Paul Bennett
Uwch Grwner dros dro ar gyfer Sir Benfro a Sir Gar
Acting Senior Coroner for Pembrokeshire and Carmarthenshire

Our Ref: 116559

Date: 12 July 2022

All correspondence should be addressed to the Coroner and Emails sent to:-
[redacted]

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO: Hywel Dda University Health Board

CORONER

1 I am Paul Jonathan Bennett the Acting Senior Coroner for Pembrokeshire and Carmarthenshire

CORONER'S LEGAL POWERS

2 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.

http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7

http://www.legislation.gov.uk/uksi/2013/1629/part/7/made

INVESTIGATION and INQUEST

On 29 March 2019 I commenced an investigation into the death of Kieran Joseph Kevan CRIMMINS. The investigation concluded at the end of the inquest . The conclusion of the inquest was Suicide.

3 1a Hanging

1b

1c

II

CIRCUMSTANCES OF THE DEATH

I found that Kieran Joseph Kevan Crimmins took his own life and intended to do so in circumstances where ongoing psychiatric monitoring and support would have been
4 appropriate. A decision was taken not to refer to the Community Mental Health Team for ongoing monitoring of his mental health and care co-ordination following his discharge from the Crisis and Home Treatment Team on the 5th March 2019 due to the fact that he was receiving support from the Dyfed Drug and Alcohol Service and the Independent Psychological Therapy Service.

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.

The **MATTERS OF CONCERN** are as follows. –

(1) I was told that the Crisis Recovery and Home Treatment Team ("CRHT") use the Care Partner records, a whiteboard and a manual diary to enter the various information and action points and that it is at the Multidisciplinary Team meetings that the actions or steps are discussed and progressed. They are either crossed out, if completed, or moved to the next date until they have been actioned. It was highlighted that in this particular case two actions were not completed either prior to Kieran's discharge from the CRHT or shortly thereafter. In one of these, the entry had been crossed out, giving the impression that the matter had, in fact been dealt with when it had not. This indicated that there was an issue as to the monitoring and execution of such actions or steps.

5 This anomaly whereby a significant step may have been overlooked remains a concern.

(2) The evidence I heard from one witness described how she was asked to contact Kieran by telephone and to advise him of the fact that a Multi-agency Referral Form ("MARF") was to be submitted. I considered this was an inappropriate means of communicating a significant procedure and which could potentially bear on his (or any other vulnerable person's) state of mind.

What was unclear is how the provision of this information and step to be taken will be approached in future.

(3) I expressed concern that someone having been discharged from the CRHT, there appeared to be no route back into the Mental Health Service short of a re-referral to the CRHT itself via A & E for someone who remains vulnerable by reason of their mental state and who is receiving therapy as part of the discharge plan. This is in the context of someone who was receiving support from the Integrated Psychology Therapy Service ("IPTS") and the Dyfed Drug and Alcohol Service ("DDAS"), both of whom were engaged in providing appropriate therapies.

My concern is that there appears to be an issue in relation to lines of communication and information sharing between Primary Mental Health Services and Tier 2 providers of therapy.

ACTION SHOULD BE TAKEN

6 In my opinion action should be taken to prevent future deaths and I believe you Hywel Dda University Health Board have the power to take such action.

YOUR RESPONSE

7 You are under a duty to respond to this report within 56 days of the date of this report,

namely by 9th September 2022. 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.

COPIES and PUBLICATION

I have sent a copy of my report to the Chief Coroner and to the following Interested Persons: [redacted]; Dyfed Drug & Alcohol Service.

8 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.

14 July 2022

9 Signature 

Paul Jonathan Bennett

Acting Senior Coroner

[redacted]
Pembrokeshire County Council / *Cyngor Sir Benfro*
NW0C
County Hall / *Neuadd y Sir*
Haverfordwest / *Hwlffordd*
SA61 1TP