Mark Andrew Beresford
Assistant Coroner for South Yorkshire (East District)

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS **THIS REPORT IS BEING SENT TO: Mr Rod Barnes, The Chief Executive** Yorkshire Ambulance Service, Springhill 2, Wakefield 41 Business Park, Brindley Way, Wakefield WF2 0XQ
1	**CORONER** I am Mark Andrew Beresford, Assistant Coroner for South Yorkshire (East District)
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. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On 05/06/2017 I commenced an investigation into the death of Christopher Cyril Kiernan, 52 . The investigation concluded at the end of the inquest on 10 October 2017. The conclusion of the inquest was Suicide. The cause of death was: 1(a) Suspension by ligature.
4	**CIRCUMSTANCES OF THE DEATH** Mr Kiernan, who lived with his wife of 30 years, had a history of mental health issues. He had suffered from periods of depression. He had a habit of drinking alcohol. He also had some history of cannabis use. Indeed, metabolites of cannabis were found in his pre – mortem blood sample. Intoxicants tended to have a negative impact upon his mood. Mr Kiernan had had involvement with the local mental health services (RDaSH). He expressed, to his family, the view that he felt that no one was listening to him. He had expressed suicidal ideation to mental health practitioners but not recently to his family. Mr Kiernan's mood was said to have worsened during the week or so prior to his death. He had become very withdrawn. On the evening of Saturday 3rd June Mr Kiernan made an emergency call but then aborted the call without providing any information. In accordance with standard practice, the matter was forwarded to an emergency call handler who, at 22:19, succeeded in contacting and speaking to Mr Kiernan. The call handler found it very difficult to obtain information from Mr Kiernan. He was uncooperative and appeared to be intoxicated. However, he did make a threat to harm himself. The emergency call handler graded the call as "immediate" to ensure the prompt despatch of resources. Police officers arrived at Mr Kiernan's home at around 22:30. They found that both Mr and [redacted] Kiernan were present. [redacted] was unaware that her husband had been in contact with the emergency services. She directed the Officers to Mr Kiernan's bedroom. The Officers found Mr Kiernan holding a small hand axe. The officers instructed Mr Kiernan to put the axe on the floor. After several seconds he complied with the request and apologised saying that he did not know who was about to enter his bedroom. Mr Kiernan was slurring his words when he spoke to the officers. He smelled of alcohol and they formed the opinion that he was intoxicated. He told the officers that he was finding it hard to cope and that he was not getting any help regarding his issues. After several minutes, Mr Kiernan's daughter arrived and began to console her father. Mr Kiernan summarised some

background family issues that were causing him distress. Initially, he told the Officers that he felt like dying, due to these issues, but, after he had spoken to them for a while, Mr Kiernan stated that he needed help and wanted to speak to someone. He refused to attend hospital for assistance but did agree to speak to a mental health worker over the telephone.

The Officers spoke to Mr Kiernan's family members who agreed to look after Mr Kiernan. They left the property at about 23:00 hrs. They informed their force control that the ambulance that was en route should be cancelled but that they should arrange for "the mental health triage" to speak to Mr Kiernan that night by telephone.

The emergency call handler's service desk contacted the YAS triage nurse at 23:03. They did not contact the crisis team.

At 23:12 the YAS triage nurse telephoned Mr Kiernan's number. He /she spoke to Mr Kiernan's daughter who informed him/her that the police had left. It appears that Mr Kiernan was too intoxicated and/or agitated to speak to the triage nurse. The triage nurse left, with Mr Kiernan's daughter, the telephone number for the RDaSH crisis team. He/she did not speak to Mr Kiernan direct.

Mr Kiernan's daughter then left her parents' home in order to return to her own home. She left the crisis team telephone number with her parents.

On 5 separate occasions, between 00:14 and 01:39 on the early morning of Sunday 4th June 2017, Mr Kiernan, unbeknown to his wife, called the emergency services and spoke to emergency call handlers. During the conversations that took place, Mr Kiernan was generally abrasive in manner and difficult to understand. He indicated, on more than one occasion that he was awaiting the call from the crisis team. Notwithstanding a note that had been logged on their PROCAD system, the emergency call handlers appear to have assumed that the crisis team were going to contact Mr Kiernan and they advised him to clear the line so that he could receive any incoming call. Throughout this process, however, the crisis team had received no notification at all regarding Mr Kiernan.

The PROCAD note referred to above read as follows:-

> "mental health nurse has made contact and made arrangements for the daughter to contact appropriate resources at patient's request. No further requirement for AMB. Thanks".

At around 06:45 on Sunday 4th June 2017, a despatcher noted that the incident relating to Mr Kiernan was still open. He contacted one of the officers who had attended the previous evening. That officer telephoned the home and spoke to Mrs Kiernan who assured him that her husband was asleep in bed.

At about 11:00 that morning Mr Kiernan left the family home. Shortly afterwards he was found in an area of nearby woodland hanging from a tree.

There was no direct contact between the mental health triage nurse and the crisis team at RDaSH. Accordingly, since the police officers and their force's service desk appear to have assumed that Mr Kiernan's crisis needs were being met, the RDaSH crisis team were not contacted by them. The YAS witness who gave evidence at the Inquest accepted that there appeared to be a general misunderstanding as to the role being played by the triage nurse. She stated that, had the officers being present when the triage nurse made contact, the triage nurse would/should have informed the officers that the YAS mental health service is not a crisis one. The YAS witness also said that, although the crisis team contact number was left with the daughter, there was a means by which the YAS Triage nurse could/should have contacted the RDaSH crisis team direct. The YAS witness also accepted that the circumstances in which the direct communication pathway between the YAS triage nurse and the RDaSH crisis team should be subject to consideration.

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. The **MATTER OF CONCERN** is as follows. – The ineffectiveness of the pathway for communicating information direct to the RDaSH Crisis Team.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you The Chief Executive has 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 **Tuesday 5th December 2017**. 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: [redacted] and [redacted] of Messrs Browne Jacobson. 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 10th October 2017 Signature Assistant Coroner for South Yorkshire (East District)

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