**Response to the Independent Review of Deaths and Serious Incidents in Police Custody call for submissions**

**Responding Organisation/Individual:** …………………………………………………

…………………………………………………………………………………………………

**Which of the following best describes you, your organisation or professional interest? Please select one option:**

a. Bereaved family/affected individual

b. Police force

c. Police and Crime Commissioner (PCC)

d. Voluntary sector / community organisation

e. Government department or agency

f. Academic institution or think tank

g. Representative body

h. None – I am responding as a member of the public

i. Prefer not to say

j. Other (please specify) ……………………………………………………………………

**In which of the following areas are you based? Please select one option:**

a. East Midlands

b. East of England

c. Greater London

d. North East England

e. North West England

f. South East England

g. South West England

h. Wales

i. West Midlands

j. Yorkshire and the Humber

k. Prefer not to say

l. Other (please specify) ……………………………………………………………………

**Consultation Questions:** (Please note the boxes will expand as you type in them)

**You do not have to answer every question.**

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| **1.** **In what ways could the risk of death/serious incidents in police custody be avoided?** |
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| **2.** **What actions could be taken by the police to avoid or reduce the risk of death/serious incidents following or as a result of police use of force, with particular reference to the use of restraint?** |
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| **3.** **What actions could be taken by the Police and other organisations to reduce the risk of self-inflicted deaths within 48 hours of police custody?** |
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| **4. To what extent is mental health a factor and how do you think this should be addressed?** |
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| **5. To what extent is ethnicity a factor, why, and how do you think this should be addressed?** |
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| **6. To what extent are drugs/alcohol a factor and how do you think this should be addressed?** |
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| **7.** **What specific considerations should be given to children and young people in custody to reduce risk of death/serious harm?** |
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| **8. Are there any other issues that affect other vulnerable groups?** |
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| **9. Do you have any suggestions on how the police and other agencies could improve the ways in which they work together so as to prevent or reduce the risk of deaths and serious incidents? For example, medical services within the police station, the ambulance service, mental health detention services, mental health community services, drug and alcohol support services.** |
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| **10. Official investigations into deaths, from immediate aftermath to final conclusions, sometimes fall short of families’ needs and expectations. If so why do you think this is, with particular reference to:**1. **Family liaison**
2. **Police statements in the media**
3. **IPCC investigations**
4. **Role of the Crown Prosecution Service and the criminal justice process**
5. **Coroners’ inquests**
6. **Police misconduct and disciplinary process**
7. **Investigations by NHS Trusts or other medical healthcare providers**
8. **Role of the Health and Safety Executive**
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| **11. In what ways could family experience, involvement and support be improved at all stages after a death has occurred?** |
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| **12. If someone you know has died in such circumstances or if you have had an experience in police custody that resulted in, or could have resulted in, serious illness, injury or self-harm please set out what happened at each stage of the incident. What went wrong and what could have been done differently?** |
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| **13. What could be done to improve accountability on the part of the police in relation to deaths and serious incident in police custody?** |
|  |
| **14. What could be done to improve sustained learning from deaths and serious incident in police custody?** |
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| **15. How can there be more effective implementation of learning and recommendations arising from investigations and inquests into deaths?** |
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| **16. We need to learn where things have gone wrong, but we can also learn from things that have worked well. Do you have any examples of good practice which has lead to positive outcomes? This could be in preventing a death or serious incident, the family involvement in the investigation and/or its outcome?** |
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| **17. Are there any other comments you would like to make?** |
|  |

Please submit your response using the [online survey](http://www.homeofficesurveys.homeoffice.gov.uk/s/GJECV/).

Alternatively you can answer the questions using this form, and send your response to the following e-mail address:

DeathsInCustody.IndependentReview@homeoffice.gsi.gov.uk

Or you can send it by post to:

Independent Review

c/o 6th Floor NW, Fry Building

Home Office

2 Marsham Street

LONDON

SW1P 4DF

Responses must be received by 6 May 2016; we cannot undertake to consider any responses received after that date.