Our Ref: [redacted]

Your Ref:

Date: 12th December 2016

[redacted]
Office of the Senior Coroner
21 Grammer School Lane
Northallerton
DL6 1DF

Dear Mr Heath

Re: Samuel Thomas Linford Carroll (deceased)
Response under Regulation 29 Notice to Prevent Future Deaths - Samuel Carroll

Thank you for affording me the opportunity to respond to your concerns raised within the above notice relating to the tragic death of Samuel Carroll. North Yorkshire Police is committed to improving the way we respond to people experiencing mental distress and recognises the importance of capitalising on every opportunity to prevent suicide. Indeed, the organisation has championed the aim of establishing a Suicide-Safer and Mental Health Friendly City and County, in partnership with the Directors of Public Health for York and North Yorkshire, which was launched on 28th October 2016.

Your report contains three matters of concern; namely that:

1. *"Police officers did not ask Mr Carroll whether he wished, or consented to, anyone being told of the fact that he was feeling suicidal or that he was being taken to the Hospital."*
2. [Refers to Yorkshire Ambulance Service]
3. *"As a consequence no family or friends were alerted to Mr Carroll being taken to or discharged from Hospital following an earlier expression of suicidal ideation."*

As you have noted, officers did not make contact with friends or relatives before Mr Carroll was taken by ambulance to hospital. Given his apparent possession of mental capacity, his adulthood and the handover to other professionals for his onward care, there has previously been no expectation that officers would make such intimations.

The report produced by Bradford District Care Trust (BDCT), following their Serious Incident Investigation into Mr Carroll's death, notes that in a meeting on 26th July 2016, Mr Carroll's family observed that they were unaware of his attendance at the hospital's Emergency Department on the day of his death. It is clear from the evidence presented at inquest that Mr Carroll spoke to his partner, [redacted], whilst at hospital and again upon discharge. There is also mention that he may have spoken to his brother Steven whilst at hospital, but there is no witness testimony from him to corroborate

that. Indeed, following his discharge from hospital, Mr Carroll had extensive contact with family members and his GP, with evidence of forward-planning for the following day, before going on to take his own life. His reasons for confiding in his partner but not his family may never be known.

Current Guidance

To this juncture, existing guidance to our staff revolves around the determinations established in case of *Webley vs. (1) The Commissioner of the Metropolis and (2) St. George's Hospital Trust (2014)*, which focuses on the police "duty of care" to:

1. Take reasonable steps to ensure that a person does not come to physical harm while in police custody;
2. Take reasonable care to release the person into a safe environment; and
3. To provide relevant information to those into whose care a person was transferred.

To that end, all existing training and policies pivots around these core determinations.

Future Guidance and Training

Since Mr Carroll's death, North Yorkshire Police has commenced a pioneering Mental Health Awareness training programme for officers, which has been developed in collaboration with the College of Policing, University of York, Tees, Esk and Wear Valleys NHS Trust (TEWV) and people who have experienced significant mental health issues. This face-to-face training, which commenced on 18th May 2016 and was delivered by mental health professionals from TEWV to the first tranche of around 200 operational officers and staff, is to be subject of evaluation by means of randomised control trial. Once evaluated, it is anticipated that this will be rolled-out to all public-facing NYP staff. It is expected that the evaluation of the training programme will be completed by March 2017 and once approved by the College of Policing, it will be rolled-out across the remaining staff throughout 2017/2018. It is worthy of note that the training includes a video scenario revolving around a suicidal person in the hospital Emergency Department and the expectations upon our staff to take positive steps to secure their safety (in line with *Webley* above).

In light of your report, I will make sure that this training includes instruction to staff to make sure that steps are taken to elicit consent to inform a nominated person of their location and the concerns for their mental wellbeing. This must be balanced against considerations of whether that nominated person may potentially exacerbate the situation, given that feelings of suicidality often emanate from relationship / familial difficulties.

The investigation by BDCT also made observation that NYP staff could have contacted the First Response Service operated by the Trust to accelerate the process of mental state assessment. Again, prior to receipt of your Regulation 28 Notice, the availability and functionality of the First Response Service was reiterated to staff in the Craven District. However, I will ensure that this valuable service is again communicated to our staff.

On 10th October 2016, the College of Policing launched Authorised Professional Practice (APP) in respect of mental health and suicidality. The document includes the salient advice:

> *"Officers should avoid leaving a potentially suicidal individual alone based on their promise to visit their mental health worker or the hospital, and should seek to ensure that family members or significant others are on the scene and accept responsibility for help-seeking."*

This APP has been made available to NYP staff and will form the basis of an NYP Mental Health and Suicidal People Policy, which is expected to be published in April 2017.

Conclusions

In conclusion, the following summarises the actions to be taken and the expected delivery times:

1. Mental Health Awareness training programme - delivered to 200 front-line officer in May 2016 and to be delivered to the remaining staff throughout 2017/18;

2. Above training to include instruction to staff to attempt to elicit consent to inform a nominated person of their location and the concerns for their mental wellbeing;

3. To re-iterate to staff the availability and the role of First Response Service – now;

4. North Yorkshire Police's Mental Health and Suicidal People Policy to be amended to reflect the College of Policing's Authorised Professional Practice (APP) in respect of mental health and suicidality – by April 2017.

I trust that this response complies with your requirements. However, please do not hesitate to contact me if you require any further information.

Yours sincerely,

Dave Jones
Chief Constable
North Yorkshire Police