Yorkshire Ambulance Service NHS
NHS Trust

PRIVATE & CONFIDENTIAL

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Date: 21.12.16

Dear Sir,

Inquest touching the death of Samuel Thomas Linford Carroll (deceased)

Response to Regulation 28 Report to Prevent Future Deaths dated 27 October 2016

Thank you for your report dated 27 October 2016, issued under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 in relation to the above inquest that was heard before you on 6 October 2016.

I am aware that two statements were provided from both the Yorkshire Ambulance Service (YAS) Paramedic and Emergency Medical Technician who attended Mr Carroll on 6 May 2015. These were admitted in to evidence under Rule 23 of the Coroners and Justice Act and were read out at the inquest. YAS were not informed at any point that the inquest was being held, were not designated as an Interested Person for the purposes of the inquest and were not asked to attend to give evidence at the hearing.

I would have welcomed the opportunity for YAS to respond to the concern you raise, either during the inquest or in the following 21 days between the conclusion of the inquest and the production of your report. Your concern was as follows:

The ambulance service did not ask Mr Carroll whether he wished, or consented to, anyone being told of the fact he was feeling suicidal and being taken to hospital.

As a consequence, no family or friends were alerted to Mr Carroll being taken to or discharged from Hospital following and earlier expression of suicidal ideation.

Having reviewed the statements and documents from the attending YAS clinicians, Mr Carroll was reporting suicidal ideations, was a consenting adult and was taken to a hospital Emergency Department, as a place of safety. They further report that Mr Caroll was on his mobile phone throughout the journey and they believed that he was in contact with his brother. Given that this is all the information that was available to you from YAS, it is difficult to understand the evidential basis for your concern, and as this was not

explored further during the inquest with any representatives from YAS, it is unclear as to the detail of the actions and conversations which took place between the attending crew and Mr Carroll prior to his arrival at hospital.

Having discussed this matter with a number of colleagues and managers from both the Clinical and Operations Directorates within the Trust, I can confirm that whilst not formalised in any written process, it is standard practice amongst clinicians as part of any welfare assessment of the patient to ask if there is any family member that can be contacted.

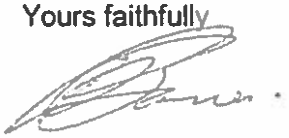
If a decision is made to convey a patient such as Mr Carroll to a hospital or other appropriate place of care, there are commonly discussions had with the patient as to whether a family member can be contacted. The next of kin contact details are recorded on the Patient Care Record (PCR) whenever these can be obtained and this is then handed over to the receiving hospital or healthcare organisation on arrival, along with the duty of care to the patient. It would be expected that a longer term management plan is then put in place by the hospital for the patient prior to discharge which would include making contact with the patient's relatives where appropriate. Given the acute nature of the ambulance function, the short period of time that is spent with patients, and the requirement under the duty of care to ensure the patient is conveyed to an appropriate facility and/or care handed over, I do not feel that under these circumstances that making contact with the family is the primary responsibility of YAS.

If, however, on assessment, it is not appropriate to convey the patient, a referral to a more appropriate service (ie GP, mental health service etc) will always be made, and it is standard practice for the patient to be asked if there is any-one who they would like us to contact, whether that be a family member or other, and in these circumstances it would be expected as standard practice for this to be done by either the attending clinicians or another member of YAS personnel.

I hope that my response provides you with reassurance that all appropriate mechanisms and processes are in place within YAS that relate to your concern, and that ensuring all patients receive the highest quality of care remains of utmost priority to the Trust.

If I can be of any further assistance, or you require any further information in relation to the contents of this letter please do not hesitate to contact me.

Yours faithfully



Rod Barnes
Chief Executive Officer
Yorkshire Ambulance Service NHS Trust