DEATHS IN POLICE CUSTODY IN THE CAPE TOWN WESTERN METROPOLE 2000-2009

By

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Dissertation submitted to the University of Cape Town

in partial fulfilment of the requirements for the degree

Master of Medicine Pathology (Forensic)

Faculty of Health Sciences

UNIVERSITY OF CAPE TOWN

Date of submission: 13th August 2015

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TABLE OF CONTENTS

DECLARATION

I hereby declare that the work on which this dissertation is based is my own original work (except where acknowledgements indicate otherwise) and that neither the whole work or any part thereof has been, is being, or is to be submitted for another degree in this or any other university.

Estevão Bernardo Afonso

5 August 2015

ABSTRACT

Deaths in police custody are a global phenomenon which continues to beset policing services worldwide. Research into these deaths has provided insight into the complexity of detention and led to the institution of preventative strategies which have seen a reduction in mortality internationally.

An improved understanding of the South African detention milieu may similarly assist in reducing the mortality burden in this country. This study retrospectively reviewed deaths in custody in the Cape Town Western Metropole between 2000 and 2009, with the aim of identifying local, modifiable factors to aid in death prevention.

Sixty two (62) cases were reviewed. Males predominated (90.3%) in the sample, with the racial profile mirroring that of the general population. The median age of the detainees was 30.5 years. Unnatural causes of death accounted for 82% (n=51) of cases, with suicidal hanging the commonest cause (n=40). Items of clothing were used as ligatures in 80% of hangings, with gate and window bars the most common points of suspension. Time in detention averaged 863 minutes for the sample. Clinical signs of intoxication at the time of arrest was identified as a statistically significant determinant (p=0.02) of a shorter detention time (446 minutes).

Ten (10) detainees were identified as either injured at the time of arrest or physically ill during detention, of which 9 succumbed to their injuries or disease. Only three of these detainees received medical attention.

These findings highlight the need for urgent review of local police cell architecture to ensure an environment conducive to safe detention, with particular attention to reducing potential points of suspension for hangings. Further, the healthcare needs of detainees must be prioritised through effective training of police personnel with regard to the assessment and management of ill detainees, particularly those intoxicated at the time of arrest.

ACKNOWLEDGEMENTS

A word of thanks to the following people for making this research possible:

My wife, for her unwavering support during the arduous journey to the completion this work.

Dr Yolande van der Heyde, for her patience and guidance.

Mr Thabo Leholo and the staff at the Independent Complaints Directorate, for their friendliness and assistance during the hours spent at their offices.

Mr Henri Carrara for his assistance with the statistical analysis of the study data.

DEDICATION

For my mother and sister.

"With memories of you,
My heart with pleasure fills,
And dances with the daffodils..."

(Adapted from "I wondered lonely as a cloud" by William Wordsworth)

LIST OF TABLES

LIST OF FIGURES

ABREVIATIONS

ADAM	Arrestee Drug Abuse Monitoring program
AIC	Australian Institute of Criminology
CAT	Convention against Torture and Other Cruel Inhuman and Degrading Treatment or Punishment
DUMA	Drug Use Monitoring in Australia program
ICCPR	International Covenant on Civil and Political Rights
ICD	Independent Complaints Directorate
IPCC	Independent Police Complaints Commission
IPID	Independent Police Investigative Directorate
NDICP	National Deaths in Custody Program
SAPS	South African Police Service
SO	Standing Order
UK	United Kingdom
UN	United Nations
USA	United States of America

CHAPTER 1: LITERATURE REVIEW

INTRODUCTION

A literature search was conducted in the PubMed and Google Scholar databases for research and published articles concerning deaths in police custody. Search terms included "death", "arrest" and "police custody". Further articles were then obtained from the references of relevant articles.

Historically, research into deaths in custody have focused either exclusively on death in prisons, or involved mixed populations from different types of custodial settings, such as police cells, prisons and mental health facilities.[1–3]

Literature exclusively dealing with deaths in police custody has mainly emerged from studies in the United States of America (USA), the United Kingdom (UK), Netherlands and Australia.[4–8]

DEATH IN POLICE CUSTODY – A GLOBAL PHENOMENON

Deaths in police custody are a worldwide concern. Although the number of deaths is small compared to the overall national mortality burden, the effect which they have on both the police service and society in general, is profound.[4]

Public reaction to these deaths is characterized by outrage and intense scrutiny, by both the media and human rights groups.[9] The apparent paradox of a death whilst in the care of society's protectors – the police – is typically viewed as an inherent failure in their duty.[10,11] The suspicion of police wrong doing is often the overwhelming sentiment.

When deaths involve individuals from ethnic minorities, minors, detained protestors or political activists, public reaction is often intensified.[4,12] Controversy is often further

propagated by the fact that these cases may only be investigated internally, raising concerns of a conflict of interest and lack of impartiality.[12]

For these reasons, a number of countries have established bodies to independently oversee the investigation of deaths in custody.[13] Examples include the National Deaths in Custody Program (NDICP) in Australia, and the Independent Police Complaints Commission (IPCC) in the United Kingdom (UK).

In apartheid South Africa, reported deaths in police custody were largely confined to those of political activists.[14–16] Given the political milieu of the time, the validity of the information provided is uncertain. Together with the lack of information regarding deaths of non-political detainees, this makes statistics from the period grossly unreliable.

Following democratisation, the importance of independent investigation of these deaths was prioritised and saw the establishment of the Independent Complaints Directorate (ICD) in 1997.[17] The ICD was subsequently replaced by the Independent Police Investigative Directorate (IPID) in 2011.[18]

Statistics published by the ICD/IPID between 2000 and 2012, show that the number of deaths in police custody has remained between 200 and 300 per year.[19–24]

In comparison, statistics from the UK show between 15 and 49 deaths per year between 1990 and 2009, while Australia reported 219 deaths over a 15 year period (1990 to 2004).[4,25,26]

DEFINING DEATH IN POLICE CUSTODY

The definition of death in police custody is not universal, with definitions varying between countries and legal systems [3,27].

In South Africa, the definition of "person in custody" as stated in SAPS Standing Orders, is:

"A person who has been arrested and who is in the custody of the (Police) Service and who has not yet been handed over or handed back to the Department of Correctional Services or any other institution for detention".

Consequently the definition of a death in police custody is:

"…the death of any person which occurs during a period commencing upon the arrest of such a person and ending when the person leaves police custody either legitimately, or by escape" [28].

This definition stresses that the death occurs following arrest. Individuals detained without arrest are thus excluded; such as those held for questioning or those in police care during transport to a medical care facility.

Shepard (2011) has suggested that these individuals, who are "otherwise under police control", should be included in any definition of death in police custody[27].

The IPCC in the United Kingdom makes use of a broader definition, which takes these individuals into account, and defines 'deaths in or following police custody' as:

"Deaths in or following police custody includes deaths of people who have been arrested or otherwise detained by the police. It includes deaths 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 or other vehicle."[29]

In Australia, NDICP at the Australian Institute of Criminology (AIC) defines deaths in custody broadly as:

"deaths in institutional settings (e.g. police stations/lockups, police vehicles, etc.; or during transfer to or from such an institution; or in hospitals, etc. following transfer from an institution)".[25]

This definition does not specify arrest as being prerequisite, but only that the death occurs in an 'institution' as described, and thus technically under police care.

In the United States of America, the "Death in Custody Reporting Act of 2000" (to be replaced by the same named Act of 2013) mandates that all states report the "death of any person who is in the process of arrest, is en route to be incarcerated, or is incarcerated at a municipal or county jail…".[30]

An important point to note is that deaths due to police action or police related operations, such as police shootings, are generally not included in the above definitions. In South Africa these deaths are separately defined as deaths "...caused, or is reasonably believed to have been caused, by a member of the South African Police Service while acting in his or her official capacity..."[28].

Deaths due to police action have held a prominent position in the media in South Africa recently. Most significantly following the so-called "Marikana massacre"" in 2012, where 44 miners were shot and killed by police.[31] This category of death is not considered in this thesis.

THE RIGHTS OF THE DETAINEE

The rights of the people in detention are recognised and promoted internationally through various treaties and conventions, and by national legislation.

International

The *Universal Declaration of Human Rights* recognises the dignity and absolute rights of all people.[32] Importantly Article 3 speaks to the rights of life, liberty and security; while Article 5 prohibits torture, cruel, inhumane or degrading treatment.[32]

The prohibition of torture and cruel treatment is further governed by the United Nations (UN) *Convention Against Torture and Other Cruel Inhuman and Degrading Treatment or Punishment* (CAT) and the *International Covenant on Civil and Political Rights* (ICCPR).[33,34] Both of these have been ratified by the South African Government.[35,36]

Article 10 of the ICCPR implicitly states that "all persons deprived of their liberty shall be treated...with respect for the inherent dignity of the human person".[34]

Detailed provisions regarding the management and protection of persons in detention are provided for by the UN document *The Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment*.[37] The rights of juvenile detainees are specifically addressed by the UN *Rules for the Protection of Juveniles Deprived of their Liberty*.[38]

South Africa

The South African Constitution affords all detainees their basic human rights.[39] Section 35 within the Bill of Rights looks specifically to the rights of arrested and detained persons, thus providing the basic tenets by which they should be cared for by the police.

Within the SAPS, various Standing Orders detail the treatment of detained persons to ensure that these rights are respected and maintained.

Standing Order (G) 341 governs the arrest and treatment of arrestees prior their booking and detention at a police station.[40] Section 8(4) of the Order specifically deals with the search for and removal of items on arrestees which may be used to harm themselves or others.

Standing Order (G) 361 deals with the management of arrestees after their arrival at a police station.[41] Here issues pertaining to special groups of detainees such as those with hearing, speech or visual handicaps, juveniles or mentally ill persons are considered. Furthermore, and importantly, the Order prescribes the rules of 'safe custody'.[41] These include:

- Separation of high risk detainees (e.g. juveniles, mentally ill or those arrested for violent crimes) for their own safety or that of others.
- Conditions of accommodation during detention.

- Frequency of cell visits by police members, for general detainees as well as those restrained or "insensible from drink".
- Provision of alternative clothing where items have been removed.
- Provision of drinking water and food

The medical care and treatment of arrestees is governed by Standing Order (G) 349, which states:
"From the moment of arrest the arresting member and thereafter, every member who exercises control over a person in custody, is responsible to promptly take the necessary steps to ensure that such person receives medical treatment whenever necessary".[42]

Section 2 of the Order, indicates that the arresting officer must at their own discretion decide whether the arrestee requires urgent medical care prior to being taken to a police station. Importantly, it states that where doubt exists as to whether urgent medical treatment is needed or not, the officer should err on the side of caution and seek treatment for the arrestee. Section 3 similarly, concerns the medical care of persons once detained at a police station, and covers a wider range of medical issues.

POLICE DETAINEES – A SUSCEPTIBLE POPULATION

Individuals detained in police custody, have been shown to have an increased risk of death when compared with the general population from whence they originate.[43–45] This increased risk has been attributed to the following factors:

- the custodial environment
- high turn-over of vulnerable individuals in police detention
- over representation of intoxicated individuals in custody
- over representation of 'suicide-vulnerable' individuals in custody
- stress and uncertainty surrounding the outcome of the arrest.[45,46]

These factors are not considered mutually independent, but rather act in concert to create an increased risk for both morbidity and mortality. This highlights the complexity of deaths in custody, and that the custodial environment is not the sole determinant of risk. The detained individual, with their own specific characteristics, and how they respond to the environment are also important factors.[47]

The Custodial Environment

Following arrest, an individual is detained in an environment – be it a police vehicle, police cell or court cell - which is usually unfamiliar to the individual. Despite the measures taken to make places of detention congruous with human dignity, the detention environment remains a foreign and stressful one. Not only is there loss of free movement, but isolation from family and friends, deprivation of accustomed lifestyle comforts, and importantly the loss of autonomy.[48]

The custodial environment cannot be viewed only in term of its static physical structure. The environment is a dynamic one moulded by the ever changing population occupying it– both police officers and detainees.

a. Physical cell conditions

The structure of a police cell, typically with concrete floors and benches, make it a stark environment often with a lack of privacy.[14,49]

In 1998 Dissel and Ngubeni, whilst investigating deaths in police custody in Gauteng, South Africa, visited 11 police stations and made the following observations regarding the police cells:

- All cells were described as "gloomy", with inadequate lighting
- Ventilation was variable between stations

- The state of cleanliness was variable. Walls of most cells described as requiring a paint, with graffiti and burn marks present.[14]

Their final word on cell conditions was that "In many instances, the conditions of the cells was not in conformity with the principle of respect for the human dignity of a person, and in several cases, could also be said to be inhumane or degrading".

b. Detainees

Police cells hold a wide variety of persons at any given time – among them violent offenders, intoxicated individuals, first time offenders, juveniles and those with mental illness.[49] Despite established Standing Orders, segregation of detainees may not always be possible, especially in times of high admission rates, which may lead to overcrowding.

In such cases, exposure of vulnerable individuals to other detainees may put them at risk of physical and psychological harm.[48] Even in cases where segregation is achieved, the sight and sounds of aggressive, intoxicated or mentally ill detainees may still cause significant disturbance or psychological stress to other detainees.[49]

c. Police as custodians

Brouwer (2006) in assessing custodial conditions in Victoria, Australia, suggested that police do not identify with their role as custodians, and do not "like dealing with angry, bored detainees".[49] Rather they see themselves primarily as crime fighters, ensuring community safety.

Nevertheless, their custodial function is an important aspect of their daily function. Detainees, having been deprived of their self determination are dependent on their police custodians for their basic well being and care.

Health screening and monitoring of detainees whilst in detention, is imperative for timeous identification of vulnerable individuals and those in need of medical care.[50] Despite such pro-active measures, a number of authors have raised concerns that a significant number of medical conditions are still not identified or managed appropriately.[5,43,51,52]

In addition, the misinterpretation of signs or symptoms by police has led to fatal consequences. Examples include mistaking seizures for resisting arrest, or altered consciousness due to a head injury for intoxication.[7,53]

A lack of appropriate training of officers and poor insight into their custodial role may contribute to misidentification of detainees in need, and thus place them at increased risk of harm.[49,54]

The Vulnerable Individual

The concept of the vulnerability refers to the susceptibility of an individual, or group, to harm.[55] Here the term "harm" broadly includes physical, psychological and socio-economic forms of harm. The source of these susceptibilities may stem from detainees' intrinsic personal characteristics, the effectiveness of their support structures or the society in which they live.

The ability to cope with a specific stressor, is thus by some measure shaped by ones environment. Removal of an individual from their usual familiar environment to a foreign one, such as a detention cell, may thus expose or enhance their vulnerability.

The reactions of individuals to the stress of arrest, the detention environment and its consequences, are unpredictable. Maslow (1941) referred to the difference between deprivations which are deemed unimportant to an individual, and those which are perceived as a 'threat to the personality'.[56] The latter may affect their life goals, defence

mechanisms, self-esteem or sense of security. The perception alone of such a threat may put certain arrestees at risk of self-harm.[47]

Personal characteristics which may affect their well-being whilst in custody include their mental health, drug use and physical health.

a. Mental health

The prevalence of psychiatric symptoms amongst police detainees has been shown to be significantly higher than that documented in the general population.[47,57] Although a wide range of symptoms are reported depression, anxiety and somatisation are the most common.[47,50,51,57–59]

Not surprisingly, those detainees with a history of a psychiatric diagnosis have been noted to exhibit more psychiatric symptoms than those without such diagnoses. [47,58] This is likely due to the exacerbation of the underlying disorder by the acute stress of arrest and detention.[57]

Detainees with a history of illicit drug abuse, have also been noted to more likely display symptoms of psychiatric disorders in custody than those who have not abused drugs.[59] The greater the number of substances abused, the greater the risk of the psychiatric symptoms.

Other factors found to be associated with increased psychiatric symptomatology include female sex, lower level of education and drug use[47,57,59]

Suicide rates in police detention have also been found to be greater than that seen in the general population.[45] This together with the fact that suicides account for a significant proportion of deaths in custody, makes the identification of 'suicide-vulnerable' individuals an important step in combating these deaths.[26,43,60,61] Defined risk factors for self-harm include a history of previous suicide attempt, mental disorder, drug abuse, and a sense of helplessness or isolation during detention.[62,63]

b. Drug use

Although the association between drug use and crime is well known, its exact nature is uncertain.[64,65] There are three main theoretical models used to explain the connection, which surmise that there exists:

- A direct causal connection, whereby drug use causes crime or vice versa;
- An indirect causal connection, where both are caused by another factor; or
- A non-causal connection, where both are simply the result of a general association or problematic behaviour.[64]

It is unlikely that these models are exclusive in any given situation. The socio-economic complexity in crime and drug use, suggests that these models are likely to overlap, varying from case to case.

The existence of a drug-crime association would suggest that drug use and dependence are common place within the arrestee population. Various international drug monitoring programmes such as ADAM and DUMA have corroborated this inference.[59,66–71]

These programmes make use of questionnaires, with or without confirmatory urine testing, to screen arrestees in detention. Published data from Australia has shown that up to 65% of arrestees test positive for at least one illicit drug.[67,69] Parry et al. (2004) screening arrestees in South Africa, found a slightly lower positivity rate at 45%.

The prevalence of drug use, as well as the type of drugs used, differs between countries, provinces and even cities.[68,71,72] Cocaine use appears more common amongst arrestees in the USA and UK than in Australia, while Australian arrestees have higher rates of opiate and amphetamine use. A 1999 study found that South African arrestees had a much lower prevalence of illicit drug (opiate, cocaine and amphetamine) use than the USA, UK or Australia.[68] One global similarity over time has been the consistently high prevalence of cannabis use.[66–68,71,72]

Peltzer et al (2010) noted that the prevalence of illicit drug use in the general South African population was lower than that in the USA and Australia.[73] This may in part explain the lower prevalence of drug use amongst South African arrestees.

In South Africa, regional differences in drug abuse may be partly understood in terms of population demographics which vary between provinces.[71] The Western Cape for example has the largest Coloured population, which has been found to have a significantly greater prevalence of illicit drug use, particularly methamphetamine, when compared to other population groups.[74] This may in part explain the finding by Parry et al. (2004) of a higher rate of drug positivity amongst arrestees in the Cape Town when compared to those in Durban and Johannesburg.

Data from rehabilitation centres in the Western Cape indicate that methamphetamine, cannabis and alcohol have been the most commonly abused drugs since 2005.[75,76]

Concomitant drug use – whether a combination of alcohol, illicit or prescription drugs – has been reported as significant amongst arrestees.[59,77] Similar to cannabis, the prevalence of alcohol use prior to arrest or intoxication at the time of arrest is globally commonplace.[66,67,69,71,78] Alcohol intoxication is not surprising highest amongst those individuals detained for driving under the influence, public disorder or drunkenness.[78]

Prescription drug use is also common amongst arrestees. Ng and McGregor (2012) found that 36% of their Australian sample used prescription drugs, the most common being benzodiazepines (25% of users) followed by morphine (12%).[79] Similarly in South Africa, Parry et al. (2004) noted benzodiazepine use to be prevalent amongst arrestees, being the third most common drug (illicit or prescription) identified in their Cape Town cohort.

Apart from drug users, detainees hiding drugs within their bodies – so called body packers, pushers and stuffers – are a group at high risk of death, particularly if unsuspected by the police.[80]

c. Physical health

A detainees health needs may be considered as being either 'forensic' or 'general' in nature.[81] Forensic medical conditions include traumatic injuries – sustained prior to, during or after arrest – and acute drug intoxications or the complications thereof.

Chariot et al. (2014) in their study of 16 618 arrestees seeking medical care, found that 22% presented with traumatic injuries.[82] The majority of these were alleged to have been sustained at the time of arrest.

The detention of intoxicated individuals may have serious health implications for arrestees.[83] These may be directly due to acute intoxication, injuries sustained whilst intoxicated or subsequent drug withdrawal. A commonly reported scenario is that of an individual detained for drunkenness in a police cell, only to be later found dead due to acute drug poisoning or an undiagnosed head injury.[53] This particular problem has led to the suggestion in certain regions that drunkenness not be criminalised, and that such individuals should be observed in an appropriate medical environment.[49]

Literature on medical care in detention, has found a higher prevalence of chronic general medical conditions amongst detainees than within their population of origin.[52,84] Commonly encountered conditions (excluding psychiatric and drug disorders) include chronic diseases such as asthma, epilepsy, cardiovascular disease and diabetes.[51,52,81,82,84]

In addition to the potential sequelae these conditions pose, the fact that individuals seldom carry their prescribed medications with them at the time of arrest, puts them at increased risk of morbidity.[81] Where medication is available, it must be retained by the police as a safety precaution. The detainee is thus reliant on the police for timeous administration of the medication, which may for various reasons not occur, adding to the risk of morbidity.[84]

DEATHS IN POLICE CUSTODY

Demographics

Worldwide, men account for the overwhelming majority of deaths in police custody.[1,4,25,26,45,85–87] Although deaths may occur at any age, most occur in the 30 to 50 year old age group with the mean age at death in the late 30's.[1,4,25,43,45,87]

Racial demographics vary worldwide based on either general population, socio-economic or local minority lines.[60]

The arrestable offences committed by the detainees appear to vary between regions, with minor offences such as drunkenness and disorderly conduct most common in the UK, while violent offences are more commonly encountered in Australia.[4,25,26]

Causes of death

Unnatural causes of death accounts for the majority of cases in most published literature[1,6,43,45,60,61,87] though occasional studies have found natural causes to predominate.[4]

Cardiovascular disease accounts for the vast majority of natural deaths. Uncommon natural causes of death cited include central nervous tumours and sickle cell anaemia.[88,89]

Among unnatural deaths, suicide is the most commonly listed manner of death with the majority due to hanging.[3,4,43,45,60,61,90] Drug overdose is also commonly described, with other methods of suicide such as immolation rarely used.[60,61]

Accidental poisoning is also common, with cocaine the main offending drug.[4,43,60,85,91] In reviewing the literature, it was evident that the distinction between suicidal and accidental drug poisoning is not always clear and some cases may well be erroneously assigned.

Other reported causes of death in intoxicated arrestees include complications of drug abuse, head injury, positional asphyxia, excited delirium and exacerbation of underlying natural disease. [26,53,83,87,92,93]

Homicide in custody is rarely reported.[6,43,60]

SUMMARY

Deaths in police custody are an ongoing and significant burden for the police and public. The aetio-pathogenesis of these deaths is heterogeneous and often multifactorial. It is not only the police staff and the detention environment which are implicated as factors in these deaths, but importantly the detainee and their own personal characteristics.

Considering this complex interaction, it is not surprising, that despite attempts to reduce the numbers of deaths in custody the phenomenon remains a global concern.

The thorough investigation of these cases is paramount to enable a deeper understanding of the factors which contributing to the fatal outcomes.

In unravelling the environmental pressures of local police stations and the characteristics of the local population from which the arrestees originate, authorities may be better equipped to direct meaningful changes which may reduce deaths in police custody.

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CHAPTER 2: PUBLICATION READY MANUSCRIPT

1. METHOD

The definition of death in custody used for this study was based on that used by the South African Police Service (SAPS), but with the inclusion of those individuals who died whilst in the care of the police but not under arrest. Thus the definition included all individuals who died:

a. Following arrest, whilst in transit to a SAPS station, during booking or once detained in a cell.
b. Whilst being transported in a SAPS vehicle to a medical or psychiatric hospital and were not under arrest,
c. Whilst being held in a SAPS station for questioning, and were not under arrest.

All deaths investigated by ICD within the Cape Town Western Metropole between 1st January 2000 and 31st December 2009 were analysed. Applying the above definition, seventy six potential cases were identified. Fourteen cases were excluded as they either did not fulfil the inclusion criteria or due to unavailability of the investigative dockets. The remaining 62 cases formed the study population for this study.

A questionnaire was designed to extract relevant data from the case dockets. Data gathering was conducted on the premises of ICD and the Division of Forensic Medicine at the University of Cape Town (UCT).

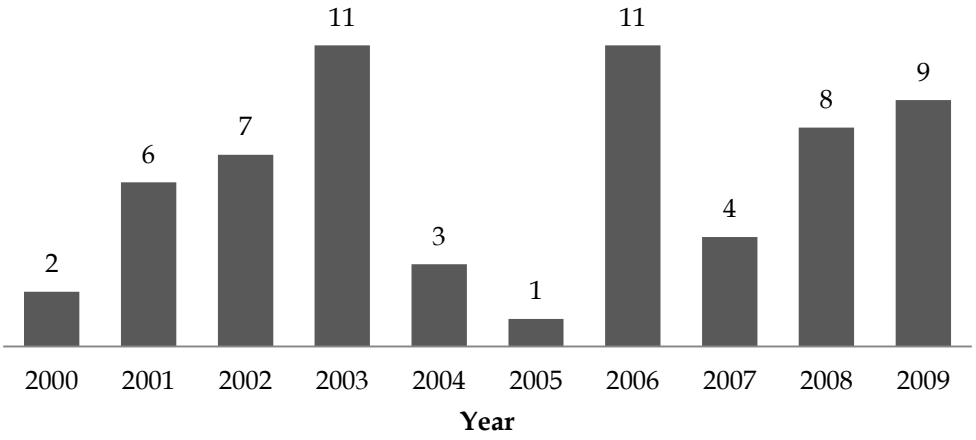
Captured data was collated in an Excel spreadsheet and exported to STATA for statistical analysis.

Ethics approval for the study was obtained from the UCT Health Sciences Faculty Research Ethics Committee. Furthermore, permissions were obtained from the National Director of IPID (then ICD) and office of the Provincial Commissioner of SAPS in the Western Cape.

2. RESULTS

There were 62 deaths in police custody over the period. The deaths were unequally distributed over the years (see Figure 1), with the greatest number of deaths (n=11) occurring during 2003 and 2006 respectively.

Figure 1: Deaths by year



The deaths occurred within the jurisdiction of 27 different SAPS stations. Three stations reported 5 or more deaths each over the period, with one of these reporting 3 deaths in a single year.

Fifty three deaths occurred in detention cells within a SAPS station, four in hospital, and 2 each in court cells and police vehicles. A single death occurred in a police station toilet.

2.1 Demographics

Males dominated the study group with 90.3%. In terms of population group, those identified as Coloured accounted for the majority of cases (45.2%). Table 1 shows the gender and population grouping of the deaths for the period.

Table 1: Gender and Population Group

	Black		Coloured		White		Total	
	N	%	N	%	N	%	N	%
Male	21	91	25	89	10	91	56	90
Female	2	9	3	11	1	9	6	10
Total	23	100	28	100	11	100	62	100

Detainees were aged between 15 and 59 years, with a median age of 30.5 years (interquartile range 22 – 40 years), and mean of 32 years.

Marital status was known for 41 cases, with 73% being single and 19.5% married.

Data regarding employment was known for only 29 cases, of which 69% were unemployed. Two arrestees were identified as scholars.

Medical conditions were identified in 9 arrestees, with tuberculosis and seizures the most commonly reported. A history of mental illness was noted in 5 cases: 2 with depression and one each with schizophrenia, bi-polar disorder and suicidality.

Information regarding alcohol or drug use history was available in 11 cases, with the type of drug only specified in 6 of these. Methamphetamine and cannabis were the most commonly reported drugs.

2.2 Arrest circumstances

Fifty six (56) individuals were detained for arrestable offences (see Table 2). Contact crimes accounted for the majority of arrests. Drug related crimes, mostly drunkenness, were also prominent.

TABLE 2: ARRESTABLE OFFENCES

CONTACT CRIME	**23**
Assault	6
Attempted murder	3
Murder	1
Domestic violence	3
Robbery	6
Sexual assault	4
PROPERTY RELATED	**11**
Burglary	7
Motor vehicle theft	2
Theft from a motor vehicle	2
DEPENDENT ON POLICE ACTION FOR DETECTION	**14**
Illegal firearm possession	2
Drug-related	10
Driving under the influence	2
OTHER	**14**
Shoplifting	7
Riotous behaviour	4
Fraud	2
Municipal bylaw	1

Note: Six (6) detainees were arrested for more than one offence

Seventeen arrestees were noted to display abnormal behaviour at the time of arrest. Of these 13 were described as intoxicated or "smelling of alcohol", 5 were aggressive or resisted arrest (2 of which were also intoxicated) and 1 individual was described as delusional.

Physical injuries sustained prior to arrest were identified in 5 individuals. Only 2 received appropriate medical care. Four of these arrestees succumbed to their injuries, one due to a stab to the chest and the other due to blunt force head injuries. No injuries were the result of the use of electrical weapons or chemical agents, such as pepper

spray. Another death could be directly ascribed to a head injury sustained following arrest.

2.3 Details of custody

Time spent in custody was available for 50 cases (see Table 3). Twenty percent of the detainees died within the first two hours of detention, with 54% dying within 9 hours. Similarly, 10% of suicidal deaths occurred within 2 hours of arrest, and 50% within 9 hours.

Outside of the first 9 hours of detention, the period between 12 and 18 hours following arrest was notable with 7 deaths (14%), six of which were suicides.

A statistically shorter detention time was associated with intoxication at the time of arrest (mean 446 minutes, p=0.02).

TABLE 3: TIME SPENT IN CUSTODY

	N	TIME (minutes) Mean	Median	IQR*	Min	Max	p-value
All deaths	50	863.88	502.5	155-1145	5	3300	
Suicide deaths	36	874.22	585	212.5-1256	40	2925	0.43
Intoxicated at arrest	13	446.30	300	80-465	5	2410	0.02

***IQR = Inter Quartile Range**

During detention, 5 individuals were identified as being physically unwell prior to death. Only 1 received medical attention. Causes of death for these individuals included myocardial infarction, peptic ulcer disease and pulmonary tuberculosis.

2.4 Circumstances surrounding death

The majority of deaths occurred during autumn (n=19) and summer (n=16). Sixty percent of suicides occurred during autumn and winter. The majority of deaths occurred between 12h00 and 18h00, though the most deaths in any single hour occurred between 18h00 and 19h00 (n=9). No deaths were reported between 02h00 and 05h00 in the morning.

Fifty three deaths occurred in SAPS station cells, four in hospital, and 2 each in court cells and police vehicles. A single death occurred in a police station toilet.

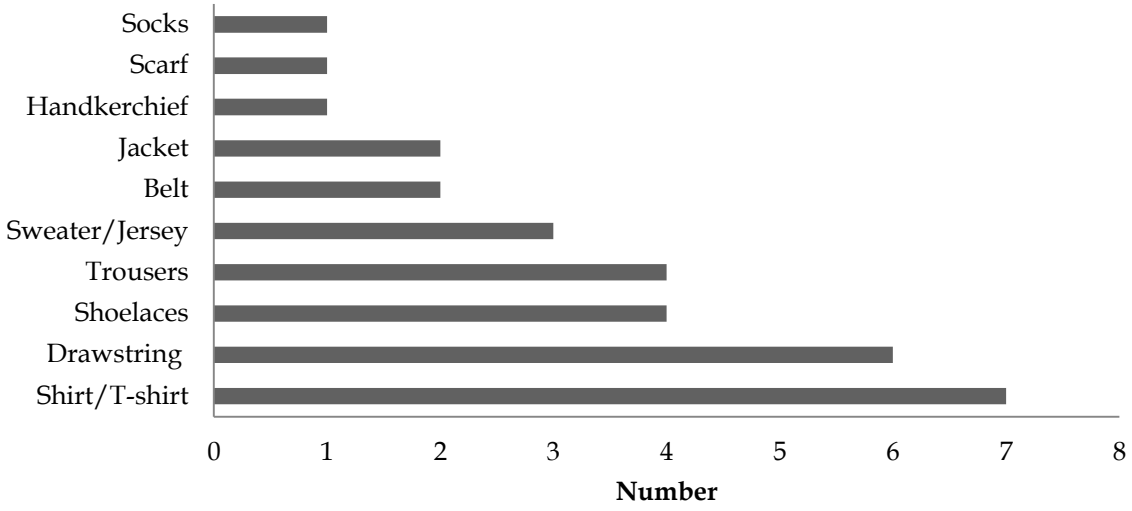
2.5 Cause of death

Natural causes were identified in 7 cases, with three each due to cardiac and respiratory diseases, and one due to gastro-intestinal pathology.

Unnatural causes accounted for 51 deaths (82%). Of these 41 were suicides, 5 homicides and 5 accidental deaths. Of the 41 suicides, 40 were the result of hanging with only one due to an overdose (Amitriptyline).

The ligatures used in hangings were predominantly derived from items of clothing (n=32), with laces/drawstrings and shirts/t-shirts being the commonest items used (See Figure 2).

Figure 2: Ligature used in hangings (n=31)



The point of suspension was known in 36 of the hangings, with cell gate bars (n=17) and window grates (n=16) accounting for 89% of suspension points. Other cases made use of a ceiling grate, light fixture or non-specified bars within detention cells.

The five homicides were the result of assaults prior to arrest (n=3) and during detention (n=1). The details of the fifth case were unavailable.

Five deaths in custody were deemed to be accidental. These were due to head injuries (n=2), choking and suspected excited delirium.

2.6 Postmortem toxicology

Sampling for blood alcohol was done in 50 cases, with only 9 (18%) testing positive. Blood alcohol concentrations ranged between 0.1g/100ml and 0.34g/100ml.

Of those testing positive, eight were correctly identified as being intoxicated at the time of their arrest.

Ten cases tested positive for at least one illicit or pharmaceutical drugs (of the 25 cases screened). Methaqualone (n=5) and methamphetamine (n=3) were the most common illicit drugs, while tricyclic antidepressants (n=3) were the commonest prescribed drug.

3. DISCUSSION

Suicide by hanging was the overwhelming cause of death in the current study. This is in keeping with national statistics reported by ICD/IPID.[22,24] Numerous international studies have similarly found hanging to be the most common unnatural cause of death.[3,43,45,60]

The phenomenon of death in custody cannot be completely eradicated.[94] Each case is unique in terms of the factors, environmental and personal, which lead to the death. Therefore we must rely on general preventative strategies to reduce the incidence thereof. Two modifiable factors were identified in this study which could be used to prevent suicidal hangings, namely: removal of potential ligature material, and limiting access to potential points of suspension.

These findings, though not novel, are still pertinent locally in a South African context.

The resourcefulness of detainees in fashioning ligatures from available material is well known.[45] Items of clothing are the most commonly used ligatures reported in the literature, as in this study.[26,95] Any piece of clothing can potentially be used, making removal of all possible ligatures impossible. The use of "safety suits" in place of detainees' own clothing, has also been shown not to prevent attempts at self-harm.[96,97] It is further suggested that their use may cause increased anxiety and further contribute to the risk of suicide.[96]

The concern in the current study though, is that the majority of the ligatures were items (e.g. shoelaces, drawstrings), which by virtue of established SAPS Standing Orders, should have been removed prior to detention.[41] Rigid compliance with such Orders may not prevent all hangings, but would assist in making it a less accessible reality to those considering suicide.

Structural improvements to detention cells, which eliminate accessible suspension points for hanging, have also been noted to successfully reduce deaths due to hanging.[4,25] The current study identified cell gate and window bars, as the most common points of suspension.

The poor general condition of South African police detention has been previously described by Dissel and Ngubeni (1999). Police cells assessed in the Gauteng Province were described as suboptimal and "in several cases could be said to be inhumane or degrading".[14]

In light of the above, urgent assessment of police cells in South Africa is required to practically advise the necessary renovation of current cells, as well as inform the design of cells in the future. In the interim, individual police stations should be encouraged to be proactive in modifying their cells whenever suspension points are identified.

Although deaths may occur at any time during custody, the first 8 hours have been identified as a high risk period for suicide.[43,45] Consistent with this, the current study found 30% of suicides occurred within the first 4 hours of detention, and 50% within 9 hours. This higher risk is ascribed to a combination of the acute stress of arrest and detention, together with personal factors such as mental illness and drug abuse.[47,98]

The current study identified intoxication at the time of arrest as being associated with a significantly shorter interval between arrest and death; 7.4 hours versus 14.5 hours. A similar finding was made by Havis and Best (2003) specifically with regard to alcohol intoxication.[91]

A second possible risk period for suicide was identified between 12 and 18 hours post-arrest. The reason for this second peak is uncertain. One possible explanation could be the introduction of a secondary stress, such as a court appearance. Uncertainty of the outcome of the court proceedings may heighten the stress of detention and thus increase the risk for self-harm.

In light of the above, careful monitoring of detainees during these two periods, especially those identified as being intoxicated, must be stressed.

Of those identified as intoxicated at arrest, half committed suicide by hanging. Cummins (2008) noted that the major risk for self harm in custody was alcohol intoxication.[96] This may be ascribed to the depressant and dissociative effects of alcohol, which influence the individual's ability to cope with the stress of detention; increasing the risk for suicide in vulnerable detainees.

Drug intoxication may also increase the likelihood of individuals sustaining fatal injuries through falls and physical altercations, as occurred in this study (n=5).

Furthermore, intoxication may obscure the presence of such serious underlying injuries with fatal conseuqneces.[26]

Given these risks associated with intoxication, careful assessment of detainees must be made at arrest and during detention so as to timeously seek medical assistance.

The provision of adequate healthcare is an important part of the police's custodial duty. Medical attention may be required for general medical or forensic related conditions.[99]

Forensic conditions not only include intoxication, but also traumatic injuries – sustained prior to, during or after arrest.

The prevalence of chronic general medical conditions amongst detainees has been shown to be higher than that of their population of origin.[52,84] Commonly encountered conditions amongst detainees (excluding psychiatric and drug disorders) include diseases such as asthma, epilepsy, cardiovascular disease and diabetes.[51,52,81,82,84]

Deficiencies in accessing appropriate health care either at the time of arrest or during detention, may have contributed to six fatalities in this study. Five succumbed to natural disease while one died as a result of a stab to the chest. Despite police members identifying these detainees as being acutely ill, medical care was deferred in favour of immediate or continued detention.

In one case, due to his infirmity, a detainee had to be carried up the court house stairs and placed in a cell. No medical care was sought. Pulmonary tuberculosis was identified at autopsy.

Though these may be exceptional cases, their fatal outcome demands further investigation. The reasons for such lapses in care are unknown. It may represent a lack of training, insight or empathy toward the detainee. Literature has suggested that police do not identify with their role as custodians.[49]

Nevertheless, this custodial function is an important aspect of their daily duty. Detainees, deprived of their self determination, are dependent on the police for their basic well being and care.

Provision of appropriate care begins with correct identification of detainees at risk. Police members thus need to be empowered with the clinical knowledge to adequately screen and monitor detainees for signs of illness - physical and mental. Furthermore, channels of referral to medical care must be clearly established together with the resources to access it.

Currently there are no dedicated forensic medical services providing health care to detainees in South Africa. Historically, this service was provided by general practitioners who were contracted to the State and referred to as District surgeons. Following the dissolution of the District Surgeon system, medical care for SAPS detainees has fallen to the nearest health care facility. This change has importantly allowed professional independence from the police, though the lack of forensically trained medical professionals has been a significant limitation. The establishment of a clinical forensic service should be considered a long term goal in improving the medical care offered to police detainees.

4. LIMITATIONS

The findings of this study, though not necessarily applicable to all regions in South Africa, provide important insights into factors influencing deaths encountered during detention. Limitations of this study include the small geographical area studied, resulting in a small sample size. This was further confounded by the lack of accessibility to SAPS case dockets and the paucity of information for certain data parameters. A larger sample may have permitted identification of other significant factors in these deaths.

5. CONCLUSION

Death in police custody is a complex multi-factorial phenomenon with no single solution. Although each case may be unique, certain universal practical prevention

measures will allow for a reduction in these deaths. These include detention cell assessment and redesign, adherence to established SAPS Standing Orders and improved training with regard to medical management of detainees.

The police have a responsibility not only to the general population, but also to those they detain. In order to fulfil this role, members must be capacitated and supported within the SAPS, and through intersectoral collaboration with Department of Health.

Further research is required to attain a more comprehensive insight into local factors which play a role in deaths in custody. Only through ongoing research, monitoring and proactive prevention strategies can these deaths be minimised.

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APPENDIX 1:

QUESTIONNAIRE

POLICE STATION _____ **SAPS CAS No:** _____

ICD CASE No: _____ **MORTUARY WC No:** _____

DATE OF ARREST __ / __ / __ **DATE OF DEATH** __ / __ / __

TIME OF ARREST ___ h ___ **TIME OF DEATH** ___ h ___

REASON FOR ARREST _____**(CAS / /)**

DETAILS OF DECEASED

GENDER M F **POPULATION GROUP** African Asian

AGE ___ years Caucasian Coloured

MARITAL STATUS _____ **EMPLOYMENT:** _____ **EDUCATION:** _____

MEDICAL HISTORY (where available) _____

PSYCHIATRIC HISTORY (where available) _____

DRUG HISTORY (where available) _____

PREVIOUS ARREST? Y N

If so, for what offence? _____

Convicted of offence? Y N

If so, duration of incarceration: _____

DETAILS OF ARREST

AT THE TIME OF ARREST:

DID THE DECEASED APPEAR: Intoxicated / Ill

DID THE DECEASED : Resist arrest / Act aggressively

WAS THE DECEASED:

1. IN POSSESSION OF DRUGS? Y N If so what? _____
2. INJURED PRIOR TO ARREST? Y N If so how? _____
3. INJURED DURING ARREST? Y N If so how? _____
4. TAKEN FOR MEDICAL EVALUATION? Y N If so where? _____

DETAIL OF CUSTODY:

WERE ANY SPECIAL PRECAUTIONS TAKEN? Y N

If so what? _____

WERE ANY ITEMS REMOVED FROM THE INDIVIDUAL? (E.g. clothing, drugs, weapons) Y N

If so what? _____

WERE THERE OTHER DETAINEESS PRESENT IN THE CELL? Y N If YES, how many? **_____**

HOW OFTEN WAS THE DECEASED CHECKED ON? 30min 1hr 2hr 3hr Never **Last seen at:**

DURING CUSTODY, WAS HE/SHE: Abusive / Aggressive / Withdrawn / Sleepy / Other (specify)

DID HE/SHE REFUSE FOOD/DRINK? Y N

COURT APPEARANCE (due date)**: _____**

DEATH SCENE

WHERE WAS THE BODY FOUND (e.g. bed, toilet, courtyard)? _____

WAS THE DETAINEE STILL ALIVE WHEN FOUND (i.e. pulse, breathing)**?** Y N

WAS CPR ATTEMPTED? Y N

DID THE FORENSIC PATHOLOGIST ATTEND THE SCENE? Y N

IN CASES OF HANGINGS:

a. **Type of ligature** _____

b. **Ligature knot** No.: ___ Site: _____

c. **Suspension point** _____

d. **Suspension** Complete / Partial

AUTOPSY FINDINGS

MAIN FINDINGS _____

_____

_____

_____

TOXICOLOGY RESULTS

Alcohol level _____ Other drug _____

_____

CAUSE OF DEATH

NATURAL _____

HOMICIDE Shot Stab Assault Strangulation Other

SUICIDE Hang Overdose Stab Other

ACCIDENT _____

UNDETERMINED

APPENDIX 2:

ICD PERMISSIONS

independent
complaints directorate

Department:
Independent Complaints Directorate
REPUBLIC OF SOUTH AFRICA

Dr S Afonso
University of Cape Town
Cape Town

Per E-Mail: steven.afonso@uct.ac.za

Date: 23 May 2011

RE: RESEARCH REQUEST: YOURSELF

The above matter refers.

You (Dr Steven Afonso) are hereby granted permission to access ICD files for purposes of research.

You are requested not to disclose any information to any person(s) without my written authority to do so.

Kind regards

_____*Signed*____
o.b.o. MR F BEUKMAN
EXECUTIVE DIRECTOR

Maureen Smit
Assistant Manager
Independent Complaints Directorate
Private Bag X 941, Pretoria, 0001
City Forum Building, 114 Vermeulen Street, Pretoria, 0002
Tel: (012) 399 0026
Fax: (012) 399 0144
F2E: 086 630 1033
Cell: 082 781 7106
E-Mail: msmit@icd.gov.za

APPENDIX 3:

HREC ETHICS APPROVAL

UNIVERSITY OF CAPE TOWN

FACULTY OF HEALTH SCIENCES
Human Research Ethics Committee

FHS016: Annual Progress Report / Renewal

HREC office use only (FWA00001637; IRB00001938) This serves as notification of annual approval, including any documentation described below.			
☑ Approved	Annual progress report / Approved until next renewal date	30 | 06 | 2016	
☐ Not approved	See attached comments		
Signature Chairperson of the HREC	pp TUBurgess	Date Signed	14 | 06 | 2015

Comments to PI from the HREC

RESEARCH ETHICS COMMITTEE
2015 -06- 12
HEALTH SCIENCES FACULTY
UNIVERSITY OF CAPE TOWN

Principal Investigator to complete the following:

1. Protocol information

Date (when submitting this form)	12 June 2015		
HREC REF Number	444/2010	Current Ethics Approval was granted until	
Protocol title	Identifying Trends and Risk Factors for Death in Police Custody in the Cape Metropole: 2000 to 2009		
Protocol number (if applicable)			
Are there any sub-studies linked to this study?	☐ Yes ✓ No		
If yes, could you please provide the HREC Ref's for all sub-studies? Note: A separate FHS018 must be submitted for each sub-study.			
Principal Investigator	Dr E. B Afonso		
Department / Office Internal Mail Address	Division of Forensic Medicine, Entrance 3 Falmouth Building, Health Sciences		

1.1 Does this protocol receive US Federal funding?	☐ Yes	✓ No
1.2 If the study receives US Federal Funding, does the annual report require full committee approval?	☐ Yes	☐ No
1.3 Has sponsorship of this study changed? If yes, please attach a revised summary of the budget	☐ Yes	✓ No

(Note: Please complete the Closure form (FHS010) if the study is completed within the approval period)

APPENDIX 4:

AUTHOR INFORMATION - JOURNAL OF FORENSIC AND LEGAL MEDICINE

JOURNAL OF FORENSIC AND LEGAL MEDICINE

AUTHOR INFORMATION PACK

PREPARATION

Subdivision - unnumbered sections

Divide your article into clearly defined sections. Each subsection is given a brief heading. Each heading should appear on its own separate line. Subsections should be used as much as possible when crossreferencing text: refer to the subsection by heading as opposed to simply 'the text'.

Headings for experimental papers should follow the usual conventions: Introduction, Methods, Results, Discussion, Acknowledgments.

Other papers may be subdivided as the authors desire. The use of headings enhances readability.

Essential title page information

- ***Title.*** Concise and informative. Titles are often used in information-retrieval systems. Avoid abbreviations and formulae where possible.
- ***Author names and affiliations.*** Please clearly indicate the given name(s) and family name(s) of each author and check that all names are accurately spelled. Present the authors' affiliation addresses (where the actual work was done) below the names. Indicate all affiliations with a lowercase superscript letter immediately after the author's name and in front of the appropriate address.
  Provide the full postal address of each affiliation, including the country name and, if available, the e-mail address of each author.
- ***Corresponding author.*** Clearly indicate who will handle correspondence at all stages of refereeing and publication, also post-publication. **Ensure that the e-mail address is given and that contact details are kept up to date by the corresponding author.**
- ***Present/permanent address.*** If an author has moved since the work described in the article was done, or was visiting at the time, a 'Present address' (or 'Permanent address') may be indicated as a footnote to that author's name. The address at which the author actually did the work must be retained as the main, affiliation address. Superscript Arabic numerals are used for such footnotes.

Abstract

A concise and factual abstract is required. The abstract should state briefly the purpose of the research, the principal results and major conclusions. An abstract is often presented separately from the article, so it must be able to stand alone. For this reason, References should be avoided, but if essential, then cite the author(s) and year(s). Also, non-standard or uncommon abbreviations should
be avoided, but if essential they must be defined at their first mention in the abstract itself.

Graphical abstract

Although a graphical abstract is optional, its use is encouraged as it draws more attention to the online article. The graphical abstract should summarize the contents of the article in a

concise, pictorial form designed to capture the attention of a wide readership. Graphical abstracts should be submitted as a separate file in the online submission system. Image size: Please provide an image with a minimum 531 × 1328 pixels (h × w) or proportionally more. The image should be readable at a size of 5 × 13 cm using a regular screen resolution of 96 dpi. Preferred file types: TIFF, EPS, PDF or MS Office files. See http://www.elsevier.com/graphicalabstracts for examples.
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Avoid abbreviations in the title and abstract. All unusual abbreviations should be fully explained at their first occurrence in the text.

Acknowledgements
Collate acknowledgements in a separate section at the end of the article before the references and do not, therefore, include them on the title page, as a footnote to the title or otherwise. List here those individuals who provided help during the research (e.g., providing language help, writing assistance or proof reading the article, etc.).

Nomenclature and units
Proprietary names of drugs, instruments etc. should be indicated by the use of initial capital letters.
All measurements should be expressed in SI or SI-derived units.

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