Findings and Conclusion

A. INTRODUCTION

1. This has been the inquest into the death of Locket Ure Williams. In this document I will refer to Locket Williams as "Locket", and I will use the pronouns "they/them", as we have done in the course of the inquest, as this was Locket's preference.

2. The Interested Persons ("IPs") in this inquest are :

   a. Stephen Ure Williams and Hazel Ure Williams (Locket's parents), and Emily Ure Buckley (Locket's siter), all represented by Rabah Kherbane of counsel and Rachael Gourley of counsel,
   b. Surrey and Borders Partnership NHS Foundation Trust, represented by Simon Turner of Clyde & Co, Solicitors, and
   c. Surrey County Council, represented by Jack Murphy of counsel.

3. At the pre-inquest stage, I ruled that Article 2 of the European Convention on Human Rights is engaged in this inquest and that the procedural obligation arising under Article 2 must be satisfied. Consequently, the purpose of this inquest is as laid out in section 5 (1) and (2) of the Coroners and Justice Act 2009, which provides that I must ascertain who the deceased person was and when, where and how (meaning by what means and in what circumstances) they came by their death. It was agreed that the scope of the inquest should include investigation of the following specific matters:

   (i) Locket's medical history, including their mental health,
   (ii) Locket's history of threatened or actual self-harm / suicidal ideation and/or acts and the consequential risk, and the extent to which relevant state agencies were aware of the same,
   (iii) The extent to which Locket's needs and risk of self-harm or suicide were recognised, monitored and met by relevant

agencies including Surrey County Council and Surrey and Borders Partnership NHS Foundation Trust (acting individually and/or in the context of multi-agency processes),

(iv) Item (iii) above to include the adequacy of any risk assessments conducted and the timeliness of any interventions, treatments, or services made available to Locket,

(v) What medications were prescribed to and taken by Locket and when, and the effect of any such medications,

(vi) The circumstances in which Locket's death came about, that is the events which occurred on the 28th September 2021, including Locket's actions, intentions, and state of mind,

(vii) The medical cause of death, and

(viii) Any prevention of future deaths issues arising.

4. In order to investigate these issues, I have received and admitted oral and written evidence from witnesses and documentary evidence. In this document, I make reference to some of the evidence I have heard but it is not intended to be, and is not, a comprehensive review of all the evidence before me. Rather, my intention is to explain, by reference to parts only of the evidence, why I have reached my findings of fact and conclusions. However, in reaching my findings and conclusions, I have taken account of all the evidence I received, both oral, written and documentary. If a piece of evidence is not expressly mentioned, it does not mean that I have not considered and taken full account of it.

5. Set out below are my findings and conclusions. All my findings have been reached on the balance of probabilities. Unless stated otherwise, I found the witnesses from whom I heard oral evidence to be truthful and doing their best to assist me. Therefore, my review of the evidence which is set out below can be taken as my findings as to what probably happened, even if I have not stated expressly that I have accepted the evidence and found the facts accordingly.

B. REVIEW OF THE EVIDENCE AND FINDINGS OF FACT

Background

6. I received evidence from Locket's parents, **Stephen and Hazel Williams**, and their sister, **Emily Buckley**. Their evidence paid tribute to Locket, with Mrs Williams describing her daughter as a lovely person with a huge character and a massive heart and brain. Emily Buckley said Locket

was bright, clever, articulate, and creative with a love of singing, dancing, and acting.

7. I was told that Locket was born on the 25th April 2006 and was named Lucy, but preferred to be addressed as Locket and by non-binary pronouns; they were also known as "*Seven*" by their friends. Mr and Mrs Williams had three children, with Emily being the eldest and Locket the youngest. In between was their son, Alex, who is severely autistic. In her statement, which was read, Emily Buckley said that Alex's behaviour was very challenging and meeting his needs dominated the household and impacted negatively on her parents' behaviour and the atmosphere in the family home. She said that the family became isolated and, she thought, the situation caused Locket to withdraw and become tearful and anxious. She said that when Locket started at secondary school, her mental health declined and they were "*always in tears about not doing well enough*". Emily, who was ten years older than Locket, left home and was married, but remained close to Locket. She said Locket's mental health declined further through lockdown, culminating in an overdose in February 2021. Emily said that, at this time, Locket reported not feeling safe at home and so they went to live with Emily and her husband when they were discharged from hospital. Emily described the strain of remaining on active "*suicide watch*" over the following weeks whilst they waiting for support from the Children and Adolescent Mental Health Service ("CAMHS") Crisis Team. The witness said that Locket later returned to live at home with their parents. She said that Locket told her that they would often say they were "*fine*" to avoid having to talk about their problems.

8. The family told me that, subsequently, there were three further incidents; Locket took a further overdose in June 2021, and considered jumping from a road bridge in July 2021, and they were admitted to hospital on both occasions. On the 28th September 2021, Locket did jump from a road bridge and that resulted in their death. Hazel Williams described the difficulties the family faced in trying to keep Locket safe through these months, especially as their mood was very changeable. Mrs Williams considered that the family received tireless support from their allocated Social Worker, and helpful support from Locket's school, but both she and Mr Williams expressed concern about the support given by CAMHS. Hazel Williams said she felt that there was delay in Locket being seen by a psychiatrist, that there was confusion between the Hope Service and CAMHS as to who should be taking active steps (a tension which, she said, heightened Locket's despair), and that there was delay in treatment

starting. She said she felt that CAMHS underestimated the risk and Locket did not receive timely interventions.

9. I heard evidence too from witnesses from All Hallows School, which was the secondary school attended by Locket. **Mark Baines**, the school's Headteacher, told me that Locket started to attend in September 2017. No concerns were reported by their primary school and, for the first three years, they coped well and had great success in many subjects. However, Locket experienced increased anxiety form year 10 onwards and the school tried to reduce the pressure on them, by reducing their target grades for GCSEs, which had been high because they were bright, and by permitting their graphics course to be dropped. **Teresa Fanshawe**, the school's Deputy Headteacher and Designated Safeguarding Lead, provided support to Locket and the family and took the lead in communicating with them and other agencies. The school also arranged for its external counselling service to support Locket, although (as I shall come to below) they considered that Locket needed more specialist provision and viewed the counselling as a stop gap whilst waiting for CAMHS therapy to start. Ms Fanshawe told me that she knew Locket throughout their time at the school, and they had always appeared to be happy, bouncy, and with a number of friendship groups. Following their overdose in February 2021, she spoke to Locket regularly to check on their welfare. Ms Fanshawe said they get on well but Locket was "*quite closed*" and, looking back, she thought they would "*often tell me what I might want to hear*".

Incidents in October 2018 and October 2020

10. The evidence of **Dr Rachel Starkey**, the family's General Practitioner, was read. She stated that Locket was well during her early childhood but had their first consultation regarding mental health in October 2018, when they reported being bullied at school and subsequently starting to self-harm by cutting. A referral was made to CAMHS who advised counselling through "*Kooth*", which is an on-line youth counselling service. Subsequently, in October 2020, Locket spoke to Dr Starkey on the telephone and, as a result, on the 26th October 2020, Dr Starkey wrote to CAMHS asking for Locket to be seen and for their "*expert help*". She stated that Locket, "*has a history of stress and deliberate self-harm. She has previously been seen by CAMHS a few years ago … She is finding school very stressful currently. … She has been having thoughts of self-harm and has been cutting her wrists. She has not told her mum about this. … Apart from the*

stresses at school she is no longer being bullied. … Lucy has had previous thoughts of suicide however she currently has no suicidal ideation and no specific suicidal plans". The witness said that on the 28th January 2021, she received a call from CAMHS wanting to check whether Locket's mother was aware of the self-harming. Dr Starkey said she spoke to Locket who was happy for CAMHS to speak to Mrs Williams about this.

11. I received evidence from **Joanna Dixon, Lewis Lanza**, and **Lorraine Dixon** from Eikon, which is a charity which works with children with mental health and wellbeing needs and provides "*tier 2*" services on behalf of CAMHS. I was told that the referral, made by Dr Starkey on the 26th October 2020, was passed by CAMHS to Eikon. Lorraine Dixon said that the referral was picked up by Eikon on the 29th January 2021, but she was not able to explain the three month delay. She said that Eikon were required to make contact with the family within 10 days in order to gather information and assess whether they were or were not able to meet the child's needs. In fact, Eikon did not contact the family until five weeks' later, on the 5th March 2021, when they learned that Locket had attempted suicide two weeks' earlier. Ms Dixon stated that Eikon realised that the level of support needed by Locket was above that which they could provide.

Incident on the 21st February 2021

12. The suicide attempt to which Ms Dixon referred took place on the 21st February 2021. Locket was admitted to Frimley Park Hospital after taking an overdose of 100 tablets of paracetamol and codeine. Dr Starkey, the GP, was told that Locket was given an intravenous treatment, as an antidote to paracetamol. Locket was discharged home the following day, with a referral to CAMHS' Crisis Intervention Service ("the Crisis Team"). Locket and the family were told that the Crisis Team would follow-up within seven days but, as I shall come to below, they did not do so.

13. I heard oral evidence from **Ufuoma Edegbe** who told me that she is a Registered Social Worker working for Surrey County Council's Children's Services, in its Children with Disabilities Team. She said that from June 2010 onwards, Locket's brother, Alex, was sitting with the team as a "*child in need*" because of his severe autism. When Ms Edegbe joined the team, she became Alex's social worker. When, in February 2021, Locket took an overdose, they too were referred to Children's

Services. Ms Edegbe said there were serious concerns for Locket's mental health. The incident was discussed with Locket who said there had been no trigger for the overdose, saying, "*I just didn't see a reason not to. I just wanted everything to stop and to be listened to because I feel like for two years, I've been trying to get help from my parents and they said they would get me therapy and it's just another one of those things where they say later, later and they never did it*." Locket said there had been an earlier overdose and that they sometimes self-harmed with a pocket-knife; they also expressed anxiety about school and fears for the future. Ms Edegbe said that the recent overdose was thought to be a "*cry for help*", as the home conditions were poor and Locket's parents were not always emotionally available, with alcohol use impacting negatively on their ability to care for the children sufficiently. It was thought that the parents had become overwhelmed by their situation and were too stressed to address their problems, and Locket was noted to be much happier since living with their older sister, following their discharge from the hospital. The witness said that she was allocated to be Locket's social worker. When she spoke to Mr and Mrs Williams, she found them to be relieved that everything was now "*out in the open*" and that they would be getting help. They agreed a safety plan for Locket to stay with Emily Buckley until they addressed their alcohol use and improved the home living conditions. Subsequently, they did take action in relation to both clearing and cleaning the house and working with Alcohol Services.

14. Ms Edegbe said she was in regular contact with the family over the weeks and months which followed. She said that Locket was, initially, "*polite, but not willing or ready to share everything with me*" and she was not able to assess Locket's mental health. She said that the family were waiting and anxious to hear from the Crisis Team, who had not been in touch as promised. On the 9th March 2021, the witness visited Locket at their sister's home; Locket told Ms Edegbe that they were ready to go home to their parents, as soon as the house was cleared up, and that they did not feel suicidal anymore; they said they now had better coping mechanisms and felt supported by their sister and friends.

15. Ufuoma Edegbe told me that Locket's case was judged by Children's Services to meet the threshold for child protection and an Initial Child Protection Conference was held on the 19th March 2021. It was attended by representatives from Locket's school, but CAMHS were not invited as she did not yet have a named contact there. Emily Buckley informed the meeting that Locket was "*still feeling the same way in her head. How she was feeling when she took the overdose. Her mental health is still poor*". The school nurse confirmed that the recent overdose was Locket's second overdose,

stating, "*18 months ago she took tablets and didn't tell anybody*". The outcome of the meeting was that Locket was placed on a Child Protection Plan (under the category of neglect) and it was recorded that Locket remained fragile, vulnerable, and in need of support. The purpose of the Child Protection Plan was to support Locket and the family, and to safeguard Locket. The plan included holding Core Group meetings every six weeks, in order to review the progress of the plan. Ms Edegbe said that Children's Services were the lead agency for the plan, with responsibility for co-ordinating the involvement of other agencies, all of which would then share responsibility for ensuring its effective implementation; it was intended that CAMHS, Locket's school, and Locket's parents would all be members of the core group, and Ms Edegbe said she subsequently spoke to a member of CAMHS Crisis Team, Esau Mbanini, to inform him of the dates of the meetings.

16. **Esau Mbanini** told me that he is a Registered Mental Health Nurse working in the Crisis Team. He explained that this team can become involved when a child is discharged from hospital and is in need of some further mental health assessment or support. In such a case, CAMHS' Psychiatric Liaison Service, which operates within local hospitals, will refer the patient to the Crisis Team and the latter is then expected to contact the patient within seven to ten days' of discharge. The Crisis Team will then assess the child's needs and either provide short-term support, usually of no more than six sessions, before discharging from CAMHS completely, or, if more were needed, escalate and transfer the child to the appropriate CAMHS team.

17. Mr Mbanini said that Locket was referred to the Crisis Team, and allocated to him, following their discharge from Frimley Park Hospital on the 22nd February 2021. He said he ought to have seen Locket within seven to ten days, but the first contact was not in fact made until nearly a month later on the 19th March 2021, and then only after CAMHS had been chased by Ufuoma Edegbe. Despite reviewing the records, the witness was unable to explain why he had not made contact earlier. He telephoned Emily Buckley and arranged a meeting for the 23rd March, and he spoke to Ms Edegbe who told him of the Child Protection Plan and Core Group meetings, and said that Locket was fragile with persistent low mood, anxiety, low self-esteem and risk to self.

18. Mr Mbanini met Locket, and their sister and brother-in-law, in clinic, on the 23rd March 2021. He recorded that Locket was a "*14 year old female, very likable and well engaging. She took quite a high overdose three to four weeks ago with intent to die. She stated, "I just thought I could do it*"…", suggesting

it had been a spur of the moment act. Locket stated that their anxiety, which they experienced since the age of eight years, arose from school, social gatherings, and crowded places; he recorded, "*She feels trapped most days, especially when a lot of people are talking at the same time, which can be overwhelming for her*". Locket's low mood was characterised by hopelessness, feeling sad, negative thoughts, and occasional self-isolation; all worse at night when alone. Locket described panic attacks with dizziness, breathing difficulties, and shaking, occurring once to three times a week. They described schoolwork as a "*nightmare*" because they really wanted to do well but, despite being in top sets in all subjects, anxiety, low mood, and intrusive thoughts affected their concentration, and they were currently very behind and overwhelmed. Locket told him, "*Sometimes I feel it would be better if I were dead, but I want to live*". Mr Mbanini recorded,

"*Lucy is quite resilient and optimistic about the future, about getting better. She is willing to get as much help as she can. It has been evident during the review that she is quite proactive in applying self-help resources. And since the overdose, Lucy's risk of suicide and self-harm has lowered to a great extent with her positive reflection to the incident promising herself that she will never do that again, and she has been overwhelmed by support from others*".

The witness said he made a crisis and support plan which included completion of the RCADS questionnaire, which tests for emotional disorders including anxiety and depression, and a further meeting was arranged for the following week. Mr Mbanini said he did not consider there was an acute risk but it was, however, already apparent to him that Locket would need longer term support. When questioned by Mr Kherbane, the witness agreed that Locket's hospital records included reference to their mother and grandmother both previously attempting suicide and that this family history was an important consideration for Locket's risk.

19. Esau Mbanini saw Locket and Emily for review on the 30th March 2021. He told me that the picture continued as before. Locket said suicidal thoughts persisted, and it was an ongoing challenge to distract themself through YouTube viewing; he spoke to Locket about the concept of thought replacement and decided to escalate Locket's referral to a post-assessment team meeting.

20. On the 31st March 2021, the first Core Group meeting took place. It was attended by Children's Services, Locket's mother and sister, their school, and Mr Mbanini on behalf of CAMHS. Mr Mbanini reported Locket's

ongoing significant anxiety and low mood, although he gave his view that the acute risk of suicide had fallen. Emily Buckley reported that she was worried about Locket posting negative content about themself on social media and avoiding dinner because they felt they were overweight. Emily indicated that Locket could self-harm again and she emphasised the urgent and ongoing need for CAMHS' involvement.

21. On the 1st April 2021, Ufuoma Edegbe visited Locket and found them happy to be on holiday from school because they felt "*overwhelmed with school-work*". She said the family were pleased that CAMHS were now involved, although they were waiting for a plan following consideration by the multi-disciplinary team ("MDT"). Emily Buckley reported that Locket "*still feels highly anxious*" and was still fragile. Ms Edegbe felt that, overall, things were going in the right direction, with Locket's parents embarking on recovery, but she noted that Locket urgently required intervention to address their mental health.

22. Subsequently, Esau Mbanini scored the RCADS questionnaires which had been completed by Locket and by Emily Buckley; the scores were high and were "*indicative of social phobia, major depressive episode, generalised anxiety, and panic disorder*". The witness said he attended a post-assessment MDT meeting on the 8th April 2021 and, on the basis of the working diagnoses, it was agreed that Locket should be offered treatment by way of Cognitive Behaviour Therapy ("CBT"); he said CBT is a form of talking therapy and it was to be delivered by CAMHS' psychology department. Mr Mbanini completed a Waiting List Form, five days' later, on the 13th April 2021, in which he stated that Locket's risk level was "*medium*". He said he did not know what the waiting period would be, although he agreed that the likely waiting period was relevant to how Locket would be kept safe. Mr Mbanini also said that no arrangement was made for Locket to be seen or assessed by a psychiatrist, as this was "*not yet indicated*", despite Locket's history and risk level.

23. Comment: It seems to me that there was clear delay in Locket being assessed following the referral in October 2020 and, despite what was clearly a serious suicide attempt in February 2021, there was an underestimation of their risk thereafter. Even by this stage, Locket reported long-term and persisting suicidal ideation and there was evidence of significant psychiatric conditions. Further, although Locket was placed on the CAMHS Community Team's waiting list for therapeutic treatment, the urgency with which Locket needed treatment

was not assessed and, consequently, no consideration was given to whether their needs were thereby being met.

24. Esau Mbanini met Locket again, with Emily Buckley and her husband, on the 13th April 2021, and he informed them that Locket would be on the CBT waiting list for some months, that the Crisis Team would continue to offer support as necessary, but that transfer to the Duty Team, which was part of the CAMHS Community Team, would have to be considered at some point. Mr Mbanini continued to see Locket, in order to assess and monitor them; he said these sessions were supportive but, he agreed, "… *they were not therapeutic sessions*".

25. On the 16th April 2021, Ufuoma Edegbe visited Locket who seemed happy, but they said they were anxious about school work and so the witness liaised with Teresa Fanshawe about school adjustments. Ms Edegbe said that Locket subsequently moved back to live with their parents. Locket were seen by Esau Mbanini on the 27th April 2021 when, for reasons he could not recall, it was decided that a psychiatric assessment should be arranged. The family was also seen at home by Ms Edegbe on the 30th April 2021, when Locket said they were pleased with improvements to her room, and were finding the counselling sessions at school, and her bi-weekly sessions with Esau Mbanini, to be beneficial.

26. The second Core Group meeting took place on the 7th May 2021. Esau Mbanini did not attend, although he could not now explain why he had not done so (and he wondered whether he had received an invitation). Indeed, Mr Mbanini agreed that he did not attend any of the subsequent Core Group or child protection meetings. He accepted that these meetings were a "*pretty critical source of risk assessment information*" that, by reason of his non-attendance, neither he nor CAMHS accessed.

27. The planned psychiatric assessment took place on the 13th May 2021 by Teams meeting. It was conducted by **Dr Kamran Afridi**, a Consultant Psychiatrist within the Crisis Team, with Locket, Mrs Williams and Esau Mbanini also present on the video link. Dr Afridi recorded his impression that Locket was suffering Depressive Disorder and Emotional Dysregulation (attachment issues). Dr Afridi prescribed sertraline which, Mr Mbanini explained, is an antidepressant to help manage mood, and he ordered a psychiatric review in four weeks' time. Esau Mbanini could not recall consideration being given to expediting the CBT at this stage.

28. Ufuoma Edegbe visited Locket at home on the 14th May 2021, and found them to look relaxed and calm, and apparently doing well. She could see

that both parents were making an effort and she was told that Locket was feeling better because of the input from CAMHS; Locket was pleased to know that they had a diagnosis now and understood it was to do with their emotions. On the 28th May 2021, Ufuoma Edegbe again saw Locket at home and they seemed further improved. Whilst still anxious about school, Locket denied suicidal feelings and was "*using strategies given to her to calm herself when she's anxious*".

29. On the 9th June 2021, Dr Afridi conducted the planned psychiatric review and recorded that Locket appeared brighter than before and was doing very well on the medication. Locket said they felt calmer and less anxious and Dr Afridi's own assessment found nothing of concern, and he noted that Mrs Williams was happy with Locket's progress. His plan was for the medication to be increased, for Locket to stay on the waiting list for CBT and, on that basis, for Locket to be discharged by the Crisis Team. Consequently, Esau Mbanini did discharge Locket from the Crisis Team that same day, although he accepted that he failed to inform Children's Services of this.

30. When seen by Ms Edegbe on the 11th June 2021, Locket was less communicative. School counselling and support from Esau Mbanini had stopped and Locket was anxious to know who would be taking their place. Locket indicated that they felt overwhelmed and were thinking about self-harming, but were not willing actually to do it. Ms Edegbe said she was clear that Locket did need ongoing support. She said Locket's school indicated a concern that Locket needed support from a specialist source, rather than the untrained counselling they had provided, which had simply been to "*keep Locket going*" whilst waiting for input from CAMHS.

Incident on the 21st June 2021

31. On the 21st June 2021, only 12 days after their discharge from the Crisis Team, Locket was found to have taken another overdose of tablets. Mrs Williams said that this came as somewhat of a surprise as it followed a clam evening, although Locket was due to take their mock examinations that day. Locket was admitted to Frimley Park Hospital where a Mental Health Assessment was completed on the 23rd June 2021 by the Psychiatric Liaison Nurse and this led to a "*high risk*" score. It was recorded that Locket said –

- The situation was now better at home and school and exams were the biggest stressors and triggers,
- They hated the way their brain makes them think and feel and cannot see a way out. Their brain races with intrusive and negative thoughts which they were tired of fighting. They feel very low and lack energy and motivation, and cannot take any more of people saying "*you are doing well*",
- They took 70 omeprazole and 60 co-codamol at 2am and did not tell anyone. Mum found them being sick at 6am,
- They had "*Googled*" how best to die with an overdose and had followed the suggestion to crush the pills prior to ingesting,
- They wrote goodbye letters to friends and family,
- They wanted to die when taking the overdose, did not expect to wake up, and were disappointed still to be alive, and
- They had felt unable to be honest with Dr Afridi on the 9th June and felt like everyone was telling them they are doing fine, and felt exhausted with telling people that they were not fine and feel no one is listening.

32. As a result, arrangements were made for Locket to be assessed by the duty psychiatrist. **Dr Aaron Vallance** gave oral evidence and told me that he is a Consultant in Child and Adolescent Psychiatry and, in 2021, was employed within CAMHS Community Team. On the 25th June 2021, he was asked, as the Duty Psychiatrist, to assess Locket. Assessments were usually being conducted remotely at that time, but the nurse considered Locket's state to be sufficiently serious as to necessitate the doctor's attendance in person. Dr Vallance said he viewed Locket's records and was aware of their history, including Dr Afridi's impressions from May 2021; he explained that "*Depressive Disorder*" is a diagnosis and "*Emotional Dysregulation*" is a commonly used term to describe fluctuating mood. He said that, together, these conditions "*would convey the fact there is a degree of persistence of low mood along with other factors like low self-esteem, suicidal thoughts or self-harming thoughts*". So far as risk was concerned, he said Depressive Disorder can increase the risk of suicidality, whilst Emotional Dysregulation would reflect that mental state, and therefore risk, can fluctuate. He said that sertraline, which had been prescribed by Dr Afridi, is commonly used for children and young people with depression, especially when anxiety is also present. Dr Vallance said that the information gathered by the nurse during the Mental Health Assessment was relevant to intent and risk. He was asked whether there was also evidence of Locket "*masking*" at times and, if so, how a clinician may overcome that; he said, "*…part of our job is to try and connect with the young person so we can get as reliable picture as possible. But also mindful, obviously, as professionals, we are not mind readers, …I think in*

terms of what we do as clinicians is we'd really try and build a rapport and try to convey to the young person that we're here to listen.".

33. Dr Vallance conducted his own assessment together with Nurse Emeka Nwosu from the Hope Service. He said that Locket engaged really well and her real distress was apparent. His note included the following:

"*Lucy had experienced low mood and anxiety for over two years escalating over the past six months. In February 21, she presented to accident and emergency with an overdose of 100 paracetamol and codeine tablets. At that time, anxiety related to school as well as difficulties at home. … Since then, the family have been supported … and she finds home life much more supportive. However, there continues to be significant stress as related to school. … When she tries to explain this worry to people in her life, she finds that people tend to say that, "you'll be fine". However, this causes more distress. … She experiences around one to two panic attacks per week related to stress. Experiences low mood daily, although this can be quite changeable. She can enjoy activities and particularly likes being with friends. She can sometimes self-harm when feeling stressed in order to manage her feelings. Sleep and appetite are intact. Energy and concentration are reduced, which exacerbates her worry about academic performance. Earlier this week, she took an overdose of 70 omeprazole and 60 co-codamol. This was planned …. She arranged to meet up with friends at the weekend in order that they can have good memories of her. She has reported writing suicide notes, although did not show them to family. After taking the medication, she eventually told her mother, after she felt it was not working. She has been settled on F1 ward for the past four days…. She expresses ongoing suicidal ideation. There is no firm suicidal intent or planning, and she was ambivalent about longer term suicidal intent. On observation, she engaged well in the review with good eye contact and rapport. …Tearful at times and appeared low in mood. She was keen for people to listen to how she is feeling and happy to have additional support"*.

34. Dr Vallance told me that he did not ask to see the "*suicide notes*" which Locket had mentioned to him. At the inquest, however, **PC Richard Edwards** of Surrey Police stated in his written statement that, after Locket's death, a series of messages which had been composed on the 21st June 2021 were found on Locket's mobile telephone. The messages were directed to friends and family members, with some headed "*A Final Goodbye*", although there was no evidence of them having been sent. There were also subsequent messages to friends in which Locket stated that they had tried to kill themself on the 21st June. Dr Vallance had not asked to see these notes, and therefore had not had the benefit of

confirming their content, which would have been relevant to risk assessment.

35. Dr Vallance concluded that Locket's risk to self was "*high*". He made a Care Plan which included an increased dose of sertraline (to be followed up by the CAMHS Community Team), the Hope Service to provide a package of "*short-term crisis support*", to include outreach visits and liaison with school, Locket to be discharged from hospital on the 28th June, Locket to remain on the waiting list for CBT, and ongoing family support to be provided by the social worker. Dr Vallance explained that the involvement of the Hope Service was a "*really important factor on deciding to discharge*" because "*the whole remit of the Hope Service was to provide support for young people with very complex needs, where there is concern around high risk … an intensive service as an alternative or to prevent a hospital admission …*". He said that the Hope Service was a unique "*three and a half tier service*", which had the "*expertise and experience … to offer more intensive work*" than the Crisis Team had been able to provide to Locket. Dr Vallance said he had not wanted to admit Locket to a psychiatric ward. He explained that there are no child and adolescent psychiatric units in Surrey and so admission would have to be elsewhere in the country, which was "*one of many factors*" which meant that "*intensive community support*" was clearly preferable to admission. He said that two beds were also available within the Hope Service, although they were usually used for respite and for up to seven days only.

36. In relation to Locket's awaited CBT, Dr Vallance stated that he was aware that the routine waiting time was probably around nine months and this was too long for Locket to wait, given their risk and clinical severity. Therefore, he contacted one of CAMHS' senior psychologists, Dr Monika Kempa, who "*absolutely agreed that the case needed to be expedited, prioritised*". He said that Dr Kempa suggested that the crisis intervention, which was to be provided by the Hope Service, was very important, almost as a prerequisite before CBT started, in order to stabilise Locket and have strategies in place to manage their emotions and suicide risk. He said that Dr Kempa suggested that after the Hope Service's short-term intervention package, there should then be a package from the Urgent Care Team, and only then would the CBT start. Dr Vallance said he assumed this meant, therefore, that CBT would start in six to 12 weeks' time.

37. **Emeka Nwosu** gave oral evidence and told me that he is a Registered Mental Health Nurse working in the Hope Service. His first involvement was on the 25th June 2021 when, at Dr Afridi's request, they had jointly

assessed Locket on the ward at Frimley Park Hospital. Mr Nwosu said he considered his role was to assess whether there was a role for the Hope Service to play.

38. Emeka Nwosu's described the Hope Service as follows:

- The service is for young people with severe mental health, social, emotional, and behavioural needs whose difficulties make it impossible for any one service to meet those needs,
- It operates with multi-disciplinary members, including psychiatrists, psychologists, nurses, drama and art therapists, family therapists, social workers, and teachers,
- When a young person is at risk of admission to hospital and the use of tier 4 services, "*The idea is to see whether that is … something that we can prevent. So, in other words, the Hope Service can be described as …Tier 3½*",
- The Hope Service offers three different services. First, there is the Hope Day Service which provides structured therapeutic, educational and recreational programmes, encompassing a range of therapeutic approaches, including individual and group therapy, art therapy, psychological CBT and Dialectical Behaviour Therapy ("DBT"), and anxiety management. Secondly, the Hope Community Service, which provides intensive community support for young people in the service, either alongside the Day Service interventions or independently. And thirdly, the Extended Hope Service which provides an out of hours service with two elements, the first being an assessing and support service and the second being the provision of two respite beds at Hope House for young people who are experiencing mental health crisis and need intensive support, but whose mental health does not require them to be admitted to a psychiatric ward, and
- When a referral is received, the Hope Service carries out an assessment in order to consider whether its admission criteria are met and, if they are, which of its services will be beneficial to the young person. The Hope Service may then act alone or in collaboration with other services, including CAMHS' Community Team.

39. Emeka Nwosu told me that, as a result of the assessment on the 25th June 2021, the Hope Service did agree to offer four weeks of short-term crisis support, which principally amounted to not much more than a weekly one-hour visit to Locket, followed by a review with CAMHS. He said the support would ideally have been provided by a female care co-ordinator, as they had noticed that Locket had seemed uncomfortable around him and Dr Vallance but, despite that concern, he was tasked to fulfil the role. He said the principal purpose of the weekly visit was to assess Locket's needs. No formal therapy was to be delivered but, he said, "*at the same time*

interaction is part of therapy". Mr Nwosu agreed that, depending upon the outcome of the assessment, there was then a possibility of Locket being accepted to the wider Hope Service, including the Hope Day Service. He said that the Hope Service could not have considered offering CBT to Locket unless and until they were accepted into the Hope Day Service programme.

40. On the 30th June 2021, both Ufuoma Edegbe and Emeka Nwosu were in contact with Locket and the family. Mr Nwosu said that Mrs Williams reported Locket "*as doing fine*", and although thoughts of self-harm persisted there were no active plans. However, he recorded that, "P*arents lamented so much about mental services disappointing their child - not providing the needed supports earlier to avert the present risks state Lucy is [sic]. Mother gave instances of times she has called to speak to the allocated CAMHS Care Co-ordinator of Lucy but to no avail. … according to them, Lucy needs every support she can get and she would need them now. At some point Dad and Lucy became emotional and Lucy was asked to leave the meeting briefly. Plan: Parents want to know who the allocated CAMHS clinician and doctor are and they asked professionals meeting with the whole professionals involved to know who does what*". Ms Edegbe said, "*I shared the frustration experienced by the parents, …that Lucy had not yet received the level of support she needed. I advised he* [meaning Mr Nwosu] *cannot discharge Lucy now, that we need to know who is doing what and when. We need support and advice from mental health practitioners. We needed a named person to contact for advice and support"*. Mr Nwosu, who was himself the Care Co-ordinator at that time, said that he sent an email to CAMHS colleagues in which he stated, "*I concurred with the idea of calling the professionals meeting and at same time agreed that I will take the responsibility to pass the message to CAMHS Crisis colleagues who would ensure that case is transferred and accepted by CAMHS CT* [Community Team] *before they sign off …*". He also recorded that the Extended Hope Service was, "*to do one more follow up tomorrow and close if no changes*".

41. Whilst waiting for the professionals' meeting, the family in fact had several contacts with the Extended Hope Service for crisis support. On the 1st July 2021, the records show a call in which Mr Williams reported that Locket was very distressed and agitated and their thoughts were telling them to end their life. The call taker recorded that she guided Mr Williams, "*to use ice for grounding with good effect and after a while assisted in planning good sleep hygiene techniques of playing some soothing rain noises and turning low the light in the bedroom*". As Locket was not feeling safe, it was also suggested that their mother would spend the night in their room and the parents would ensure that all dangerous items were locked away. Mr Nwosu accepted

that this further episode of suicidality was relevant to the overall risk and that it was his responsibility, as Care Co-ordinator, to monitor risk.

42. On the 2nd July 2021, Dr Vallance sent an email to Esau Mbanini and Emeka Nwosu to say that he was not going to be Locket's allocated psychiatrist. He wrote, "*We have a new Psychiatrist, Dr Cedric LeClercq, starting on the 13th July, who will pick up the case when he arrives*", although he indicated that he would provide cover in the meantime. Dr Vallance also sent a message on the 6th July 2021, copying in CAMHS' Urgent Care Team, to explain that he had discussed the case with Dr Monika Kempa, CAMHS' Clinical Psychologist, who had agreed that CBT was required and, given Locket's high risk, that it could be expedited. He wrote that Dr Kempa said the case would be picked up, "*once the acute crisis has subsided and…advised that it would help to have a package of Urgent Team support after the Hope Service input and before CBT. In that respect, Mandy, please could this case be considered for the Urgent Team input in the first instance. … Once Hope discharge, probably in three weeks or so, to continue to do a crisis piece of work for the subsequent few weeks. After that, Monika or Florina can take over with CBT*". The reference to "*Mandy*" was to Amanda Watson. Mr Nwosu said that, once the Urgent Care Team, which is part of the Community Team, were involved, they would have taken the lead as Care Co-ordinator. When asked, Mr Nwosu said he did not understand what was meant by the words "*once the acute crisis is over*".

43. **Dr Monika Kempa** gave oral evidence and said that she worked in CAMHS as a Highly Specialist Clinical Psychologist. She has doctorate-level training in clinical psychology and specific training in the delivery of CBT, which she described as, *"…a very well established and longstanding therapeutic approach which looks at the connections between the patient's thoughts, feelings, behaviours and physical sensations, which are all interconnected. CBT is very targeted in that we look at specific cognitions, or thoughts, and seek to change them*". She said that CBT can be effective in treating depression or Depressive Disorder but, she said, "*it's a huge commitment … both in terms of the therapist but also the person who is receiving therapy to actually take it on board and to be able to engage with that as well*". Dr Kempa said that her role, principally, was to assess a child's potential for effective therapy and deliver such therapy as may be appropriate. She said there was a role too in supporting the wider team to understand what may be the underlying cause of, for example, a child's depression. The witness told me that, in 2021, there were about seven psychologists in CAMHS Community Team, although some were on long-term leave, and there were about 50 young people on the waiting list, with the average waiting time being about nine months. Treatment

would usually involve one session per week and could last between six and 12 months.

44. Dr Kempa recalled agreeing to expedite Locket's CBT treatment. She was asked why she had indicated a need for input from the Hope Service, and then the Urgent Care Team, before CBT could start, and she said that Locket suffered emotional dysregulation difficulties and, "*we need to be confident, as much as we can be, that they would be able to access therapy safely and effectively. So somebody who is considered to be in a crisis state, as they perceived Locket to be at the time, I felt that there was need for that stabilisation process to take place*". Dr Kempa explained that it was preferable to provide some preparation to enable the patient to cope with the CBT, stating,

    "*…therapy can be a very intensive piece of work which requires the young person to engage with the content of the sessions. And in psychological therapy there is always a potential of things becoming more unsettled. We often explain to families, when we seek consent for treatment, that there is a possibility that things can get worse before they get better. So, for example, when we are touching something that is highly emotional, something that is very difficult to talk about, that can raise a lot of emotions. … So I felt that in this context of two suicidal attempts, there was a need for good risk management and stabilisation to allow that therapeutic process to happen safely*".

    Dr Kempa was asked why the transfer to the Urgent Care Team could not have happened immediately and she said that, "*…we felt that it was the intensity of support that the Hope Service were able to provide which we in the Community Team would not have had. So they had an ability to visit, typically twice a week. … So it was felt that it would have been a more intensive piece of intervention that would also allow the Hope clinician to link with other services supporting Locket at the time*".

45. The planned meeting of the medical professionals took place by Teams on the 8th July 2021. Emeka Nwosu, Esau Mbanini, Dr Kempa, Amanda Watson, Locket's parents, Teresa Fanshawe from Locket's school, and Ufuoma Edegbe attended. Dr Kempa's note of the outcome of the meeting recorded, "*All informed Lucy will access CBT with me once the risk has been stabilised. She will remain with Hope, then will be seen by Mandy (UCT) to further stabilise risk before seeing me. Lucy remains on CP Plan*." Dr Kempa said that, at this time, she estimated that she would not be able to start Locket's treatment until late September or early October, as that was likely to be her earliest availability to pick up a new case. Amanda Watson noted that her meeting with Locket had been arranged for the

22nd July and, "*Due to staff annual leave, Hope will remain as case holder until the 3rd August when she will be open to CAMHS and supported by the Urgent Team until she can access CBT through CAMHS*". Ms Edegbe told me that she was happy with the plan made at the meeting and, when she spoke to the family later that day, Locket was pleased that a support plan was now in place and they were being listened to.

46. However, the evidence I received from Emeka Nwosu, I find, shows that there was not clarity or full agreement as to what was to be provided to Locket and by whom. Whereas Dr Kempa (and Dr Vallance before her) had relied upon the Hope Service to undertake important and intensive specialist work to support and stabilise Locket, when he was asked about these arrangements, Mr Nwosu again indicated that he did not view the reference to "*stabilising*" Locket as suggesting he should do anything in particular; he said, "… *If there is any thought of therapy to be attached to that, I made clear to even the parents that there was no such a thing within that role of Short-Term Crisis Support*". He emphasised this point by adding that the issue, *"…was raised to my manager and my manager clarified to CAMHS that there was no support of therapy nature that Short-Term Crisis Support provides, other than the informal therapy work that we do when we see a young person. That was raised to my manager and I did put across that to parents that there was no such extra support other than this support. We can't provide what we are not privileged or prescribed to provide".* He said, *"…sometimes our colleagues do struggle to understand the level of support we do offer*".

47. On the 12th July 2021, Mrs Wiliams told Ms Edegbe that Locket had been in touch with one of the girls with whom she had been in hospital, and that Locket was consequently very distressed and had started cutting themself, saying they wanted to go back to hospital. Locket was angry and distressed and said they did not feel safe at home because they had not had therapy. The parents were watching Locket at all times. Ms Edegbe recorded, "*I am worried that the support planned by the mental health practitioners for Lucy have delayed and impacting on her. Support has come very slow and other professionals are worried about this. The parents are doing the best they can to keep Lucy safe but I am concerned that without extensive support from the mental health team, they might struggle to keep Lucy safe. Psychiatrist assessed should have commenced long before now. I am also of the view that the Hope Service should accommodate Lucy within a therapeutic environment to calm her and support her mental health. It is my plan to request this from the Hope Service for Lucy*".

48. Also on the 12th July 2021, Mr Williams sent an email to Amanda Watson, copying in other professionals who had attended the meeting on the 8th July, and stating,

"*I am writing because I am extremely worried about Lucy at the moment. Last night she was extremely distressed and angry. When questioned, she said she wanted to go back to hospital as, when she was discharged, she was told there would be people to help her stop feeling like she wanted to die. She feels that no-one is helping her to do this. Lucy knows that there have been meetings to discuss who will be doing what, but she stated that she hasn't actually been given any "help". I am anxious that, if Lucy does not start receiving direct treatment very soon, her condition will deteriorate and she may attempt to end her life again, despite all our best efforts to keep her safe. Please would you advise us as to what can be done to help Lucy in this crisis. There is only so much reassurance we, as parents, can give Lucy*".

49. Ms Watson replied to Mr Williams stating, "*I have forwarded your email high importance to Emeka at Hope. They are completing assessment period before CAMHS take over. I am also going on leave as from tomorrow. I have also rung Hope to pass this on to him*". Emeka Nwosu sent a reply to Mr Williams, acknowledging his concerns and stating, "…*Following my home visit today, I saw first-hand how distressed and agitated Lucy can be as a result of her feelings of disappointment at services not doing as much as she expects. In view of this, I said I was going to speak to Doctor Aaron about PRN. I said I will kindly request that Doctor Aaron gets back to you to discuss further, because he is the one that can write up medication if he agrees. You can recall that I called a professionals meeting last week, so the family get to know which services does what. I also explained to Lucy today that the support she is talking about is a process that takes a little while to come through and that I will surely be discussing further with my CAMHS colleagues and get back….*"

50. On the 13th July 2021, Ms Edegbe sent an email to Emeka Nwosu concerning respite accommodation being provided by the Hope Service, as she had told the family she would. She wrote, "*I visited yesterday I am as well very worried over Lucy. I do think she should be accommodated in Hope's respite to calm her down while treatment for her commences. I am not sure if the parents can keep her safe at home at this moment as she is very distressed.*" Mr Nwosu replied, stating, "…*Certainly if Hope bed becomes available, I will certainly make a case for that, if that could provide respite for the family for seven days. But we must accept that, after the seven days, she gets discharged home and, if the root cause is not addressed, we will still be back to square one. So I suggest that Social Services could be looking, from their end, the alternative options, since your concern is linked to the parents not being able to keep her*

safe, and Lucy not being deemed to be at risk of Tier 4 at the moment." When pressed about this response, Mr Nwosu accepted that he had considered that Locket met the criteria for a Hope bed, and he accepted that the issue was availability. Ms Edegbe replied immediately to his message, stating, "*I visited yesterday and the parents are worried they might not be able to keep her safe due to her high level of distress, which is understandable. I am not concerned about parenting capacity right now. The parents are doing their best to keep her safe. I am concerned because of her mental health. We cannot accommodate her because of her mental health. We are already in Child Protection and, if our concerns were relating to parenting, then we would address accordingly. But that is not the case right now*".

51. Ms Edegbe explained that Children's Services' options for providing other accommodation would have been limited to a placement with foster parents who would not be skilled in mental health, and so the underlying cause of distress would still not have been addressed. She said this was now clearly a medical matter in which CAMHS needed to take the lead, rather than a Child Protection matter for which Children's Services would take the lead. She said she had hoped the issue could be sorted by contact between senior management in each organisation. To that end, on the 15th July 2021, Ms Edegbe escalated her concerns to her manager, Claudia Gerrie, stating,

"*I would like to escalate my concerns regarding the lack of adequate support from mental health professionals to Lucy. … At the meeting* [on the 8th July] *both social care and school, including the parents, voiced out their worries/frustration that Lucy's mental health is fragile and she does not seem to be getting substantial support from the mental health teams as expected. Dr Monika stated Hope Services will be the contact person for now to support Lucy until Monika returns from annual leave to take over in August. Lucy is on a waiting list for therapy with Dr Monika. However, I am told that Lucy continues to remain fragile with her mental health, and show signs of distress at home. The parents have to sleep on the floor next to her bed in her bedroom to watch over her. I am concerned about the delay in providing any form of therapy for Lucy. The school has stepped in to provide counselling … but they are not trained to deal with mental health. I expect the mental health services to take a lead in assessing the risk and providing support asap. Family Psychotherapy is urgently needed. I have also asked Hope Service to provide a therapeutic respite provision for Lucy to help reduce her anxiety as she is currently very distressed. The parents are doing their best to keep her safe and this is hard without mental health team offering adequate support. …I am seeking your advice on this and if you can escalate by speaking to the managers at Hope Service for Lucy to go into their therapeutic respite provision at this time.*"

52. I heard evidence from **Claudia Gerrie** who told me that she was the Team Manager for the Children with Disabilities Team. She said she received this email from Ms Edegbe and thought that she would have contacted CAMHS in response, but accepted that there was no record of her having done so.

53. On the 15th July 2021, the third Core Group meeting took place. Again, it was not attended by CAMHS. The meeting was attended by Teresa Fanshawe from the school, and it is recorded that she, "*shared her concerns that Lucy still feels the same, despite having been offered some counselling …. Lucy knows and feels something is not right and wants to fix it, but she does not know how. … Lucy is asking for therapy and feels angry she is not getting it*". Ms Fanshawe told me that she was worried about what support would be in place over the summer holidays. She said that Locket declined the offer of more counselling from the school counsellor; "*I think by that stage she had had a lot of meetings with [*the counsellor*], and she wanted something different … it wasn't what she wanted. She wanted more*". As CAMHS had not attended this meeting, they did not receive this information at the time, although Ms Fanshawe had contributed to the earlier professionals' meeting.

54. On the 16th July 2021, Emeka Nwosu visited Locket at home. He recorded that he found her to be friendly and relaxed, and denying any current suicidality, but their parents reported ongoing low mood. Further, the witness noted that Locket was "*very angry and hostile*" when questioned about their eating. Mr Nwosu also recorded,

    "*In the end Dad asked me when Hope Services was going to start therapy on Lucy. Dad told me that Dr Aaron had informed him that Hope was going to provide therapy in addition. I explained to Dad that there is no such support like "Hope therapy" being provided for patients accepted under Hope STCS. I explained that any therapy work from Hope can only be provided if patient is taken full time or long term support by Hope and certainly not Hope STCS for four weeks. Dad was furious, said he would be going to speak to Dr Aaron to question why he was told that Hope was supposed to provide therapy alongside STCS. I said that he may have misheard or misunderstood what Dr Aaron said, he sounded more angrier. I said to Dad I am only going by the boundaries/limits of supports prescribed under Hope STCS and assured him that notwithstanding I was going to inform my managers about what he said Dr Aaron told him. He seemed reassured and calmed as a result*".

    Mr Nwosu told me that when he raised this with his managers, "…*they were able to have that conversation with CAMHS. Again, it is all about education,*

trying to point out what are the limits of support that we provide under Short Term Crisis Support". I find that whilst it was reasonable for Mr Nwosu to make clear his understanding of the limits of the service which the Hope STCS was able to provide, I find it difficult to understand why, as Care Co-ordinator, Mr Nwosu did not put his mind to who would provide the necessary support to Locket.

55. Dr Vallance was asked about these matters and said that it was his understanding that the Hope Service short-term crisis intervention was not purely for assessment and monitoring, but was also to provide intervention and support, and strategies and advice, which is "*a very large intervention*", and this is what he had intended to convey to Mr Williams. He was asked whether there had been a misunderstanding of expectations, given Mr Nwosu's response and the family's view that Locket was not receiving any meaningful or effective therapy, and he did not agree, saying that he believed Emeka Nwosu was referring to CBT, which he would not be delivering. Dr Vallance said he was contacted by Mr Nwosu's manager and, he said, he explained his understanding to her and she had agreed. I find that there clearly was a difference of understanding as to the role of the Hope Service's short-term intervention, with Emeka Nwosu stating repeatedly, both at the time and in his evidence to the inquest, that his role was limited. I find that Mr Nwosu's position is particularly difficult to understand, especially as he was Locket's Care Co-ordinator. However, whoever was right in this debate, the reality was that nothing changed for Locket, who continued to wait for effective therapy to commence.

56. Dr Kempa was asked about the email exchanges referred to above, about which she was aware. She was asked in particular whether she had given consideration to the possibility of CBT being provided by the Hope Day Service and whether this may have been quicker, and she said, "*…that wouldn't have been a decision for me to make*". When asked whose role it was to consider that possibility, she said, "*So typically it would be the Hope clinician who was already involved*". That would, of course, have been Emeka Nwosu and, as is apparent from the evidence reviewed above, he did not take steps to ensure this potential way forward was explored.

57. **Amanda Watson** told me that she is a Registered Mental Health Nurse who was working for CAMHS as the Urgent Care Team Lead. Her understanding was that she had been asked to support and stabilise Locket before they started CBT. She was aware that Dr Vallance had asked for expedition because of Locket's high risk. She said the precise support given in these circumstances would depend on the individual

and would be "*need led*". Ms Watson said she met Locket for the first time on the 22nd July 2021, as planned, and this was simply to make contact before she went on holiday. Locket's transfer to the Urgent Care Team was planned to follow her return, at which point, Ms Watson said, she would become the allocated clinician and Care Co-ordinator. She said she informed Locket of her role and that the CBT would be starting around the end of September or early October, which was the date she had been given by Dr Kempa; Ms Watson said the actual date depended upon when Dr Kempa or her colleague became available. Locket spoke to Ms Watson about themself and their anxieties, and indicated that they felt assistance with strategies to manage the intensity of their mood would be helpful. Ms Watson advised Locket about using a "*soothe box*" as a coping technique which, she said, was relationship-building rather than therapy. She said that she considered Locket to be stable at this time.

58. On the 23rd July 2021, coincidentally both Mr Nwosu and Ms Edegbe visited the family at the same time. Ms Edegbe told me that Locket was more relaxed and their thoughts of suicide had gone down. It was the school holidays and the medication appeared to be assisting. Ms Edegbe said she explained that she had escalated the issue of lack of support for Locket's mental health to her manager; Emeka said he understood, but that his role was coming to an end and CAMHS will now take over. Mr Nwosu's recollection was similar and he recorded that Mr Williams was now more relaxed knowing that Amanda Watson and Dr Kempa would be picking up Locket's care.

59. Emeka Nwosu saw Locket again on the 28th July 2021, and found them to be bright and cheerful, and denying "*any thoughts of self-harm for a while now*", although Mr Willimas did not consider there had been a significant shift in Locket's recovery. They were looking forward to an appointment with Amanda Watson on the 2nd August, following her return from leave, and "*the work CAMHS will be doing with Lucy from 3rd August*".

The Incident on the 28th July 2021

60. I was told about the contents of a Hampshire Police report concerning an incident on the 28th July 2021. It stated that Police were called by Locket and that, *"…she was on a bridge and was going to jump. Police attended and spoke with Lucy, who was visibly upset. Lucy stated she had been struggling with her mental health for some time now and feels depressed and suicidal. Lucy stated nothing had happened today to trigger this. She had planned to attend the bridge*

as other options were not available to her due to her parents locking up her medication after she tried to overdose around one month ago. Lucy lives at home with her mother, father, and brother. She said she does get on with them however, both mum and dad were on antidepressants …When asked if she wanted to return home, Lucy said she did not as nothing changes when she goes home in relation to her mental health. Lucy was more comfortable attending Frimley Park Hospital with officers. Lucy was okay with officers calling her dad to update him that she was there and was happy for him to attend. … Lucy is currently involved with CAMHS and has a social worker and psychiatrist. She has only seen a psychiatrist once, and stated it was easy to lie to them that she is feeling okay. Officers advised Lucy to be honest with the health professionals, so they can give her the support she needs. … Lucy was taken to Frimley Park Hospital and Father attended. … I believe Lucy needs continued support in relation to her mental health and well-being. Lucy and her father, Steve, were glad of police assistance and more than happy for us to make a referral to get Lucy support."

61. **Dr Kian Chong Lee** is a Consultant Paediatrician working at Frimley Park Hospital. He told me that on the 29th July 2021, at just after half past midnight, Locket was admitted to the children's ward, where he saw them later that morning. On the basis of the records, the witness told me that Locket described having severe depression and told the doctor that they have, *"…been having suicidal ideation heightened this year, says everything is being a bit much. Says wants life to end as life, school, social situation has been stressing. Leaving the home also is a problem as she feels stressed when she goes out. Went to a bridge to jump off a bridge, but has a fear of heights, as such stepped back and called 999. Other methods, overdose, sharps not accessible. Friends, sister, really supportive, feels hopeless and feels medical treatment is not working"*. Dr Lee explained that he found Locket to be physically well and, as the hospital does not provide psychiatric services, his plan was for CAMHS to review them. The witness said that if a patient requires a psychiatric admission, *"…the most common place for young people in our area to go to would be Hope House, but obviously they may be offered a Tier 4 bed elsewhere in the country depending on availability and depending on need*". He said decision-making concerning such admission, and risk assessment at the time of discharge, were matters entirely for CAMHS.

62. Mr Nwosu agreed that this incident, which occurred very shortly after he had seen Locket and they had appeared to him to be cheerful and not currently suicidal, showed that their suicidality was unpredictable, and he accepted that this was relevant to Locket's risk of suicide, which was high. He said that on the 29th July 2021, he spoke to Mr Williams who made it clear that he was not willing to allow Locket to come home until

they had been assessed by a psychiatrist. Consequently, Mr Nwosu contacted Dr Mura, a Consultant Psychiatrist in the Hope Service, to arrange this.

63. **Dr Salvatore Marco Mura** told me that he is a Consultant Child Psychiatrist and in 2021 he was working within the Hope Service. He said that he, together with Dr Afridi, had responsibility for the children who had come into the Hope Service via a route other than CAMHS; but if the child was already with CAMHS when the Hope Service became involved, then the patient would be allocated to a psychiatrist in CAMHS' Community Team. Dr Mura said that on the 30th July 2021, he was asked by Emeka Nwosu to attend Frimley Park Hospital to review Locket and he did so. He was not sure why he had been contacted, rather than the CAMHS Duty Psychiatrist, although it may have been because he was available. He said Emeka asked him to review Lucy "*with the aim of facilitating discharge*" but he went with an open mind. He said he read Locket's notes, including the full Mental Health Assessment from June 2021. In addition to Dr Lee's record, the current notes recorded that Locket, "*…walked from her house to the bridge. She was thinking that this is the last time she is going to speak with her friends. She planned this … Did not tell anyone about it. She was planning it for a week, she reports she is done with it, that she wants her brain to stop. No intrusive thoughts, no visual hallucinations. … She decided to call 999 and some boys from her school stood with her so she could not jump. She did not regret her actions. … The depression started since 2019 … She says, if she was given a chance to do it again, she would do it again*".

64. Dr Mura recalled that when he spoke to Locket they made it clear they were "*not being heard*". He said. "*It was very much about, rather than just wanting to die, I cannot live like this anymore, I need help*". Locket said they felt safe in an environment like hospital, but did not feel safe anywhere else, at home specifically. Locket explained that they had "*running thoughts all the time, … too many thoughts and I cannot control them at times*". Dr Mura found Locket to be logical and coherent, and a very bright young woman, and he saw a very good bond with their father, who was willing to do anything to be supportive. Dr Mura decided to continue the sertraline prescription and increase the sleep medication. He said he was aware that CBT was planned and so he tested Locket's ability to engage and said, "*I felt at that moment in time, Locket was going to be able to engage with CBT. So, that's something I established at that time, and I think it's an important point to make*". Dr Mura said that Locket did not want to be discharged and so he made a plan to keep them in hospital, but gradually test the possibility of discharge through home leave. Dr Mura told me

that there was a clear and severe mental illness, severe depression with anxiety and mood-swings, that needed treatment. He was asked whether commencing CBT was an important element in keeping Locket safe from that point onwards and he said, "*It was. Yes. A combination of CBT and medication is the gold standard for depression and anxiety*". When asked specifically, Dr Mura confirmed that it was his view that Locket was ready to start CBT, immediately. Dr Kempa was asked about this and agreed that Dr Mura had conveyed his view to her at the time but, she said, she had not agreed with him. Dr Kempa was asked about the basis for her disagreement, given that Dr Mura had assessed Locket, specifically for their suitability and readiness for CBT, whereas she had not even met Locket. Dr Kempa accepted that she had not assessed Locket herself but said, nevertheless, she was concerned about Locket's emotional vulnerability and felt that more support from Amanda Watson, "*around emotional regulation strategies would help with that therapeutic process for me to then continue with CBT*". Dr Kempa was asked, "*If you had been available to start CBT at this time, would there have been any reason for you not to start*?" and she said, "*I would have started, but whether or not I would have implemented kind of CBT interventions for depression or chosen to focus on a different type of presentation based on my formulation would have been guided by the presentation at the time*".

65. Dr Mura said he had understood that the CBT would probably begin within four to six weeks under the Community Team and so he had not considered exploring transfer to the Hope Day Service for that purpose. He explained that the Hope Day Service delivers DBT, which is slightly different to CBT, and operates as a registered school, in school hours, but treatment can continue in the holidays. He said that, generally speaking, if a young person is willing to engage, and it is thought that therapy could be successful within the Community Team, that would be the starting point, with the Hope Day Service being something which could be tried subsequently if the Community Team's treatment was unsuccessful, although each case could be considered individually. The waiting time for therapy in the Hope Service was then about three months. When questioned, he confirmed that he had not believed that Locket's CBT was due to start the following week, as was suggested in a subsequent email from the Safeguarding Team (which I shall come to below); he said that he understood there would be contact with Amanda Watson the following week, but not commencement of the CBT. Dr Mura said that whilst waiting for the CBT, Locket was to be monitored by Emeka Nwosu, and he considered that Mr Nwosu could also deliver effective strategies to support thought and mood management and sleep hygiene.

66. As mentioned above, on the same day, the 30th July 2021, the Safeguarding Team at Frimley Park Hospital sent an email to those involved, including Emeka Nwosu and Children's Services, stating, "*I have just spoken to Dr Marco, Consultant Psychiatrist, from Hope Service. He has reviewed Locket with parents. He has created a very robust plan. Lots of interventions were started officially next week. Lucy will remain an inpatient over the weekend, but will be going on home leave during the day. She will be seen on Monday by Care Co-ordinator and then discharged home. She has professional contact scheduled every day next week and treatment of CBT is to start next week. Her medication has been increased*". Claudia Gerrie said she spoke to Emeka Nwosu who confirmed that Locket would be starting CBT the following week. Wherever the confusion had come from, this was plainly not the case.

67. On the 2nd August 2021, as planned, Locket was seen again by Amanda Watson, this time together with Dr Kempa. The purpose was to discuss "*the pathway of care*". Dr Kempa said she explained CBT and gave Locket the start date of the 24th September 2021. She was asked how it was possible to give a specific start date if she needed to achieve stabilisation before starting, and could not know at the start of August whether Locket would be "*stabilised*" by the 24th September, and she said the date was given for the benefit of the family but could in fact have been later, depending on Locket's presentation.

68. When Ms Watson spoke to Locket alone, they spoke about their history of self-harm and the recent incident. Locket said they started to self-harm by cutting in 2019 and found it helped with emotional pain. Locket said they later became more fixed on wanting to die and took an overdose after their 13th birthday. There were no attempts in 2020 but as the lockdown was being lifted, they realised that things had not become easier, and in February 2021, they took the 100 tablets. In June 2021, there was a planned, bigger overdose, eight hours before their mock examinations. So far as the last incident was concerned, Locket said they had been thinking of jumping from the bridge for some time, had felt sad at the thought of not seeing their friends again, but happy that all the pain would soon be over. Locket said that they continued to experience suicidal thoughts, and did not feel safe in themself if they were to leave hospital. Ms Watson said she was pleased Locket had felt able to share this information but considered that they needed to stay in hospital to be safe. Ms Watson said she contacted Emeka Nwosu and Dr Mura to tell them that Locket was "*not in a good place*".

69. On the 3rd August 2021, a professionals' meeting took place, attended by Dr Kempa, Amanda Watson, Emeka Nwosu and Ufuoma Edegbe. Dr Kempa recorded that, in the Hope Service's view, in-patient admission was not warranted and Locket should be discharged. There was discussion about closer working between the mental health and children's services, about a possible referral for assessment for autism, and about ways in which the parents could work to keep Locket safe at home. Dr Kempa also noted that CBT was planned for the end of September 2021. Mr Nwosu was asked why, as Care Co-ordinator, he had not challenged that start date, given that, only the day before, he and the family had been told that CBT would commence the following week. He said that although he was the Care Co-ordinator, he was not the person with responsibility for organising the CBT and so it was not his role to question this. Overall, the outcome of the professionals' meeting was that Locket could be discharged with a Safety Plan.

70. Mr Nwosu said the Safety Plan had been discussed with Mr Williams earlier, but when he spoke to him on the 4th August 2021, Mr Nwosu "*…was surprised to hear from him that Locket is not ready for discharge, and themselves would not agree to take her home either, because, like Locket, they agree she is not ready for discharge and they cannot keep her safe at home*". The witness said that he re-iterated that, *"…we are saying there is no case for tier 4 admission for Locket for now as that does not serve her best interest, given all the evidence. I asked Dad what he thinks would help, or he would like to see happen to help Locket and themselves feel safe to go home. He replied, 'If Locket is discharged home and she does something similar again, who would be held responsible?' I explained to him that no clinician would guarantee that Locket will not do such or any other risk behaviour again. He was adamant that he was not going to accept her discharge home*." Ms Edegbe told me she agreed with the parents' resistance to discharge, because, *"I didn't think in the long-term they could continue to sit and watch over her every night*".

71. Locket was seen later in the afternoon of the 4th August 2021 by **Dr Cedric Leclercq**, who told me that he is a Consultant Child and Adolescent Psychiatrist and also an Adult Psychiatrist, with specialist experience in neurodevelopmental conditions. Dr Leclercq said he was employed, on a part-time basis, in CAMHS Community Team from July 2021, when he inherited a large case load with a backlog of appointments. He said that by the end of September he had a caseload of 50 young people, all with risks comparable to Locket's. The appointment on the 4th August had been arranged because he had become Locket's allocated psychiatrist. The witness said that he read Locket's notes and spoke to Dr Mura and Amanda Watson before meeting Locket.

72. Dr Leclercq told me that he recalled his meeting with Locket well. He talked to them for some time and started to build their therapeutic relationship. He said Locket engaged in the conversation and was very articulate, bright, and insightful. Their mind was very active, with ideas racing. The witness spoke of Locket being a perfectionist, of not wanting to be a burden, and of not being understood. Dr Leclercq said that it was clear that Locket was over-thinking life and was exhausted and anxious, leading to thoughts of self-harm and suicide which they could not calm down and regulate, and there was an obsessive anxiety around it. He said that Locket, "…*mentioned clearly that self-harming was less of a problem now than it had been previously…. But from time to time she had these moments of very high thoughts of getting rid of this over-thinking and of maybe committing or taking an overdose, it was there but at the same time she was clear about, "I don't want to die, and I have many things I want to do in my life". So it was very clear that at least an important part of her suicidal thoughts were related to, "I tried to find a way to be relieved from these over-thinking thoughts and anxiety, and I don't know how*"". Dr Leclercq said that in seeking to assist a young person with periodic suicidal ideation, the central issue was not identifying triggers and predicting suicidality, but reinforcing protective factors, meeting their needs, and supporting them to think for themselves through the therapeutic process.

73. Dr Leclercq said that Locket was definitely indicating that they wanted to receive help and that, without doubt, they would engage in treatment. He said Locket had responded positively to Amanda Watson which meant that an effective therapeutic relationship had started. The witness was asked whether he considered Locket's condition to be treatable, and how effective he expected therapy would be. He said, "…*this is not black or white so by considering that it was treatable it does not mean we are certain it will work. But … if I do what I do with my patients, usually, she should benefit from it. And there is a good reason to believe that we can get there really because she was engaging, she was bright, she had many resources. … and I was also reassured by the fact that there was some therapy process with Mandy, really started and with the Hope Service being there as a safety net if needed. And with, well, yes, the good relationship we had and the medication we can expect also some help there*". So far as the start date for the CBT itself was concerned, he said, "*…the sooner the better, clearly and she was ready, in my opinion, to have it started the next day*". He said that his mindset had always been,"…*let's start therapy as soon as possible and do not wait for a patient to be cured before starting therapy*". Dr Leclercq also reviewed Locket's medication and decided to increase the dose of sertraline, to change the sleep medication, and to add a prescription for lorazepam for the anxiety

symptoms. He did not, he said, become involved in the question of whether Locket should be discharged from hospital, but his view was that there was no need for them to be admitted to a psychiatric ward.

74. On the 5th August 2021, Claudia Gerrie sent an email to her Service Director, Dan Kataka, and to Carol Adamson, the Assistant Director, stating,

"*… Since this Child Protection Plan has been active, Lucy took a second overdose on 20 June, then last week Lucy left the family home after parents had gone to bed and she went to a road bridge … from where Lucy called police who took her to Frimley Park ED. Lucy was assessed by the con Psychiatrist there. CAMHS reviewed Lucy again yesterday and she and parents declined discharge from hospital. CAMHS has a planning meeting this morning that Ufuoma and I will join. Ufuoma is rightly concerned about the support in place for Lucy's mental health; their current plan appears to be counselling, CBT, EDT out of hours and medication PRN in the event of agitation. CAMHS does not identify a need for Tier 4 admission*."

Dan Kataka replied, stating that it would be useful to know what the proposed plan to manage this risk in the community is when she is discharged. He stated, "*We can then escalate this to senior managers if we feel the risk is too high for her to return home. Often in these situations we support the parents who know the child very well to insist on admission to a ward as an in-patient for an assessment as the minimum. I am concerned that this is not the first time she is doing this. I am also concerned that no foster carers will agree to have a child presenting with suicidal ideation. She needs to stabilise … preferably on a hospital ward before she goes back home or in any sort of placement. Given the history, I feel that a 28 day assessment as an in-patient is essential. But the health professionals may have a different view. …*"

75. Claudia Gerrie said she did not make a record of what happened at the subsequent meeting with CAMHS, which was attended remotely by herself, Ms Edegbe, and Mr Kataka, but she recalled that they raised concerns about Locket's mental health and what CAMHS were going to do. She agreed that the outcome of the meeting was that Locket should be discharged home but, Ms Gerrie said, this was with a support plan in place, which included, for the following two weeks, support from the Urgent Care Team, an extension of the Hope short-term support, and the availability of the Extended Hope Service. Ms Gerrie said she was reassured that CAMHS were putting in place a sufficiently robust plan and she recalled that Mr Williams had also been content with it, which was important. The witness said she thought they had also been told that the

CBT was to start in "*a couple of weeks*". I will note here that although Ms Gerrie said she was satisfied with the plan at this stage, she did also tell me that she regretted not escalating the concerns about CAMHS at an earlier stage, particularly in view of the frustration that Ufuoma Edegbe had felt for some time.

76. Ms Edegbe said that, following Locket's discharge, she visited the family at home on the 6th August 2021 and recorded that Locket looked well, felt better on the medication, and felt that they were now being listened to. Locket understood that the CBT was to start "*sometime in the third week of August and she is excited about that*". Ms Edegbe said that as Locket had been seen by a psychiatrist and CBT was due to start, the parents felt matters were being taken more seriously and they felt more confident to have Locket home.

77. On the 16th August 2021, Locket was seen again by Amanda Watson who said that Locket shared an experience from the previous week, "*…where she felt her brain was racing. She felt that everyone outside of her brain was slow, and she felt motivated and full of energy. She felt anxious and managed her feelings by calling a friend and splashing cold water on her face, and watching a film. Lucy reported that she does not feel fully recovered from this. She has not self-harmed, however, she has lots of thoughts that everyone wants her to stay alive, and she doesn't. Feels she is staying alive as everyone is making plans for her to do so. She shared that at the end of Grandma's garden there is a train track. She reported to having thought about the trains. However, she adamantly confirmed that she had the thought, but had not acted on the thought and as it would be wrong. And then she shared other thoughts when cooking, how she could just burn her hand. She has not, but she knows she could do. Lucy has no means to self-harm. She says everything's been taken away, so she has been biting her lip. I asked her what she would like to work on for our sessions and she said reducing the self-harm. Discussed strategies that she found helpful and others that have not been so good. Lucy will try a different technique with ice, as well as spicy foods. She has not completed her Hope box, emergency box, and was encouraged to do so. She has also shared that she is learning Italian through an App, enjoying this and would like to study in Italy. This was positive. ... Lucy would like to meet once every two weeks. Mum is okay with this, and Lucy or Mum will call if she needs support in the interim*". Ms Watson was asked whether she considered she was undertaking a programme of work at this stage that had to be completed before CBT could start and she said that she did not consider this was the case.

78. Dr Leclercq saw Locket again on the 18th August 2021 when, he said, they were positive about their relationship with Amanda Watson and were

looking forward to working with Dr Kempa. Locket also spoke of plans for their future, including studying in Italy. Locket indicated that family therapy was currently impossible and that they wanted to concentrate on individual therapy. The doctor made no changes to the medication prescriptions. He said that Locket's presentation was improved and he did not consider there was masking of their true state; he said that Locket's emotional dysregulation would have made it very difficult for them to mask their feelings and to convince a doctor that they were improving if that was not the case.

79. Emeka Nwosu told me that he visited Locket at home on the 8th, 12th and 20th August 2021, on each occasion finding no crisis and an improving picture on the prescribed medication, and he then discharged Locket from the Hope Service. The witness was asked who, if anyone, was then responsible for staying in regular contact with Locket and monitoring risk. He said that this would be CAMHS' Community Team, but that contact would be through Locket's attendance at the clinic rather than through home visits.

80. On the 23rd August 2021, there was a professionals' meeting and Ufuoma Edegbe was told that the Hope Service were discharging Locket and transferring them to CAMHS' Community Team. Ms Edegbe told me that she was aware of the delay in CBT starting which, she had understood, was because of the lack of availability of a therapist. On the 24th August 2021, Mr Nwosu wrote a discharge letter to Locket's General Practitioner in which he summarised the care which had been given and then stated, "*Risk on discharge is currently **LOW***", which assessment, he told me, was based on the recently improving picture and Locket's current level of engagement. By way of comment, I will record here that it is very difficult to see how this risk level could be justified. Mr Nwosu had himself, only about three weeks earlier, recognised that Locket's risk was high because of the unpredictability and changeability of their mood and suicidality.

81. On the 23rd August 2021, the fourth Core Group meeting was held and was attended by Locket's parents. Although the other core participants did not attend, the record shows that the new Safety Plan was recognised and no further concerns were raised.

82. Amanda Watson told me that she met Locket on the 2nd September 2021. Locket said that over the past few weeks, their mood had been low and their anxiety high. They could not complete the worksheet to monitor mood as it changed too quickly. They reported self-harming behaviours

on occasions where they would bite their lip. Ms Watson recorded that, "*Lucy says that she constantly thinks about taking her life. However, she will reflect that there are people who don't have the support she does and feels sad for people who are using services, and as a result has stopped following someone who was posting about their life in a psychiatric hospital as it distresses her. I was also very conscious that the 2nd September is back to school and that was a huge anxiety for her as well. Lucy also shared that she would love to live in a world following an apocalypse, where she would meet someone and be able to have everything she wanted from shops as there would be no one to stop her. I asked what she would look like, and she said she would be non-binary and would be known as Seven and would wear a style of clothes called tech wear. I showed Lucy some handouts to look at mood and what would work for her. Some of the handouts were basic. She felt it was something more her brother would understand*", that being a reference to their simplicity. Ms Watson was asked whether she considered that her work with Locket was effective and she said she felt that their sessions were very helpful for them as they provided a safe space to share worries. Ms Watson advised Locket to monitor their mood within two hourly intervals, listen to music, think happy thoughts, especially if their mood is dipping, work on the Hope soothe box, organise prompts, and ensure that she has activities to hand to distract her. Following this session, she scored the RCADS which had been completed by Locket, and found that the scores were above the threshold for separation anxiety and panic, depressive disorder, and total anxiety and depression.

83. Teresa Fanshawe told me that after the new school term started, All Hallows School was "*getting telephone calls to say that Locket's mental health was not great*" and that Locket was off school on a number of days; their attendance was reduced to 68%. However, when she saw Locket, they were "*very excited because there was going to be a party, and she had been invited, and it was a sleepover …*".

84. Ms Edegbe visited Locket on Thursday the 9th September 2021, and was given a letter Locket had written, in which they expressed upset at being asked to keep their bedroom tidy and about the ongoing involvement of Children's Services. The witness said that, mentally, Locket was not in a good place and appeared to be fragile. Mr Williams reported that Locket's anxiety had increased since school started and they had not attended since Monday. Ms Edegbe recorded that Locket continued to access mental health support from Dr Leclercq and was benefitting from those sessions, and that CBT was expected to start soon.

85. On the 16th September 2021, Amanda Watson met Locket as planned. She found Locket to be settled in mood. They had returned to school for three days the previous week, but felt anxious and so did not go in for a few days. However, they had managed every day so far this week. Ms Watson recorded that Locket, "*described a panic attack earlier today when she was in English. Went to the medical room and counted back from 100 and drank water, which helped. … she said mood remains up and down, averaged it at around two to three out of ten. Has noticed it has had some high points, especially when at a friend's birthday party. ... Mood dropped when she caught sight of herself in a mirror. Lucy shared that she doesn't like the size she is, she'll often compare her size against others. … Lucy has thoughts of suicide daily, always present. She manages them by banging her arm until it stings and will then use red watercolour paint to paint her arm. This brings relief and the paint and pain will wear off. Explored or attempted to explore a safer way to manage, however, Lucy did not wish to have that conversation. Lucy has, however, not self-harmed as regularly as she used to. She has not made any attempt on her life and is looking forward to studying economics, further maths, and English at college. She'd also like to meet her friend in California and go to Italy. …She felt she was okay, and is looking forward to starting her therapy with Monika, as well as going to a friend's birthday celebration on Saturday. I explained to Dad and Lucy I'm on leave for a week, and if there are any concerns, they can call duty or crisis helplines*". Amanda Watson said this was intended to be her last session with Locket, because she was going to be starting the CBT. She was asked whether the realistic and accurate way to describe the work she had been doing with Locket, was "*monitoring and some support with coping techniques while they were waiting for the CBT to start*" and she agreed. She said that it was not treatment but was "*continuative care*" which was, effectively, filling the gap.

86. Ms Edegbe visited the family on the 23rd September 2021 and this proved to be her final contact with Locket. Mr Williams said Locket was experiencing raised anxiety but Locket's mental health was stable. Locket had returned to school and was due to start CBT the following day. Ms Edegbe spoke to Locket and although "*there were always suicidal thoughts*", Locket was managing them and the medication appeared to be working well. Locket talked of specific plans for university and the future, which Ms Edegbe considered were genuine. Overall, she had no acute concerns for Locket or the family at that time.

87. On the 24th September 2021, Dr Kempa held her first CBT session with Locket. She said that after speaking to Amanda Watson, she "*had the sense that there was an improvement compared to the previous weeks*". She said the purpose of the first interaction was to build rapport and formulate goals.

Locket said that they wished to be known as Seven. Locket reported, "*Ongoing suicidal thoughts …doesn't want to live but all means of self-harm, suicide were removed so they are safe because others keep them safe. Seven is frustrated that they can no longer self-harm because that gave them some sense of control and relief. Seven said other coping strategies don't work as well. Lots of frustration expressed. … Self-harm and eating considered by Seven to be the best forms of exercising control. All other areas seemed to be out of control. … Seven has returned to school. Considers it stressful. GCSE prospect is scary. … Is planning to do A Levels and go to university. Seven is in school full-time but has missed odd days due to anxiety*." The witness explained that she discussed the CBT model with Locket who responded positively. Dr Kempa thought that both CBT and DBT may be necessary. She said that Locket was animated and well engaged throughout the session; they volunteered information and, at the end, agreed to keep a "*situational diary*" to capture their thoughts, feelings, behaviours and physiological reactions, in preparation for the next meeting on the 1st October 2021. Dr Kempa said that she had not felt that Locket was emotionally upset by the session, nor daunted by what was to come.

Events of the 27th and 28th September 2021

88. Hazel Williams stated that on the evening of the 27th September 2021, Locket had said they had a "*busy head and wanted some medication, she was very unsettled*". Stephen Williams' recollection was that, "*Nothing out of the ordinary had happened. We were at home during the evening, and we all went to bed. As usual, I got up at about 3:00 am to get ready for work. On getting up, I realised the front door of our house was ajar. I went upstairs and saw Locket's room was empty. Her stuff was in her room and some handwritten notes were lying on her bed. … I got into the car and drove around the local area. I drove onto the nearby roundabout junction over the A331 Blackwater Valley dual carriageway and saw a lot of police activity. Fearing the worst, I got out of the car and almost immediately saw Locket on the road. I realised it was Locket as I recognised the clothing. I was spoken to by the police, and they brought me back home. I showed the police Locket's room and the handwritten notes … we are content they are written in Locket's handwriting*".

89. The evidence of **PC Wayne Rogers** of Surrey Police was read. He attended the scene on the A331 at Ash. Recognition of life extinct was performed by **PS Geoffrey Hill** at 00:01 hours on the 28th September 2021. The witness recorded that Locket had jumped from a bridge onto the A331 road where they were run over, by more than one vehicle,

travelling northbound on the road. The exact location was the overhead bridge on the flyover crossing the A331 Blackwater Valley relief road and the Aldershot slip road. **PC Iain Lumbard** of the Forensic Collision Investigation Unit stated that the incident occurred during hours of darkness on an effectively unlit stretch of a national speed limit dual carriageway. The witness was not critical of the manner in which the vehicles had been driven and the police concluded that none of the drivers of the vehicles could have avoided colliding with Locket.

90. A post mortem examination was performed by **Dr Chapman**, Consultant Pathologist, and it was his opinion that the medical cause of death was

    Ia Multiple Injuries.

    In relation to the toxicological testing, Dr Chapman stated,

    "*Locket was prescribed sertraline, and the results are in keeping with such a scenario. They were prescribed lorazepam, a benzodiazepine drug, but it was not detected in the vitreous humour sample. I would, however, not necessarily expect to detect low therapeutic use of the dose prescribed. The results rule out use of a high dose of the drug in the few hours prior to the incident. No alcohol was detected in the vitreous humour sample, and the results rule out Locket consuming a significant amount of alcohol in the few hours prior to the incident. The analysis for cannabis, metabolite only, was inconclusive, and I am therefore unable to comment on the involvement of cannabis at the time of the incident*".

91. The handwritten note which was found in Locket's bedroom by Stephen Williams stated as follows,

    "I did it ! I fooled all of you. I told you I overdosed before it killed me. I called the police on myself. I was enthusiastic to answer your questions. I feigned a future for myself so everyone believed I was hopeful and thought I would live that far. Does this mean I win ? I had everyone fooled. In reality, I knew I'd never live. I will never be healthy, I will never be mentally okay. I will never be skinny. I can dream all I want but I'll never live up to any of it. What is the point of prolonging a truly unhappy existence. It's a real shame because my friends are truly the best in the entire world. They are so awesome, and it really sucks that I'm leaving them but oh well. They'll move on. I'm incredibly replaceable. I hate that it's happening like this but I'll be dead so who cares. I guess it's a shame I'll never watch another YouTube video LMAO. But at least I'm smiling forever as the person I want to be. Lots of love, Seven. …I failed. I was never really that good at anything anyway. I'm weak, let's admit it. I love you guys so very much. Thank you for not perceiving me as a girl. I love you, I'm sorry. Seven".

C. CONCLUSIONS

92. On the basis of the evidence I have received in this inquest I have reached the following conclusions.

93. In relation to the immediate circumstances of their death, I have considered whether Locket died as a result of suicide. This would be the case if I were satisfied that Locket died as a result of their own deliberate act and that they intended that act to end their life. I am satisfied that when Locket jumped from the road bridge, this was their own deliberate act; there was no third party involvement and no evidence to suggest this happened accidentally. I am also satisfied that it was Locket's intention to end their life. Locket had openly discussed their suicidal ideation and intentions on many occasions and to many people, and had expressed an intention to end their life in the notes found on their telephone, and expressly in the handwritten note found in their bedroom. Further, I find that Locket would have appreciated that the nature of the act of jumping from the bridge and into the path of the traffic below would almost inevitably result in their death. I have borne in mind that, on some occasions, Locket told others that they considered suicide in order to stop their thoughts and feelings, but that they really wanted to live. However, I must decide what was Locket's intention at the time they jumped from the bridge, and for the reasons I have given, I am satisfied that, at that time, Locket had decided to end their life. In the circumstances, I do find that Locket died as a result of suicide.

94. As stated above, the scope of this inquest has included investigation of the extent to which Locket's risk of suicide was recognised, monitored and addressed by relevant state agencies, namely Surrey County Council and Surrey and Borders Partnership NHS Foundation Trust acting individually and/or in the context of multi-agency processes. In this regard, I find the following relevant facts:

    a. Prior to their death, Locket had a long history of self-harm, suicidal ideation, and suicide attempts. There was reported self-harming from October 2018 and a referral to CAMHS, with a report of self-harm and suicidal ideation, in October 2020. Thereafter, Locket told many professionals that they lived with persisting thoughts and urges to self-harm and take their life and I find this to be the case. Although their intensity varied, doubtless affected by Locket's highly changeable mood, it is clear that Locket lived with regular thoughts of suicide which they could not effectively eliminate or control. Those thoughts led to Locket's

three suicide attempts, in February, June and July 2021, and their death in September 2021. For the avoidance of doubt, I do find that the incidents in February, June and July 2021 must be viewed as suicide attempts; the two overdoses both involved a very high number of tablets, and in July 2021 Locket went to the road bridge with the intention of jumping from it, pulling back only because they became frightened of the height,

b. Whatever may have been the underlying cause or causes for the deterioration in Locket's mental health, by the time she was assessed clinically in April 2021, there was clear evidence of psychiatric conditions. Esau Mbanini found evidence of social phobia, major depressive episode, generalised anxiety, and panic disorder. In May 2021, Locket's first assessment by a Consultant Psychiatrist, Dr Afridi, resulted in his impression of Depressive Disorder and Emotional Dysregulation and these were working diagnoses which were endorsed by the psychiatrists who subsequently saw and assessed Locket,

c. Importantly, I am satisfied that from April 2021 onwards, it was recognised by all the clinicians involved that Locket's condition was, potentially at least, treatable by CBT and that they needed that treatment; that is why, in April 2021, Locket was put on the waiting list to receive it. I am also satisfied, however, that the high level of risk faced by Locket was not fully recognised by the clinicians at this stage, and that there was a consequential failure to recognise that Locket needed to receive treatment quickly. I heard no evidence to suggest that any or any proper assessment was made of the likely impact of a wait for treatment, nor of whether Locket could be kept safe whilst waiting for as long as nine months on the Community Team's waiting list. I find that such assessments would have revealed that treatment was needed more quickly,

d. On the part of CAMHS, I am satisfied that there was a delay in diagnosing Locket and recognising their need for treatment, not least because Locket was not seen at all between the date of the first referral in October 2020 and their suicide attempt in February 2021, and there was then a further delay until March 2021 until CAMHS Crisis Team saw them. Further, once the need for CBT was recognised, there was a failure to commence that treatment in a timely manner, which is to say, within a timescale which was commensurate to the nature and severity of Locket's mental health conditions and their high risk of suicide. This delay was despite CAMHS being pressed regularly for treatment to commence by Locket, by Locket's family, by Locket's school, and by Children's Services. I find that the support provided prior to Dr Kempa's first CBT

session in September 2021, did not amount to effective treatment; it may have been helpful to a degree, but it is clear from the evidence that Locket did not consider it to be effective treatment, Esau Mbanini and Emeka Nwosu denied that they were providing treatment, and Amanda Watson accepted that her support was not treatment but was "*continuative care*". I find, not least on the basis of the express views of Dr Mura and Dr Leclercq, that Locket needed the CBT to start months earlier than it did, and that there was no need to delay the start of the treatment in order to "*stabilise*" Locket,

e. I find that the delay in the CBT starting resulted in part from:

(i) a lack of continuity of care and a lack of clarity as to who was responsible for Locket's care and who had responsibility to advocate for them; Locket was seen by four Consultant Psychiatrists, none of whom was the responsible clinician with the role of overseeing their care or advocating for their needs; further, Locket was managed under a number of different teams (the Psychiatric Liaison Service, the Crisis Intervention Team, the Hope Service and the Extended Hope Service, the Urgent Care Team, and the Community Team) and, as I have found above, there was some disagreement about the remit of some, in particular the Hope Service; additionally, Locket was in the care of two Allocated Clinicians or Care Co-ordinators, neither of whom apparently considered it part of their role to press for and, if possible, secure timely treatment, including by consideration of the use of the Hope Day Service provision if necessary,

(ii) a lack of available psychologists in CAMHS Community Team, and

(iii) an underestimate of Locket's risk level by some; in this regard, I note for example, that when Locket was referred for CBT their risk level was described as only "*medium*", and when they were discharged from the Hope Service they were described as being at "*low*" risk by Emeka Nwosu, an assessment which was based on Locket's recent presentation but which took a wholly insufficient account of their longitudinal risk,

f. The question of whether the delay in the CBT commencing more than minimally contributed to Locket's death is one I have considered with caution and considerable care. As Dr Leclercq explained, and I accept, there would have been no guarantee as to the effects, or effectiveness, of the CBT, whenever it had started. There were, however, high hopes for its effectiveness for Locket because of their intelligence and insight, and their keenness to engage and receive help. Locket indicated more than

once their desire to live, voicing clear hopes and plans for their future. CBT was not a quick fix, but had it been started in a timely manner, I consider there was a realistic prospect of success, at least to the extent of helping Locket to manage their suicidal ideation and impulse. I am conscious that, of course, the first session of CBT had taken place shortly before Locket's death, and I have considered with care whether this suggests that Locket may have acted to end their life in response to the start of the treatment, whenever the CBT had commenced. However, the evidence does not suggest that Locket took their life in response to the CBT therapy, for example because it was too challenging. Dr Kempa told me, and I accept, that Locket had engaged well, was not distressed, and had not found it daunting. Rather, I find that the therapy had simply started too late; I accept the family's evidence, that the delay had caused Locket to lose faith to an extent, and by the time the CBT started, their level of despair and lack of self-worth had become entrenched; this is reflected, I find, in Locket's handwritten note, and is the reason Locket acted as they did, despite the long awaited treatment finally starting,

g. It is suggested on behalf of the family that there were also causative failings relating to Locket's medication and the clinicians' decision-making concerning Locket's potential admission to a psychiatric ward or a Hope bed. Having considered these matters carefully, I am satisfied that all relevant decision-making on those matters can properly be seen as clinical judgments, none of which was obviously wrong; further, I do not consider that there is any evidential basis on which I can properly view those decisions as more than minimally contributory to the death. So far as the medication is concerned, questions were put in relation to the prescribing of sertraline, but none of the psychiatrists from whom I heard disagreed with Dr Afridi's prescription of it, indeed, they continued it. I have no evidence before me to show that it ought not to have been prescribed or continued, nor that its use contributed to Locket's death. So far as admission to a psychiatric ward or a Hope bed is concerned, the question of whether Locket needed to be admitted or could safely be managed through tier 3 services, was a question of clinical judgment; I was told that there are many reasons why management out of hospital is preferable and that admission can be detrimental to the patient, and in this regard I note that Locket's contact with another suicidal young person, when in Frimley Park Hospital, had caused them considerable distress. I accept that admission to a psychiatric ward or a Hope bed, following the June or July 2021 suicide attempts, may have provided Locket with additional support and may have kept them safe whilst in hospital (although it would not necessarily have done so), but I do not consider that there is any evidential basis for

my concluding that the absence of a period on a psychiatric ward or in a Hope bed more than minimally contributed to Locket's death, and

h. I have considered also whether there were any failings on the part of Children's Services which could properly be said to have more than minimally contributed to Locket's death. I have concluded that there were not. I find that Children's Services acted promptly to initiate child protection and took proper steps to formulate and implement a plan, staying in regular contact with Locket and the family and providing support. It is correct to say that their role was to lead other state agencies in that regard, and that they did not secure CAMHS' attendance at all Core Group meetings, but I do not consider this was causative of death. I accept, as Ufuoma Edegbe asserted at the time, that it became clear that what Locket needed, crucially, was therapeutic intervention and responsibility for delivering that lay with CAMHS. I have noted Claudia Gerrie's regret for not escalating Children's Services' concerns about CAMHS earlier, but I do not consider that I can be satisfied, on the evidence, that this would have resulted in a different outcome, not least because it is clear that CAMHS were already aware of concerns about delay in treatment being expressed by Ms Edegbe, as well as by the family and others.

D. RECORD OF INQUEST

Legal Submissions

95. I received written legal submissions from the Interested Persons, all of which I have read and considered. There are only two matters which, I consider, I need address expressly. They are (i) the engagement of Article 2 of the ECHR and (ii) Neglect.

96. Article 2 ECHR: I am invited by Surrey County Council and Surrey and Borders Partnership NHS Foundation Trust, at this stage and having now heard all the evidence, to rule that the procedural duty under Article 2 is no longer applicable in this inquest. I have reconsidered the issue but, in the light of the evidence I have heard, I remain of the view that there are arguable breaches and that the procedural duty continues to apply. I find that Locket's risk of death from suicide was a real and immediate one at the time of their death. The risk may have fluctuated to a degree, but I find that it was chronic and persistent in nature, giving rise to a relevant longitudinal risk, and I note the relevance of Johnson J's judgment in

Traylor v Kent and Medway NHS Social Care Partnership Trust [2022] EWHC (QB) in this regard.

97. The two state agencies argue that the test set out in *Rabone v Pennine Care NHS Foundation Trust* [2012] UKSC 2 AC 72 is not satisfied, and the family has submitted to the contrary. I consider that the test is satisfied. For the reasons set out above, I consider that there was a real and immediate risk to Locket's life, and I consider that there is abundant evidence of Locket's vulnerability and the exceptional risk they faced. So far as the state's "*assumption of responsibility*" is concerned, I have considered carefully the arguments of Mr Turner in paragraphs 3 to 10 of his written submissions. I do not accept that the effect of the case law is to limit the circumstances in which there can be a relevant assumption of responsibility to circumstances in which the deceased person was either detained or was a voluntary inpatient in a psychiatric unit, that is too narrow an approach. Rather, I find that the state were very well aware of the specific risk to Locket's life from suicide and that there was an assumption of responsibility, by Surrey and Borders Partnership NHS Foundation Trust, in relation to that specific risk; the care which was given, and the planned CBT treatment, was intended to address the risk of suicide. I am, therefore, satisfied that the *Rabone* criteria are met and that it is not necessary for me to consider the test set out in *R (Parkinson) v HM Senior Coroner for Kent* [2018] EWHC 1501 (Admin).

98. In view of this decision, it is uncontentious that I must record any failings on the part of the state agencies which probably more than minimally contributed to Locket's death. In the light of my findings above, I intend to record that Locket's death was more than minimally contributed to by CAMHS' initial delay in assessing Locket's condition and needs, and their underestimation of Locket's risk of suicide, and their failure to deliver necessary therapeutic treatment in a timely manner. In my discretion, I may also record any possibly causative failings, but there are no matters which I intend to record on that basis.

99. <u>Neglect:</u> Mr Kherbane and Ms Gourley invite me to consider recording a finding that Neglect on the part of CAMHS contributed to Locket's death. Mr Turner and Mr Murphy submit that Neglect is not open to me on the evidence.

100. I have considered whether there is any proper basis for recording Neglect. According to the Court of Appeal's ruling in *R (Jamieson) v HM Coroner for North Humberside* [1995] QB 1, this conclusion may be appropriate where there is evidence of a gross failure (meaning a very

serious failure) to provide or procure basic medical attention for someone in a dependent position, in the face of an obvious need for such attention. There must be a clear and direct causal connection between that failure and the death; the causal connection is satisfied if the failure represented a missed opportunity to render care which would have prevented the death (see *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin)).

101. I have concluded that it would not be appropriate to record Neglect. Whilst I have found failings on the part of CAMHS, I am not satisfied that they can properly be characterised as constituting "*neglect*" in the sense intended by the judgment in *Jamieson*. In particular, whilst I accept that neglect is not limited to those cases in which there has been a failure to take any action, the concept is concerned with a gross failure to act in the face of obvious need for basic medical attention; in my view, given the steps which were taken by the Trust between March and September 2021, it would not be correct to characterise the failures I have identified in that way.

Entries on the Record Of Inquest

102. I shall, therefore, record the following on the Record of Inquest :

Box 1 :

Lucy Ure Willimas, known as Locket Ure Williams

Box 2 :

Ia Multiple Injuries.

Box 3 :

Locket Williams was 15 years of age when they died. They had a history of self-harm, suicidal ideation, and suicide attempts. This history included a referral to Surrey and Borders Partnership NHS Foundation Trust's Children and Adolescent Mental Health Service, with a report of self-harm and suicidal ideation, in October 2020, and three subsequent suicide attempts, in February, June and July 2021. Locket

was suffering a Depressive Disorder and Emotional Dysregulation and, in April 2021, they were placed on the waiting list for Cognitive Behaviour Therapy, which was expected to be effective in treating their conditions and controlling their suicidal ideation. Although Locket was prescribed medication, and received some monitoring and support from the Children and Adolescent Mental Health Service, the Cognitive Behaviour Therapy did not commence until very shortly before their death, and no effective treatment had been provided prior to their death.

On the night of the 27th September 2021, Locket left their home and walked to the overhead bridge on the flyover crossing the A331 Blackwater Valley relief road and the Aldershot slip road, from where they jumped to the road below. Locket's death, from consequential injuries, was recognised at 00:01 hours on the 28th September 2021.

Box 4 :

Locket Ure Williams died as a result of Suicide.

Their death was more than minimally contributed to by Surrey and Borders Partnership NHS Foundation Trust's Children and Adolescent Mental Health Service's:

(i) delay in assessing Locket's condition and needs,
(ii) underestimation of Locket's risk of suicide, and
(iii) failure to deliver necessary therapeutic treatment in a timely manner.

I would like to record my thanks to counsel for their work and assistance, which I have appreciated, and to pass my very sincere condolences to Mr and Mrs Williams, to Emily Buckley, and to Locket's wider family.

Richard Travers
HM Senior Coroner for Surrey

31st May 2024