, police officers used handcuffs on 138 (41%) of the 333 deceased people. In 32% of cases (105), handcuffs were not used. Information was not stated in 90 cases (27%). Other strategies were rarely used. Batons and CS/PAVA spray were each used in 12 cases (4%); they were not used in 86% of cases and information was not stated in 10% of cases. We found no evidence of tasers or firearms being used. It is likely that there would be mention of either in the report if they had been employed, and it is therefore fairly safe to assume that there

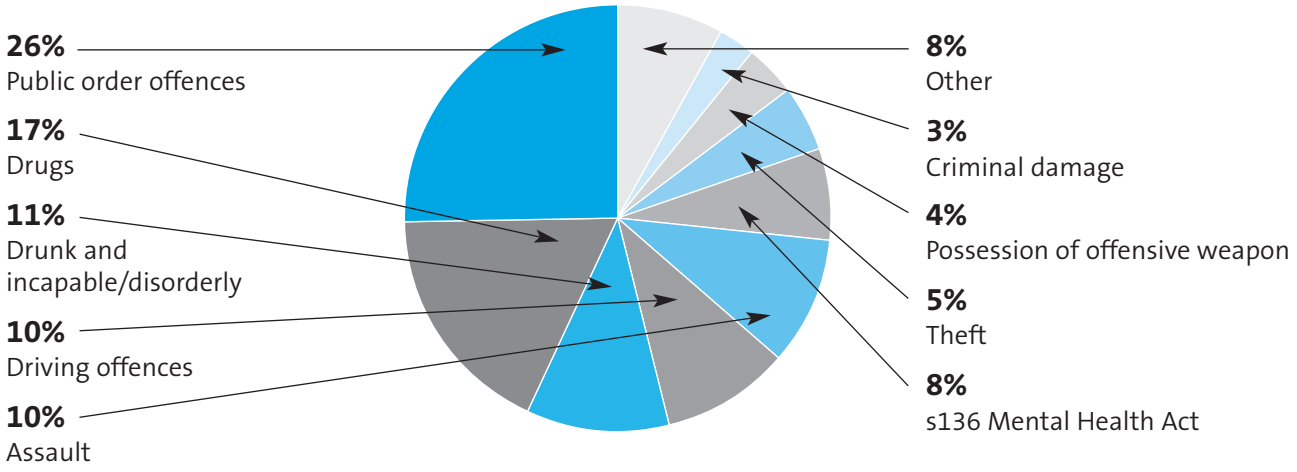
Figure 3.1 **Percentage of cases in which a struggle or violence took place on arrest and in custody/hospital**



Base = 333 detainees.

35 To anticipate findings presented later in this report, investigators' reports have also included recommendations on the use of such equipment.

Figure 3.2 **Offences for which arrested if restrained at any point**



Base = 87 detainees.
Percentages are rounded and may not add up to 100%.

were no cases in our sample where tasers or firearms were deployed during the arrest.

Handcuffs were used while detainees were in custody or hospital in 29 cases (9%), with handcuffs not used in 206 cases (62%), and information not stated in 74 cases (22%)[36]. A taser was used once[37]. Other devices were not used at all[38].

In addition to the 138 people on whom handcuffs were used at point of arrest, two people not handcuffed on arrest were handcuffed while in custody or hospital. Therefore in total at least 140 (42% of the whole sample) were handcuffed either on arrest, or while in custody or hospital[39].

When was restraint action taken?

Restraint action most commonly took place at the arrest stage. Of the 333 deceased people, 24% (81) were restrained on arrest, 62% (206) were not restrained, and information was not stated for 14% (46). While being transported to custody or hospital, 5% (18) were restrained, 66% (218) were not restrained, information was not stated for 24% (79), and the question was not applicable for 5% (18). While in custody or hospital, 7% (24) were restrained, 73% (243) were not restrained, information was not stated for 13% (43), and the question was not applicable for 7% (23).

In addition to the 81 people restrained on arrest, one person who was not restrained on arrest was restrained while being transported to custody. A further five people, not restrained on arrest or during transportation, were restrained while in custody or hospital. Therefore in total, 87 people (26% of the whole sample) were restrained on arrest, during transportation or in custody or hospital.

Reasons for arrest

Figure 3.2 shows the offences for which people were arrested, for the 87 restrained on arrest, during transportation or while in custody or hospital.

These 87 people had been arrested for 105 offences. The two most common offences were public order (27 offences) and drugs (18 offences), with people who had been arrested for drug offences being significantly more likely to be restrained[40]. These two made up nearly half (43%) of all offences for

36 The question was not applicable in 24 cases (7%).

37 Tasers were not used in 276 cases (83%). Information was not stated in 33 cases (10%), and not applicable in 23 cases (7%).

38 Batons were not used in 272 cases (82%). Information was not stated in 37 cases (11%), and not applicable in 24 cases (7%). CS/PAVA spray was not used in 275 cases (83%). Information was not stated in 37 cases (11%), and not applicable in 21 cases (6%). Firearms were not used in 276 cases (83%). Information was not stated in 33 cases (10%), and not applicable in 24 cases (7%).

39 Seventy-eight people (23% of the sample), all of whom were handcuffed on arrest, were also handcuffed while being transported.

40 This finding is statistically significant at the 95% confidence level.

the restrained group. The wider sample of 333 people had been arrested for 399 offences, but the proportion of these which were public order or drugs offences was much lower (21%).

Personal characteristics of those restrained

For the 87 members of the sample restrained at the point of arrest, during transportation, or while in custody or in hospital, the proportions of males (90%; 78 individuals) and females (10%; nine individuals) were similar to those in the full sample of 333 cases. However, there were differences in terms of age and ethnicity. In the 87 cases where restraint was used, complaints were made in 24 (28%) of the cases – a much higher proportion than for complaints cases in the sample as a whole (15%; 49 out of 333).

Age

For the 87 restrained at any point, the age range was 14 to 75 years (similar to the wider sample) but the mean age was 34 years, lower than the mean of 39 years for all cases. Figure 3.3 shows the age groups of the 87 restrained people. Over half (52) were aged between 25 and 44. This is a higher proportion than is made up by this age group in the entire sample of 333 people, and people aged between 25 and 34 were significantly more likely to be restrained, whereas those aged 55-64 were significantly less likely[41].

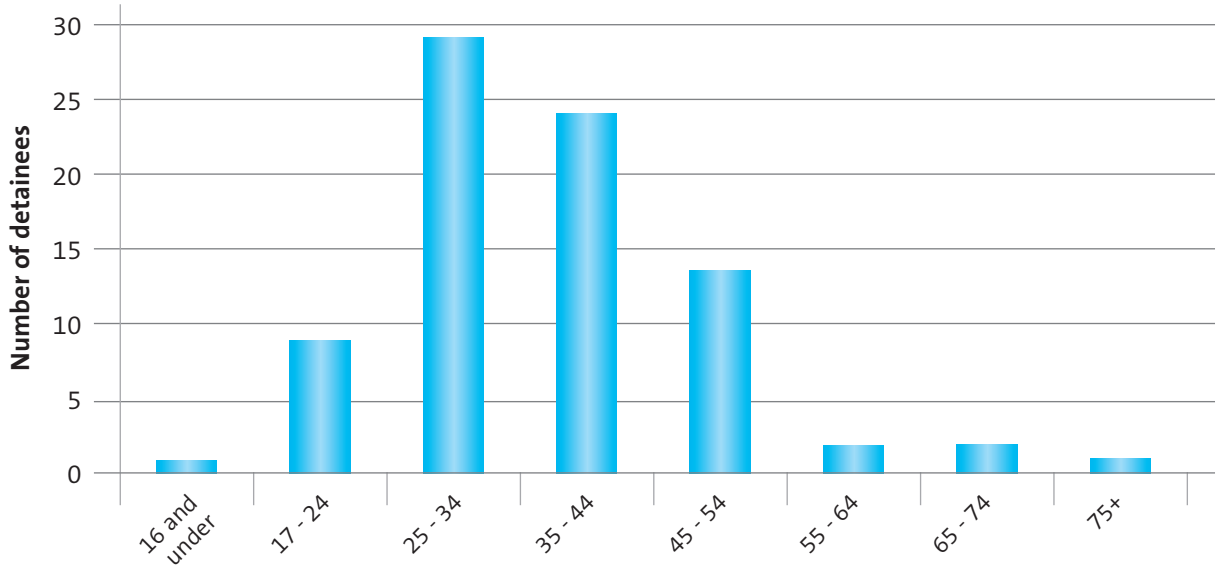
Ethnicity

Previous research has raised particular concern about deaths involving ethnic minority men and police restraint (Leigh et al, 1998; PCA, 2002b; OHRN, 2009). In this study, of the 87 restrained at any point, 67% (58) were White, 16% were Black, 7% were of Mixed ethnicity, and 6% were Asian. Ethnicity was not stated in 5% of cases . Comparing this with the details presented in chapter two shows that Black people, and those of Mixed ethnicity, therefore formed a greater proportion of those restrained than they did of the entire sample, while the opposite was true of White people. When the BME groups were combined for analysis, people from BME groups were significantly more likely to be restrained than White people .

Restrained at all points of contact

Five members of the sample were restrained at all three points – arrest, during transportation and in custody or hospital. The five were all male, and

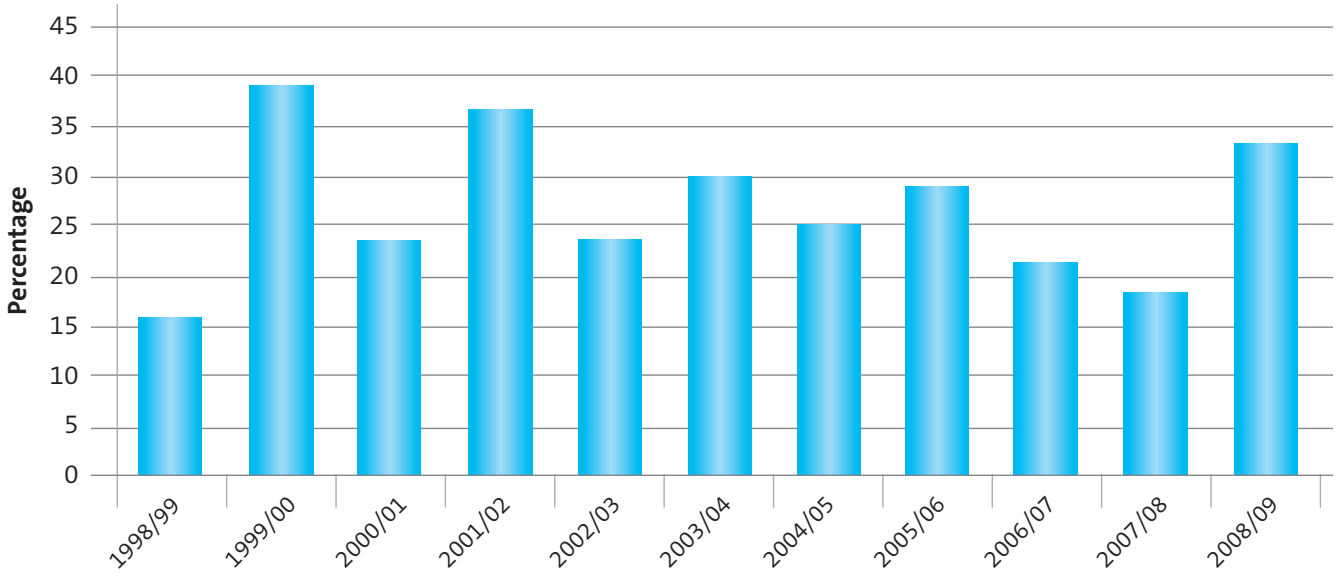
Figure 3.3 **Age group of those restrained at any point**



Base = 87 detainees.
In six cases, information was not stated.

41 This finding is statistically significant at the 95% confidence level.

Figure 3.4 **Percentage of cases in each year involving restraint at any point**



had a mean age of 38 (range 32 to 47). Three were White and two were Black.

Further statistical analysis

Because the use of restraint is a controversial area, we undertook a piece of extra analysis which aimed to provide greater clarity. This involved a statistical technique called logistic regression. Given that factors such as details of the arrest and the characteristics of those in these cases may be closely associated, we used logistic regression to identify which factors predicted the likelihood of restraint when all others were controlled. The results showed that being arrested for a public order offence was the most powerful factor in terms of increasing one's odds of being restrained. This was followed by being arrested for drug offences, being from a BME group and being aged between 17 to 34 years old. Appendix C provides more information on this analysis.

Trends in use of restraint

Figure 3.4 shows the proportion of cases in each year which involved restraint at the point of arrest, during transportation, or while in custody or in hospital, as a proportion of all deaths in each year. There is no reason to think that the perceived need for restraint of suspects declined during the period under examination. Therefore, we would expect to see the use of restraint techniques remaining proportionally constant over the period while, if they were being used safely, observing a reduction in the number of deaths associated with restraint.

Figure 3.4 shows that in 1999/00, the proportion of cases involving restraint at arrest, during transportation, or in custody or hospital was higher than in any other year. The proportion of cases in which restraint was used has fallen across the period, although this decrease has fluctuated and has not been even. Proportions are generally lower in the latter half of the 11 year period. However, the proportion of deaths in which restraint was used is relatively high in the most recent year, 2008/09. This reflects a steeper fall in the number of deaths than in the number of cases in which restraint was used.

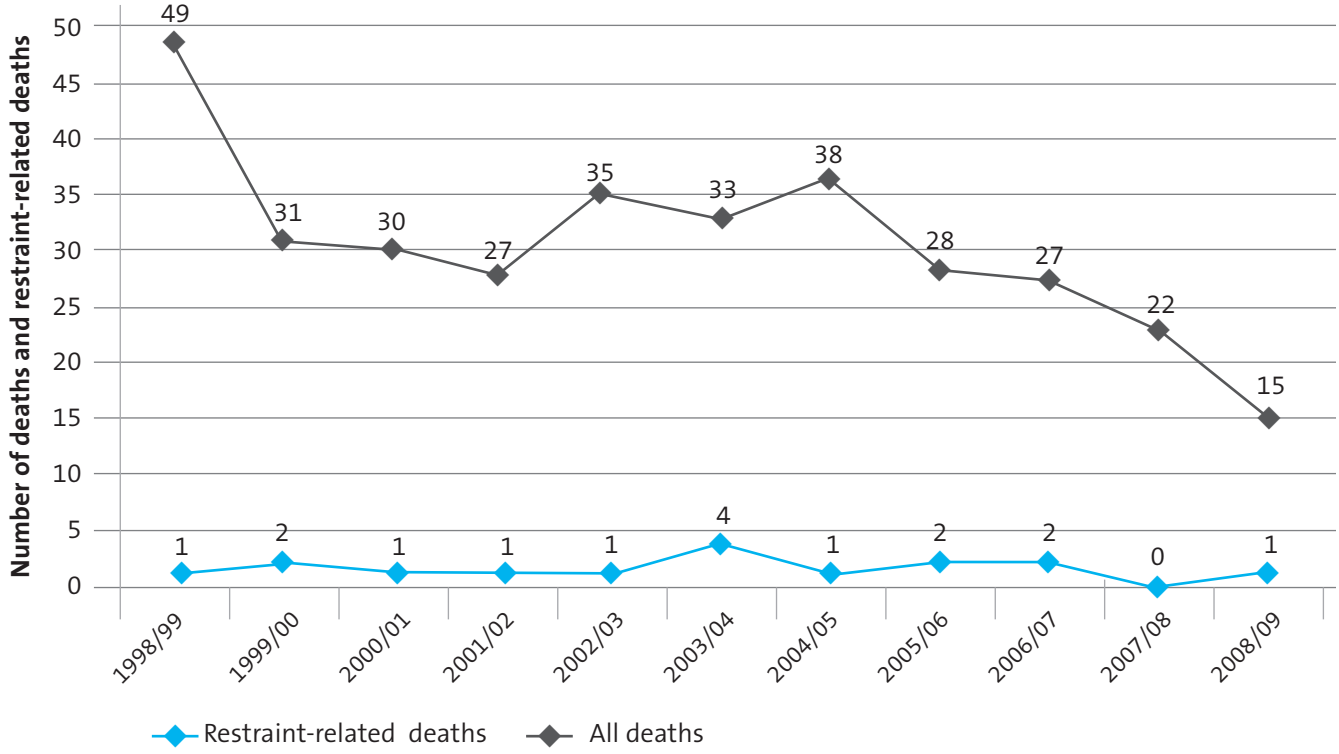
Restraint techniques used[42]

The most common form of restraint used, either on arrest or in custody or hospital, involved the deceased being held down manually by police officers. During arrest, 93 separate techniques were used on the 81 restrained people[43]. Manual holding down by police officers was used in 54 cases (58%).

42 Manner of restraint during transportation was not included in the data collection exercise.

43 Two methods of restraint were used on 12 people.

Figure 3.5 **Number of deaths each year and cases which were classed as restraint related at inquest**



Base for detainees: 1998/99, 49; 1999/00, 31; 2000/01, 30; 2001/02, 27; 2002/03, 35; 2003/04, 33; 2004/05, 36; 2005/06, 28; 2006/07, 27; 2007/08, 22; 2008/09, 15.

A specialist restraint device was used on 14 occasions (15%), and the restraint was carried out by security guards/door staff on three occasions (3%). Restraint involving a police dog was used once, one person was restrained by a paramedic, and one was restrained by a police officer applying a pain compliance technique. Each of these accounted for 1% of the techniques used. On 19 occasions (20%), the method of restraint was not stated.

In custody or hospital, 23 separate techniques were used on the 24 restrained people[44]. On two occasions the method of restraint was not stated. As with restraint on arrest, the most common form of restraint was being held down by police officers, used in 21 cases. A specialist restraint device[45] was used on two occasions.

Did restraint action taken contribute to death?

In earlier research, Leigh et al (1998) found that police actions may have been associated with the death in 6% of cases. In this study, cause of death was classed as restraint related for 16 people (5%). Of these deaths, 12 people were White, three were Black and one was Asian. In 11 of these cases, restraint-related reasons for the death were noted at post mortem. Others were noted at the Inquest. Figure 3.5 shows how these cases were distributed across the period. Four of the restraint-related deaths were in 2003/04. The distribution of restraint-related deaths across the period is more erratic than that of deaths overall. This is likely to be due to the small number of cases.

In 23 cases, the post mortem mentioned that injuries had been sustained following restraint or a struggle. In all, 31 separate injuries were noted. The most common were

44 Two methods of restraint were used on one person.

45 A number of such specialist devices have been used over the last decade. The PCA report on safer restraint (2002b) noted two types of equipment: the Violent Person Emergency Restraint System (VIPERS), first introduced by Sussex Police in September 2000; and the Emergency Restraint Belt (ERB), with which Northamptonshire Police began force-wide training in March 2001. Other devices used include Velcro limb restraints (see for example Devon and Cornwall Constabulary, 2010). In 2009, ACPO issued guidance for officers on the use of limb restraints.

Case study 3.2

Cause of death related to restraint and positional asphyxia: officers prosecuted

A man was arrested for criminal damage and then taken by van to the police station where, despite being given first aid, he subsequently died. A narrative verdict was returned at the inquest, where cause of death was given as "positional asphyxia caused by restraint". The jury concluded that the man had died in the police van before being removed from it and that one or more factors had combined to make his death more likely.

The investigator made a number of restraint-related recommendations:

- Positional asphyxia and excited delirium should be the subject of structured input at both initial and refresher training. Every officer should be provided with documents that set out the risks and appropriate response in such cases.
- A review should be conducted of the equipment available to frontline officers to assist them to safely restrain and transport violent detainees without injury to anyone.
- Centrex (now NPIA) produces guidance (with medical reviews) on the safe lifting, carriage and transportation of prone detainees.
- The force should investigate further whether PAVA spray is a more appropriate incapacitant to be issued to police officers than CS spray.

The investigator also made a number of recommendations for disciplinary proceedings in relation to ten officers. All faced a misconduct hearing. None were found guilty.

cuts/abrasions/puncture wounds (on ten occasions), bruising (ten), breakages or fractures (five), injuries to head or limbs (four) and two unspecified injuries. In three of the 23 cases, some level of concern was expressed that the injuries sustained during restraint might have contributed to the death.

Inquest verdicts

In this study, three inquest verdicts identified restraint as a cause of death; one involved excited delirium, the other two positional asphyxia. In a further nine cases, restraint techniques used by police officers were mentioned in the narrative verdict.

Case study 3.3

Cause of death restraint related: officers' actions considered appropriate by the investigator

The deceased died a few minutes after being restrained at the scene after assaulting a police officer. Cause of death was given as "aspiration of gastric contents during restraint of a person in a prone position, with chronic schizophrenia and myocardial fibrosis".

The investigator's report highlighted concern over a mouthpiece used to resuscitate the deceased, which appeared to be defective. However, the report noted that the two arresting officers had restrained the deceased in a controlled and professional way, using reasonable force and appropriate application of handcuffs. The report also found that the officers were quick to identify that the deceased had pre-existing health problems, and to use the skills taught in their training to assist a paramedic in administering first aid. Evidence showed that the deceased was in the prone position for less than two minutes.

Was the restraint action taken proportionate?

Previous research has recommended that officers receive training on safe restraint procedures and positions (PCA, 1999; Leigh et al, 1998). There is also guidance for officers on how to control and restrain people in custody (APCO, 2006). The recommendations from investigators' reports on these cases[46] are examined in chapter seven, along with other recommendations across the whole sample, but examples are given here of cases which were considered to be both disproportionate and proportionate. Case study 3.2 offers an example of a case where the investigator's report found the restraint action taken to be disproportionate.

There were eight cases, illustrated by case study 3.3, where the investigator felt that the officers involved had exercised good judgment in the degree of force and level of restraint used.

This chapter has examined deaths involving police restraint. The next chapter looks at the risk assessment, care and medical provision that all detainees received while in police custody and identifies any issues and trends.

46 See Lawrence and Mohr (2004) for an account of the need to investigate whether any part of the deceased's experience in custody led to their death.

4. Risk assessment, care of detainees and medical provision

Previous research has stressed that deaths in custody can potentially be reduced through good risk assessment and better healthcare provision (Bucke et al, 2008; Bucke and Wadham, 2009). This chapter examines the risk assessment conducted on detainees in the sample. It explores the extent to which risk assessments were carried out on the deceased once they entered custody, and the actions taken by police officers and FPs in response to the risks identified. Following this, the chapter looks at a range of issues relating to the training and resources available to custody staff and police officers. The chapter then offers some views on the quality of the risk assessments that were conducted, and the quality of the advice or examinations given by FPs.

PACE and risk assessment

The importance of thoroughly risk assessing detainees in police custody is not new. In 2000, a Home Office circular noted that *"...*[risk assessment] *procedures are essential to ensuring the safety and well-being of both detainees and police staff"*. The circular went on to highlight *"the key risk factors which should be considered at every assessment and the key questions which should be asked of* every *detainee"* (Home Office, 2000, original emphasis).

PACE Code C sets out the requirements for the detention, treatment and questioning of suspects in police custody. As discussed in chapter one, significant revisions were made to Code C in 2003 to strengthen the risk assessment of detainees, and further guidance on the safer detention and handling of persons in police custody was issued by ACPO in 2006. Paragraph 3.6 of the Code states: *"...the custody officer is responsible for initiating an assessment to consider whether the detainee is likely to present specific risks to custody staff or themselves. Such assessments should always include a check on the Police National Computer...to identify any risks highlighted...Reasons for delaying the initiation or completion of the assessment must be recorded."*

Paragraph 3.8 goes on to state: *"Risk assessments must follow a structured process which clearly defines the categories of risk to be considered and the results must be incorporated in the detainee's custody record. The custody officer is responsible for making sure those responsible for the detainee's custody are appropriately briefed about the risks. If no specific risks are identified by the assessment, this should be noted in the custody record."*

Discussing deaths in police custody, Leigh et al (1998) found that most deaths stemmed from the deceased's own actions or medical condition. This suggests that the care detainees receive once they arrive at the police station is of critical importance. Bucke and Wadham (2009) have also suggested that, in such cases, it is important to investigate the possibility that police neglect or failure to provide adequate care for the detainees may have played a part in the death. This is especially important as research in the Metropolitan Police Service area (Bucke et al, 2008) identified that, in a *"notable number of cases"* of near deaths, custody practice failed to reflect the policies and guidance in the PACE Codes of Practice. Bucke et al recommended that *"police forces...ensure that Custody Officers, as part of their training, gain sufficient awareness of the symptoms of key conditions...to be able to conduct robust risk assessments"*.

The remainder of this chapter will examine the extent to which risk assessment was carried out on the current sample, the actions taken as a result, and whether any failure to adhere to guidance or to adequately risk assess the deceased may have contributed to the deaths.

Risk assessment at point of arrest

Before a person enters custody, police officers, paramedics or others who come into contact with them may identify a number of factors which can give cause for concern. This is not a risk assessment as described within Code C of PACE. However, decisions made by police officers at this stage will have an effect on a person's detention, and may determine whether the person is admitted to custody, or taken directly to hospital. Figure 4.1 shows how many of the sample were identified as having a particular issue at point of arrest, for a number of different issues. Intoxication through alcohol was the most regularly identified issue at point of arrest, with half the sample (166 people) showing signs of this.

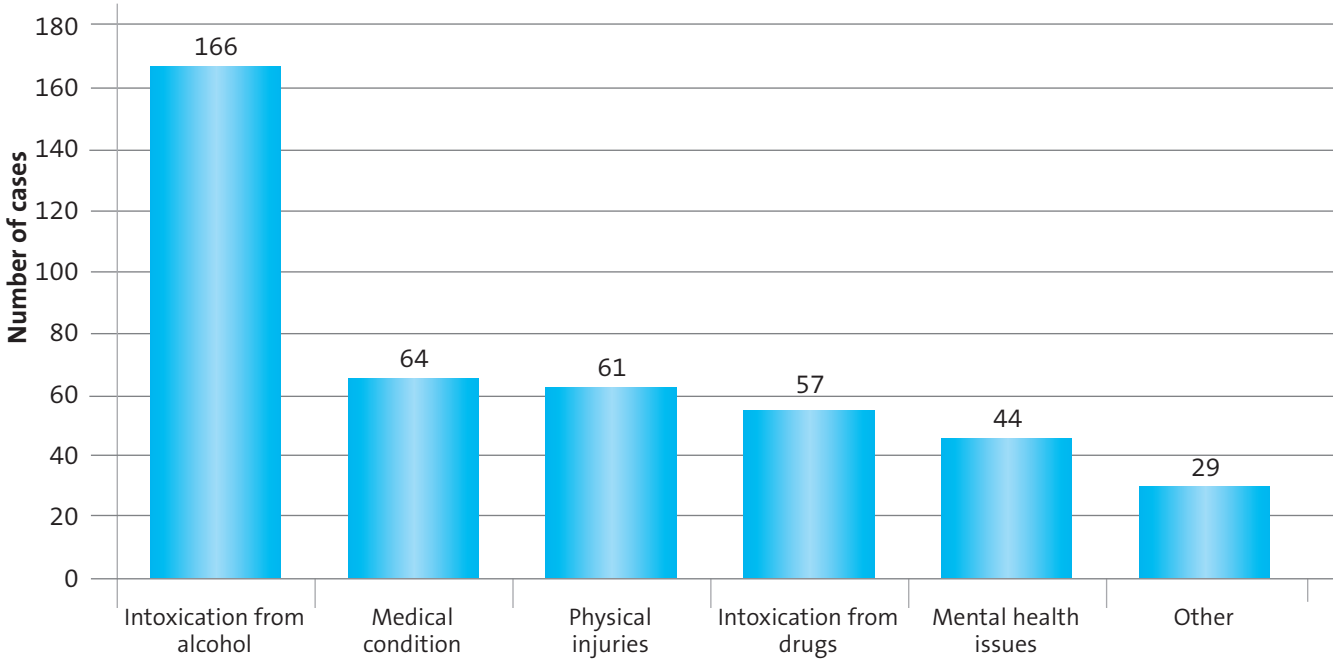
Figure 4.1 also shows that 64 detainees (19%) were identified on arrest as having some type of medical condition and 61 (18%) had physical injuries. Figure 4.2 shows the nature of these conditions. A total of 73 conditions and injuries were identified. Head injuries, identified on 14 occasions, were the most commonly noted, followed by minor cuts/grazes (eight).

Alcohol- and drug-related conditions comprise those where an issue was identified beyond straightforward intoxication, and where there was an indication that the detainee might be physically or psychologically addicted.

What happened to detainees following arrest?

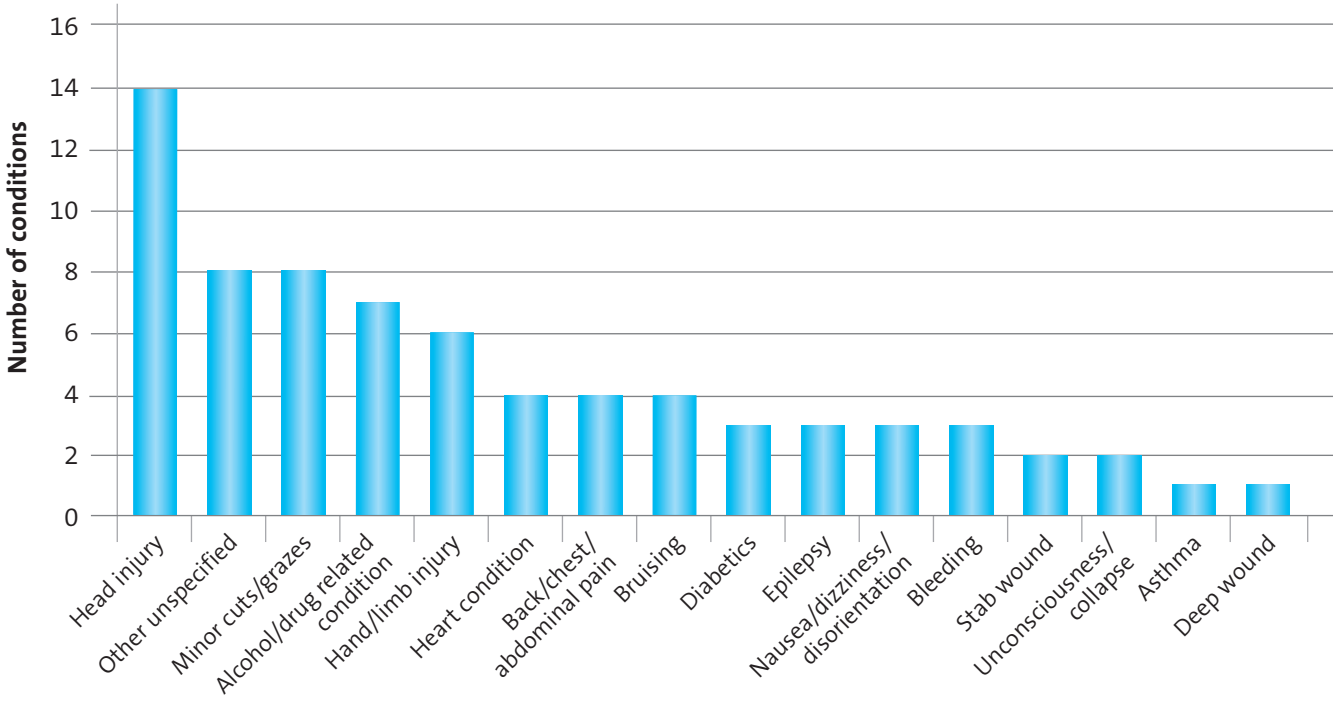
Figure 4.3 shows what happened to the 333 detainees in the sample following arrest. Nearly three-quarters (73%; 244) were admitted to custody. A further 3% (10) were also taken to

Figure 4.1 **Number of cases in which issues were identified at point of arrest**



Base = 333 detainees.
'Other' includes: suicide/self-harm risk (5); propensity for violence (5); domestic issues/problems (4); overdose (1); intoxication from other substances (1); known drug users (1); and other unspecified issues (12).
Percentages are calculated from the 333 detainees and not from the number of factors. Individuals could have multiple factors.

Figure 4.2 **Physical injuries and medical conditions identified on arrest**



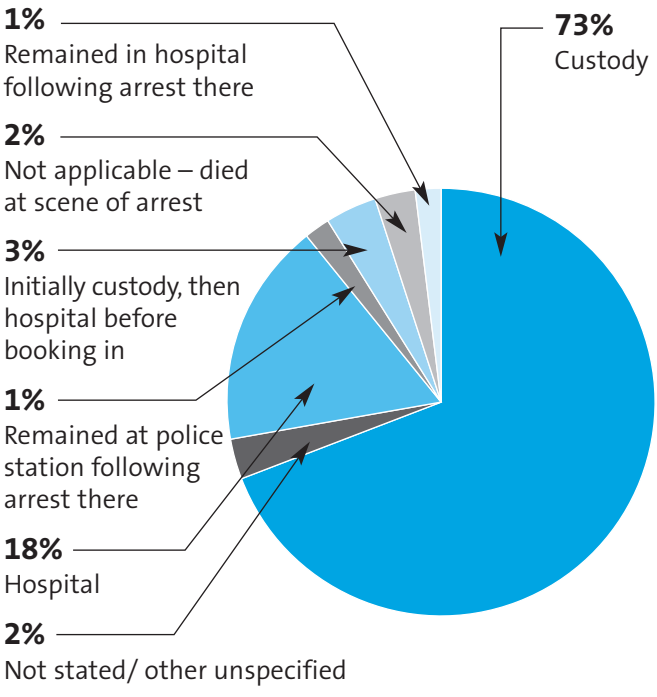
Base = 83 detainees.
For some detainees the nature of the condition was not specified.

custody, but were then transferred to hospital before they could be booked in, due to concerns about their condition. Three other detainees were also booked into custody, having been arrested at the police station. In all, therefore, 74% (247) of the detainees were booked into custody and liable for a risk assessment at the police station. Most of the remaining detainees (59; 18%) were taken directly to hospital from the scene of arrest. Four remained in hospital having been arrested there. Five investigators' reports did not specify where the detainee was taken. The remaining eight detainees died at the scene of the arrest.

Searches

Of the 320 detainees known to have either been taken to custody or hospital, or to have remained there following arrest, 114 (36%) were searched on arrival. Just over half of these searches (59) involved a search of clothing and 'pat down'. Strip searches were carried out in 22 cases, and details of the search were not stated for the remaining 33 cases.

Figure 4.3 **Action taken following arrest**

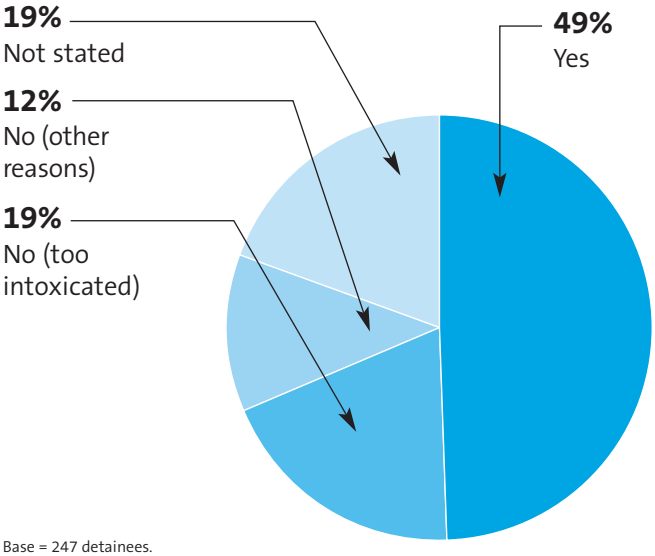


Base = 333 detainees.

Risk assessment of those admitted to custody

Figure 4.4 shows whether a risk assessment was conducted on the detainee on arrival at the custody suite. Bucke et al (2008) recommended that all intoxicated detainees should be risk assessed, whether or not they display any immediate signs of concern when entering custody. Of the 247 detainees who were booked into custody, just under half (121; 49%) were risk assessed. In 48 cases, no risk assessment was conducted because the detainee was too intoxicated. In a further 30 cases it was not conducted for other reasons. This means that, overall, the detainee was not risk assessed in 78 cases. Information was not stated in 48 cases, and the question was not applicable in two cases.

Figure 4.4 Proportion of cases in which a risk assessment was conducted when the detainee arrived at custody

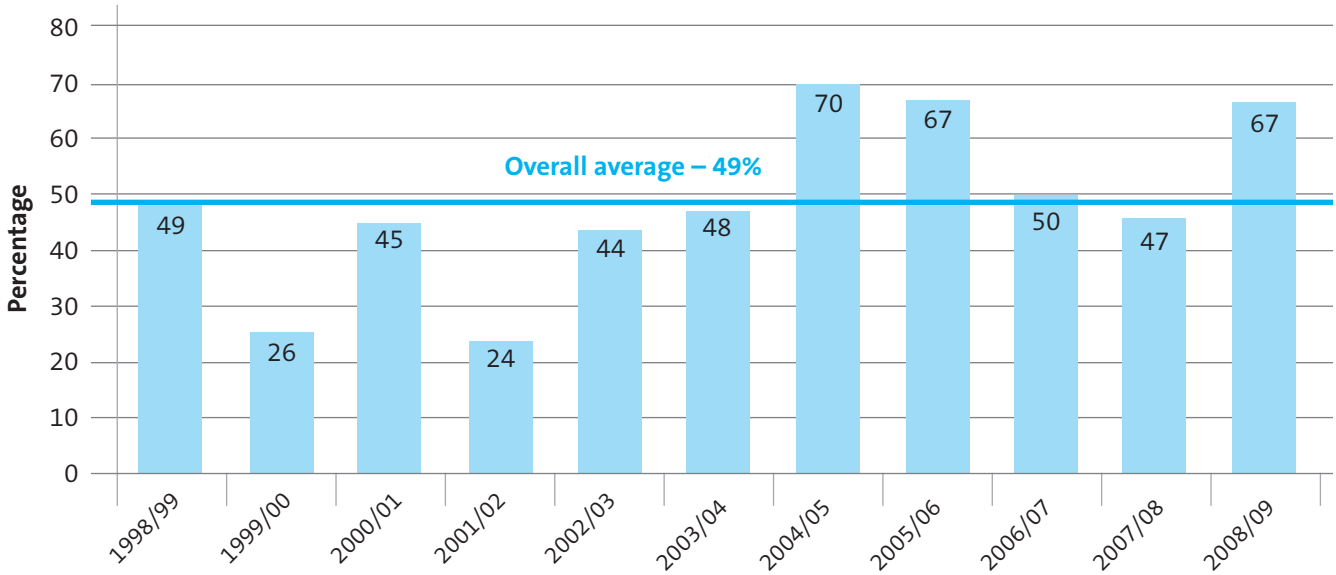


Base = 247 detainees.

Trends in risk assessment

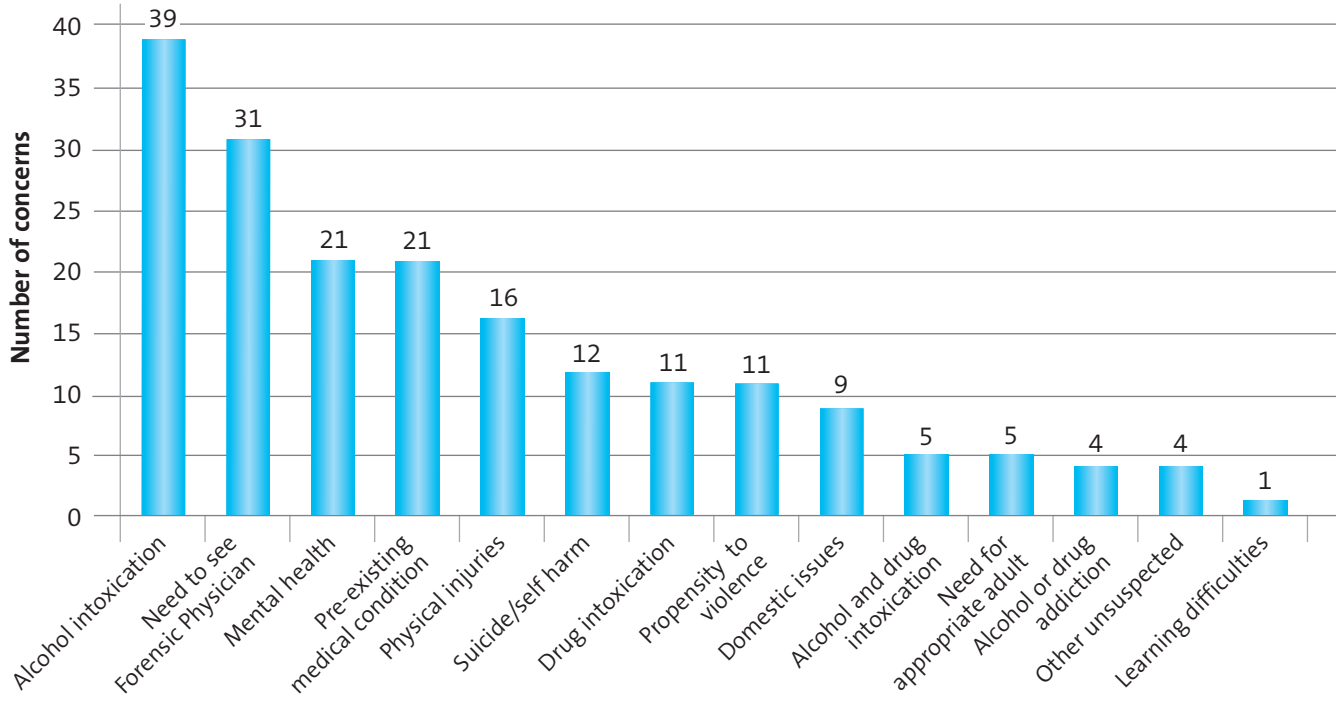
Figure 4.5 shows the percentage of assessments actually carried out each year as a proportion of these applicable cases. It shows that proportions were at their lowest during the early part of the 11 year period, especially in 1999/00 and 2001/02. The data suggests some improvement in the second half of the period, particularly between 2004, 2006 and 2008. This improvement has not been consistent, however; the proportion of detainees actually receiving a risk assessment in

Figure 4.5 Risk assessments conducted as a proportion of those people entering custody



Base for detainees: 1998/99, 39; 1999/00, 19; 2000/01, 22; 2001/02, 21; 2002/03, 25; 2003/04, 23; 2004/05, 30; 2005/06, 24; 2006/07, 18; 2007/08, 17; 2008/09, 9.

Figure 4.6 Concerns identified from risk assessment of detainees



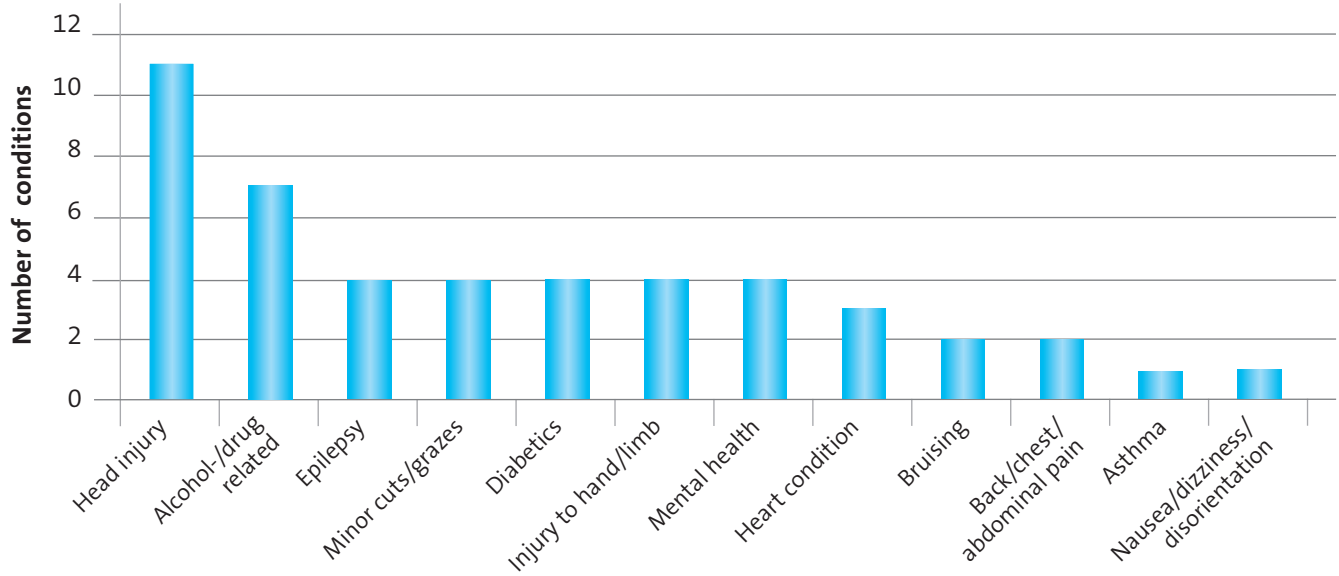
Base = 247 detainees.

2007/08 was lower than the average for the whole period[47].

Figure 4.6 shows the concerns identified from the risk assessment carried out when the detainee arrived at custody. In all, 190 concerns were raised.

The most common concerns were detainees' alcohol intoxication (on 39 occasions) and the need for detainees to be examined by a FP (on 31 occasions). Between them these accounted for 70 (37%) of the 190 concerns raised.

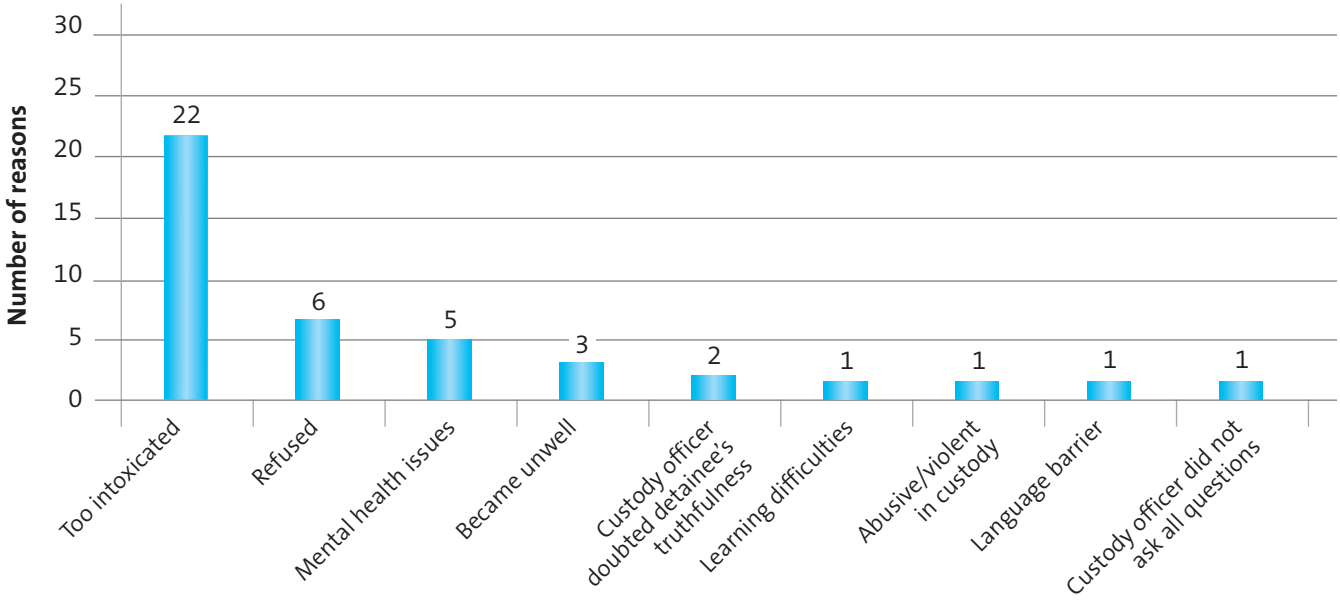
Figure 4.7 Physical or medical conditions identified from risk assessment of detainees



Base = 247 detainees.
The total will not equal the sum of the physical and medical conditions shown in figure 4.6, as detainees could have multiple conditions.

47 Caution should be exercised when interpreting these figures, as the numbers in each year are small.

Figure 4.8 **Reasons why detainees did not answer all risk assessment questions**



Base = 80 detainees.
In 38 cases the reason for not answering all of the questions was not stated.
Each detainee could have two reasons for not answering all of the questions.

Physical or medical conditions

Figure 4.7 shows the physical or medical conditions identified through risk assessment on arrival at custody, where the nature of the condition was known[48]. Of the 47 conditions noted, the most common were head injuries, which were noted on 11 occasions.

Number of questions answered at risk assessment

Among Bucke et al's (2008) recommendations was that *"police forces...consider whether Custody Officers have been provided with sufficient guidance on the management of those detainees who are either unwilling or not able to participate in a risk assessment"*. Of the 121 detainees on whom an assessment was conducted on arrival at custody, one third (41) answered all the questions put to them as part of the assessment. A further 12% (15) answered some questions, and 7% (nine) did not answer any questions. In the remaining 46% of cases (56) the information was not stated. Figure 4.8 shows why detainees did not answer all risk assessment questions. In all, 42 reasons were given. The detainee's level of intoxication was by far the most common, accounting for 22 of these 42 reasons. Case study 4.1 offers an example of a risk assessment which, had it been more thorough, could have prevented a death.

Custody warning markers

Along with self harm reported by the detainee, markers on the Police National Computer can identify risk. Police officers use such markers to warn colleagues of a detainee's previous behaviour in custody. This will alert custody staff when booking in a detainee who has previously been arrested, but with whom they themselves may be unfamiliar.

Figure 4.9 shows the markers noted in investigators' reports for the 333 detainees in the sample. In all, there were markers for 195 detainees (59%) although markers were not stated for 125 of these. For the remaining 70 detainees, 105 markers were noted. Some markers are more strongly linked than others to the possibility of death in custody. The most common markers were for detainees' propensity to violence (on 17 occasions), previous examination by a FP (16) and accompaniment during previous spells in police custody by an appropriate adult (14).

Taking the information found at each of the stages

48 In all, 62 conditions were noted; however, in 15 cases investigators' reports either did not specify the condition or simply recorded that the detainee was prescribed unspecified medication.

Case study 4.1
Incomplete risk assessment

The detainee was arrested for criminal damage and taken to the police station. Several factors could have alerted the police to the fact that the detainee was in need of medical attention. First, he told the officer who arrested him that he had been drinking, that he was addicted to heroin and that he was prescribed methadone. This information was not relayed to the custody officer. Second, he had been detained in police custody on many occasions over the previous four years. On one such occasion he was taken from the police station to hospital after telling officers he had swallowed a bottle of tablets. Third, previous custody records detailed evidence of the detainee harming himself and suffering from mental illness. Fourth, in the self-assessment section of the risk assessment dealing with illness and injury, the detainee recorded that he had cut his hand after punching a window.

The custody sergeant's risk assessment recorded that the detainee had no injuries or ailments, and was not on any medication. It also indicated that the detainee was not drunk or in need of medical attention, although he was placed in a cell for drunken detainees.

Fifteen-minute checks were decided upon; however, the custody record contained no evidence that any cell checks were conducted until almost two-and-a-half hours later, at which time the detainee was found in his cell with a ligature around his neck. Medical assistance was then given by police staff, and subsequently an ambulance crew, but the detainee was pronounced dead in the cell. A later entry on the custody record, nearly two hours after death, noted that checks were not possible to log due to the number of persons passing through custody at the time. However, this entry also noted that these were not 15-minute checks, but hourly.

outlined above, 32 individual detainees[49] were identified as having mental health issues. This compares with a total of 58 people identified in chapter five who were arrested under Section 136 of the Mental Health Act, arrested under other Sections of the Act, or were identified at arrest or in custody as having mental health needs.

Investigators' reports noted that, in the case of 75 detainees, police officers and staff continued to carry out risk assessment while they were in custody. No continued risk assessment was noted in 29 cases. Information was not stated in 69 cases and was not applicable in the remaining cases.

Vulnerable detainees

Based on a detainee's risk assessment, physical or medical conditions, or warning markers on the custody record system, custody staff may treat them as vulnerable or at risk. Of 220 applicable cases[50] in the whole sample, 41% (90) were treated as vulnerable once received into custody, 35% (77) were not and information was not stated in the remaining 24% of cases (53).

Provision of facilities and items

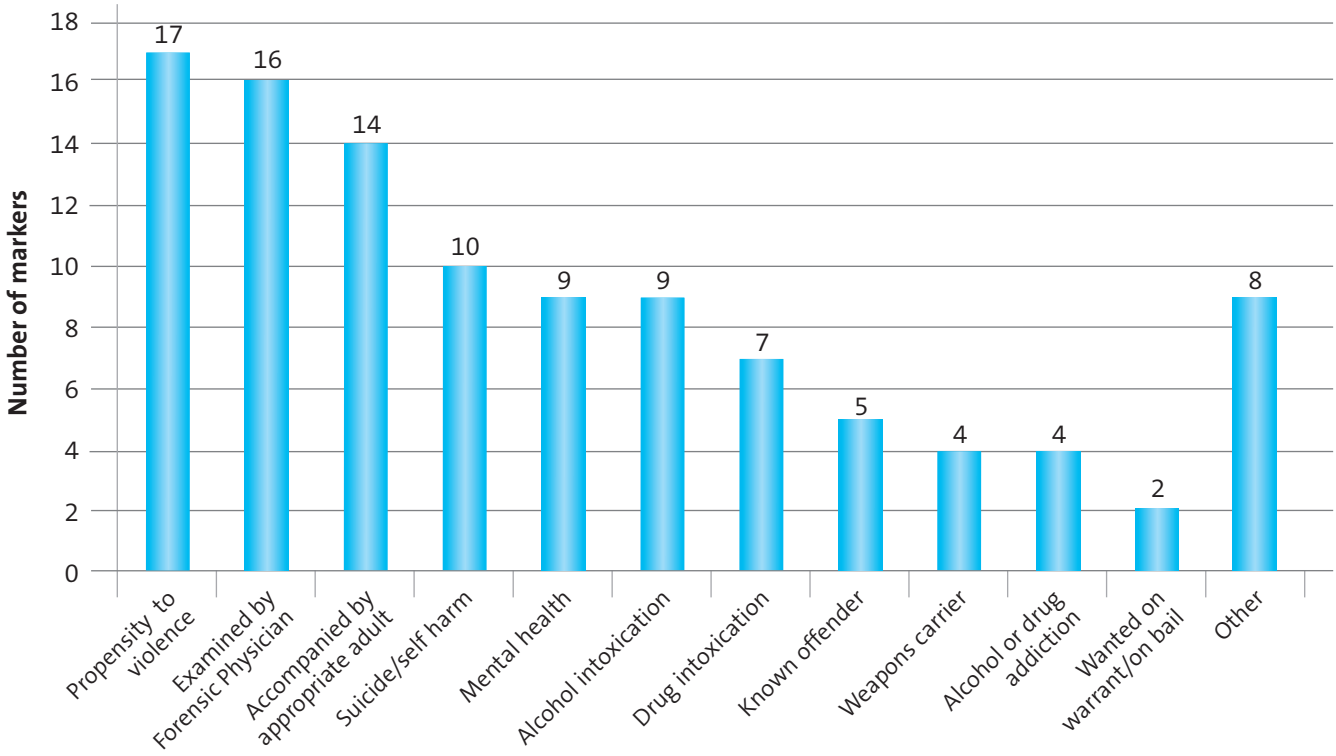
If a detainee is classed as vulnerable or at risk, custody staff may provide them with certain facilities and house them differently from other detainees during their time in custody. Investigators' reports noted that 66 of the deceased were placed in a cell for detainees deemed to be vulnerable or at risk. The two most common types of additional protection in these cells were CCTV (in the case of 27 detainees) and a low bed to ensure that, in the event of falling, they would only travel the minimum distance and be less likely to sustain injury (25).

Nineteen detainees were provided with items for their own safety while in custody. The most

49 For nine detainees, mental health issues were evident from more than one source.

50 Where the question was not applicable, this was commonly because the deceased had died before arriving in custody, had been taken directly to hospital, or had been taken to hospital or died before being placed in a cell.

Figure 4.9 **Number of markers found on the custody system for detainees**



Base = 70 detainees.
'Other' includes: pre-existing medical conditions (2); domestic issues (2); known to attempt escape from custody (2); alcohol and drug intoxication (1) and, racist behaviour (1).

common item provided was a safety suit/special clothing (nine occasions), followed by a 'safety blanket' (five), a 'special mattress' (four), a 'special pillow' (once) and one unspecified item[51].

Removal of clothing or property

The PACE Codes of Practice C state that custody officers may withhold a detainee's clothing and personal effects where they consider that *"they may use them to cause harm to themselves"*. Of 223 applicable cases[52] in the whole sample, at least one item was removed from over one third (81; 36%). No items were removed from 47 detainees (21%) and information was not stated in the remaining 43% of cases (95). In all, 153 items were removed. The single most common items of property removed were miscellaneous, unspecified items (on 19 occasions, accounting for 12% of all items removed).

51 One detainee was provided with two items for his own safety.

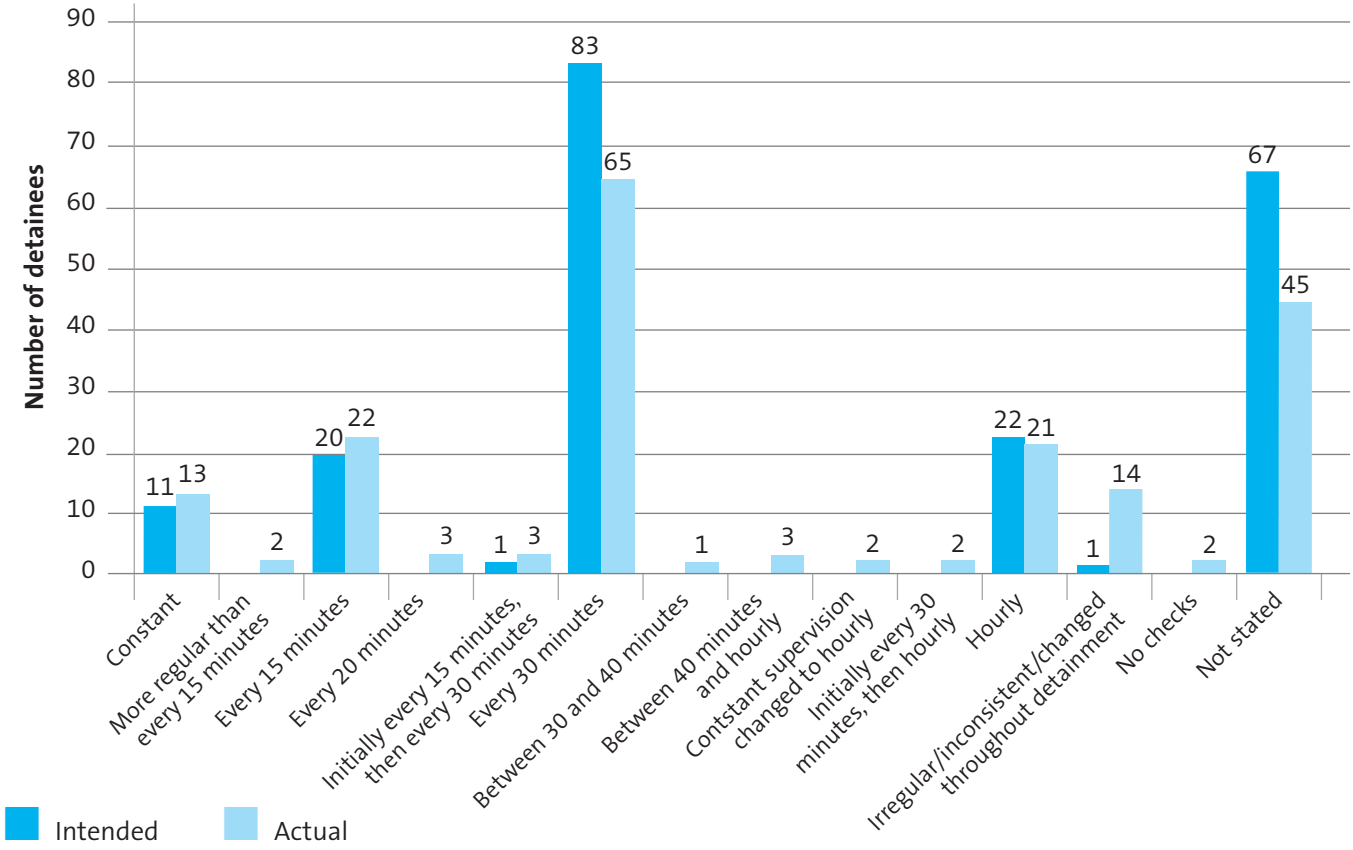
52 Where the question was not applicable, this was commonly because the deceased had died before arriving in custody, had been taken directly to hospital, or had been taken to hospital or died before being placed in a cell.

Checking and rousing during detention

Custody staff have a number of options when deciding the level of checks each detainee should receive while in custody. If no concerns are apparent from a risk assessment, checks may be carried out at hourly intervals. If concerns are identified, this may be increased, with checks at 15- or 30-minute intervals. Detainees considered to be at high risk of self harm, who are treated as mentally ill, or about whom there are concerns regarding their consciousness, may be placed on constant supervision. This may involve constant monitoring through regular physical checks, as well as use of CCTV.

The PACE Codes of Practice state that the custody officer is responsible for implementing the response to a risk assessment. The Codes also emphasise that custody staff should seek advice from healthcare professionals if any element of their assessment of

Figure 4.10 **Type of checks detainees should receive and those actually received**



If no bar is shown, this indicates that no checks for these periods were intended.
128 of the 333 cases were not applicable.
In a large number of cases – 67 for intended checks, 45 for actual checks – information was not stated.

a detainee is unclear. Paragraph 9.15 states: *"When clinical directions are given by the appropriate healthcare professional...and the custody officer...is in any way uncertain about any aspect of the directions, the custody officer shall ask for clarification. It is particularly important that directions concerning the frequency of visits are clear, precise and capable of being implemented."*

Figure 4.10 shows the level of checks which it was decided the sample should receive, alongside the level of checks actually received. The figure shows the shortest intervals between actual checks on the left, and the longest period between actual checks on the right.

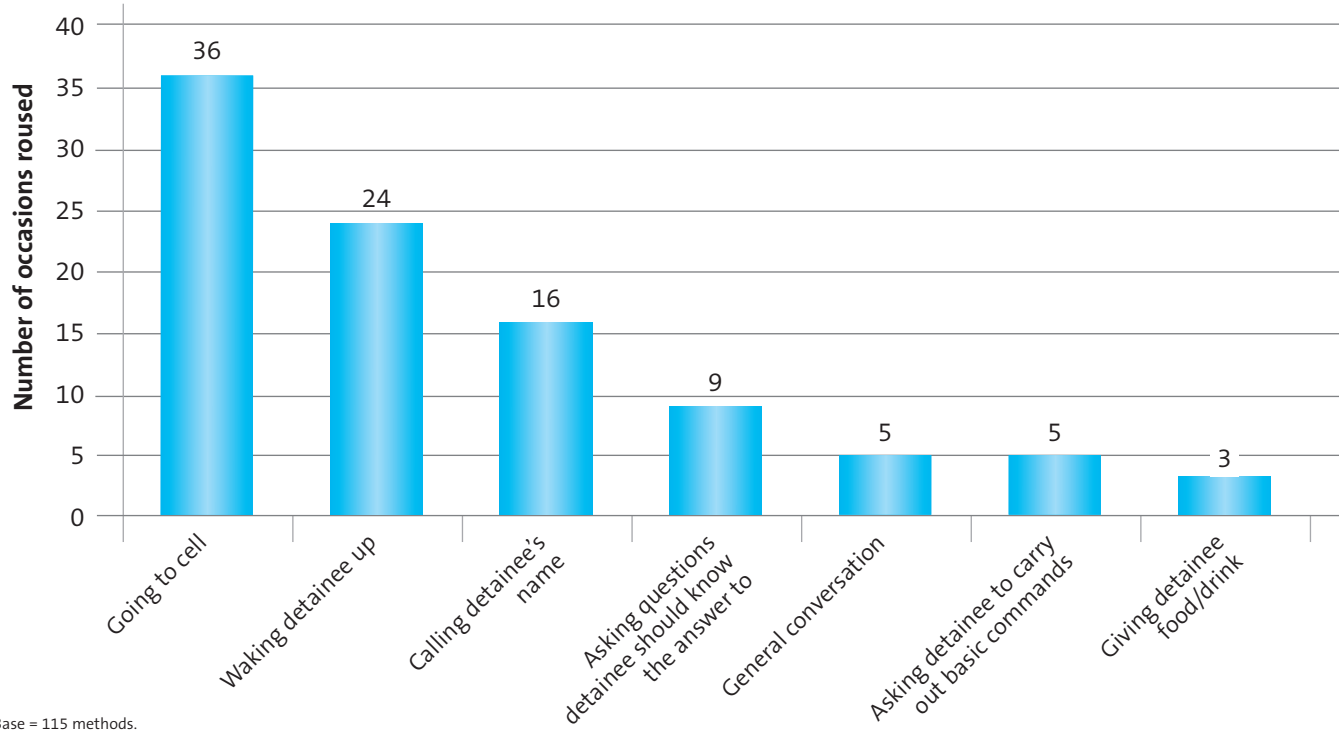
Of 205 detainees for whom the question was applicable[53], 13 actually received constant supervision. In the case of four of these detainees, custody staff had not initially decided to do this. Nine of the 11 detainees who were intended to receive constant supervision actually did so – the remaining two received hourly checks.

Most typically (83 cases; 40% of those applicable), detainees were scheduled to 30 minute checks. However, only 65 received checks at these intervals. These 65 comprised 50 detainees who were intended to be checked every 30 minutes, plus a further 15 detainees who actually received 30 minute checks but were not scheduled to do so. Of the 33 detainees who were intended to receive 30 minute checks but did not, four received more regular checks, while 12 were checked less regularly.

Levels of checks required, and detainees' needs, were most commonly recorded on the custody record/IT system (120 cases). In 15 cases (7% of

53 A total of 128 cases were not applicable because no checks were either intended or carried out. Typically this was because the detainee had not been booked into custody, or had died or been transferred to hospital before checks could be decided upon and carried out. In a further three cases the detainee was known to be in custody. However, the investigator's report stated that there were false entries on the custody record, and did not record the times of scheduled or actual checks.

Figure 4.11 **Methods used to rouse detainees**



Base = 115 methods.
In 17 cases, information was not stated.

those applicable) this information was written on a white board in the custody suite. In 62 cases the information was not stated, while in one case the investigator's report noted that it was recorded by other unspecified means[54].

PACE also states that a note must be made in the custody record of *"...the responses received when attempting to rouse a person using the* [rousability, response to questions, and response to command] *procedure"*. Recording a person's responses when attempting to rouse them enables any change in the individual's consciousness level to be noted, and clinical treatment arranged if appropriate. Other research suggests that officers' understanding of the term 'rousing' varied widely (Havis and Best, 2003). Drawing on a small sample of custody sergeants, police officers and FPs, it concluded that none of those interviewed appeared to understand its purpose.

Figure 4.11 shows the different means by which detainees were actually roused. Most methods required the detainee to show a direct response to some sort of stimulus, either conversationally or using movement[55]. However, the most commonly used method (on 36 occasions) involved a police officer simply going to the cell, with no record of any interaction with the detainee beyond visual observation. This chapter has shown that a large number of detainees were identified through risk assessment as suffering intoxication from alcohol. Visiting a cell and conducting a visual observation has implications in such cases, as a detainee who appears to be sleeping, and therefore comfortable, may in fact be suffering from something more serious.

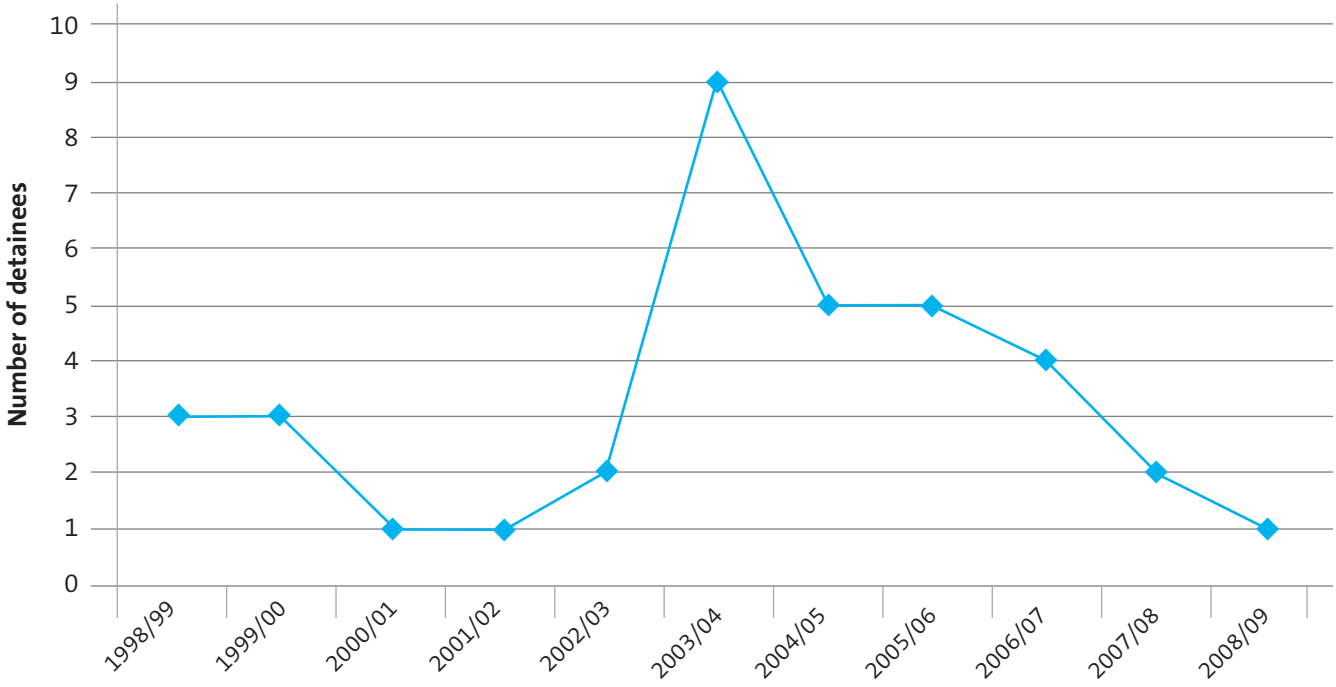
Trends in rousing methods

Figure 4.12 shows how the rousing methods of going to the cell were distributed in each of the 11 years. Figure 4.12 shows that 2003/04 saw the highest number of such forms of rousing of any single year. There has been a steady fall since then; however, the majority of occasions on which rousing simply constituted *"going to the cell"* nevertheless occur in the years following 2003/04 (17 occasions) rather than the years preceding 2003/04 (ten occasions). As numbers are small across the period, caution should be exercised when interpreting these findings.

54 More than one method could be used for recording detainees' checks and needs.

55 More than one method could be used to rouse a detainee.

Figure 4.12 **Occasions on which detainees were roused by 'going to the cell'**



Case study 4.2 shows how lack of training and confusion between police officers can result in failure to identify detainees' medical needs. This in turn can lead to failure to alert healthcare professionals, inadequate checking of detainees, and failure to rouse them, culminating in fatality.

Case study 4.2

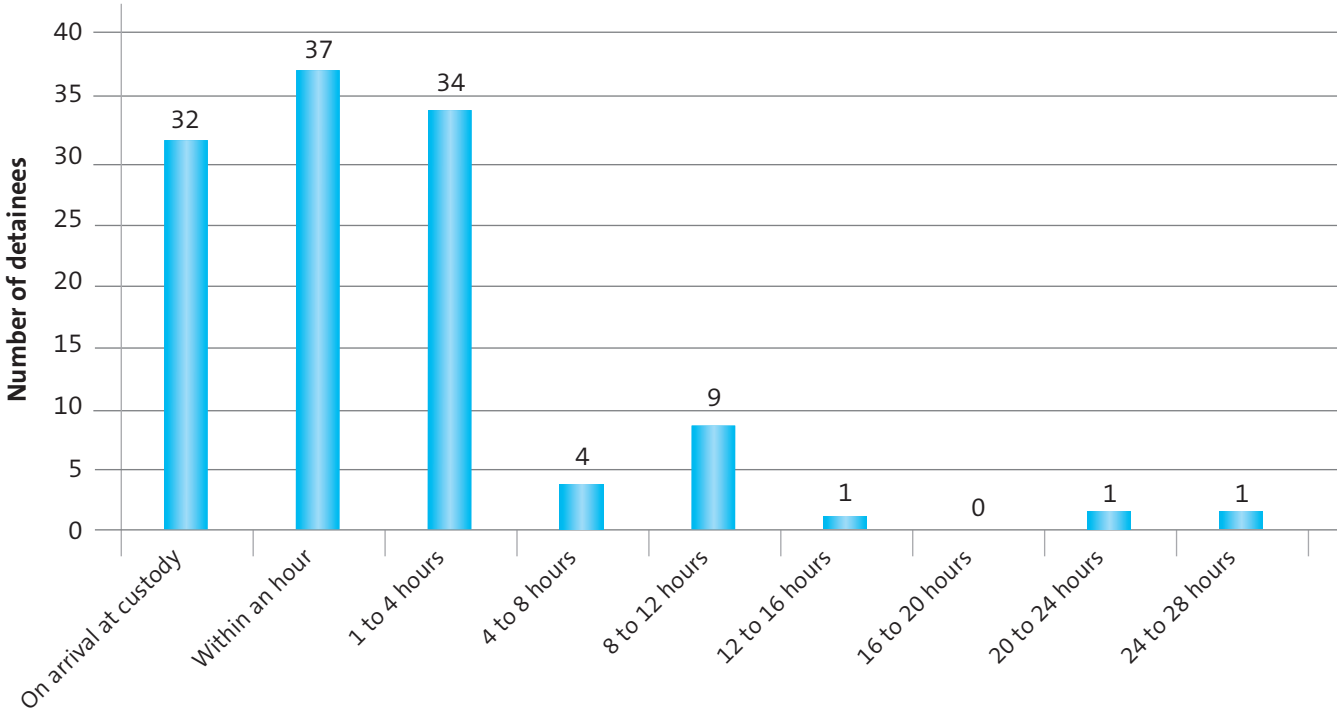
Systemic issues regarding healthcare contributing to death

The deceased was found lying on the ground by a member of the public. He had taken heroin and had also been drinking, but refused the assistance offered by an ambulance crew called by a member of the public. The ambulance crew then called the police, who arrived, arrested the man for being drunk and incapable and transported him to the police station.

At the custody suite, he was placed in a cell for drunken detainees. Checks on the man were arranged for every 30 minutes, although this decision was made without the input of a FP, who was not called to assess the detainee, despite his intoxication and even though he had been arrested in an area where drug users and dealers were known to operate. The first four checks were carried out as planned, but were then reduced to one hour intervals. The investigator was unable to determine why this decision was made and by whom. None of the checks involved the man being roused.

Five hours after arriving into custody, the man was found lying in his cell, not breathing. The inquest verdict found the cause of death to be non-dependent drug misuse, contributed to by systemic failure by the police. Among 31 recommendations made, the investigator noted shortcomings in: training provided to deal with intoxicated detainees; calling a FP; the recording and authorising of changes in the number of cell visits; procedures for laying detainees properly in a cell and providing blankets; regular checking and rousing; and keeping observation windows free of obstruction.

Figure 4.13 **Time elapsed before a FP was called to the police station**



Base = 146 detainees.
In 27 cases, information was not stated.

Involvement of Forensic Physicians

Data obtained by a joint Home Office and Department of Health survey of police forces (2010) showed that, on average, 35% of detainees are treated by a healthcare professional when in custody. Unsurprisingly, given the nature of our sample, a higher proportion of those in this study were seen by a healthcare professional. A FP was called to the station to examine detainees in 146 cases (62% of applicable[56] cases). No FP was requested in 70 cases (30% of applicable cases), and information was not stated in 20 cases (8% of applicable cases). FPs were most often requested[57] by custody officers or staff (in 115 of the 146 applicable cases).

Figure 4.13 shows how soon FPs were requested for the 146 detainees. In 27 cases the time elapsed was not stated. Of the remaining 119 cases, over half (69) resulted in the FP being requested either on the detainee's arrival at custody (32) or within an hour of arrival (37). This suggests that, in most cases, it was apparent from an early stage that the detainee was experiencing difficulties and perhaps should not have been taken into custody.

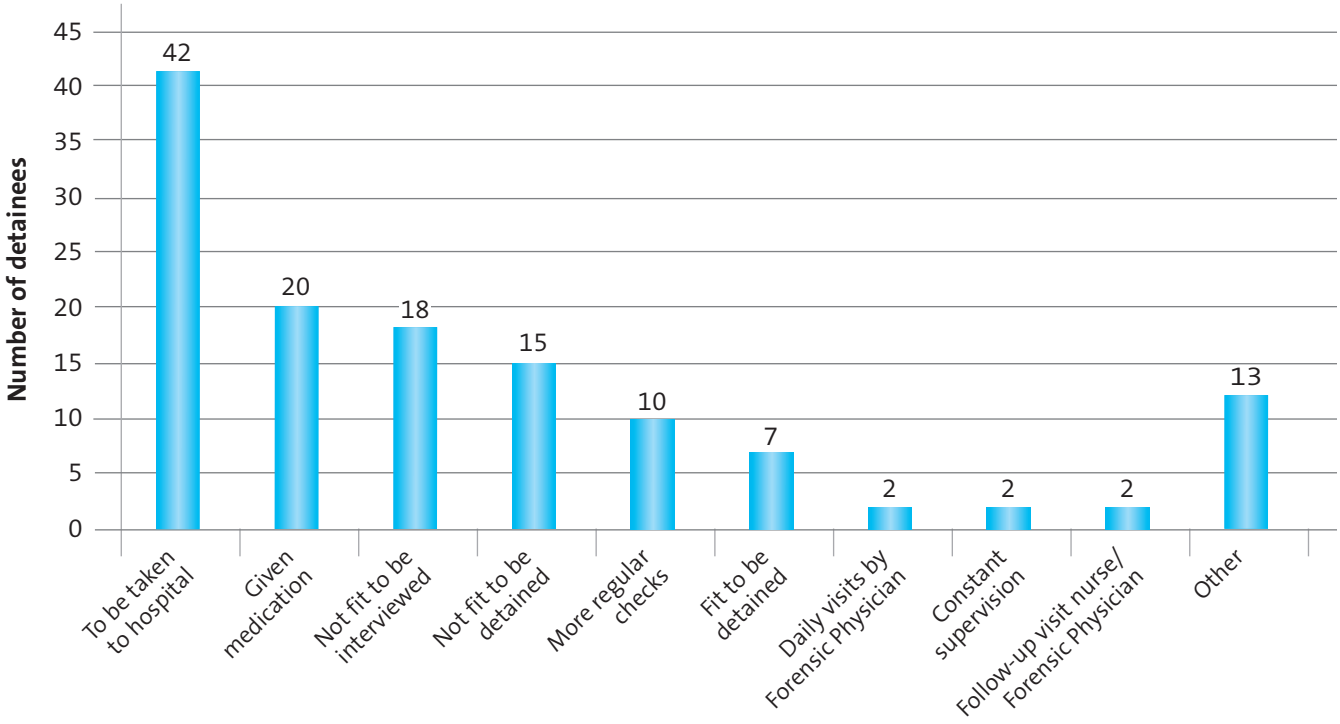
In most (116) of the 146 applicable cases, an FP attended the police station and assessed the detainee. In 23 cases a FP did not attend and carry out an assessment. Information was not stated in four cases and was not applicable in three cases.

Figure 4.14 shows the comments made and action taken by FPs following assessments. In all, 137 responses were recorded. By far the most common was the comment that the detainee should be taken to hospital (42 cases). In one further case, the FP advised that the detainee be taken to hospital if their condition worsened.

56 There were 97 not applicable cases, reflecting the number of detainees who were not booked into custody, or who died or were transferred to hospital before a FP could be called. Two detainees who were initially taken into custody but transfered to hospital before they were booked in were seen by a FP.

57 In cases where FPs were requested more than once, details of the first call-out only have been used.

Figure 4.14 **Comments made by FPs following assessment of detainees**



Base = 116 detainees.
'Other' includes: fit to be interviewed (1); risk of self harm (1); needs appropriate adult (1); alcohol withdrawal (1); drug withdrawal (1); low blood pressure (1); medication offered but refused (1); needs to see Approved Mental Health Practitioner (1); needs to be released (1); needs to be taken to hospital if condition worsens (1); interview to be stopped if detainee feels stressed (1); and, other unspecified (2). In six cases, information was not stated.

Police officer first aid training and staffing

In the Metropolitan Police Service (MPS) area, custody policy states that all custody staff must have 'Emergency Life Support' training and re-qualify every 12 months unless they hold a current 'First Aid at Work' certificate (reported in Bucke et al, 2008). The ACPO (2006) Safer Detention guidelines also state that custody officers should be trained in first aid prior to taking up the post and that they should have refresher training every 12 months. Bucke et al's (2008) research in the MPS also raised the question of whether the ability of custody staff to follow PACE Code C is compromised at particularly busy times. This section examines issues to do with first aid training and staffing.

Extent of first aid training

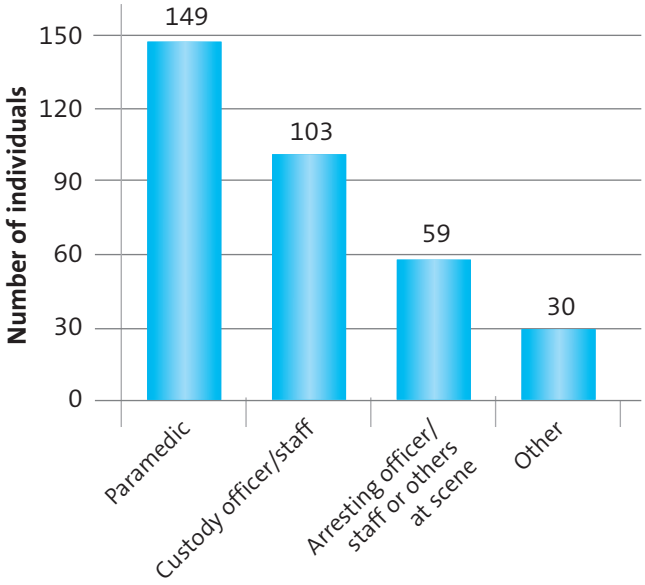
Based on the information contained in investigators' reports, the situation in the MPS does not appear to be the case across all police forces. In fewer than one in five cases (59 out of 333; 18%), at least one of the officers or members of staff dealing with the case was trained in first aid. In 13 cases (4% of the 333 in the sample), at least one of the officers or members of staff dealing with the case had received refresher first aid training. The proportion of cases in which officers or members of staff had received first aid training was higher (27%) in 2008/09, the final year of the period in the sample, than in 1998/99 (the first year), when the proportion was 20%. However, the proportion has not gradually increased across this period – for example, it was 27% in 2003/04, but only 7% in 2006/07. We would like to see all custody officers being trained in first aid, in line with the 2006 ACPO guidance.

First aid given to detainees

First aid was given to 201 of the 333 detainees (60% of the whole sample). It was not given in 84 cases (25%). Information was not stated in the remaining 48 cases (14%)[58]. Figure 4.15 shows the

58 Percentages are rounded and therefore may not add up to 100%.

Figure 4.15 **Role of individual giving first aid to detainees**



Base = 201 detainees.
'Other' includes: FP in custody (16); doctor attending at scene (3); custody nurse (3); and, not stated (8).

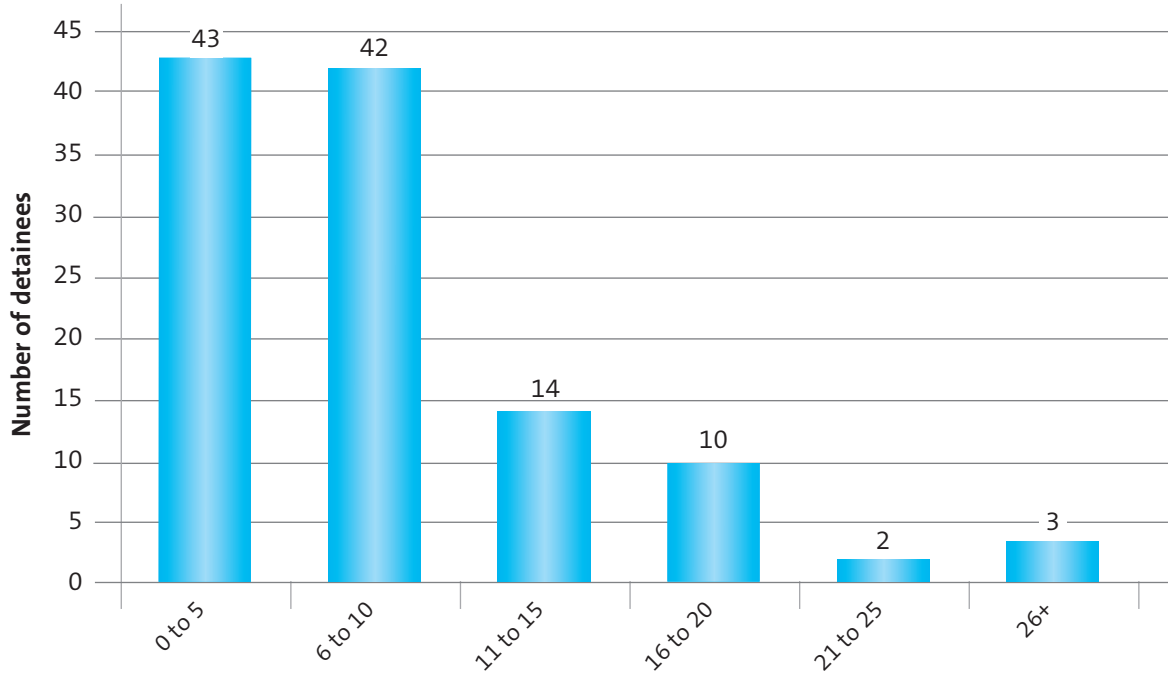
role of the individuals who gave first aid to detainees[59]. Paramedics (on 149 occasions) were most likely to do this. However, sizeable numbers of custody officers and staff (103 occasions), and arresting officers/staff or other officers/staff at the scene (59 occasions) also did so. Given the low proportion of police officers and staff shown in investigators' reports to be trained in first aid, this suggests that first aid was being given by a number of officers who were not properly skilled at delivering it.

Other medical assistance given to detainees

As noted above, paramedics were among those providing first aid to detainees. An ambulance crew was called by police to convey the detainee to hospital in 265 cases (80% of the whole sample). In 49 cases (15%) no ambulance crew was called. Information was not stated in the remaining 19 cases (6%).

Figure 4.16 shows the amount of time it took for an ambulance to arrive in the 114 cases for which information was available and applicable[60]. In most cases (85) an ambulance arrived to attend to the detainee within ten minutes. However, the arrival time was more than 15 minutes in 15 cases – three of which resulted in an ambulance taking over 35 minutes to arrive.

Figure 4.16 **Time between ambulance being called and arrival (minutes)**

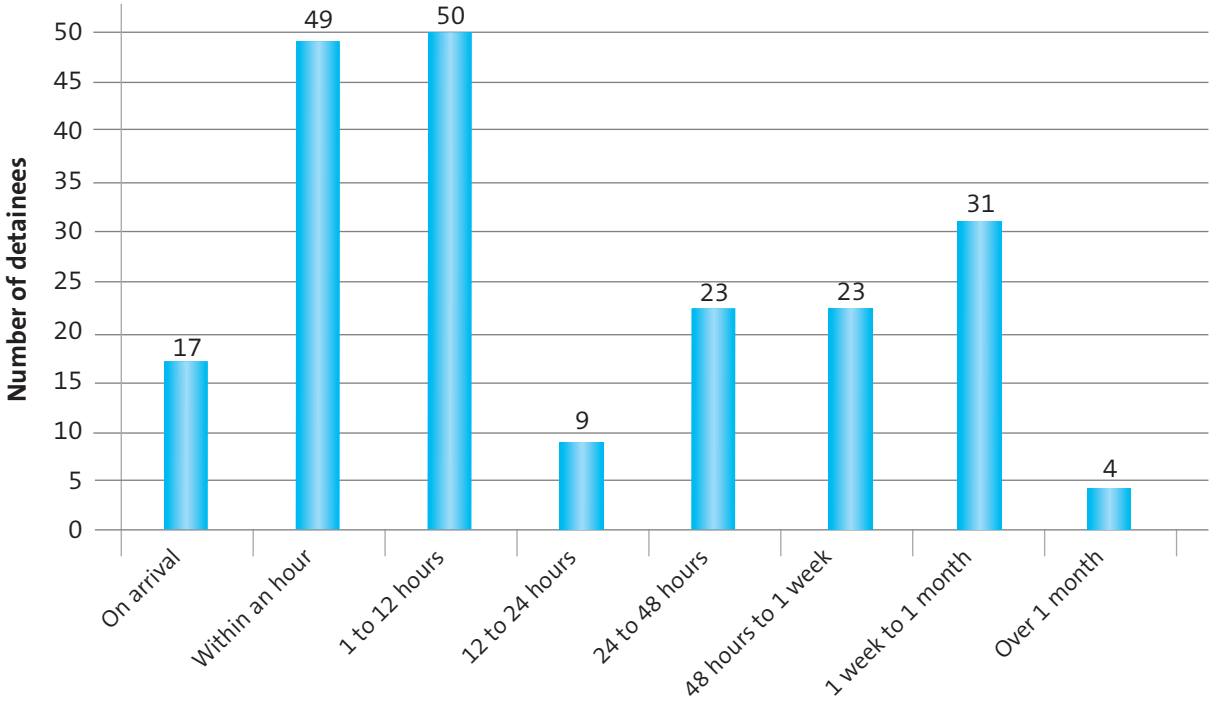


Base = 114 detainees.

59 The overall total will not sum to 201 as, in some cases, more than one individual gave first aid to the same detainee.

60 The figure excludes the 149 cases for which information was not stated, and two cases for which it was not applicable, because the ambulance crew was subsequently re-contacted and told not to attend as the deceased had died.

Figure 4.17 **Time between detainee arriving at hospital and dying**



Base = 206 detainees.
All deaths were related to the period of detention.

Figure 4.17 shows the length of time that passed between the detainee arriving at hospital and dying, in the 206 cases for which information was available and applicable[61]. In most cases (116) death occurred within 12 hours of arrival at hospital. However, 81 deaths took place at least one day after the detainee arrived in hospital, of which 31 occurred at least a week after the detainee was admitted. A further four deaths happened over a month after the detainee was brought into hospital.

Number of police officers and detainees in custody area

According to information contained in investigators' reports, staffing levels in the custody suite during the period in which detainees were in custody at the police station were adequate in 13% of cases (31 of 235 applicable cases). Staffing levels were not considered adequate in 3% of cases (eight of 235). Information was not stated in the remaining 83% of cases (196).

61 The figure excludes the 30 cases for which information was not stated and 97 cases for which it was not applicable.

Information sharing – between police officers

Detainees are often held in custody for a number of hours. During this time, there are likely to be changes in police shifts. It is therefore important that officers handing over to their colleagues are aware of the circumstances and needs relating to all detainees.

We have used two measures to assess the adequacy of communication between police officers. The first draws on details of police briefings provided in investigators' reports. These noted that custody officers and staff were given a briefing on the detainee and their needs when arriving for duty in 49 cases (26% of the applicable 187 cases). No briefing was noted in 21 cases. However, it is difficult to interpret these findings due to the large number of cases (117) in which information was not stated. In most (38) of the 49 cases in which a briefing was provided, this was done verbally. In two cases it was provided in a written handover note, and in a further two cases the briefing was given via the custody IT system. In

the remaining eight cases the method of briefing was not stated.

The second method explored investigators' views of the circumstances leading up to the death and the actions of those who played a part in the deceased's detention and care. Breakdown in communication was identified in ten cases (3% of the whole sample), as follows:

- An officer not related to the detention of the detainee did not pass on health concerns to the custody officers/staff.
- Lack of common practice between custody sergeants.
- Confusion over risk assessment led to a detainee strangling herself with property that was initially removed then subsequently returned to her.
- Unexplained relaxation of checks on the detainee.
- Confusion between officers over the number of checks arranged.
- Arresting officers did not inform custody staff that the detainee had threatened to kill himself. He was therefore not treated as vulnerable while in custody.
- Poor communication between officers led to poor record keeping and risk assessment and incorrect handling and storage of the detainee's property and clothing.
- A busy custody suite, and a lack of training for one detention officer, led to inadequate briefing, no overseeing of visits, and a failure to rouse or correctly check the detainee.
- The incoming shift was not informed by the previous shift that the detainee needed medication.
- Failure to pass information between officers resulted in a delay in calling an ambulance.

Information sharing – police and others

A survey of police forces by the Department of Health and the Home Office (2010) found that most forces (33 of 43) had joint arrangements with NHS Primary Care Trusts, the ambulance services (33), local health boards (33) and social services approved mental health practitioners (27). However, few had arrangements with the NHS with respect to covering custody, NHS mental health and social care, or criminal justice liaison services (all only ten forces each).

As the above shows, when police identify that a detainee is in need of medical intervention, they are likely to involve a FP and/or paramedics. Certain procedures must be followed when this occurs. Previous research has suggested that these procedures are not consistently adhered to. One example concerns the transportation of detainees directly to hospital rather than custody. In certain forces (for example the MPS – see Bucke et al 2008), custody policy states that ambulance service regulations require that they take a detainee to hospital, unless medical aid is positively refused and the detainee is in a fit state of mind to make this decision (MPS, 2005). However, if ambulance staff refuse to take the detainee to hospital, police officers may instead take them into custody, which may not be appropriate. Bucke et al (2008) also noted that 'on street' diagnosis by ambulance crews may be inaccurate; therefore, officers should not be afraid to question it.

A second example relates to cases in which detainees are conveyed to hospital from custody. In such cases, they should be sent with a letter or form, to be updated by hospital staff, documenting the treatment or medication received. Bucke et al's (2008) research in the MPS found that this form was not consistently used by hospital staff, and that FPs often learned about a detainee's previous hospital treatment from the detainee themselves.

Investigators' reports in this study show that, in the case of nine of the 333 detainees in the whole sample, there were criticisms of the way information was shared between the police and other agencies. These criticisms centred mainly, though not exclusively, on healthcare matters. Most focused on the actions of specific individuals while a detainee was in custody, although some also reflected wider concerns about policy and partnership working arrangements. These are described below.

- Breakdowns occurred in communication between custody staff and the FP attending at the police station, who was unable to give medication to a detainee as there was no record of what treatment he had received earlier that day in hospital.
- Breakdowns occurred in communication between custody staff and a hospital where a detainee had received treatment.
- After arresting a man, a police officer requested an ambulance crew attend, but when it arrived, the officer did not provide paramedics with full details of the man's apparent state of health leading up to the incident. Neither did the ambulance service communications officer who took the police officer's call ask why the ambulance was required.
- Two FPs refused to provide the investigator with witness statements regarding their assessment and treatment of a detainee.
- Shortcomings were found in interactions between the police and hospital staff following the arrest of a man outside the hospital for a breach of the peace.
- Poor communication took place between hospital staff, the ambulance service and police officers in dealing with a detainee.
- There was a lack of communication between the police and staff at a secure mental health unit, which meant that a detainee's need for constant ongoing supervision was not known by custody officers and staff.
- Concerns were raised about the level of communication between the police and subcontracted medical services in the case of a detainee who was known to have been extremely distressed in the days leading up to the death.
- Disagreement existed between the police and the NHS trust about how best to restrain a detainee at hospital in order to best protect himself, the arresting officers and hospital staff.

In three of these cases, the investigator identified either evidence or a possibility that more prompt action, or a different course of action, might have saved the life of a detainee.

Investigators' criticisms of other organisations

In 15 cases, investigators' reports also highlight criticisms specifically targeted at specific types of healthcare staff and at healthcare organisations more widely. Details were as follows:

Hospital/accident and emergency staff

- Believing he was drunk, a hospital discharged a detainee back into police custody. A subsequent scan revealed that the detainee had a fractured skull.
- A detainee was discharged from hospital and returned to the police station with a cannula[62] still in his arm.
- Hospital staff initially refused to admit a detainee. Checks when he was admitted were not thorough and failed to identify a blood clot on his brain.
- Instructions left by two FPs on the medical care of a patient were not written sufficiently clearly.
- Concerns were expressed about the record keeping of hospital staff following a death, as this compromised the thoroughness of the investigation.
- The low standard of care at the emergency department of a hospital dealing with a detainee's head injury was believed to have contributed to his death.

Ambulance staff/paramedics

- Two paramedics attending at the scene of arrest were criticised for both leaving to fetch an ambulance, and leaving no one to administer further healthcare.
- The actions of ambulance staff attending the scene were questionable, with a witness at the scene stating that the crew had not examined the detainee.
- Ambulance staff failed to recognise that the detainee was showing signs of 'acute behavioural disturbance' and the possible effects of restraint.

62 This is a small tube that is inserted into the body, often for the delivery or removal of fluid or administration of medication.

Forensic Physicians

- Doubts were raised about the expertise of two FPs, both of whom failed to recognise that the detainee had suffered a haemorrhage.
- The FP was inexperienced and required further training[63]. His examination of the detainee was incomplete and not based on information written by police in the custody log.

Mental healthcare professionals

- NHS Trust policies on the management of violence and aggression, and the guidelines for rapid tranquillisation of disturbed patients, were not followed.
- A hospital refused to admit a patient suffering from mental health issues into its psychiatric ward. The reasons for not doing so were not explained.

Multiple individuals/organisations

- The detainee's deteriorating health could have been addressed earlier by the local healthcare trust and by the residential home where the detainee lived.
- The actions of a detainee's psychiatrist and mental health crisis team when sectioning him caused him to be aggressive. He later died of positional asphyxia.

The next chapter looks at deaths involving individuals with possible mental health issues, and suicides.

63 This is an area which needs further study, as initial research by Wall (2008) indicates that around 30% of FPs may not have been appropriately trained. Information about the training of the relevant FP (or other healthcare professional should also be considered in the investigation report.

5. Deaths involving mental health and suicide

Police custody is by its nature a potentially stressful and unpleasant environment. From a medical perspective it is not a suitable environment in which to hold individuals who have mental health issues and who are therefore more vulnerable. The IPCC has raised concerns about this area in the past, in particular about police custody being used as a place of safety under the Mental Health Act 1983 (Docking et al, 2008). People with mental health needs are likely to find the custody environment distressing and this can exacerbate their mental state and in some cases lead them to try to self harm or attempt to commit suicide.

This chapter looks at the extent to which the deaths in our study involved people who were mentally vulnerable. It will consider the sources of evidence available to suggest mental health issues, whether the evidence was available to the police at the various stages of arrest and detention, and the extent to which the police identified any mental health issues. It will look at people who were detained under Section 136 of the Mental Health Act and subsequently died, and the extent to which suicide featured in the deaths.

Section 136 detentions

Section 136 detainees are atypical of other people in this sample in that they have not been arrested for a criminal offence, but have been detained for their safety and that of others around them. They will therefore be examined as a discrete group of people. Section 136 of the Mental Health Act 1983 allows for someone who is in a public place and is in need of *"immediate care and control"* to be taken to a *"place of safety"* by the police. Once at a place of safety they can then be assessed by a suitably trained approved mental health practitioner and doctor to see if they need to be *"sectioned"* to hospital, have relevant treatment in the community or released without the need for further treatment. A place of safety can be a *"hospital, police station, mental nursing home or residential home or any other suitable place"* under the Act. However, concerns by various officials and practitioners have been raised about the use of police custody as a place of safety, as the environment may exacerbate the individual's mental condition (Docking et al, 2008). The Codes of Practice that accompany the Mental Health Act have always been clear that use of police stations should be a last resort, but evidence has suggested that this is not the case. It is therefore important to look at deaths which may have occurred when individuals have been detained using this power.

In our sample there were 17 people who were detained under Section 136 and died during or following the detention. They ranged from 19 to 71 years of age. Thirteen were British (four not stated), 15 were male and 12 were White (four people were from BME groups and one was not stated). Most were detained in a public place (nine people) but six were detained in their own home. This is in breach of the legislation, which requires Section 136 detentions to take place in a public place, and supports evidence from other research that officers sometimes use the power inappropriately (Docking et al, 2008). For five people the time of arrest was not stated, but of the remaining 12 individuals, seven were detained between 6pm and 6am. This supports previous research which suggests that Section 136 detentions at police stations may be more likely to occur outside of normal office hours when alternative resources are not available (Docking et al, 2008).

Investigators' reports described the detention as involving either a struggle or some violence in ten

cases (it was not stated in three cases). This led to eight people being restrained by officers, two of whom were restrained using specialist equipment. Five of the individuals appeared to be intoxicated through alcohol at the point of detention and three through drugs. Two people had physical injuries that were identified on the point of detention and two people had medical conditions. Two other factors were noted at the point of arrest for two individuals – one had a propensity to violence and one was noted to be a suicide/self-harm risk.

Despite the official policy on places of safety, of the 17 individuals nine were taken to custody as a place of safety, six were taken to hospital and two people died at the scene of detention. When looking at how these cases are spread across the financial years the numbers become very small, although five deaths occurred in 1998/99. However, there does still seem to be an issue with detainees being taken to police custody and subsequently dying, as the most recent death following detention in police custody occurred in 2007/08, and every year prior to that had at least one death where the person had been detained in custody (as opposed to an alternative place of safety). Previous research has shown that police officers are often unable to take Section 136 detainees to an alternative place of safety to the police station, either because it simply does not exist, or because staff refuse to accept detainees who are intoxicated and/or violent (Docking et al, 2008). Case study 5.1 below highlights the need for alternative places of safety to be available and used rather than police custody.

The Mental Health Act Code of Practice (2008) states the ambulance service should generally transport Section 136 detainees rather than the police. Most of the Section 136 detainees in our sample were taken to the place of safety in a police vehicle (12 people), two were taken by ambulance and it was not stated how the remaining individual was transported. Of the five individuals who were taken to hospital, one had taken an overdose and one had breathing problems.

Case study 5.1

Lack of alternative place of safety for a Section 136 detainee

An ambulance had been called to help a woman who appeared to be mentally unwell. She was apparently acting violently and trying to smash windows on the street. The ambulance crew were unable to get the woman into the ambulance and so called the police for assistance. The police officers decided to detain her under Section 136 of the Mental Health Act and she was conveyed to the custody suite as there were no alternative places of safety in the force. She was calm in the police car and no restraint was used.

On arrival at the police station it was noticed that she was very yellow and an officer recognised that she was possibly suffering from jaundice. As she arrived she became incontinent and urinated on the floor. She then slipped in the urine and struck her head on the floor. Enquiries in the intervening period had revealed that the woman had mental health, drug and alcohol problems. A FP was already present and advised that she be taken to hospital as she was clearly suffering from jaundice, possibly liver/alcohol related, and suggested that the injury to her head could be serious because of her general health problems. The woman was conveyed to hospital by ambulance in a serious condition, and was later declared to be brain stem dead. She died the next day.

The investigation report referred to a similar incident in the force and recommended that custody should not be used as a place of safety, and that an urgent review should be held of the signatory bodies (to the Section 136 policy) to find, and if necessary establish, suitable alternative 24-hour facilities at a Mental Health Unit. At the inquest into the death the coroner stated that if the deceased had been taken to an alternative facility she may not have died.

As with the arrest time, for those for whom the information was available, most arrived in custody or hospital between 6pm and 6am. Under Section 136 of the Mental Health Act individuals can be held for up to 72 hours to be assessed. The length of detention was not stated or not applicable for 11 of the 17 people. Four people were held for three hours or less, one person was held for three to six hours, and one person was held for 36 to 48 hours. Again, two individuals were reported as struggling with officers or being violent in hospital/custody and were therefore restrained by officers holding them down, and one was also restrained using a specialist restraint device.

Of the nine people who were taken to custody, three had a risk assessment conducted on them, two did not because they were too intoxicated, and two did not for other reasons[64]. Five of the deceased were treated as vulnerable detainees, and four had clothing or property removed.

By asking the risk assessment questions, custody officers identified additional concerns about the deceased. This included being a suicide/self-harm risk, suffering from epilepsy, having a propensity to violence, domestic issues/problems, and intoxication from alcohol and drugs[65]. The custody officers can also check the custody system for any markers against individuals' names. This revealed some of the factors that had already been identified from the risk assessment, but in addition highlighted that two of the individuals needed an appropriate adult[66] (an appropriate adult was called for one of the deceased). For those to whom it was applicable, information stated two people only received irregular/inconsistent checks. The investigator was critical of the lack of regular checks in these two cases.

Once a Section 136 detainee has been taken to a place of safety, they need to be assessed under the Mental Health Act to decide what treatment, if any, they may require. This should ideally be done by a doctor and mental health practitioner who are approved under the Act – meaning that they have the requisite skills to identify mental health issues. The information on Section 136 assessments is only available in this study for people who were held in police custody. Some FPs may have the relevant training but many will not, so it may be that the detainee needs to be seen by a FP and a specially trained doctor. A FP was called out for six individuals by custody officers/staff. Four people were actually assessed, and it was advised that three people should be taken to hospital and one should be seen by an approved mental health practitioner[67]. Four people had a mental health assessment in custody prior to their death, with three of them being seen by an approved doctor and all of them being seen by an approved mental health practitioner. Two were then 'sectioned' and sent to hospital, and one was to be released into the community for treatment.

On being taken ill, ten people were given first aid at the scene (information on this was not stated for three other people). An ambulance was called for 11 people (information on this was not stated for two people). Four ambulances arrived within five minutes and one between 11 and 15 minutes, this information was not available for the remaining cases. Table 5.1 shows that two of the deceased

Table 5.1 **Where the deceased was pronounced dead for Section 136 detainees**

	N	%
In hospital (from arrest)	6	35
In hospital (from custody)	6	35
In custody	2	12
In public place during arrest	2	12
In hospital (following release from custody)	1	6
Total	**17**	**100**

64 This was not stated for the other two detainees.

65 Each person could have up to eight risk concerns, so these concerns may be associated with one or more individuals.

66 PACE created the role of an appropriate adult in order to safeguard the rights and welfare of young people and vulnerable adults. Appropriate adults are required for individuals in custody considered to be vulnerable, such as those under the age of 17, people with mental health difficulties, people with a learning disability and those who have trouble communicating and understanding things. The role of the appropriate adult is to support and advise a young person or vulnerable adult in police custody and to facilitate communication between them and the police. This person is different from a solicitor and does not give legal advice. An appropriate adult can be a family member, a friend, a volunteer or a social/healthcare professional.

67 This would be necessary anyway for the mental health assessment and prior to 2007 transfer from one place of safety to another was not permitted unless a person had emergency medical needs.

Table 5.2 **Primary and secondary cause of death for Section 136 detainees**

Primary cause \ Secondary cause	No secondary cause	Drug related	Head injury	Alcohol and drug related	Restraint related	Not stated cause	**Total primary cause of death**
Natural causes - heart related	4	0	0	0	0	0	**4**
Unascertained/ inconclusive	2	0	0	1	0	0	**3**
Injuries received prior to detention	0	0	1	0	0	1	**2**
Overdose accidental - drugs related	0	0	0	0	1	0	**1**
Injuries sustained during detention	0	0	1	0	0	0	**1**
Alcohol and drug related	1	0	0	0	0	0	**1**
Overdose intentionality unknown	0	1	0	0	0	0	**1**
Suicide - hanging	1	0	0	0	0	0	**1**
Suicide - overdose	0	1	0	0	0	0	**1**
Suicide - poisoning/substance	1	0	0	0	0	0	**1**
Not stated	1	0	0	0	0	0	**1**
Total secondary cause of death	**10**	**2**	**2**	**1**	**1**	**1**	**17**

were pronounced dead in custody, two at the scene of the arrest and the remainder in hospital.

Table 5.2 shows the primary and secondary cause of death for the Section 136 detainees. It shows that, despite others being aware of their vulnerability, three people were still able to commit suicide, and two people overdosed (one of these deaths was also related to the restraint).

Other Mental Health Act detentions

In addition to the Section 136 detentions, two of the deceased were detained under other sections of the Mental Health Act. They were both over 75 years of age and White, while one was male and one female. They were both given first aid but both died – one within one to 12 hours of arrival in hospital and the other individual having been in hospital between one and two days. One, who had been restrained, died due to heart failure brought on by this. The cause of death for the other individual was not stated.

Individuals identified as having possible mental health needs

In addition to the 17 people who died while being detained under Section 136 of the Mental Health Act and the two people who died while being detained under other sections of the Mental Health Act; there were 39 people who were identified either during the arrest or once in police custody as having mental health needs. This includes people who were identified by the arresting officers, by checking the Police National Computer, by the custody officers/staff and by checking the custody system. They were mostly male (32 people), White (33 people), British (37 people) and ranged in age from 23 to 76 years old, with a mean age of 37 years. Most were arrested in a public place (27 people), but 11 were arrested in either their own home or the home of a friend or relative (it was not stated where the remaining person was arrested).

Table 5.3 shows the reasons why these people

Table 5.3 Arrest reasons for people who were identified as having mental health needs

	N	%
Public order offences	15	33
Criminal damage	6	13
Assault	5	11
Drunk and incapable/disorderly	5	11
Theft offences	3	7
Burglary/robbery	3	7
Other	3	7
Driving offences	2	4
Drug offences	2	4
Possession of offensive weapon	1	2
Not stated	1	2
Total	**46**	**100**

Each person could have up to five arrest reasons.

were arrested. The most common reason for arrest was public order offences which included breach of the peace. It may be that some of these people could perhaps have been detained under Section 136 instead, but were arrested for minor offences. Previous research has shown that officers in different forces exercise their discretion, and that some forces encourage officers to use Section 136, whereas others encourage them to arrest the individual for an offence if possible (Docking et al, 2008).

A struggle or violence was reported in 14 of the arrests, with 12 people being restrained by officers and two being restrained using a specialist restraint device.

Following the arrest, nine people were taken to hospital (including one who was initially taken to custody but transferred to hospital before being booked in), and 29 people were taken to custody. One was taken to an 'other' place. Most were transported in a police vehicle but seven people were taken by ambulance and one by a private security vehicle.

For 11 people, it was not stated how long they were detained prior to their deaths. Of the remainder, most were held for relatively short amounts of time, with ten held for up to three hours and eight for three to six hours. Four people were reported as being involved in a struggle or violence once in custody/hospital.

From asking the risk assessment questions and checking the custody system for markers, custody officers were able to identify a range of additional factors/risks associated with the individuals. This included individuals who were identified as:

- Being a suicide/self-harm risk.
- Having a propensity to violence.
- Having previous domestic issues/problems.
- Needing to see a FP.
- Being known offenders or an escape risk.
- Needing an appropriate adult.
- Having an alcohol/drug addiction.

Following the risk assessment it was decided that two detainees should have constant supervision, three should have 15 minute checks, nine should have half-hourly checks and one should have hourly checks. It was also decided that nine detainees should be roused regularly by custody officers/staff. This information was not stated or not applicable for the remaining detainees. More information was available in the reports regarding the checks and rousing that the detainees actually received. Four people had inconsistent/irregular checks and it was established in one case that the entries on the custody record regarding the checks were false. Case study 5.2 highlights a case where the appropriate checks were not undertaken or recorded.

It appears that two detainees who were arrested for public order offences were actually dealt with under Section 136 of the Mental Health Act once they were taken to custody. As stated above, Section 136 detentions should take place in public, but we are aware from previous research that we have conducted (Docking et al, 2008) that individuals are

Case study 5.2

Lack of agreed checks and failure to accurately record in the custody record

Police were called to a residential home by staff who reported that one of their residents was "being violent" towards them. The police attended and arrested the resident to prevent a further breach of the peace. She was taken to custody and there were markers on the custody system for her as having mental health issues and previously suffering from depression. She was therefore placed in a cell with CCTV and on 30 minute checks. She did not receive the checks she was supposed to; the custody record showed that she was checked after one hour, after two hours, and then after another hour. After checking the CCTV it was discovered that there were some additional checks that had not been recorded on the custody record, but that the woman had still not been checked every 30 minutes in accordance with PACE (for vulnerable detainees).

When the woman was last checked on she was lying on the floor in a foetal position, but rather than physically check her, the officer assumed she was asleep and continued her duties. Shortly after this, the custody sergeant was able to confirm that the deceased could return to her home, and was going to inform her of this. At that point an officer checked the CCTV monitor and saw the deceased lying on the cell floor. The custody sergeant and gaoler attended the cell and found her collapsed and not breathing. They began first aid and called for an ambulance. Paramedics arrived and continued resuscitation attempts but the deceased was pronounced dead in hospital shortly after.

The investigator found that the officer who was supposed to check the deceased did not check her every half an hour, did not accurately record the checks that were undertaken, did not record the search of the deceased, did not record the visit by the doctor, and failed to attend the cell straight away when it was recognised that the deceased was lying on the floor. It should be noted that this officer had never received any formal custody training but did recognise her PACE duties. The investigator also found that the custody sergeant failed to give appropriate instructions to the other custody staff regarding the monitoring of CCTV and failed to ensure the custody records were properly maintained. The file was referred to the Crown Prosecution Service to consider possible criminal actions against the police officer for neglect of duty of care. The custody sergeant was given words of advice. The investigator also noted that when the deceased had previously been detained, the risk assessment had stated she was "violently suicidal/ had self-harm tendencies", but this information was not on the system when the risk assessment was conducted for the more recent detention.

occasionally arrested for minor offences, such as breach of the peace and then when their mental health needs are clearly identified by the custody sergeant they are processed using Section 136. The two detainees were therefore assessed by an Approved Mental Health Practitioner and a suitably qualified doctor (qualified under Section 12 of the Mental Health Act) and it was decided that both should be subsequently admitted to hospital under Section 136.

In total, FPs were called to see 19 individuals and actually assessed 16. Table 5.4 shows the concerns that were raised by the FPs, the most common being that the individual needed medication. However, in four cases the individual was deemed not fit to be detained and in seven cases it was suggested that they should be taken to hospital. Given how soon most of the FPs were called out, the data suggests that some of these individuals should have been taken to hospital following arrest.

Once the deceased was taken ill, an ambulance was called in most cases (30 people). It was not stated for the majority of cases (21 people) how long it

Table 5.4 **Concerns/issues raised by FPs following the assessment**

	N	%
Requires and given medication	7	24
To be taken to hospital	7	24
Not fit to be detained	4	14
Not fit to be interviewed	4	14
More regular checks	2	7
Needs appropriate adult	1	3
Stop interview if deceased feels stressed	1	3
Fit to be detained	1	3
Low blood pressure	1	3
Not stated	1	3
Total	**29**	**100**

Each individual could have up to four concerns issues/issues.

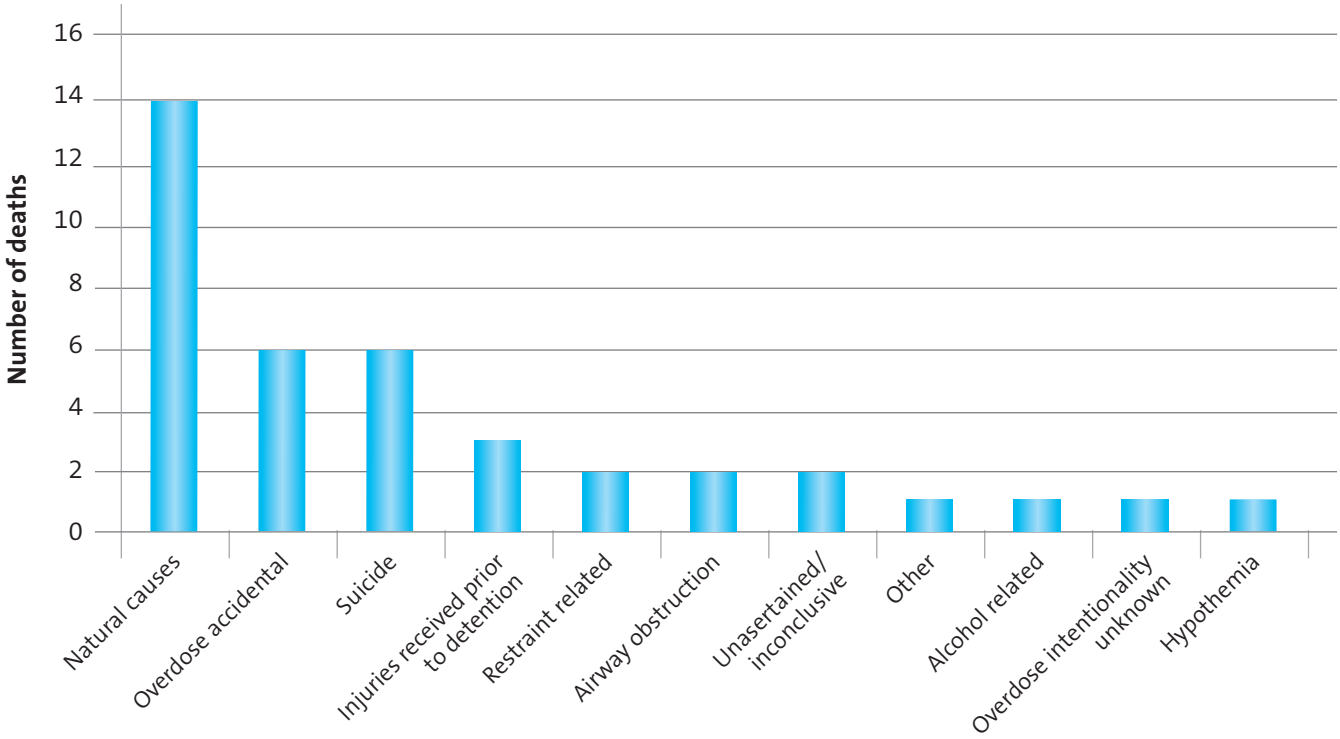
took for the ambulance to arrive. Twenty of the deceased were given first aid (it was not stated for six people whether they received any first aid). Those involved in giving first aid to the deceased included paramedics, custody officers/staff, arresting officers/staff or others at the scene, or FPs.

Nine people were pronounced dead in custody, 28 in hospital, one in a public place following their release (the death was related to their detention and so has been included in the study) and for the remaining individual this information was not stated. Figure 5.1 shows that of these 39 people, the most common cause of death was natural causes (14 people), followed by accidental overdoses and suicides (six people for each cause), and then injuries received prior to detention (three people). Eighteen of the individuals also had a secondary cause of death, the most common being alcohol and/or drug related (nine people), followed by additional natural causes (five people), head injuries (two people), restraint related (one person), and other causes (one person).

People identified as a suicide/self-harm risk

Several of the people discussed above who had mental health needs were also identified as being

Figure 5.1 **Primary cause of death for individuals identified with mental health needs**



a potential suicide/self-harm risk, and some committed suicide. However, there were an additional 11 people who were not identified as having any mental health needs but were identified as being a suicide/self-harm risk. They were all male and ten were White and British (this information was not stated in the remaining case). The most common reasons for arrest were theft offences (four reasons), being wanted on warrant/bail offences (four reasons) and drunk and disorderly/incapable (two reasons). Only one case involved a reported struggle or violence at arrest and in custody.

All of the 11 individuals were taken to custody, where most (eight) had a risk assessment conducted. Seven of the individuals had some of their property and/or clothing removed following the risk assessment. A FP was called for seven people; most were called by custody officers/staff within an hour of the detainee being in custody or on arrival. A FP assessed six of the individuals, and as a result one was deemed to be unfit for interview, it was suggested that one should have constant supervision, and two were given medication.

Once taken ill, an ambulance was called for eight people, and seven were given first aid by officers/staff and paramedics. Five people were pronounced dead in custody, five in hospital and this information was not stated for the remaining person. The most common cause of death (for seven) was suicide by hanging, even though they had been identified as a possible suicide risk. This raises questions as to whether more could have been done to try to prevent these deaths.

Suicides with no mental health or suicide/self harm factors identified

The final group of people are those for whom no mental health needs or suicide/self-harm risks were identified at any stage of the arrest or while being detained, but who went on to commit suicide. There were 26 such individuals in our sample. Of these individuals 23 were White, two were Asian and the ethnicity of one was not stated. Twenty-four were male, 23 were British and two were foreign nationals (information for one person was not stated). The mean age of 30 years was younger than the overall sample. Just over a third of the deaths (nine) took place in the first year of the sample, 1998/99.

Following the arrest most (22 of the 26) were taken to custody, two to hospital, one to an 'other' place, and one person died at the scene. The two people who were taken to hospital had both tried to kill themselves in the police van – one by hanging himself and one by consuming poison.

Of the 22 people who were taken to custody, 16 were risk assessed, one person was too intoxicated to be risk assessed, and for five people it was not stated whether they were risk assessed or not. Five people were treated as vulnerable detainees, 11 were not, and it was not stated for six people whether they were or not. Four people were put in a vulnerable/at risk cell, one of which had CCTV and two of which had low beds. Ten people had property or clothing removed from them, including three people that had all their clothes removed.

Several people had less frequent checks than they were supposed to receive and one individual was not checked at all. Given that all of these individuals went on to commit suicide this raises questions about the standard of care they received in custody. Case study 5.3 highlights a case where the deceased did not receive an appropriate level of care and where the risks of self harm should have been known.

A FP was called out to assess the detainee in 14 of the 22 cases. This occurred within the first four hours of detention for eight people (time taken to call out a FP was not stated in five cases, and in one case they were called out after between eight and 12 hours of detention). Twelve of the deceased were assessed by a FP; this information was not stated for two people. Four people needed medication, one was not fit to be interviewed, and

Case study 5.3

History of attempted suicides not captured, poor risk assessment, lack of checks and inadequate recording of checks

A man was arrested for assault/wounding with intent. He was a vulnerable individual as he was homeless and had addictions to alcohol and drugs (including solvents, amphetamines and crack cocaine) and had made several suicide attempts in the past. Despite the involvement of the police in one of the previous suicide attempts, there was no marker on the Police National Computer for self harm.

At the risk assessment stage (in police custody), the investigator states that no efforts were made to probe or encourage responses to the risk assessment questions. The officer in charge of the risk assessment simply marked 'no' against the different points. In addition, an officer in the custody suite pointed to the detainee's waist band and shoelaces as a potential risk but this was ignored by the officer conducting the risk assessment. Many of the cell visits were not carried out when required, and the checks which were conducted were not adequately recorded on the custody record. No cell visits were carried out between 1am and 4am, a three-hour gap in which the man hanged himself in his cell. The deceased hanged himself from the pipe attached to the sink in the cell. It transpired that the officers in the custody suite had been watching a DVD during the three-hour time period.

The pipe from the sink had not been identified as a ligature point before. The investigator stated that he believed the actions of the three custody officers *"fell short of the positive obligation under Article 2* [ECHR] *to protect* [the deceased's] *life"*. The file was passed to the CPS to consider a prosecution for misconduct in public office.

one was to be taken to hospital.

Nineteen of the deceased were given first aid (at the point when they were at risk of dying), four were not, and information was not stated for three. Of the 26 suicides, 20 were hangings, four were poisonings and two were cases which involved self harm. The majority (13) died in custody, nine people died in hospital and the others died in a mixture of private premises or public places.

The next chapter looks at deaths which involved alcohol and/or drug use by detainees.

6. Deaths involving alcohol and/or drugs

This chapter examines the circumstances of those who died in or following police custody where alcohol and/or drugs were a feature in the case. The aim is to identify the extent to which the deceased had alcohol and/or drug issues identified and how it contributed to the death. The chapter will examine the arrest process, where people were taken following arrest, the arrival into police custody and the care received whilst there, and the cause of death. The analysis of the cases prior to the care they received in custody is divided into three groups:

- Cases only associated with alcohol.
- Those only associated with drugs.
- Those associated with both drugs and alcohol.

For the analysis on the care the deceased received in custody and the circumstances of their death, the three groups have been combined with any differences drawn out and highlighted. To fall into one of these categories an association with alcohol or drugs could be identified prior to death; for example, it was identified at arrest, via a risk assessment or from markers on the custody system. It could also be identified after arrest, for example via a post mortem. We have divided the sample into these three categories to reflect the different groups and issues involved in these cases.

Figure 6.1 **Percentage of cases associated with alcohol or drugs**

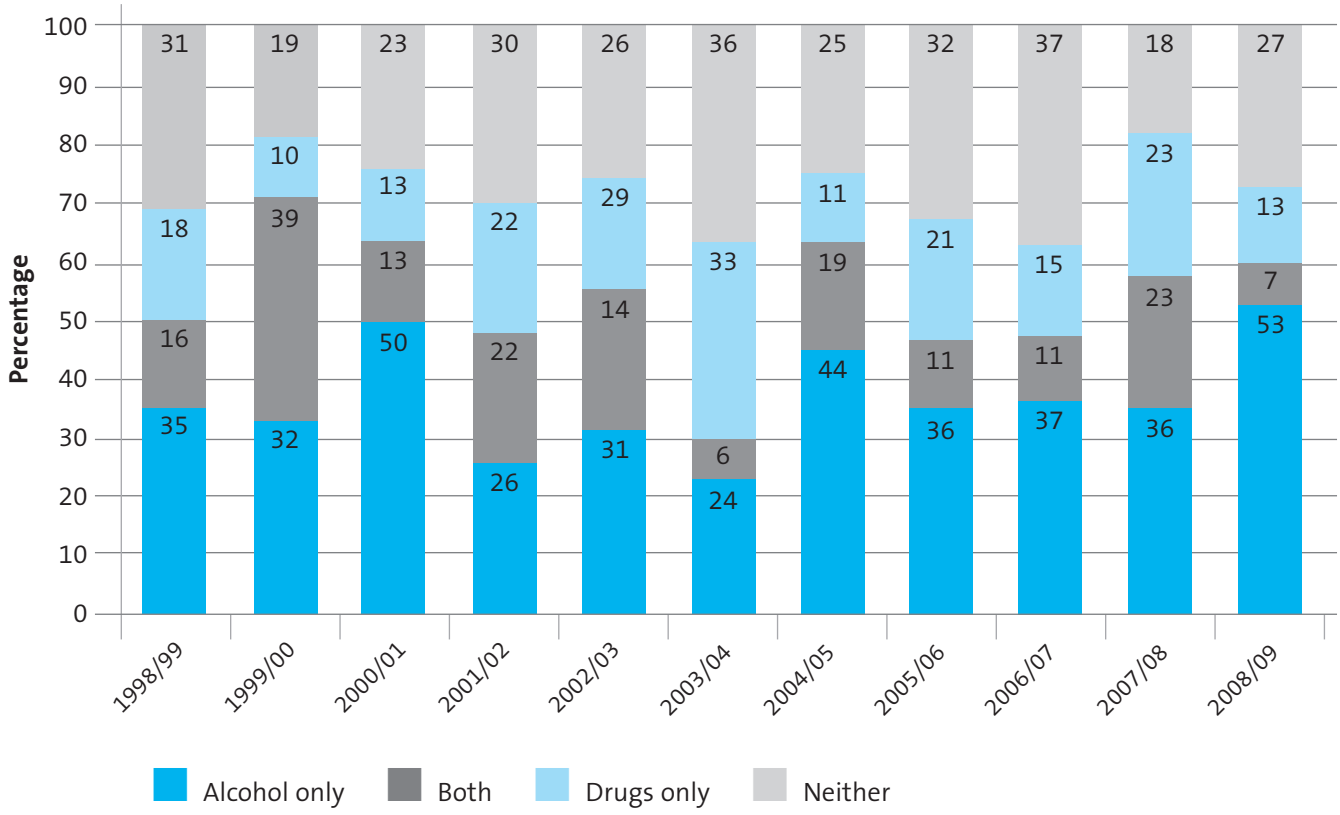


Table 6.1 **Demographics of those associated with alcohol or drugs**

	Alcohol only		Alcohol *and* drugs		Drugs only		No factor		Total in sample
	N	%	N	%	N	%	N	%	N
Male	111	37	61	20	42	14	85	28	**299**
Female	9	26	3	9	14	41	8	24	**34**
White	98	39	50	20	38	15	67	27	**253**
BME	13	27	8	17	11	23	17	33	**49**
Not stated	9	27	6	19	7	21	9	30	**31**
17 and under	0	0	0	0	1	50	1	50	**2**
18-24	0	0	10	37	10	37	7	26	**27**
25-34	11	14	27	33	24	30	19	23	**81**
35-44	34	42	12	15	11	14	24	30	**81**
45-54	32	48	9	13	7	10	19	28	**67**
55-64	23	68	2	6	0	0	9	26	**34**
65-74	9	60	0	0	0	0	6	40	**15**
75 and over	1	14	0	0	0	0	6	86	**7**
Not stated	10	53	4	21	3	16	2	11	**19**
Permanent address	84	33	48	19	44	17	76	30	**252**
No permanent address	28	54	9	17	6	12	9	17	**52**
Not stated	8	28	7	24	6	21	8	28	**29**
Total	**120**	**36**	**64**	**19**	**56**	**17**	**93**	**28**	**333**

Prevalence

Figure 6.1 shows the proportion of deaths between 1998/99 and 2008/09 that were associated with alcohol or drugs. Over the 11-year period the majority of deaths in custody were linked to alcohol or drugs, with both factors featuring in between 60% and 80% of the deaths.

Table 6.1 gives more details for all 333 people in the sample and includes characteristics categorised by whether or not there were links to drugs or alcohol (by this we mean that they were arrested for reasons related to alcohol and/or drugs, were intoxicated by either, and/or the cause of death was related to either). Of the 333 people in the total sample, 72% (240) were linked to either drugs and/or alcohol.

'Alcohol only' cases

Past studies have shown that a notable proportion of police detainees are intoxicated (Deehan et al, 2002). Research going back more than 20 years has identified drunken detainees as one of the most common groups to die in police custody (Johnson, 1982; Giles and Sandrin, 1992). Studies have also shown that drunk detainees are more likely to be agitated, aggressive, abusive, noisy, disruptive and violent than other detainees (around a quarter caused at least one of these problems, compared with 5% of other detainees), and there are issues regarding hygiene with vomiting in cells (Havis and Best, 2003; Man et al, 2002). Due to the vulnerabilities associated with drunken detainees it has been argued that custody is not a suitable environment for them (Norfolk and Stark, 2000; Noble et al, 2000).

Figure 6.1 shows that while deaths in police

Table 6.2 Reason for arrest for 'alcohol only' cases

	N	%
Drunk and incapable/disorderly	68	48
Driving offences	25	18
Public order offences	9	6
Wanted on warrant/bail offences	9	6
Assault	7	5
Theft offences	4	3
Burglary/robbery	4	3
Criminal damage	3	2
Section 136 Mental Health Act	3	2
Other	3	2
Threats to kill	2	1
More serious violence	2	1
Sex offences	1	1
Possession of offensive weapon	1	1
Not stated	1	1
Total offences	**142**	**100**
Total people	***120***	**-**

Each person could have up to five arrest reasons.

custody have decreased over the past 11 years, alcohol has always remained a feature in these cases. Of the 333 people in our sample, 120 (36%) were linked to alcohol at arrest, on arrival at police custody, or as the cause of death (see table 6.1). People in the 'alcohol only' group tend to be older, with the age group 55 to 64 years being significantly more likely to be associated with alcohol than the younger age groups[68]. The 'alcohol only' group was also significantly[69] more likely to be White, male and have no permanent address compared to their counterparts.

At arrest

Table 6.2 details the reason for arrest for those linked to alcohol. Each case could have up to five reasons for arrest. The most common reason for arrest was for being drunk and incapable/disorderly (68 offences).

Overall, there were 17 cases that involved a struggle or violence between the individual and the arresting officers during their arrest, and 13 individuals were restrained by the police. The method of restraint used was the individual being held down by officers in six instances and specialist restraint equipment[70] was used in two instances.

Of the 120 'alcohol-only' cases in this study, 105 individuals were taken into police custody following arrest and 15 were taken to hospital. The latter figure includes four people who were initially taken to police custody but then transferred to hospital before they could be booked in. The majority of information on whether the individual was searched before transportation was not known (72 cases).

At arrest, 56 people were identified as having physical and/or medical conditions; of these, 47 people were taken to police custody following arrest and nine people were taken to hospital. For people taken to police custody, the conditions identified were generally minor; however, there were 11 instances of a head injury, two complaints of feeling dizzy/nauseous, one heart condition, one deep wound and one collapse. One individual was

Table 6.3 Reasons for going to hospital following arrest for 'alcohol-only' cases

	N
Heart attack	3
Physical injuries	3
Intoxication	3
Condition deteriorated	3
Breathing problems	2
Unconscious/unresponsive	2
Stopped breathing/collapsed	1
Other	1
Total reasons	**18**
Total people	***15***

Each person could have up to two reasons for going to hospital.

68 This is significant at the 95% confidence level.

69 These findings are significant at the 95% confidence level.

70 Restraint equipment, such as limb restraints or Velcro leg straps, are devices designed and used to restrict the range of movement of the arms and/or legs. Its application should prevent a person from kicking and/or punching and allow for safe transportation of the person in a vehicle (ACPO, 2009).

identified as having a heart condition, head injury and felt disorientated; they later died in police custody of brain related natural causes. It is questionable whether some of these individuals should actually have been taken to hospital rather than custody. Table 6.3 shows the reasons for the person being taken to hospital or remaining there following arrest.

Arrival into police custody and the checking in process

Following arrest, of the 120 'alcohol only' detainees, 105 were taken into police custody. This section considers the risk assessment and care provided on their arrival to custody. Alcohol use was primarily identified at the point of arrest; however, in four cases it was identified during the risk assessment questions in police custody[71].

Past studies have highlighted the need for intoxicated detainees to be risk assessed, regardless of whether or not they display any immediate signs of concern (Bucke et al, 2008). Intoxication should not be a reason for omitting a risk assessment and should be viewed as a risk in itself. Of the 105 alcohol-only cases, 44 did not have a risk assessment on arrival into police custody. Of the remainder, 47 people did have a risk assessment and information was not stated for 14 cases. The reason given for 33 of the 44 people not being risk assessed was because they were too intoxicated. Where a risk assessment was commenced, 13 individuals managed to answer all the questions, seven answered some and four answered none. This information was not stated in the other cases. The main reason for not answering any or only some of the questions was that the person was too intoxicated (11 reasons). Other reasons included the individual becoming unwell (one instance) or having mental health problems (one instance).

A physical condition was identified from the risk assessment in 15 cases, and a medical condition in 14 cases. The risk assessment process and markers on the custody system identified other factors in relation to the individual. Table 6.4 lists these factors where the information was known.

71 These cases have been included in the analysis in the previous section.

Table 6.4 **Additional factors identified from risk assessment and custody system for 'alcohol-only' cases**

	N	%
Need to call FP/Dr	21	39
Mental health issues	9	17
Propensity to violence	7	13
Need for appropriate adult	7	13
Suicide/self-harm risk	5	9
Domestic issues/problems	2	4
Known offender	2	4
Racist behaviour	1	2
Total factors	**54**	**100**
Total people	***36***	**-**

Of the 105 'alcohol-only' people in custody, 54 were treated as a 'vulnerable' detainee, 21 were not, and this information was not known for the remainder of the cases.

On arrival in police custody, 35 people were subject to a search, 25 people were not and this information was not known for the remainder. Items of clothing or property were removed from 32 individuals; this information was not known for 49 people. Each person could have up to nine items removed. The type of items removed was not known for five people. The most common items removed were clothing (17), including six instances where all clothing was removed. Three people were issued with special clothing such as an anti-rip suit, two were given a "safety blanket" and two people had a "special mattress" in their cell[72].

As stated in PACE Codes of Practice C, those suspected of being intoxicated through alcohol should be visited and roused at least every half an hour. However, this does not seem to have been reflected in practice. It was decided that only 42 people should be roused regularly while in the cell; seven people did not need rousing and the rest of this information was not stated. Where this

72 These items are designed to tear when force is applied to them to help prevent their use as ligatures.

information was available, it was decided that 65% of people with an alcohol factor on their case (46) should receive checks every 30 minutes while held in police custody. Thirteen people were to have checks every 15 minutes, and eight were to have hourly checks. Two people should have been constantly supervised.

'Drugs-only' cases

Of the 333 people in the sample, 17% (56) were linked to drugs, but not to alcohol. A link to drugs may have occurred during the arrest process, on arrival into police custody or as part of the cause of death. Figure 6.1 shows that the number of deaths where drugs were identified has fluctuated over the 11 years, with a peak of 12 cases recorded in 1999/00. Generally, cases in which an association exists with 'drugs only' make up a smaller proportion of cases compared to those involving 'alcohol only', and those where alcohol and drugs are linked together.

Table 6.1 above details the demographics of the 'drugs-only' individuals. Drugs were associated with 41% of all the females in the sample compared to only 14% of men. The age groups 18 to 24 and 25 to 34 years were significantly more likely to have the 'drugs-only' factor (37% and 30% respectively) compared to the older age groups, who were significantly[73] more likely to have the 'alcohol-only' factor. A higher proportion of individuals from BME groups were identified with the 'drugs-only' factor (23%) compared to White individuals (15%), who were more likely to be associated with the 'alcohol-only' factor.

At arrest

Table 6.5 shows the reasons for arrest for the 56 people associated with drugs. Each case could have up to five reasons for arrest. The most common offence was related to drug offences (26), followed by being wanted on warrant/bail offences (ten) and then public order offences (nine).

Table 6.5 **Reason for arrest for 'drugs-only' cases**

	N	%
Drug offences	26	37
Wanted on warrant/bail offences	10	14
Public order offences	9	13
Other	5	7
Theft offences	4	6
Burglary/robbery	4	6
Driving offences	3	4
Possession of offensive weapon	2	3
Assault	1	1
Criminal damage	1	1
Section 136 Mental Health Act	1	1
Sex offences	1	1
Threats to kill	1	1
Not stated	2	3
Total offences	**70**	**100**
Total people	***56***	**-**

Each person could have up to five reasons for arrest.

Overall, there were 25 cases that involved a struggle or violence between the individual and the arresting officers during their arrest, and 23 that did not. This information was not stated in eight cases. A greater proportion of drug-factor cases (43%) involved restraint of the individual compared to the alcohol-factor cases (11%). Restraint was significantly more likely to appear on a drug-related case than a non-drug-related case[74]. Each case could have up to two methods of restraint. The most common restraint technique used involved the individual being held down by officers (18 instances); there were four instances where specialist restraint equipment was used and one instance of a pain compliance technique[75]. Case study 6.1 provides an example of someone who was intoxicated through drugs, was restrained, and subsequently died.

73 These findings are significant at the 95% confidence level.

74 These findings are significant at the 95% confidence level.

75 Pain compliance techniques are those used to control a person through applying weight to pressure points such as those found in the neck or around joints.

Case study 6.1
Restraint and drug use

A man aged 26 years was in a state of 'excited delirium' from taking cocaine and was running around the streets telling people not to shoot him. The police were called. Two members of the public attempted to restrain the man but were unable to as he was lashing out violently. Two police officers who attended effectively took over in restraining the man but found that he was very strong. Handcuffs were placed on the individual and he was laid down in the recovery position. It was noted that the man's eyes were bulging; he was sweating and having trouble breathing.

An ambulance was called and the officers administered first aid. The handcuffs were removed prior to the arrival of the ambulance and the man was given medical care on the way to hospital. The man was pronounced dead within an hour of arrival at the hospital and the cause of death was 'excited delirium' due to cocaine intoxication. The incident lasted just over an hour from the point of police arrival to life being pronounced extinct.

Following arrest, most people were transported to police custody (35) or to hospital (18)[76]. Of the remaining three, one died at the place of arrest, one was taken home (the death would have been related to the period of detention) and for one no information was available. Of the 16 people taken directly to hospital from arrest, 12 were transported by ambulance, three by police vehicle and this information was not stated in one case. In situations where intoxicated and/or injured detainees are being transported to hospital, officers need to exercise caution if using a police vehicle and consider whether or not an ambulance would be preferable (ACPO, 2006).

At arrest, 13 people were identified as having physical and/or medical conditions (up to three conditions per person). Table 6.6 shows the reasons for the person being taken to hospital or remaining there as it was the place of arrest (each person could have up to two reasons). The most common reason was that the person had swallowed a drugs package.

Table 6.6 **Reasons for going to hospital following arrest for 'drug-only' cases**

	N
Swallowed drugs package	9
Breathing problems	3
Stopped breathing/collapsed	3
Heart attack	1
Section 136 Mental Health Act	1
Medication/drugs overdose	1
Seizure	1
Total reasons	**19**
Total people	***18***

Each person could have up to two reasons for going to hospital.

Case study 6.2 provides an example of a case where an individual swallowed a drugs package and was initially taken to custody.

Arrival into custody and the checking-in process

There were 35 individuals identified with a drugs factor that were taken to police custody and booked in following arrest. On arrival to police custody 17 people had a risk assessment, nine people did not and this information was not stated for a further nine people. Where a risk assessment was conducted, the individual answered all of the questions in seven cases, some of the questions in one case and this information was not stated in the remaining nine cases. A physical condition was identified from the risk assessment in three cases, and a medical condition was noted in two cases. The risk assessment and markers found on the custody system identified other factors related to the individual and these are shown in table 6.7; each person could have multiple factors identified.

Of the 35 people held in police custody, seven

76 This figure includes one person who was transported to a police station but taken to hospital before being 'booked in', and one person who was arrested in hospital and remained there.

Case study 6.2
Swallowed drugs package

During the process of an arrest, which involved a struggle and use of restraint, an individual swallowed a drugs package (later known to be heroin). He was taken to custody where a search of his clothing and a 'pat-down' was conducted. A risk assessment was not performed as the individual's health had deteriorated. After only spending ten minutes in custody he was transferred to hospital by police vehicle.

The hospital staff identified the cause of his deterioration in health to be due to foreign body asphyxiation. Although the officers could have intervened earlier and administered first aid, the pathologist noted that for the officers to have identified this would have been over and above the standard of care expected, as even medical staff can overlook this diagnosis. The cause of death was due to airway obstruction from the inhalation of a foreign object and the effects of morphine.

individuals were treated as a 'vulnerable detainee' and 15 cases were not. Information was not stated in the remaining 13 cases. Five individuals were placed in a cell for vulnerable/at risk detainees.

On arrival into custody, 28 people were subject to a search. No information was available on whether the remaining seven people were searched. A strip search took place in 13 cases. This number is higher than for the alcohol group (three cases) and probably reflects a suspicion that the person is concealing drugs on their person. Items of clothing or property were removed from individuals in ten cases, in six they were not and this information was not stated in the remaining cases. Each person could have up to nine items removed which were recorded at the data collection stage. The most common items removed were clothing (five times), including three instances where all clothing was removed.

Table 6.7 **Additional factors identified from risk assessment and custody system for 'drug-only' cases**

	N
Suicide/self-harm risk	2
Mental health issues	2
Propensity to violence	2
Need for appropriate adult	2
Known to carry offensive weapons	2
Need to call FP/Dr	2
Other	2
Known offender	1
Wanted on warrant/bail offences	1
Total factors	**16**
Total people	***12***

PACE Code of Practice C states that those suspected of being intoxicated through drugs or having swallowed drugs must be visited and roused at least every half an hour. However, there was some evidence in our study that this did not occur in practice. Of the 35 people in the drugs-only group held in custody, it was decided that two people should be roused while held in the cell. One of these was also to have constant supervision; the other was to have checks every 30 minutes. However, it was decided that seven people did not need to be roused. Information was not stated in 26 cases. The level of checks that individuals should have received was known in 15 cases. It was decided that six people should have checks every 30 minutes, four people should have hourly checks, a further four should have constant supervision and one person should have checks every 15 minutes.

'Alcohol *and* drug' cases

There were 64 people in the sample who were associated with both alcohol and drugs. This could

Table 6.8 Reason for arrest for 'alcohol and drugs' cases

	N	%
Drunk and incapable/disorderly	19	25
Driving offences	12	16
Public order offences	9	12
Drug offences	8	11
Assault	5	7
Section 136 Mental Health Act	5	7
Theft offences	4	5
Wanted on warrant/bail offences	4	5
Other	4	5
Burglary/robbery	2	3
Possession of offensive weapon	2	3
Criminal damage	1	1
More serious violence	1	1
Total offences	**76**	**100**
Total people	***64***	**-**

Each person could have up to five reasons for arrest.

have been identified during the arrest process or on arrival into police custody, or it may have been a feature of the cause of death. As Figure 6.1 shows, the number of deaths where individuals had both a drugs and an alcohol factor has fluctuated over the years and peaked in 2003/04 with 11 cases (accounting for a third of all deaths recorded in that year). This has gradually decreased to two cases in 2008/09. Table 6.1 lists the demographics of the individuals. They tended to be younger than the other groups and the sample as a whole, with a third (33%) drawn from the 25-34 year old age group.

At arrest

Table 6.8 shows the reasons for arrest for all those identified with alcohol and drugs. Each case could have up to five reasons for arrest recorded. The most common reason for arrest was being drunk and incapable/disorderly (19 offences).

There were 22 cases that involved a struggle or an incident of violence between the individual and the arresting officers during their arrest. There were 17 incidents where the individual had been restrained by the police, which is just over a quarter (27%) of all alcohol and drug factor cases.

Following the arrest, 48 people were then transported to police custody and two people died at the scene of arrest. Of ten people who were taken directly to hospital from arrest, seven were taken by ambulance and three were taken by police vehicle. Before being transported to police custody, six individuals were searched and 12 were not, with information not stated for the remaining cases.

At arrest, 24 people were identified as having physical and/or medical conditions. Each individual could have up to three physical or medical conditions identified. These included in five instances of an alcohol or drug related condition, six were minor cuts, bruising or bleeding, two were head injuries and one was diabetic.

Table 6.9 shows the reasons for the person being taken to hospital or remaining there (each person could have up to two reasons). The most common reason was that the individual was to be detained for assessment under Section 136 of the Mental Health Act.

Table 6.9 Reasons for going to hospital following arrest for 'alcohol and drug' cases

	N
Section 136 Mental Health Act	3
Heart attack	2
Intoxication	2
Swallowed drugs package	2
Breathing problems	2
Medication/drugs overdose	2
Other mental health issues	1
Physical injuries	1
Condition deteriorated	1
Stopped breathing/collapsed	1
Total reasons	**17**
Total people	***14***

Each person could have up to two reasons for going to hospital.

Table 6.10 **Additional factors identified from risk assessment and custody system for 'alcohol and drug' cases**

	N
Need to call FP/Dr	6
Suicide/self-harm risk	5
Mental health issues	5
Propensity to violence	5
Need for appropriate adult	3
Domestic issues/problems	2
Known to carry offensive weapons	1
Known offender	1
Wanted on warrant/bail offences	1
Known to escape	1
Other; general health	1
Total factors	**31**
Total people	***22***

Arrival into custody and the checking-in process

There were 48 people with alcohol and drugs as a factor on their case who were taken to police custody following arrest and booked in. On arrival into police custody 22 people had a risk assessment; 15 people did not due to being too intoxicated. Where the risk assessment was conducted, seven people answered all of the risk assessment questions, four answered some and two answered none; this information was not stated in the remaining cases.

A physical condition was identified from the risk assessment questions in two cases, and a medical condition in six cases. In one case, the individual still had a cannula in his arm after a previous visit to hospital. The risk assessment and markers present on the custody system identified other factors related to the individual. These are shown in Table 6.10. Each person could have multiple factors identified.

Of the 48 people in custody with alcohol and drugs in their case, 18 were treated as a vulnerable detainee, 17 were not and this information was not known for the remainder of cases. Eleven people were put in a cell for vulnerable or at risk detainees. On arrival at police custody, 26 people were subject to a search, seven were not and this information was not known in the rest of the cases. In 12 cases this involved a search of individuals' clothing and a 'pat-down', and in five cases this was a strip search; the type of search was not stated in the other cases. Items of clothing or property were removed from 18 individuals, for seven they were not and this information was not stated for the remaining 23 cases. The most common items removed were miscellaneous or electronic items (nine).

For the alcohol and drug factor cases in police custody, where this information was available it was decided that 18 individuals should receive checks every 30 minutes while held in police custody, five people should be checked every 15 minutes, four people should receive hourly checks and two people should be constantly supervised. It was decided that 12 people should also be roused while in the cell.

All alcohol and/or drug cases – care provided in custody

This section looks at the actual care provided to all individuals with alcohol, drugs, or alcohol *and* drugs factor on their case while in police custody. It considers whether the individual was medically assessed, the result of this assessment, the frequency of checks conducted and whether they were roused. Any differences between the different groups are highlighted.

The role of the FP is to assess the fitness of the individual to be detained, to recognise the potential for self harm and to deal with any presenting illness or injury. Research has indicated that the majority of FP work is connected to drunken detainees, with between 73% and 80% of people seen by FPs being intoxicated (Hunt, 1996; Deehan et al, 2002). A study conducted by Man et al (2002) found that 53% of those arrested for alcohol-related offences and 36% of those arrested for alcohol-specific offences required the attention of a FP. A more recent study by Payne-

James et al (2010) found that 25% of detainees in police custody were dependent on alcohol.

In our study a total of 188 people with an alcohol, drugs or alcohol and drugs factor on their case were taken to police custody following their arrest. Length of time in custody was known for 123 people. The findings suggest that problems leading to a person's death tended to be identified a number of hours after his or her detention. Over half (71) were in police custody up to six hours prior to death.

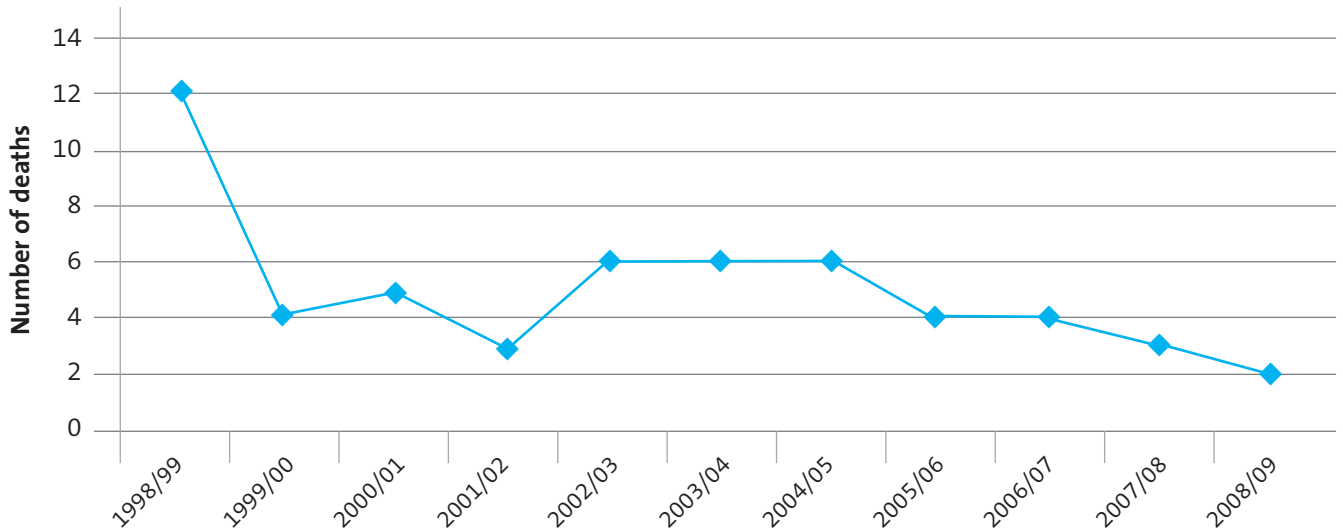
For cases where the information was recorded, a FP or doctor was called in 107 cases (57%). In most cases where information was available, the FP was called out at the point of arrival into custody or within an hour of arrival. The FP assessed the detainee in 81 of these 107 cases. The most common recommendation was that the individual be taken to hospital (31 cases). One 'drugs only' individual was identified as suffering from drug withdrawal, being at risk of self harm and needing medication. This last point raises a concern which has been highlighted by previous research. Bucke et al (2008) identified issues about the management of detainees who have taken drugs in terms of staff understanding drug withdrawal, overdose and appropriate care, and the danger of assuming that the condition of those who arrive under the influence of drugs (or alcohol) will improve with time.

In the majority of cases where the information was known, the frequency of checks provided was consistent with the level it was decided that the detainee should receive according to the custody records. However, two issues emerge from these cases. First, 12 individuals were not roused when it was decided that they should be (this information was not stated for one other individual). Second, where the information was known, the majority of instances of rousing were described as the custody officer or staff going into the cell (30), which does not equate to rousing the detainee. Other approaches which did equate to rousing were: waking the individual up (21), calling their name (13), asking them questions they should know the answer to (nine) or asking them to do basic commands (five), engaging them in general conversation (four) or taking them food or drink (two).

Circumstances of the deaths

Of the 240 people linked to alcohol, drugs or both, 164 were pronounced dead in hospital, 55 in police custody, 12 in an 'other' location such as their home or public place following release or in an ambulance (their deaths would have been linked to the detention to be included in the study), and two people died at the scene of arrest. This

Figure 6.2 **Number of people pronounced dead in police custody associated with alcohol, drugs or both**



information was not stated for seven people. Figure 6.2 shows the number of 'alcohol', 'drug', and 'alcohol and drug' people who were pronounced dead in police custody over the 11 year period. It shows that this figure was highest in 1998/99 with the figures remaining low in more recent years.

For the 188 individuals taken to police custody from arrest, first aid was provided to the deceased in 103 cases, 59 people did not receive first aid, and this information was unknown in 26 cases.

There were some differences in the cause of death between the cases with the different factors. For 'alcohol-only' cases in our study the most common cause of death was natural causes (47 deaths). Alcohol featured as the next most common cause of death either as primary or secondary cause in 37 cases. Twenty six deaths for the 'alcohol-only' group were due to injuries received prior to custody or injuries received during custody (four). The majority of these were head injuries and people with an 'alcohol-only' factor were significantly more likely to die due to injuries received prior to custody. The Faculty of Forensic and Legal Medicine has produced guidance (Payne-James and Wyatt, 2007) on head injuries for custody officers and staff, the patient, the FP and the responsible adult (if they are released from custody). This guidance, if followed, may help to get the detainee the appropriate care and possibly prevent deaths from these injuries.

Head injuries, and other conditions such as diabetes, can involve symptoms which are very similar to those displayed by someone intoxicated with alcohol. Alcohol can also impair an individual's awareness of the severity of injuries and intoxicated detainees may be less likely to report such conditions (Bucke et al, 2008). Case study 6.3 provides an example of someone whose head injury was missed when in custody. The relationship between injuries as a cause of death and intoxicated detainees raises questions as to whether such individuals should be taken to custody from arrest or initially to medical premises to be checked for underlying health conditions.

Case study 6.3

No risk assessment due to being too intoxicated and masked head injury

The deceased suffered from epilepsy and was known to be a frequent drinker. He was found by a member of the public in a semi-collapsed state. An ambulance was called but he refused to go. The paramedics requested police support and he was arrested for being drunk and disorderly and taken to police custody.

On arrival at custody no risk assessment was conducted as he was deemed to be too intoxicated. A FP assessed him and considered him to be drunk, recommending he should be placed on half-hourly visits and roused. The 30 minute checks to rouse him were not carried out properly and in the first hour of his detention, no officer entered his cell. A FP re-visited him much later on, after concerns raised by custody staff, and he was then transferred to hospital. He died a couple of days later with the cause of death recorded as a head injury received prior to detention.

Examinations carried out seemed to conclude that the deceased was drunk and the lack of risk assessment meant that injuries went unidentified. No one considered him to be injured, even when he was seen rubbing his head and was seen to have blood on him. The medical consensus was that if his head injury had been picked up earlier they may have been able to save his life.

For cases with a 'drug only' factor, drugs featured as the most common cause of death either as a primary or secondary cause in 46 cases, and in 30 of these cases this was related to an accidental overdose. There were 23 individuals with drugs featuring as part of the cause of death, but drugs had not previously been identified during the arrest or detention through the risk assessment. Natural causes appeared on the primary or secondary cause of death in 11 cases, eight of which were in conjunction with drugs.

For the cases with an 'alcohol and drug' factor the most common primary cause of death was an accidental overdose (30 deaths); this was related to drugs in 19 cases and alcohol and drugs in 11. Alcohol and/ or drugs featured on the cause of death as a primary or secondary cause in 19 cases. Natural causes featured as a primary or secondary cause in 14 cases; this was heart related in seven cases, brain related in three, liver related in two and defined as 'other' on three cases. More detailed information can be found on the primary and secondary cause of death for each of the three groups in the additional tables in Appendix A.

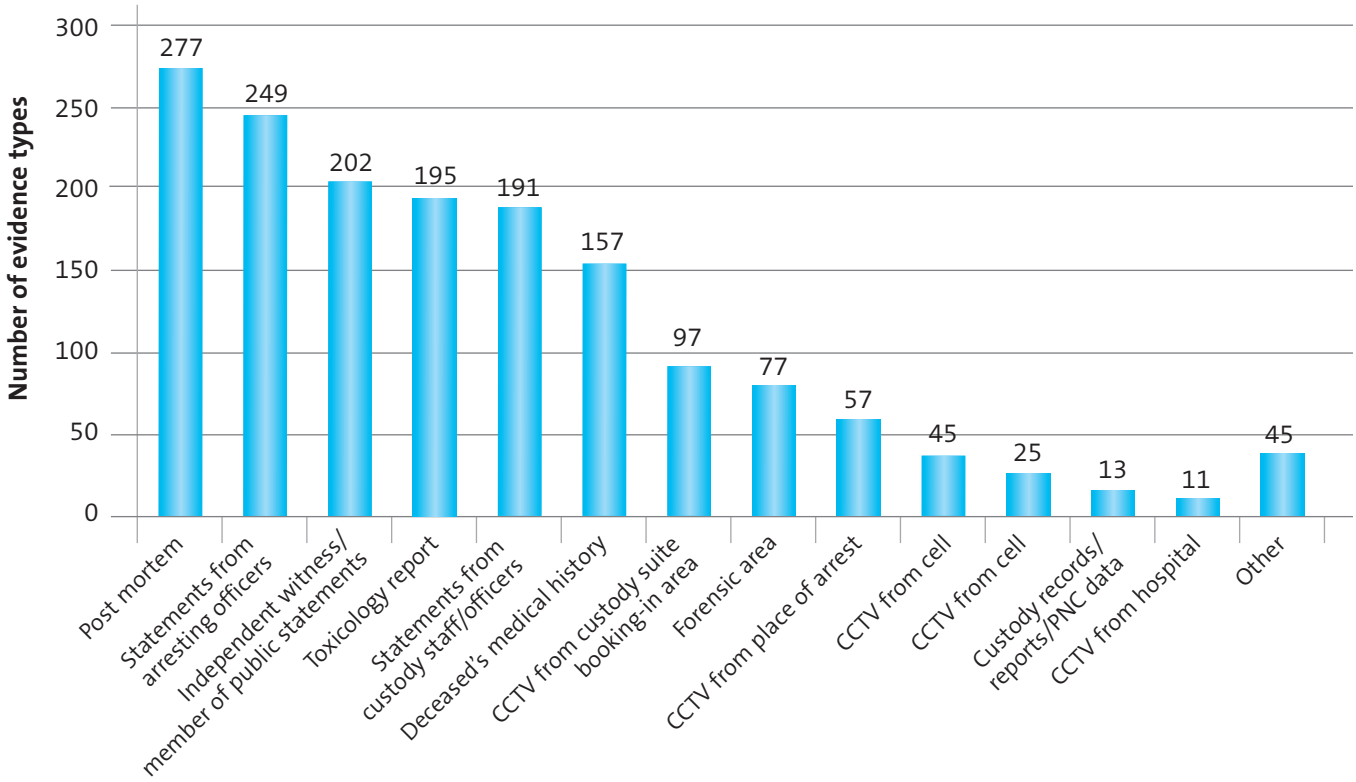
The next chapter looks at the investigations of the 333 deaths in custody in this study, and examines their outcomes, recommendations, lessons to be learnt and any good practice identified by the investigators.

7. Investigations and investigation outcomes

This chapter examines the investigations by the IPCC, PCA or individual police force into deaths in or following police custody, and their outcomes. It begins by describing the types of investigation that made up the sample. This includes a breakdown of the types of evidence gathered, and a discussion of instances in which police officers' and staff evidence differed from other available evidence. It then presents the inquest verdicts in the 333 cases and examines trends in inquest verdicts over the 11 years.

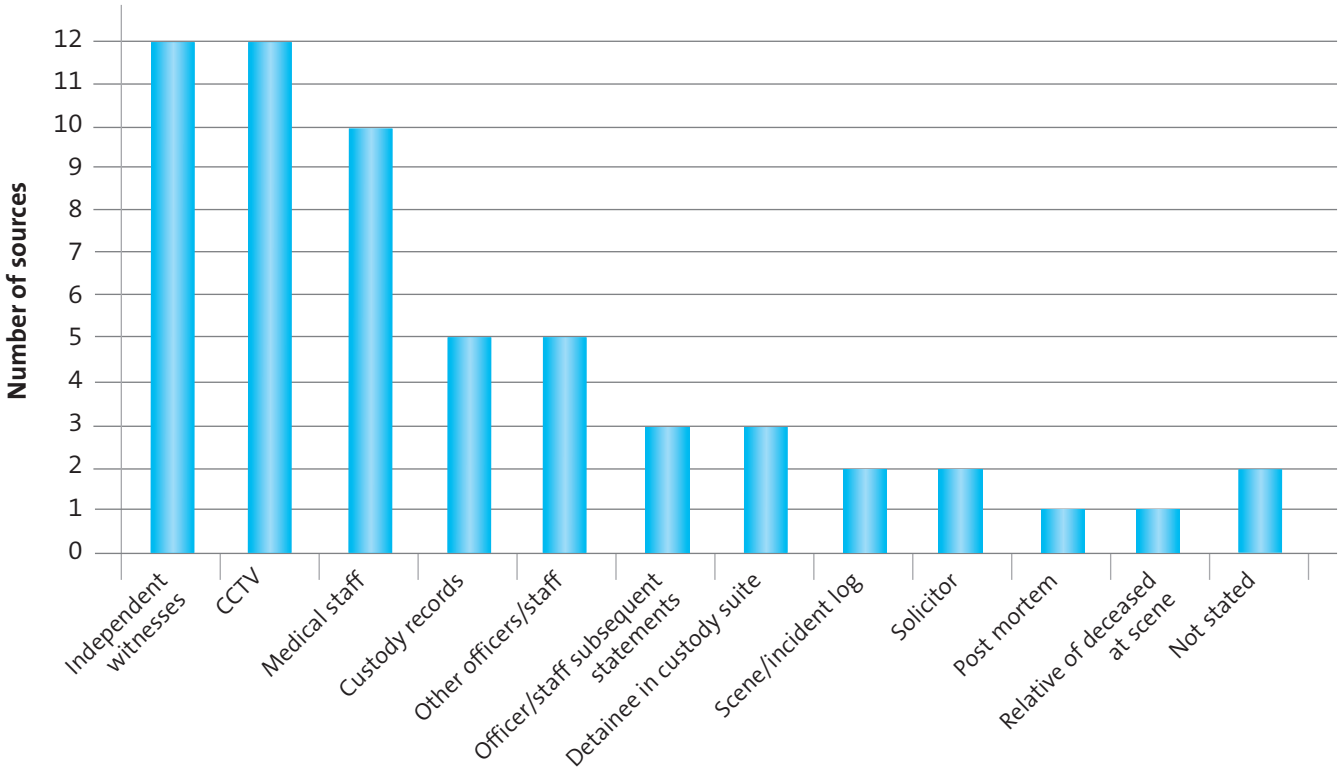
This is followed by an assessment of whether or not force policy and practice were followed. The subsequent investigator recommendations are described with a particular focus on some of the themes examined in this report such as restraint, mental health and suicide, and risk assessment, including cell design and safety. There is then a consideration of previous similar incidents and good practice examples within the same police force. After this, the chapter describes the extent to which force policy and practice recommendations were implemented by the time the investigation report had been completed. Following this, there is an overview of investigators' recommendations for individual officers and staff, with a specific emphasis on training needs, misconduct/disciplinary proceedings and prosecutions. This includes a look at variations in recommendations according to the ethnicity, age and gender of the deceased. It also

Figure 7.1 **Evidence types used during investigations**



'Other' includes: call transcripts/recordings (10); statements from professionals/healthcare staff (10); photographs (8); statements from family/friends (3); expert evidence reports (3); road traffic incident assessments and incident reports (3); and, other unspecified issues (7).

Figure 7.2 **Sources contradicting initial evidence of police officers/staff**



examines the quality of investigation reports in terms of the level of information provided in the reports and how this differs by type of investigation (i.e. IPCC independent, PCA supervised etc). This analysis can be found at Appendix B.

Type of investigation and evidence used

In our sample, just over half of the investigations into the deaths (176; 53%) were supervised by the PCA[77]. A further 52 (16%) were subject to local investigation, 43 (13%) were independently investigated, 36 (11%) were managed by the IPCC and the remaining 26 cases (8%) were supervised by the IPCC[78].

During the 333 investigations, a total of 1640 separate evidence types were used – an average of five evidence types per case. Figure 7.1 shows how often different evidence types were used in the 333 investigations. Post mortem evidence (277 occasions) and statements from arresting officers (249 occasions) were the two most commonly used evidence types.

77 PCA supervised' includes 'PCA supervised' and 'PCA supervised external force'. Thirteen cases (4%) involved PCA supervision of an investigation by an external force.

78 'IPCC managed' includes 'IPCC managed' and 'IPCC managed external force'. Five cases (2% of the whole sample) involved IPCC management of an investigation by an external force.

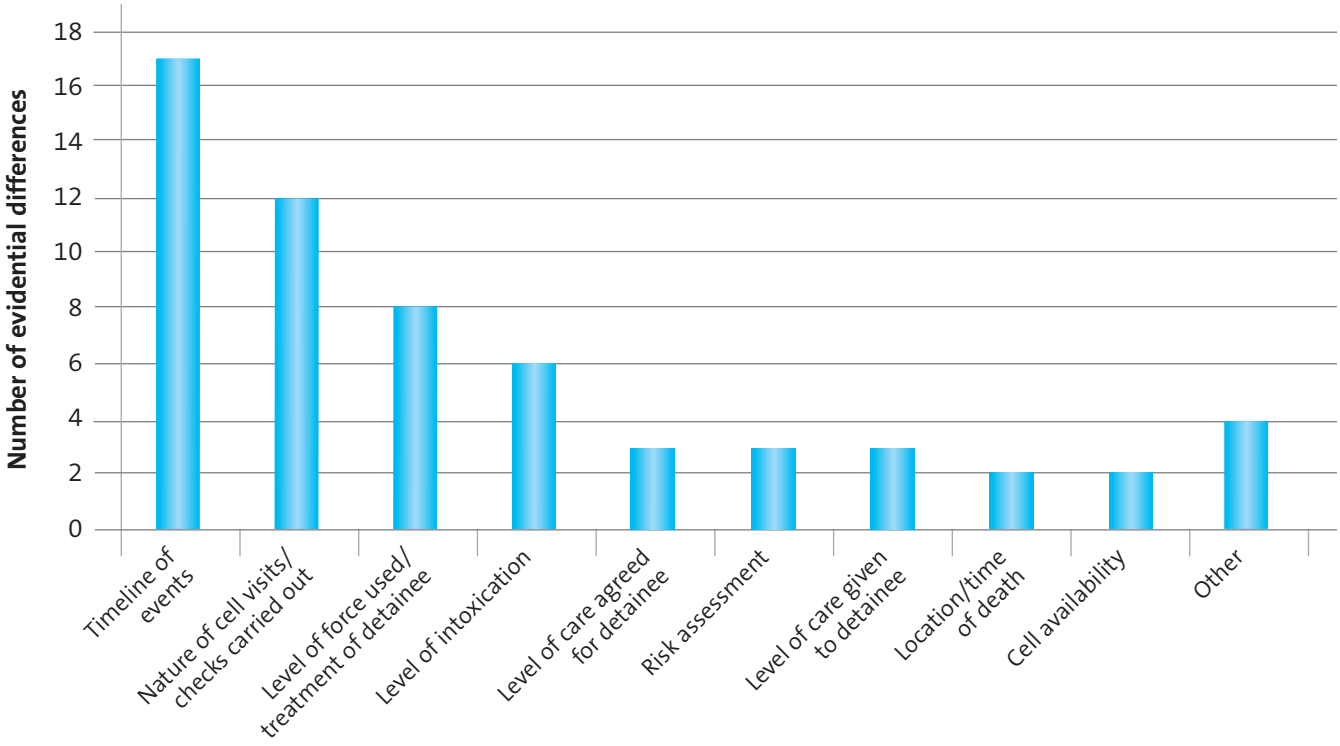
Evidence contradicting initial evidence of police officers/staff

Investigators' recommendations in deaths in custody cases may be shaped by apparent inconsistencies in police officers' accounts of the circumstances leading up to the death. We examined investigators' reports for indications that police officers' and staff evidence differed from other available evidence such as witness statements or CCTV footage.

In 51 cases (15%), other evidence contradicted the evidence initially offered by police officers or staff when interviewed. In 215 cases (65%), evidence was not contradictory. In the remaining 67 cases (20%) the information available in the investigation report meant it was not possible to tell whether or not the evidence given by police officers or staff was contradicted by alternative evidence.

Figure 7.2 shows the nature of the evidence which

Figure 7.3 **Evidential differences from police officer/staff accounts**



'Other' includes: how busy custody suite and staff were; unexplained injuries on deceased; search of deceased; and, not stated – each one occasion.

contradicted the evidence initially given by police officers and staff. In all, there were 58 evidential contradictions. They most commonly related to the statements of independent witnesses and CCTV footage (both mentioned on 12 occasions), and the statements of medical staff (ten occasions).

Figure 7.3 shows that the main differences related to the timeline of events leading up to the death (17 occasions) and, more specifically, the number, nature and timing of visits and checks carried out on the deceased while they were in a cell (12).

Inquest verdicts

Figure 7.4 shows the results of inquest verdicts for the 333 cases. For over half of all cases, the inquest verdict was either not stated (102 cases; 31%) or awaited (69 cases; 21%). However, the number of cases where we could not find a record of the inquest verdict has been low in recent years. Only three of the 102 occurred in the five years from 2004/05, whereas almost one quarter (25) occurred in 1998/99, the first year covered by the

Figure 7.4 **Inquest verdicts from investigations**

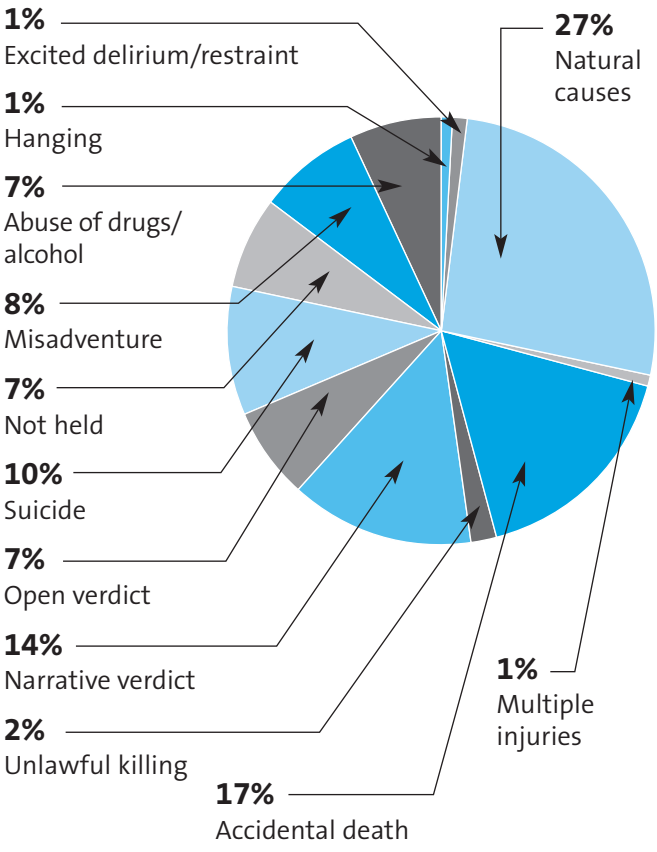


Table 7.1 **Trends in inquest verdicts from investigations**

	1998 /99	1999 /00	2000 /01	2001 /02	2002 /03	2003 /04	2004 /05	2005 /06	2006 /07	2007 /08	2008 /09	Total
Natural causes	3	5	4	3	3	4	6	7	8	0	1	**44**
Accidental death	3	4	3	1	2	1	7	1	2	3	0	**27**
Narrative verdict	1	0	0	0	1	4	11	3	0	0	2	**22**
Suicide	6	2	0	2	1	3	0	1	0	0	1	**16**
Misadventure	2	5	2	0	1	0	2	0	0	1	0	**13**
Abuse of drugs/alcohol	2	1	4	1	2	1	1	0	0	0	0	**12**
Open verdict	2	0	3	0	1	1	1	2	0	1	0	**11**
Unlawful killing	1	0	1	1	0	0	0	0	0	0	0	**3**
Excited delirium/ restraint	1	0	0	0	0	0	0	0	0	0	0	**1**
Hanging	0	0	0	0	0	0	1	0	0	0	0	**1**
Multiple injuries	0	1	0	0	0	0	0	0	0	0	0	**1**
Not held	0	2	0	1	2	1	1	1	1	2	0	**11**
Not stated	25	9	12	16	20	17	0	0	1	2	0	**102**
Awaited	3	2	1	2	2	1	6	13	15	13	11	**69**
Total deaths	**49**	**31**	**30**	**27**	**35**	**33**	**36**	**28**	**27**	**22**	**15**	**333**

study. Natural causes was the single most common inquest verdict in the remaining 162 cases, accounting for 27% of all known inquest verdicts (44).

Table 7.1 shows the trends in different types of inquest verdict over the 11 year period. The most striking findings are:

- The number of deaths due to natural causes in the second half of the period is similar to that in the first, despite the fall in deaths overall (showing that these deaths may be more difficult to prevent).
- Only two of the 15 suicide verdicts were recorded since 2004/05.
- The relatively large number of narrative verdicts in 2004/05, (accounting for nearly a third of all cases in that year, and half of all narrative verdicts across the 11 years) indicates a trend for coroners to use narrative verdicts more often.

In four cases, concerns were expressed that the death might have been avoided. These concerns fell into two categories. First that the arresting officer, custody staff or FP might have taken a course of action which they did not take. Second that a course of action which had been taken might have been pursued more promptly.

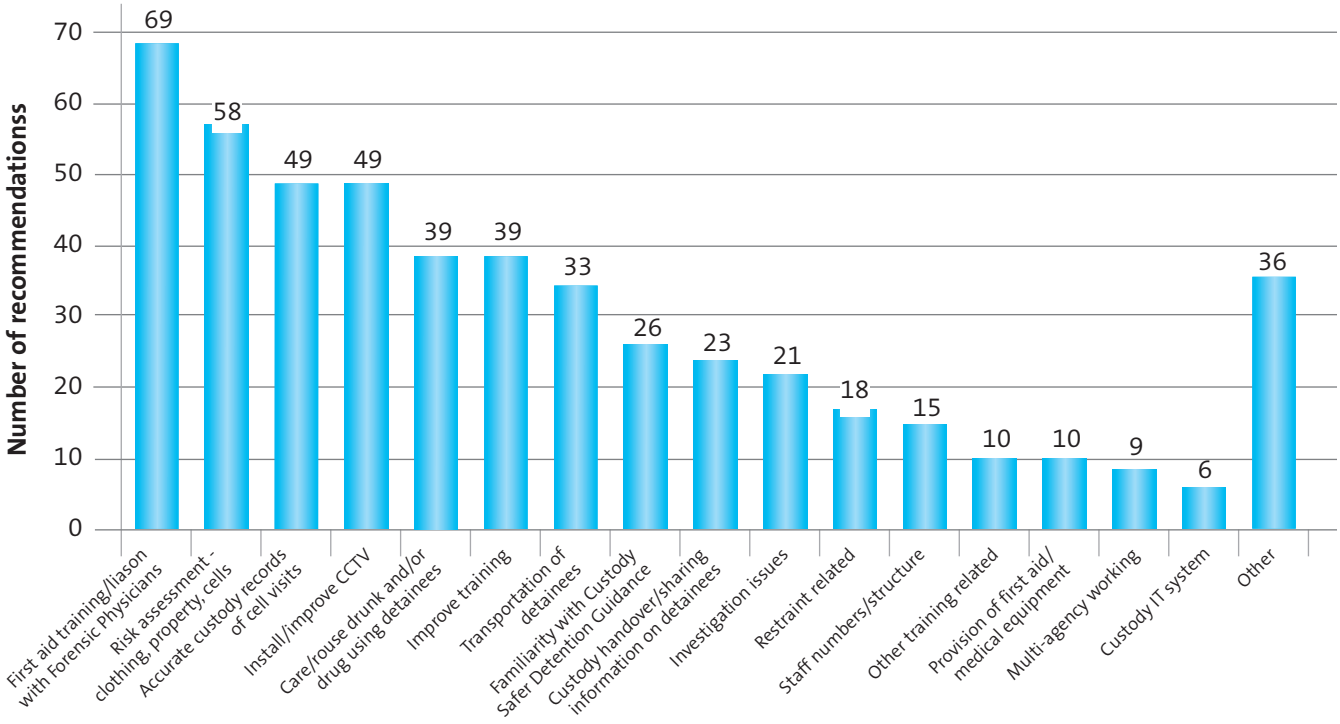
Force policy and practice

Force policy and practice on custody matters was followed in 162 cases (49% of the whole sample). It was breached in 91 of the 333 cases (27%), and information was not stated in the remaining 80 cases (24%)[79]. Where breached this would not necessarily have impacted on the actual death.

In 149 cases (45%) the investigator's report made

79 Since the IPCC replaced the PCA in April 2004, the rate of "not stated" cases has fallen, from an average of ten per year in the six years to 2003/04, to an average of five per year in the five years to 2008/09.

Figure 7.5 **Recommendations as a result of deaths in custody**



'Other' includes: using alternative places of safety for detainees (6); understanding of violent patients in hospital (1); mental health issues (1); self-defence training (1); and other unspecified issues (27).

recommendations for changes or improvements to force policy and practice. In all there were 510 recommendations. As figure 7.5 shows, the most common points mentioned by investigators were the need for officer training in first aid and liaison with FPs (69 recommendations) and risk assessment in relation to custody cells and detainees' property and clothing (58 recommendations). Between them these two categories accounted for a quarter of all recommendations. The most common recommendations made in relation to the cases involving the themes discussed earlier in this report – restraint, mental health and suicide, alcohol and drugs – are outlined in more detail below. Recommendations related to the issue of cell design are also discussed.

Investigator recommendations on restraint

The recommendations by investigators in the cases involving restraint take three forms:

- Training for individual officers or staff involved in the case.
- Changes to force policy and practice.
- General recommendations on restraint, use of CS spray, positional asphyxia and acute behavioural disorder, not relating to individual officers or staff.

Combining these three categories, 22 separate recommendations were made in relation to restraint techniques, drawn from 16 (5%) of the 333 cases[80]. Many of the recommendations reflected the need for new or refresher training, and for greater awareness from police officers of how to respond to a detainee's behaviour. The 22 recommendations comprised:

- Five recommendations for training for individual officers.
- Five recommendations on changes to force policy and practice. Specifically, these stated that: officers be aware, both for their own safety and the safety of others, of the dangers of extended use of CS spray on a suspect who has used large quantities of cocaine; the force look into making

80 Eight of these were supervised by the PCA, five were independently investigated, two investigations were managed by the IPCC, and in one case the IPCC supervised the investigation.

approved restraints that are more suitable when dealing with heavily intoxicated detainees; the force review its method of delivering information on positional asphyxia and 'excited delirium'; police officers (and other involved professionals) record their considerations concerning restraint, as two medical experts stated that it was likely, though impossible to ascertain, that positional asphyxia may have played some part in the death; and the force review training on restraint.

- Six general recommendations on restraint, use of CS spray, positional asphyxia and 'acute behavioural disorder', which did not relate to individual officers or staff. These comprised the following:

  - CS spray should only be used as a graduated and appropriate level of response to the level of aggression or violence offered. Any officer using CS spray should be supported providing the guidelines have been strictly adhered to.
  - A national policy should be formulated to clarify the understanding of medical staff when dealing with violent patients/prisoners who have been restrained by police but are in need of medical care.
  - If officers are deployed to hospital wards to deal with an inpatient, information should be obtained on the clinical condition of the inpatient, and of other patients likely to be affected by any action taken by officers. (This was flagged as being particularly important where the use of CS spray is considered as a tactical option.)
  - Two reviews should be conducted: one of the use of leg restraints for violent prisoners, the other on the caged areas of police vans, to explore if they can be enlarged to allow the restraining of prisoners while they are lying down.
  - Further development of good practice principles in a force-wide programme focusing on safer restraint.

- Six recommendations on training across the force on restraint:

  - Training on restraint is needed, despite the fact that the investigator found that the restraint and force used was within reason considering the level of violence shown by the deceased.
  - More training for officers and custody staff is needed to identify 'excited delirium' in intoxicated detainees.
  - Training is required on how to identify the symptoms associated with 'excited delirium'.
  - Requalification courses should be extended to conform to national police training guidelines. Training should encompass positional asphyxia, 'excited delirium' and first aid.
  - Changes are needed to the force-wide training on recognising signs of acute behavioural disturbance, as officers in one case failed to realise the deceased had experienced this during the arrest. Force guidance should be issued on the conveyance of detainees suffering acute behavioural disturbance, in cases when police transport is not equipped to deal with such emergencies.
  - Training material on the use of leg restraints should differentiate between positional asphyxia and 'excited delirium'.
  - Positional asphyxia, acute behavioural disorder and 'excited delirium' should be the subject of structured input at both initial and refresher training. Every officer should be provided with documents that set out the risks and appropriate response. A review should be conducted of the equipment available to frontline officers to assist them to safely restrain and transport violent persons, without injury being caused to anyone.

Investigator recommendations for vulnerable detainees

The recommendations made by investigators in the cases discussed in chapters five and six cover very similar themes. Some cases will appear in both chapters, and as such are looked at together here. If all 96 cases in chapter five are taken together[81], recommendations were made for changes to policy and practice in 29 cases, and more general recommendations in 39 cases (some of these will

81 This includes people who were detained under the Mental Health Act, were identified as having mental health needs, were identified as being a suicide risk, and those that committed suicide but were not identified as having any mental health needs or as being a suicide risk.

be the same cases). For cases involving alcohol and/or drugs where the individual was taken to custody (140 cases), the investigator identified that the force policy on custody procedures was breached in 44 cases. Of the 240 cases that were identified as having an alcohol and/or drugs factor, there were 108 unique cases in which the investigating officer made recommendations for changes to force policy and practice, or general recommendations. The recommendations that were made across all of the cases in both chapters fell into the three areas set out below:

1. Custody suite and cell design

- There were a number of recommendations made by the investigator in relation to having CCTV installed in the custody suite or improvements to the existing systems such as better audio, picture clarity and accuracy of the time stamp, as well as better overall coverage[82].
- Other recommendations concerned the management of the custody suite having clearly defined roles and responsibilities, including a review of the number of personnel in the suite and a reminder on the importance of the custody handover at the point of changes in shifts (and sharing relevant risk information at this point).
- The auditing of cells and detention rooms to identify possible ligature points or areas that fall below expected standards, and develop an action plan to reduce the risk they present to vulnerable detained persons.
- Improvements needed in the accuracy of custody recording practices so that they reflect a true account of visits conducted and the monitoring of cell visits, with the importance of comprehensive records to be highlighted in custody training courses.

In addition to the recommendations made by the investigators in these cases, issues around cell design and ligature points were identified in 16 cases in chapter five and ten cases in chapter six. The issues around cell design and ligature points for cases in both chapters included cell hatches being left open and used as a ligature point, other ligature points in the cell, material that could be used to self harm in the cell and areas where objects could be secreted, poor checking of cells more generally, and a blanket that could be used as a ligature. For the detainees in chapter six there were also issues about the cell being unsuitable for drunken detainees and issues around temperature or lighting problems.

2. Risk assessment and medical care

- Investigators highlighted the removal of clothing and personal possessions which could present a risk to the individual, searches of the cells and having the correct safety equipment. For example, there is a need to ensure that the blankets issued are those with no material strength so they would easily tear if pressure is applied in the event of them being used as a ligature.
- There were some cases in which the investigator raised concerns about the service provided by the FPs and the need for arrangements to be reviewed or monitored. This included making sure contracted medical providers were aware of their responsibilities under PACE prior to commencing duty at a custody suite, a review of the recording and undertaking of any advice given to officers by FPs, and ensuring contracts between the medical provider and the police were clear and covered issues such as call-out procedures.
- In several cases it was recommended that detoxifying centres should be established, such as a secure unit with trained professionals which will allow non-violent severely drunk detainees, who have often been arrested for their own welfare or safety, to be cared for more effectively than at a police station.
- Improvements were recommended in first aid equipment or other specialist equipment that is used in the custody suite, including a review of the procedures and mechanisms of reporting faults with equipment to ensure early rectification.
- Recommendations were made in relation to general improvements in the training given to custody officers and staff and others, focused on the need for improvements in first aid and medical care training. This included, for example,

82 We do not believe that CCTV is a replacement for completing the relevant risk assessment and checks on vulnerable detainees but believe that it can provide additional protection. Therefore where CCTV is available efforts should be taken to ensure that it is operational. Independent custody visitors could check whether CCTV is operational as part of their custody visits.

understanding the effects of drug ingestion and recognising when a person is suffering from a drugs overdose or withdrawal, and increasing awareness that head injuries require close observation as more serious internal injuries may have occurred.
- Investigators identified the need for guidance and training on the care or rousing of detainees who are on drugs. Similarly, training related to drunken detainees was also a recommendation in a number of cases by investigators, with an emphasis on the requirements and responsibilities as stated under PACE Code C around rousing detainees. In addition, it was stressed that remote cell monitoring should not under any circumstances be used as a replacement for physical cell visits.

3. Policy and guidelines
- Some of the recommendations focused on multi-agency working and the importance of sharing and checking information on a detainee. The importance of multi-agency working in the context of Section 136 detentions and developing alternative places of safety was also mentioned in a few cases.
- There was a need to collate and disseminate best practice that has been identified through regular custody officer's meetings, and to have the information circulated within the force area. In addition, there was a need to highlight to custody staff, through a formal process, relevant publications and circulations relating to the care of detainees and identification of risks.
- Some recommendations related to investigative issues in relation to, for example, scene preservation and the design of the scene log, obtaining forensic evidence and especially securing blood samples.
- Some recommendations were related to the transportation of detainees. These included a review of policies on the suitability of using police vehicles to transport drunken detainees, conveying ill people to hospital, and training in relation to the risks associated with the transportation of vulnerable and restrained prisoners and the specialist tactics used in relation to this.
- Recommendations were made in relation to the use of CS spray, restraint techniques and the understanding and recognition of positional asphyxia and 'acute behavioural disorder'. These have been highlighted above in the restraint section.

Lessons to be learnt identified by investigators

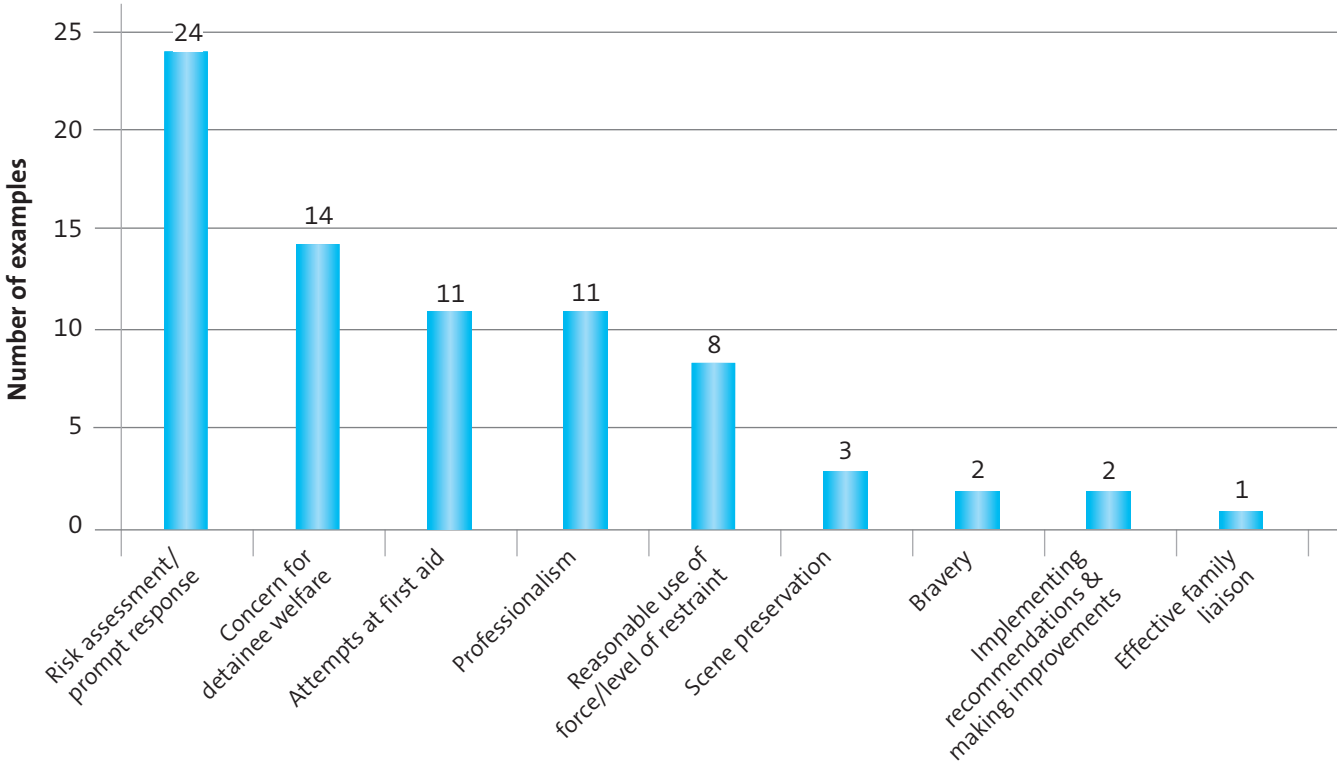
In the case of 36 (11%) of the 333 deceased people, investigators' reports noted lessons to be learned from the death. Between them the 36 cases yielded 45 lessons to be learned. The most commonly noted were the need for an accurate custody record of cell visits (mentioned in seven cases), the need to improve first aid training for all officers and staff (six), and the need for a strategy on the risk assessment of drunk and drug-using detainees (six). The full list of lessons to be learned reflected the following points:

- Accurate custody records of cell visits (7).
- First aid training for all officers/staff (6).
- Developing a strategy for risk assessing drunk and drug-using detainees (6).
- Better in-force and partner communications (5).
- Better risk assessment of all detainees (4).
- Redesign of cells to remove ligature points (3).
- Better training for custody officers and staff (3).
- Improved CCTV (2).
- Improved investigative processes (2).
- Producing an aide memoire on the Safer Detention Guidance (2).
- Greater awareness of the risks related to restraining detainees (1).
- Better custody handover arrangements (1).
- Checking by FPs of medication dates for detainees (1).
- Setting up a detoxification centre for drug- and alcohol-misusing detainees (1).
- Promptly notifying the deceased's family of the death (1).
- Upgrading technology/equipment (1).

Similar incidents within forces

In 17 of the 333 cases (5% of the sample) the investigator identified similar incidents which had

Figure 7.6 **Examples of good practice from investigations**



previously occurred in the same force[83]. No similar incidents were noted in most cases (247; 74%), and the information was not stated in the remaining 69 cases (21%). The similar incidents involved the following issues:

- Similar recommendations unimplemented following on earlier death (3 cases).
- Other suicides/attempts at suicide involving ligature points (3).
- Suicide using items smuggled into cell following on incomplete search (2).
- Insufficient cell visits and incomplete custody record keeping (1).
- Detainee swallowed drug package (1).
- Diabetic was mistakenly treated as drunk (1).
- Failure to properly check/rouse a drunk detainee (1).
- Detainee suffered from drug withdrawal (1).
- Death in same police station within previous six months (1).
- Several incidents also involving excessive force (1).
- Detention under Section 136 Mental Health Act (1).
- Failure to store detainees' possessions safely (1).

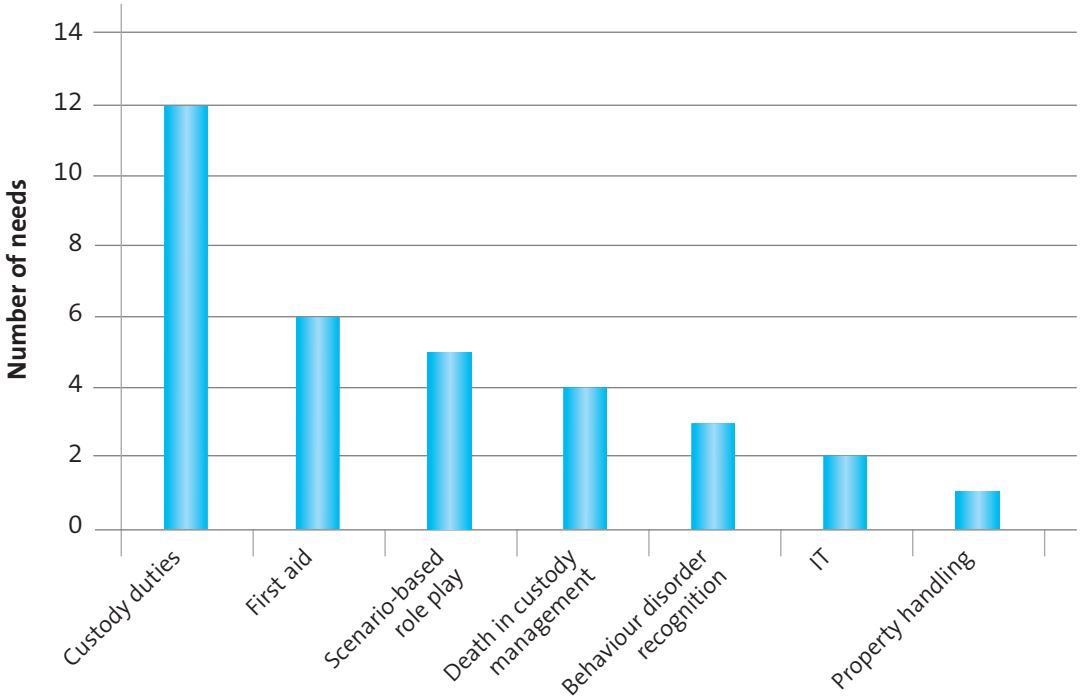
Good practice within forces

In 50 of the 333 cases (15% of the sample) the investigator identified examples of good practice in the same force. No examples were noted in most cases (187; 56%), and the information was not stated in the remaining 96 cases (29%). In all, investigators noted 76 separate examples of good practice – an average of one in every four cases. As figure 7.6 shows, the most commonly noted example of good practice was risk assessment involving a prompt response when a detainee first showed signs of health difficulties. This accounted for 24 of the 76 examples.

Further evidence of good practice comes from investigators' recommendations in relation to individual officers and staff. Between them, investigators suggested that a police officer be commended for their actions in a case on 20 occasions, and that a member of staff be commended on five occasions.

83 The actual number of similar incidents may well be higher, as this measure only reflects investigators' knowledge of previous incidents.

Figure 7.7 **Training needs for individual police officers and staff**



In five cases the needs were not stated.

Implementation of force policy and practice recommendations

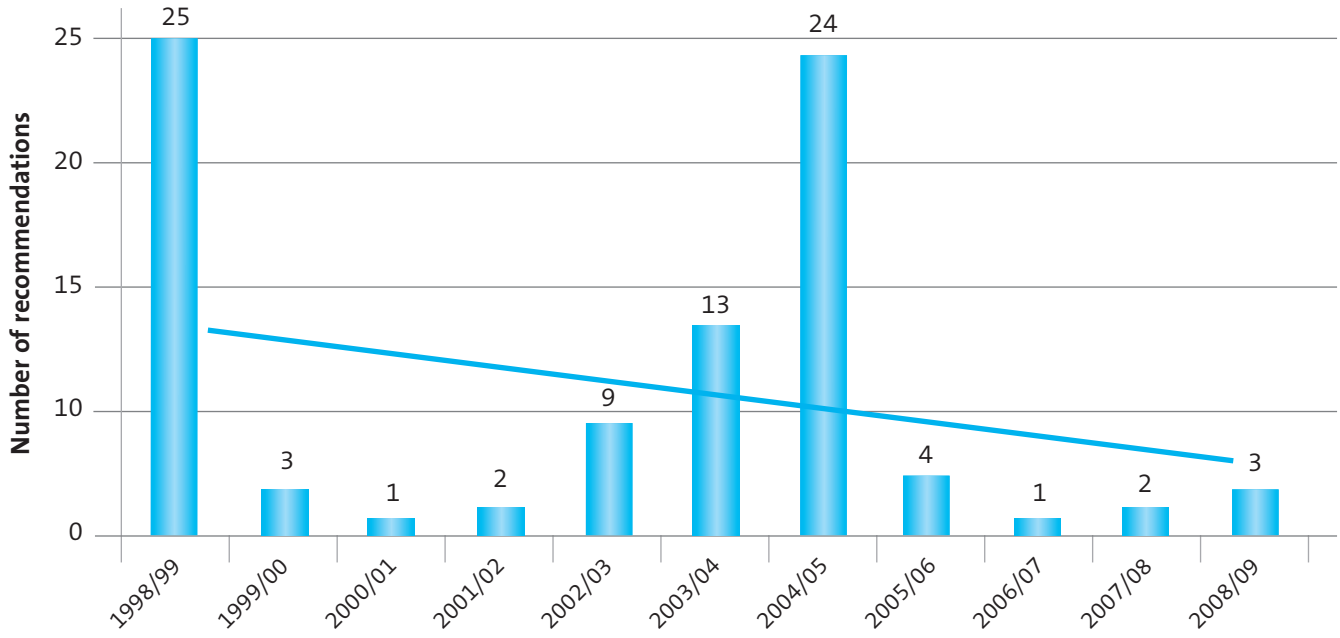
In the case of 28 (8%) of the 333 deceased people, recommendations were reported by the investigator to have been implemented by the time the investigation report had been completed[84]. For 91 people (27%), no recommendations had been implemented (this may simply be because the information has not been fed back to the relevant investigator on the case). Information was not stated in 28% of cases (94 people), and was not applicable in the remaining 36% of cases (120). Between them the 28 cases yielded 34 implemented recommendations. The most commonly addressed were improving familiarity Guidance, and reviewing and updating the custody suite and cells, both of which were implemented on seven occasions. The full list of implemented recommendations were:

- Improving familiarity with the Safer Detention Guidance (7).
- Reviewing and updating the custody suite and cells (7).
- Installing/improving the custody CCTV system (4).
- Updating guidance on dealing with mentally disordered detainees (3).
- Updating first aid/medical training for all officers/staff (2).
- Improving the custody IT system (2).
- Providing better first aid/medical equipment (1).
- Producing guidance on the use of CS spray (1).
- Producing guidance on the supervision of detainees in the exercise yard (1).
- Removing material that could be used to self harm (1).
- Implementing a policy on detainees swallowing drug packages (1).
- Improving the police radio system (1).
- Reducing risk by providing replacement clothing for detainees (1).
- Improving the checking/sharing of information on detainees (1).
- Establishing a group to address deaths in custody issues (1).

84 It should be noted that, for cases which the IPCC investigated, the IPCC does not have the power to enforce recommendations for changes to policy and practice in police forces.

Recommendations for individual officers and staff

Figure 7.8 **Trends in investigators' recommendations for misconduct/disciplinary proceedings for police officers and staff**



The line shows the trend across the 11 year period.

This section examines investigators' recommendations for individual police officers and staff on a number of issues.

Training needs

Figure 7.7 shows the training needs of individual police officers and staff identified by investigators. In all, 38 such needs were noted (five were not stated). The single most common recommendation involved training on custody duties (12 recommendations).

Training recommendations for individual officers and staff were mainly concentrated in three years – 1998/99, 2002/03 and 2004/05. No training recommendations were made for any individuals in the last three years of this study, although this does also of course reflect the downward trend in the number of deaths.

Misconduct/disciplinary proceedings and criminal charges

Over the 11 years, misconduct/disciplinary proceedings were recommended for 78 police officers and nine staff members in our sample. Figure 7.8 shows that these recommendations were mainly concentrated in two years – 1998/99 and 2004/05. On average, investigators have recommended misconduct/disciplinary proceedings for fewer police officers and staff in the more recent part of the period than they did in earlier years. This may in part reflect the downward trend of the number of deaths[85]. We do not know how many actually resulted in misconduct/disciplinary proceedings since this information is not included within the investigation report. It would be useful to have this information recorded in one easily accessible place.

Prosecutions were recommended on 13 occasions for police officers – an average of one in every 26 cases. In all, the 13 police officers who were prosecuted faced a total of 36 charges. These were as follows:

- Manslaughter (8 charges).
- Neglecting to perform duty in treatment

85 Consideration was given to calculating the proportion of cases per year which had recommendations for officers/staff to face misconduct/disciplinary proceedings, in order to see if things had improved over the time period. However, the number of officers and staff under investigation for any one case can vary greatly from a minimum of one officer and no staff members to a maximum of 15 officers and/or nine staff members. Therefore the number of recommendations you would expect to see per year would vary regardless of the trend in the number of cases. In more recent years the numbers become very small so it is difficult to identify any clear trends. For these reasons we therefore did not calculate a proportion of cases resulting in a recommendation for misconduct/disciplinary charges per year.

Table 7.2 **Investigators' recommendations for police officers and staff, by ethnicity of deceased**

Ethnicity / Recommendation	Asian	Black	Mixed	White	Chinese/ Other	Not stated	Total
Words of advice	12	10	0	177	0	4	**203**
Misconduct/disciplinary charges	0	8	0	59	0	20	**87**
Written warning	3	1	0	25	0	1	**30**
Commendation	0	0	0	25	0	0	**25**
Prosecution	0	7	0	5	0	1	**13**
File to IPCC	0	0	0	3	0	0	**3**
Demotion	0	0	0	1	0	0	**1**
Not stated/other	11	8	8	147	6	61	**241**
No recommendations	57	95	33	886	6	85	**1162**
Total recommendations	**83**	**129**	**41**	**1328**	**12**	**172**	**1765**
Total cases	**17**	**22**	**7**	**253**	**3**	**31**	**333**

The number of recommendations is much higher than the number of cases, as cases can involve multiple officers and staff, and multiple recommendations for each officer/staff member.

of detainees (8).
- Manslaughter by gross negligence (6).
- Misconduct in public office (5).
- Health and safety offences (3).
- Actual bodily harm (2).
- Dangerous driving, Section 2 Road Traffic Act (2).
- Assault (2).

None of these 36 charges resulted in a guilty verdict. In 23 cases the verdict was not guilty (seven of which followed a judge's direction to the jury). In the remaining 13 cases the verdict could not be found in the investigator's report[86]. One member of police staff faced prosecution for misconduct in a public office. This individual was found guilty at court and sentenced to six months imprisonment, having resigned prior to the prosecution. Information on prosecutions is not recorded in the investigation report (as this would be completed prior to any prosecution) but, again, it would be useful if this information was recorded in an easily accessible place.

86 This information may be held elsewhere but could not be found by the researchers. In Appendix B, which assesses the quality of investigation reports, we have suggested that this information be attached to the investigator report/case file once known.

Ethnicity, age and gender of deceased

Tables 7.2 and 7.3 show the investigators' recommendations for police officers and staff[87] according to, respectively, the ethnicity and age group of the deceased. There were no noticeable differences by gender of the deceased.

The number of recommendations is much higher than the number of cases, as cases can involve multiple officers and staff, and multiple recommendations for each officer/staff member[88].

Points of note from Tables 7.2 and 7.3 are that:

- Although making up 7% of all cases, the 22 cases involving Black detainees accounted for seven of the 13 recommendations for prosecution.
- Compared with White detainees, cases involving Black detainees were more likely to lead to a recommendation of misconduct/disciplinary

87 Caution should be exercised when interpreting these findings as, especially in cases involving staff members, some categories contain low numbers.

88 Commonly, more than one police officer or member of staff was involved in a case (the greatest number of police officers in a case was 15; the greatest number of staff was nine). If added together, figures in each column will therefore exceed the number of cases in the sample of 333 deceased people. Consequently the bottom row in each table shows the total number of cases in each category among the sample of 333, and is included for reference.

Table 7.3 **Investigators' recommendations for police officers and staff, by age group of deceased**

Recommendation \ Age group	17 and under	18-24	25-34	35-44	45-54	55-64	65-74	75 and over	Not stated	Total
Words of advice	0	15	45	49	76	8	9	0	6	**208**
Misconduct/ disciplinary charges	0	14	19	36	10	7	1	0	0	**87**
Written warning	4	1	7	8	6	0	1	0	3	**30**
Commendation	0	5	10	3	2	0	5	0	0	**25**
Prosecution	0	0	7	6	0	0	0	0	0	**13**
File to IPCC	0	0	0	0	0	3	0	0	0	**3**
Demotion	0	0	0	0	1	0	0	0	0	**1**
Not stated/other	0	16	70	73	40	25	0	9	7	**240**
No recommendations	1	100	304	284	205	107	48	17	96	**1162**
Total recommendations	**5**	**151**	**462**	**459**	**340**	**150**	**64**	**26**	**112**	**1769**
Total cases	**2**	**27**	**81**	**81**	**67**	**34**	**15**	**7**	**19**	**333**

The number of recommendations is much higher than the number of cases, as cases can involve multiple officers and staff, and multiple recommendations for each officer/staff member.

charges, and to a recommendation that a file be sent to the CPS for consideration.

- Compared with Black detainees, cases involving White detainees were more likely to lead to a recommendation that words of advice or a written warning be given.
- A disproportionate number of misconduct/ disciplinary charges were recommended in cases involving 18-24 year olds.

This chapter has examined investigations in cases involving deaths in or following police custody, and their outcomes. In the final chapter we draw out the conclusions from the study, and offer recommendations for future policy and practice to help prevent deaths in custody.

8. Conclusions and recommendations

This study sought to examine the nature and extent of deaths in police custody over an 11 year period. It looked at a number of specific areas to identify lessons for policy and practice, with the objective of preventing deaths in the future. The findings therefore provide a solid and up-to-date evidence base about who dies in police custody and why the deaths occur. As well as informing policy and practice, we hope the findings will also inform public debate about this area. This chapter discusses the main findings from the research and sets out recommendations which we hope may help to prevent further deaths.

Prevalence of deaths in custody

Over an 11 year period from 1998/99 to 2008/09 there were a total of 333 deaths in or following police custody. This means that over this time period an average of 30 people died in police custody each year. These figures need to be placed in the context of the numbers of people who pass through police custody each year. On this basis we estimate that deaths in custody are rare events, with an average over the period of 2.2 deaths per 100,000 arrests. Furthermore, a major finding of this study is that deaths in custody have fallen. A total of 49 people died in the first year of the study and this fell to 15 in the final year.

We cannot provide a conclusive reason for why this fall has occurred. However, we can point to some plausible explanations which concern operational practice in police custody suites. Three examples are presented here. First, suicides (particularly by hanging) are rarer than they once were, which indicates that police cells are safer and have fewer ligature points. Second, in recent years more individuals in this study were taken straight to hospital rather than custody, which may indicate greater ability on the part of arresting officers to recognise illness and risk. Third, there may also have been an increase in custody sergeants refusing to admit people into custody who appear unwell, and being quicker to realise when detainees are taken ill and seek help. Wider contextual issues may also play a role in these operational changes. These include changes in the custody population, management of the custodial estate, the influence of custody visitors, and more recently the changes to the risk assessment procedure in Code C of PACE (in 2003) and the introduction of the Safer Detention and Handling guidance (ACPO, 2006). Perhaps a significant factor here is the impact of past deaths, both on the force concerned and on other forces.

Despite the finding that deaths in custody have fallen, every fatality in police custody remains a tragedy. Furthermore, because of the controversial nature of this area, each death has the potential to have a negative impact on trust and confidence in the police. Nor should the consistent fall in deaths over several years lead to complacency. There are still problems which persist across the time period we have examined, and these need to be addressed. These are explored in more detail below.

Characteristics of the deceased and nature of the deaths

The vast majority of the deceased were male (90%) and White (76%), and had an average age of 39 years. Despite public concern about BME deaths, this research has shown the number of deaths are proportionate to the make-up of the custody population. However, Black people in particular are overrepresented in the custody population, and

there are complex reasons for this, such as the potential for over-policing of this group. This will therefore not provide complete reassurance to people from these communities.

Most were arrested for relatively minor offences which were often linked to intoxication such as being drunk and incapable/disorderly, public order offences, and driving offences. Of the 87 arrests for being drunk and incapable/disorderly, 60 were not arrested for any other offences but were taken to custody (this included one person who was also being detained under Section 136 of the Mental Health Act). This raises questions about why some of these individuals were taken to custody. ACPO Safer Detention Guidelines (2006) highlight the powers officers have to take individuals to alcohol treatment centres when arrested for being drunk and incapable, and state that these people should be treated as a medical issue and taken to hospital (and only to custody as a last resort). However, it appears that in practice this does not happen, and whilst we are aware of examples of good practice around the country with some specialist facilities for people who are severely intoxicated, it appears that most still end up in police custody.

Recommendation 1: Police forces and local health service providers and commissioners should adopt the ACPO Safer Detention Guidelines (2006) and develop protocols on the care of drunken detainees. Given the strong link between alcohol and deaths in custody the Home Office and Department of Health should pilot alternative facilities for intoxicated people with access to medical provision, with a view to developing a national scheme.

The most common causes of death were natural causes, overdoses, suicides and injuries received prior to detention. There were some significant differences in terms of the demographics of the deceased and the cause of death. In our sample women were significantly more likely to die of an overdose than men, and people who had not been arrested for drug offences and were older were more likely to die of natural causes. People who had not been arrested for drug offences and were younger were more likely to commit suicide.

There was a strong link to alcohol and/or drugs running through the sample (i.e., individuals had been arrested for offences related to alcohol and/or drugs, were intoxicated, and/or the cause of death was related to alcohol and/or drug use). Over half of the sample had an alcohol factor on their case, over a third had a drugs factor, and a fifth had both. In addition, there were 58 people who had a mental health factor, of whom 35 also had an alcohol and/or drugs factor. Of the 58 people with a mental health factor, 17 were detained under Section 136 of the Mental Health Act to be taken to a place of safety, two were detained under other sections of the Act, and a further 39 people had mental health needs identified by arresting officers or by custody officers once they were at the police station.

Of the people detained under Section 136 of the Mental Health Act, half were taken to police custody as a place of safety, despite official guidance stating that the police station should be the last resort as a place of safety. However, previous research has found that police officers are often unable to take Section 136 detainees to alternative facilities, either because they do not exist in their force area or because staff at such facilities refuse to accept detainees who are intoxicated and/or violent (Docking et al, 2008). In previous research the IPCC has recommended that NHS commissioners develop alternative places of safety (Docking et al, 2008: Recommendation 1) and we would reiterate this here. This previous research also highlighted the need for sufficient numbers of FPs (or other healthcare professionals) to be approved under section 12 of the Mental Health Act 1983 to assess Section 136 detainees who are taken to police custody, and again we would reiterate this here (Docking et al, 2008: Recommendation 12).

There were a further 11 people who were identified by the police as being a possible suicide/self-harm risk, and 26 additional people who committed suicide but had not been identified as having any possible mental health

needs or as being a suicide/self-harm risk. This highlights the vulnerability of many people who die in police custody and their potentially complex needs once in the custody environment.

Use of restraint

There were 87 people who were physically restrained by the police (this excludes those who were handcuffed). This most commonly occurred during the arrest, although this was not always the case. The most common restraint technique used was being held down by one or more officers. Previous research has raised concerns about deaths involving men from BME groups and police restraint (Leigh et al, 1998; PCA, 2003b). We found that the BME people who died in our sample were more likely to be restrained compared to White people, and that this was statistically significant. However, this restraint was not necessarily related to the death.

Our study showed that the restraint was related to the death in 16 cases (5% of the sample). Of these deaths 12 people were White, three were Black and one was Asian. A series of recommendations on restraint was made in the investigation reports into these deaths and other cases involving restraint. These were predominantly around ensuring that restraint was carried out safely and that, when complications from being restrained arose, they were dealt with effectively.

Detailed recommendations by investigators in cases where restraint was used are set out in chapter seven. We have used these to formulate our own recommendations. In addition to these, we understand that the Police Federation is planning a strategy aimed at gaining the recognition of 'excited delirium' by the British medical profession[89], training for police officers and emergency medical staff, and development of joint protocols between agencies. The evidence, from the USA in particular, suggests this should be supported. We would suggest that it should include training on transportation of detainees suffering from 'excited delirium'.

89 It is currently recognised by the Faculty of Forensic and Legal Medicine but not by accident and emergency staff or ambulance staff.

Recommendation 2: ACPO should ensure that training manuals clearly state which restraint techniques are unauthorised, and which should only be used for a maximum length of time (for example, restraint in the prone position).

Recommendation 3: Control room staff should ask for details on the clinical condition of the detainee, and of other patients on the premises when police officers are called to restrain detainees at medical facilities. This will enable the officers on the ground to make a judgment on whether to exercise restraint and on how to do it safely.

Recommendation 4: Custody sergeants, as part of a risk assessment, should ask the arresting officer(s) whether they or any other person have used any restraint techniques on the detained person. This information should be shared with healthcare professionals attending to the detainee; any concerns should be noted on the custody record by the healthcare professional.

Risk assessment, care of detainees and medical provision

The area where we found the greatest number of issues was the care of detainees once they arrived in custody. All detainees are supposed to be risk assessed on entry to custody. However, of the 247 detainees who were booked into custody, only just under half were risk assessed. A detainee's level of intoxication was by far the most common reason given for why no risk assessment was carried out. It is likely that a lack of risk assessment would have played some part in the circumstances leading to some of these deaths. Furthermore, the inability to conduct a proper assessment should have been recognised as a significant warning of potential risk.

We found examples of individuals with mental health needs, at risk of suicide/self-harm, or intoxicated through drugs and/or alcohol who were

not checked as frequently as they should have been. We also found shortcomings with regard to the rousing of detainees. The most commonly used method was simply 'going to the cell' and not proactively engaging the detainee, such as asking them a question. Simply visiting a cell and conducting a visual observation has implications, as a detainee who appears to be sleeping, and therefore comfortable, may in fact be suffering from something more serious. Some of these detainees did not therefore receive the standard of care they ought to have received if PACE Codes of Practice were adhered to or ACPO Safer Detention and Handling Guidelines (2006) were applied.

Recommendation 5: Police forces should emphasise to custody personnel the risks around head injuries being masked by intoxication, with a view to custody sergeants including this within the standard risk assessment. The Faculty of Forensic and Legal Medicine has issued useful guidance for custody officers on head injuries which forces should circulate to custody officers and staff. The dangers of being complacent about the risk posed by someone regularly in police custody should also be reinforced by forces to officers and staff.

Recommendation 6: Custody officers and staff should ensure that colleagues are aware of the circumstances and needs of all detainees (including any risks and medical needs) as part of handing over custody duties at the end of a shift. This should be done verbally, in view of the CCTV in the custody suite (where available), in addition to a written acknowledgment that the custody officers/staff have been fully briefed on the risks and needs. If CCTV is not available this should be recorded on the custody record in addition to being communicated verbally.

Recommendation 7: Police forces should ensure that CCTV is available in at least one cell in the custody suite, to be used when a detainee is identified as being at risk, and, where available, that it is fully operational[90]. Independent custody visitors should check that CCTV is operational when carrying out their custody visits.

Recommendation 8: Police forces should ensure that custody officers and staff are clear about their individual roles and responsibilities in the custody suite, so that checks and information recorded on the custody record are completed accurately.

Recommendation 9: Police forces should adopt procedures to ensure that custody officers and staff adhere to PACE Code C with respect to risk assessing, checking and rousing. It should be emphasised that:

- Rousing involves the use of a stimulus designed to elicit a response from the detainee (as per PACE Code of Practice C Annex H).
- Cell visits and checks are completed and recorded in a timely and accurate manner.
- All detainees should be risk assessed on arrival to the custody suite and throughout their detention, regardless of their level of intoxication.
- A detainee's unwillingness or inability to participate in a risk assessment should be viewed as a possible warning of risk.

There were also issues around medical provision. In fewer than one in five cases was an officer or member of staff dealing with the case trained in first aid. In only 4% of cases had at least one of the officers or staff members received any refresher training. It was noted in some cases that there were failures in communication between the police and health service both in custody and at hospital. There were also cases where the investigator was critical of the standard of medical care the detainee had received, both in custody (from a FP) and at hospital.

Recommendation 10: Healthcare professionals should ensure that their directions for custody staff on the frequency of checks required for a detainee are written in the custody record, in addition to being verbally passed on. The same applies to any recommendations on the rousing of a detainee.

90 CCTV is not a substitute for the necessary checks a vulnerable individual should receive but is an additional form of protection.

Investigations and investigation outcomes

The focus on deaths in police custody in the past has frequently been discussed in terms of police misconduct and/or failings and neglect in the care of detainees. There are examples in our study which reflect this, in terms of instances of officers potentially using disproportionate force when restraining an individual, and failing to adequately risk assess, check, and rouse detainees in their care. On occasion these failings may have contributed to the death, and have led to the officers/staff being disciplined and prosecuted.

Investigators found that police force policy and procedure on custody had been breached in 91 cases (these breaches would not necessarily have impacted on the death). The most common recommendations in the reports were around officer training in first aid and liaison with FPs, and risk assessment of custody cells and detainees' property and clothing. The cases in this study fall both before and after the ACPO Safer Detention and Handling Guidelines (2006) were published and revisions were made to PACE Code C (most significantly the strengthening of risk assessment in 2003). It is therefore inevitable that there are examples of practice which do not meet the standards set down in these documents. However, even in more recent cases there were examples where officers did not adhere to the standards, and in some cases there is the possibility that if the proper procedures were followed some deaths may not have occurred.

Misconduct/disciplinary charges were recommended on 78 separate occasions for police officers and on nine separate occasions for staff members – an average of one in every four cases. However, as decisions relating to these matters are finalised after the investigation report is completed, it is not possible to say how many officers and staff members were actually subject to misconduct/disciplinary sanctions.

One member of police staff was prosecuted for misconduct in a public office and was found guilty and imprisoned for six months. Prosecutions were recommended against 13 police officers, who faced a total of 36 charges. None resulted in a guilty verdict that we are aware of from the information available. The acquittal rate of police officers and staff members is therefore very high despite, in some cases, there appearing to be relatively strong evidence of misconduct or neglect. This study was unable to examine why this might be, but it is something that future research could explore. Although making up 7% of all cases, the cases involving Black detainees accounted for seven of the 13 recommendations for prosecution of police officers.

Healthcare, police custody and the future

Aside from cases which may have involved police misconduct, a strong theme to emerge in the cases we have examined concerns the healthcare of a population of people who commonly have a range of physical and mental health risks. These include people with medical needs such as diabetes and heart problems, people with long-term drug or alcohol addiction, individuals with mental health needs, people with no fixed abode and transient lifestyles, and individuals who have a combination of many of these needs and issues. The individuals in our study are reflective of the wider custody population, in terms of being a group who often have complex and extreme health needs. For example, Robertson et al (1995) estimate that between 22% and 25% of detainees are reported to be 'drunk' on arrival at police stations. In a study by Giles and Sandrin (1992), 85% of deaths in police custody over the ten year period analysed were linked to recent alcohol consumption or chronic alcohol abuse. Norfolk (1998) reported alcohol-related deaths as the second most prominent cause of death in police custody. Bennett (1998) found that an average of 69% of arrestees gave positive urine samples for at least one drug, 36% tested positive for two or more drugs, and 38% tested positive for opiates and/or cocaine. Finally, estimates on the number of people with mental health needs passing through

police custody vary between 2% and 20% (Burney and Pearson, 1995; Winstone and Pakes, 2005).

There is a debate about whether many of these individuals should actually be in police custody; for example, those who have only been detained because they are extremely intoxicated. We are aware that there are alternative facilities in which intoxicated people can sober up – so-called "drunk tanks" or "SOS buses" – which have been used in various places around the world as an alternative to police custody (Griesbach et al, 2009). However, the evidence from our study would seem to suggest that they are not very widespread in England and Wales and that the majority of these people are still therefore being detained in a custody suite. There is also the issue of police custody being used as a 'place of safety' under Section 136 of the Mental Health Act, despite guidance stating that it should only be used in exceptional circumstances. Previous research has found that in some police force areas there are no alternative places of safety available outside of police custody (Docking et al, 2008).

Of the 87 arrests for being drunk and incapable/disorderly sampled in this study, 60 were not arrested for any other offences but were taken to custody (this included one person who was also being detained under Section 136 of the Mental Health Act). This raises questions about whether people who are very inebriated and who are suspected of having committed such offences, or who are arrested due to their level of intoxication, should be taken to custody. The Association of Chief Police Officers (ACPO) Safer Detention Guidelines (2006) state that people detained for being drunk and incapable should be taken to alternative facilities, but this does not seem to be occurring.

Given that it seems likely, at least in the short term, that many of these vulnerable individuals will continue to be taken to police custody, the question is then whether the level of care they receive meets their often complex needs. This study has shown that there is a need to ensure that the PACE Codes of Practice and ACPO Safer Detention Guidance are adhered to in terms of risk assessments, checks and rousing of detainees – particularly those who are more vulnerable because of their alcohol/drug use and/or mental health needs. In addition, our research has identified issues with custody officers and staff not having adequate first aid training. We are not suggesting that custody officers and staff should become medical experts, but having a basic understanding of first aid should be a given for individuals expected to be responsible for such a vulnerable population. Custody inspections run jointly by Her Majesty's Inspectorate for Constabulary and Her Majesty's Inspectorate for Prisons have also identified issues in custody suites around a lack of first aid equipment or outdated equipment. It is reasonable to suggest that such equipment be provided in custody suites in order to facilitate basic first aid needed in an emergency.

Finally, our study also highlighted issues around problems with communication and information sharing between healthcare agencies and the police, and in some instances problems with the healthcare provision given to detainees. We are aware that wider reform of healthcare provision in custody is being explored jointly by the Department of Health and the Home Office, following a pilot study in one police force area (see Viggiani et al, 2010) and publication of the Bradley Report (2009). This work aims to see the commissioning of healthcare in police custody move from the police to the health service, as now happens in prisons. There are various models of healthcare provision that could be provided in custody using a range of healthcare professionals (Viggiani et al, 2010). Overall it is hoped that, with the health service commissioning the provision of healthcare in custody directly, the level of medical care provided will improve, and there will be increased provision available on a 24-hour basis. It may also help to join up the work of various agencies, but in particular the police and health service, increase communication and information sharing and, ultimately, potentially prevent further deaths in custody.

References

Association of Chief Police Officers (ACPO) (2006): *Guidance on the Safer Detention and Handling of Persons in Police Custody.* Produced on behalf of ACPO and the Home Office by the National Centre for Policing Excellence. Bedfordshire: Centrex.

Association of Chief Police Officers (ACPO) (2009): *Guidance on the Use of Limb Restraints* London: ACPO and the Self-Defence, Arrest & Restraint Working Group of the Uniformed Operations Business Area.

Bennett, T. (1998): *Drugs and Crime: The results of research on drug testing and interviewing arrestees*. Home Office Research Study 183. London: Home Office.

Blaho, K., Winbery, S., Park, L., Logan, B., Karch, S. and Barker, L. (2000): 'Cocaine Metabolism in Hyperthermic Patients with Excited Delirium'. *Journal of Clinical Forensic Medicine*. Vol. 7 (2): 71-76.

Bowling, B. and Phillips, C. (2002): *Racism, Crime and Justice*. London: Longman.

Bradley, K. (2009): *The Bradley Report: Lord Bradley's review of people with mental health problems or learning disabilities in the criminal justice system*. London: Department of Health.

Bucke, T. and Wadham, J. (2009): 'Deaths in Custody', in Wakefield, A. and Fleming, J. *The Sage Dictionary of Policing*. London: Sage.

Bucke, T., Teers, R., Menin, S., Payne-James, J. and Stark, M. (2008): *Near Misses in Police Custody: A Collaborative Study with Forensic Medical Examiners in London*. IPCC Research and Statistics Series, Paper 10. London: Independent Police Complaints Commission.

Burney, E. and Pearson, G. (1995): 'Mentally Disordered Offenders: Finding a Focus for Diversion', *Howard Law Journal,* Vol. 45: 291-313.

Byard, R.W., Wick, R. and Gilbert, J.D. (2008): 'Conditions and Circumstances Predisposing to Death from Positional Asphyxia in Adults'. *Journal of Forensic and Legal Medicine,* Vol. 15: 415-419.

Cartwright, J. (1997): 'Investigating Deaths in Police Custody', in Liebling, A. (ed) *Deaths of Offenders: The Hidden Side of Justice*. Proceedings of a Conference held at Brunel University, Uxbridge, England, July 1997. Winchester: Waterside Press.

Chan, T.C., Vilke, G.M., Neuman, T. and Clausen, J.L. (1997): 'Restraint Position and Positional Asphyxia'. *Annals of Emergency Medicine,* Vol. 30 (5): 578-586.

Community-Police Consultative Group for Lambeth (1996): *Lessons from Tragedies: Deaths in custody in the Metropolitan Police District 1986-95*. First Report by the Deaths in Custody Working Group of the Community-Police Consultative Group for Lambeth. London: Furnival Press.

Davis, N. (1999): 'Death in Custody'. *Journal of the Royal Society of Medicine,* December, Vol. 92 (12): 611

Deehan, A., Marshall, E. and Saville, E. (2002): *Drunks and disorder: Processing intoxicated arrestees in two city-centre custody suites*. Police Research Series Paper 150. London: Home Office.

Department of Health (2008): *Code of Practice Mental Health Act 1983*. London: The Stationary Office.

Department of Health and Home Office (2010): *Police Healthcare Baseline Survey.* Unpublished data.

Devon and Cornwall Constabulary (2010): *Policy and Procedure – Personal Safety, Handcuffs and other Limb Restraints, Batons and CAPTOR incapacitant Sprays.* Devon and Cornwall Constabulary Force Publication Scheme. April 2010.

Di Maio, T. and Di Maio, V. (2005): *Excited Delirium Syndrome: Cause of Death and Prevention.* Boca Raton: CRC Press.

Dimsdale, J. E., Hartley, L. H., Guiney, T., Ruskin, J. and Greenblatt, D. (1984): 'Post-exercise Peril: Plasma Catecholamines and Exercise'. *Journal of the American Medical Association,* February, Vol. 251 (5).

Docking, M., Grace, K. and Bucke, T. (2008): *Police Custody as a "Place of Safety": Examining the Use of Section 136 of the Mental Health Act 1983.* IPCC Research and Statistics Series, Paper 11. London: Independent Police Complaints Commission.

Forensic Drug Abuse Advisor (2000): 'More on Positional Asphyxia'. March, Vol. 12 (3): 18.

Forum for Preventing Deaths in Custody (2007): *Annual Report for 2006/07*. London: Independent Police Complaints Commission.

Giles, G. H. and Sandrin, S. (1992): 'Alcohol and Deaths in Police Custody'. *Alcoholism: clinical and experimental research*, Vol. 16 (4): 670-672.

Griesbach, D., Lardner, C. and Russell, P. (2009): *Summary of Findings and Recommendations from a Research Study on Managing the Needs of Drunk and Incapable People in Scotland: A Literature Review and Needs Assessment.* Scottish Government Social Research: www.scotland.gov.uk/socialresearch

Havis, S. and Best, D. (2003): *Sleeping it off: Safety Issues in Detaining Intoxicated Individuals in Custody Suites. London:* Police Complaints Authority.

Home Office (2000): *Detainee Risk Assessment and Revised Prisoner Escort Record Form.* Home Office Police Leadership and Powers Unit. August 2000. Home Office: London

Huish, K. (2010): 'Hidden Danger'. *Police Magazine,* April 2010.

Hunt, R. (1996): 'Alcohol and the Police Surgeon'. *Alcoholism,* Vol. 15 (6): 3.

Independent Police Complaints Commission (2008): *Deaths During or Following Police Contact: Statistics for England and Wales 2007/08.* Extracted from IPCC Annual Report 2007/08. London: Independent Police Complaints Commission.

Independent Police Complaints Commission (2009): *Deaths During or Following Police Contact: Statistics for England and Wales 2008/09.* Extracted from IPCC Annual Report 2008/09. London: Independent Police Complaints Commission. http://www.ipcc.gov.uk/deaths_report_0809.pdf

Inquest (1997): *Death in Police Custody.* Report on the death of Ibrahima Sey. London: Inquest.

Inquest (2004): *2004 Annual Report*. London: Inquest.

James, D.S. (2009): *Pathological Aspects of Sudden Restraint Deaths Associated with Struggle against Restraint. Pathology Report on Baha Mousa.* Baha Mousa Public Inquiry.

Jauchem, J.R. (2010): 'Deaths in Custody: Are Some Due to Electronic Control Devices (including TASER devices) or Excited Delirium?' *Journal of Forensic and Legal Medicine,* January, Vol. 17 (1): 1-7.

Johnson, H. R. M. (1982): 'Deaths in Police Custody in England and Wales'. *Forensic Science International,* Vol. 19: 231-236.

Karch, S.B. and Stephens, B.G. (1999): 'Drug Abusers who Die during Arrest or in Custody'. *Journal of the Royal Society of Medicine,* Vol. 92: 110-113.

Lawrence, C. and Mohr, W. K. (2004): 'Investigator Protocol: Sudden In-Custody Death'. *Police Chief,* Vol. 71 (1): 44-49.

Leigh, A., Johnson, G. and Ingram, A. (1998): *Deaths in police custody*: Learning the lessons. Police Research Series Paper 26. London: Home Office.

Macpherson, W. (1999): *The Stephen Lawrence Inquiry Report*. London: The Stationery Office.

Man, L.H., Best, D., Marshall, J., Godfrey, C. and Budd, T. (2002): *Dealing with alcohol-related detainees in the custody suite.* Home Office Findings 178. London: Home Office.

Mash, D.C., Duque, L., Pablo, J., Qin, Y., Adi, N,, Hearn, W.L., Hyma, B.A., Karch, S.B., Druid, H. and Wetli, C.V. (2009): 'Brain Biomarkers for Identifying Excited Delirium as a Cause of Sudden Death'. *Forensic Science International*, Vol. 190: 13-19.

Metropolitan Police Service (2005): *Unpublished statistics provided by the MPS Forensic Medical Services*.

Ministry of Justice (2009): *Statistics on Race and the Criminal Justice System 2007/8*. A Ministry of Justice publication under Section 95 of the Criminal Justice Act 1991. London: Ministry of Justice.

Norfolk, G. (1998): 'Deaths in Police Custody during 1994: A Retrospective Analysis'. *Journal of Clinical Forensic Medicine*, Vol. 5: 49-54.

Noble, A., Best, D., Stark, M. and Marshall, J. (2000): *The role of the Forensic Medical Examiner with "drunken detainees" in police custody*. Police Research Series Paper 146. London: Home Office.

Norfolk, G. and Stark, M. (2000): 'Care of Detainees', in Stark, M. (ed) *A physician's guide to clinical forensic medicine*. Totowa: Humana Press.

Norfolk, G., Stark, M. and Travis, M. (2010): *Acute Behavioural Disturbance: Guidelines on Management in Police Custody*. Produced by the Academic Committee of the Faculty of Forensic and Legal Medicine, September 2010. http://fflm.ac.uk/upload/documents/1285761388.pdf

Offender Health Research Network (2009): *Report to the Independent Advisory Panel on Deaths in Custody: Working Group on the Use of Restraint*. Manchester: OHRN.

O'Halloran, R. L. (2004): 'Reenactment of Circumstances in Deaths related to Restraint'. *American Journal of Forensic Medical Pathology*, Vol. 25 (3): 190-193.

O'Halloran, R.L.M.D. and Frank, J.G.M.D. (2000): 'Asphyxial Death During Prone Restraint Revisited: A Report of 21 Cases'. *American Journal of Forensic Medicine and Pathology*, Vol. 21 (1): 39-52.

Otahbachi, M., Cevik, C., Bagdure, S. and Nugent, K. (2010): *'Excited Delirium, Restraints, and Unexpected Death: A Review of Pathogenesis'*. February 2010 [Epub ahead of print].

Police and Criminal Evidence Act (PACE) (2008): *Codes of practice C, revised edition* London: The Stationery Office.

Paquette, M. (2003): Editorial – 'Excited Delirium: Does it Exist?' *Perspectives in Psychiatric Care*, Vol. 39 (3): 93-94.

Parent, R. (2006): 'Deaths During Police Intervention'. *FBI Law Enforcement Bulletin*, Vol. 75 (4): 18-22.

Payne-James, J., Green, P. G., Green, N., McLachlan, G. M. C., Munro, M. H. W. M. and Moore, T. C. B. (2010): 'Healthcare Issues of Detainees in Police Custody in London, UK', *Journal of Forensic and Legal Medicine*, Vol. 17, Issue 1: 11-17.

Payne-James, J. and Wyatt, J. (2007): Head injury advice leaflet for custody officers, gaolers and detention officers. Produced for the Faculty of Forensic and Legal Medicine, November 2007 https://fflm.ac.uk/upload/documents/1195227243.pdf

Police Complaints Authority (1999): *Deaths in Police Custody: Reducing the Risks*. London: Police Complaints Authority.

Police Complaints Authority (2000): *The 1999/2000 Annual Report of the Independent Police Complaints Authority*. London: Police Complaints Authority.

Police Complaints Authority (2002a): *Policing Acute Behavioural Disturbance*. Revised Edition. London: Police Complaints Authority.

Police Complaints Authority (2002b): *Safer Restraint*. Report of the conference held in April 2002 at Church House, Westminster http://www.ipcc.gov.uk/safer_restraint_june2003.pdf

Pollanen, M.S., Chiason, D.A., Cairns, J.T. and Young, J.G. (1998): 'Unexpected Death Related to Restraint for Excited Delirium: A Retrospective Study of Deaths in Police Custody and in the Community'. *Canadian Medical Association Journal*, Vol. 158 (12): 1603-1607.

Postill, F.J. and Rowan, J.R. (1998): 'Managing Use of Restraints Liability'. *American Jails*, July/August, Vol. 12 (3): 29.

Povey, D., Smith, K., Hand, T. and Dodd, L. (2009): *Police Powers and Procedures England and Wales 2007/08* (2nd Ed.) Home Office Statistical Bulletin 07/09. London: Home Office.

Povey, D., Hand, T., Singh Rishiraj, A. and Mulchandani, R. (2010): *Police Powers and Procedures England and Wales 2008/09*. Home Office Statistical Bulletin 06/10. London: Home Office. http://rds.homeoffice.gov.uk/rds/pdfs10/hosb0610.pdf

Robertson, G., Gibb, R. and Pearson, R. (1995): 'Drunkenness among Police Detainees', *Addiction*, Vol. 90: 793-803.

Schmidt, P. and Snowden, T. (1999): 'The Effects of Positional Restraint on Heart Rate and Oxygen Saturation'. *Journal of Emergency Medicine*, Vol. 17: 777-782.

Stratton, S.J., Rogers, C., Brickett, K. and Gruzinski, G. (2001): 'Factors Associated With Sudden Death of Individuals Requiring Restraint for Excited Delirium'. *American Journal of Emergency Medicine*, Vol. 19 (3): 187-91.

Strote, J. and Hutson, H.R. (2006): 'Taser Use in Restraint-related Deaths'. *Prehospital emergency care*, Vol. 10 (4): 447-450.

Viggiani, N., Kushner, S., Last, K., Powell, J. and Davies, J. (2010): *Police custody healthcare: An evaluation of an NHS commissioned pilot to deliver a police custody health service in a partnership between Dorset Care Trust and Dorset Police*. Bristol: University of West England.

Wall, I. (2008): 'Lack of Training in Custodial Medicine in the UK – A Cause for Concern?', *Journal of Forensic and Legal Medicine*, Vol. 15 Issue 6: 378-381.

Winstone, J. and Pakes, F. (2005): *Mental health literature review: Effective practice*. London: Home Office/Office for Criminal Justice Reform.

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