REGULATION 28 REPORT TO PREVENT FUTURE DEATHS

THIS REPORT IS BEING SENT TO:

1. [redacted], **Counsellor**
2. **The Senior Partner, Rope Green Medical Centre, Shavington, Crewe**

1 **CORONER**

I am Peter Sigee, assistant coroner, for the coroner area of Cheshire.

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 4th September 2018 the Senior Coroner for Cheshire commenced an investigation into the death of Mr Sam Spooner, aged 20 years. The investigation concluded at the end of the inquest when I determined that Mr Spooner took his own life by suicide, suffocating himself by plastic bag and helium.

4 **CIRCUMSTANCES OF THE DEATH**

Mr Sam Spooner died at Leighton Hospital on 31st August 2018, aged 20 years.

Mr Spooner had last been seen alive at his home address at approximately 6:30pm on 31st August 2018 and he had last spoken to a family member by telephone at approximately 6:40pm on 31st August 2018. Mr Spooner was found unresponsive in his bedroom having suffocated himself with the intention of ending his life at approximately 8:00pm on 31st August 2018. Mr Spooner was taken to hospital by ambulance on an emergency basis with ongoing resuscitation efforts but these were unsuccessful.

Mr Spooner had a known history of mental health issues dating back to at least December 2016 with previous concerns that he was at risk of suicide. Urgent mental health referrals were made by Mr Spooner's GP on 21st May 2018 and on 20th August 2018 following reports of active suicidal thoughts.

On 30th August 2018 Mr Spooner attended a counselling session with a private counsellor and reported that: (1) he wanted to end his life; (2) he had attempted to do so on 26th August 2018; and (3) since then he had carried out further research and made further preparations to enable him to take his own life.

Mr Spooner's family and GP were informed of this conversation by the counsellor but no adequate plans were put in place by the health care providers for Mr Spooner's safety and the police were not contacted to inform them of the concerns for Mr Spooner's mental health and of the real and immediate risk identified to Mr Spooner's life.

There were missed opportunities to provide additional care and support to Mr Spooner when he was known to be at real and immediate risk of suicide; it was not possible to determine whether this additional care and support would have prevented Mr Spooner's death.

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 could 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) There was a lack of multi-agency information sharing, co-operation, co-ordination and effective communication both within and between health care providers which meant that:

   a) The private counsellor who provided treatment to Mr Spooner did not have adequate information from other health care providers as to his medical/mental health history, diagnosis and treatment by other healthcare professionals.

   b) There was a failure to adopt an effective multi-agency approach to the care for Mr Spooner from 20th August 2018 when it was known that he was actively considering ending his life.

   c) There was a failure to adequately intervene from 30th August 2018 when it was known that: (1) Mr Spooner had recently attempted to take his life; and (2) Mr Spooner had subsequently undertaken additional research and made further preparations to enable him to do so.

2) There was an excessive and unreasonable reliance placed upon Mr Spooner's family by health care providers to keep him safe when those providers knew that Mr Spooner's family were not in a position to do so. Health care providers lacked awareness of and/or failed to adequately involve other agencies who may have been able to keep Mr Spooner safe, for example the police who may have been able to exercise their powers under section 136 of the Mental Health Act 1983 to take Mr Spooner to a place of safety.

6 **ACTION SHOULD BE TAKEN**

In my opinion action should be taken to prevent future deaths and I believe you and/or your organisation 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 3rd January 2020. 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 Mr Spooner's family. I have also sent it to the Cheshire & Wirral Partnership NHS Foundation Trust, the Royal College of General Practitioners and the British Association for Counselling and Psychotherapy who may find it useful or of interest.

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.

8th November 2019