Jon Heath
Assistant Coroner for Western Area of North Yorkshire

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO:** North Yorkshire Police Yorkshire Ambulance Service NHS Trust Armstrong Luty Solicitors
1	**CORONER** I am Jon Heath, Assistant Coroner for Western Area of North Yorkshire
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** On 6th May 2016 an Investigation was commenced into the death into the death of Samuel Thomas Linford Carroll, aged 20. The investigation concluded at the end of the Inquest on 6th October 2016. The conclusion of the Inquest being that on 5th May 2016, Samuel Carroll, took his own life and intended to do so. Mr Carroll had contacted the emergency services on the morning of the 5th May 2016 stating he was suicidal and wanting to jump off a bridge. Police And ambulance attended and Mr Carroll was taken to Airedale General Hospital. After a consultation with a Mental Health Liaison Nurse, Mr Carroll was discharged that same morning. Mr Carroll was found later that same day hanging from a tree. Life extinct was confirmed by attending paramedics and the cause of death was asphyxia due to or as a consequence of hanging by ligature. There were no suspicious circumstances.
4	**CIRCUMSTANCES OF THE DEATH** On 4th May 2016, Mr Carroll and his partner had argued at home. The following morning, 5th May 2016, Mr Carroll left the house. He later received a text from his partner requesting that he move out. Mr Carroll called 111 stating he felt suicidal and was wanting to jump off a bridge. Police officers and an ambulance crew attended on Mr Carroll. He agreed to a further assessment and was taken by ambulance to Airedale General Hospital. Mr Carroll was seen by a Mental Health Liaison Nurse and agreed to an assessment of his mental health. That assessment concluded with the impression that Mr Carroll was suffering from low mood. A referral was made that day for counselling and he agreed to make an appointment with his GP as the assessment from hospital together with any clinical recommendations would be sent to his GP that day. He was given contact details for the First Response Team. Mr Carroll was discharged. He attempted to see his preferred GP that day but as his preferred GP was not available he made an appointment to see the GP at 5.30pm the following day (6th May 2016). At 5.30pm on 5th May 2016, Mr Carroll was found hanging from a fallen tree by dog walkers. There were no suspicious circumstances or any suggestion of any third party involvement. Death was due to Asphyxia due to Hanging by ligature.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths will occur unless action is taken. In the circumstances it is my statutory duty to report to you.

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	The **MATTERS OF CONCERN** are as follows. – 1. The Police Officers did not ask Mr Carroll whether he wished, or consented to, anyone being told of the fact he was feeling suicidal or that he was being taken to the Hospital. 2. The Ambulance service did not ask Mr Carroll if he wished, or consented to, anyone being told of the fact he was feeling suicidal and being taken to Hospital. 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.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely by 23 December 2016. I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: Mrs Tracey Carroll. I am also under a duty to send the Chief Coroner a copy of your response. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response by the Chief Coroner.
9	Dated 27 October 2016

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