Findings and Conclusion

A. INTRODUCTION

1. This has been the inquest into the death of Jennifer Sharren Chalkley. In this document I will refer to Jennifer Chalkley as "Jen", as we have done in the course of the inquest.

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

a. Sharren Bridges, Jen's mother, represented by Maya Sikand KC,
b. Neil Chalkley, Jen's father, also represented by Maya Sikand KC,
c. Surrey and Borders Partnership NHS Foundation Trust, represented by Simon Turner of Clyde & Co, Solicitors,
d. Surrey County Council, represented by Katie Ayres of counsel and, on the 15th February 2024, by Annie Mackley of counsel,
e. Guildford College, represented by Cian Murphy of counsel, and
f. From the 5th February 2024 onwards, Michael Oyadeyi, represented by David Manknell KC and, on the 15th February 2024, by Sophie Mortimer of counsel, and on the 1st May 2024, by Brooke Foster of Hill Dickinson, Solicitors.

3. Jen was 17 years of age when she died on the 12th October 2021 at her mother's home address. At the pre-inquest stage, it was agreed that the scope of the inquest should include investigation of the following specific matters:

a. Jen's medical history, including her mental health,
b. Her diagnoses of Attention Deficit Hyperactivity Disorder and Autistic Spectrum Disorder and their relevance to her behaviour, needs, and risk levels,

c. Jen's history of threatened and actual self-harm / suicidal ideation and/or acts and her consequential risk, and the extent to which relevant state agencies were aware of the same,
d. The extent to which Jen's needs and her 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),
e. The direct circumstances in which Jen came by her death, that is the events which occurred on the 12th October 2021, including her actions, intentions and state of mind,
f. The medical cause of death, and
g. Any prevention of future deaths issues arising.

4. Further, in a written Ruling dated the 21st November 2023, I indicated that the inquest must satisfy the procedural requirements of Article 2 of the European Convention on Human Rights. Subject to my reviewing that decision at this stage (which I do below), this means that 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) she came by her death.

5. 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 conclusion. However, in reaching my findings and conclusion 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.

6. Set out below are my findings and conclusions. All my findings have been reached on the balance of probabilities. Unless stated otherwise in my findings below, I found the witnesses from whom I heard oral evidence to be truthful and doing their best to assist me. Therefore, unless I have

stated otherwise, 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. Where I have found facts contrary to a witness' evidence, I shall say so expressly.

B. REVIEW OF EVIDENCE AND FINDINGS OF FACT

Background

7. I received written evidence from Jen's parents and was told that Jen was born on the 2nd February 2004. Jen's parents separated when she was very young and she then lived with her mother until she was 16 years of age, when she went to live with her father, stepmother and half-sister. Ms Bridges has a disability and Jen acted as a young carer when they lived together.

8. Ms Bridges also told me that in June 2014, when Jen was 10 years old, she was diagnosed with Attention Deficit Hyperactivity Disorder ("ADHD") by Dr Fernandez, a paediatrician at Epsom General Hospital. This was followed by a diagnosis of Autistic Spectrum Disorder ("ASD") in September 2015. These diagnoses confirmed Ms Bridges' long-held concerns about Jen and her behaviour, concerns which she had raised with her GP and Jen's primary school over the years. Despite the problems, Ms Bridges said that Jen seemed to thrive at her primary school, Eastwick Primary School, which was a nurturing environment, but it was when she started at her secondary school, which was the Howard of Effingham School, that matters became more difficult.

9. I do not, at this stage, set out the evidence of Ms Bridges and Mr Chalkley concerning what followed, although their accounts are reflected to some extent in my review of the evidence below.

The Effect of Jen's Neurodevelopmental Conditions

10. I did not hear evidence directly from the Eastwick Primary School, but it is clear from the records that Jen's difficulties were apparent from a young age. In May 2014, the school's Special Educational Needs Co-ordinator ("SENCo") supported a referral of Jen, by the family's General Practitioner, to the paediatric team at Epsom Hospital, recording her concerns as follows:

"Our concerns are both academic and social and can be summarised as follows.

- *In spite of support in the classroom, Jen has not made expected progress. She is a slow processor, finds it very difficult to organise her thoughts in writing. She is also often disorganised, both at home and at school and can misinterpret tasks.*
- *Jenny is easily distracted and finds it difficult to focus on her work without adult intervention. She rarely completes a task that has been differentiated for her. Mum reports that she struggles to complete tasks set for homework and can sit for hours doing nothing. She struggles to get herself dressed ready for school in the morning or for horse riding at the weekend. …*
- *She has few friends in school and prefers the company of younger children outside school. She is often on the outside of groups and is never invited to parties.*
- *She has sensory issues eg she is very particular about socks and is very sensitive to the feel of material. …*

We have had concerns about Jennifer since she started in year 3. Mum did raise these concerns two years ago and we are now raising them again and wonder whether her inattention and slow processing could be examined more closely by the paediatric team."

11. As stated above, Jen was seen by Dr Patrick Fernandez, a Speciality Doctor in the Paediatric Department of Epsom General Hospital. In June 2014, he diagnosed ADHD and recorded "*low self-esteem and emotional immaturity*" and "*other concerns*". He wrote to the family, the GP, and the school indicating that Jen would "*need a high level of support in the school environment to help her with her academic and non-academic learning*". Dr Fernandez reviewed Jen over the following months and, by the summer of 2015, was also concerned she may have a "*social communication disorder ?*

autism". He went to diagnose ASD, as well as recording, "*Significant difficulties with social communication resulting in difficulties in social emotional reciprocity; Deficits in understanding social relationships; Emotional immaturity; Low self-esteem; Literal use of language and difficulties with higher language function; and Difficulties with settling to sleep*", as other current concerns.

12. I did not receive evidence from Dr Fernandez himself, but I did hear oral evidence from other members of the paediatric team at Epsom Hospital who were subsequently responsible for Jen. **Dr Bozena Zoric** is a Consultant Paediatrician with very extensive experience of neurodevelopmental disorders such as autism and ADHD. I shall come to her evidence concerning her care of Jen below, but she also assisted this investigation by explaining the relevance of Jen's diagnoses to her mental health, and to her risk of self-harm and suicidal ideation. Dr Zoric stated that if a child has both ASD and ADHD, the development of mental health problems, especially anxiety and depression, is common, particularly in teenagers. Dr Noor Kafil-Hussain, also a Consultant Paediatrician at Epsom Hospital, told me of a Finnish study which provided an evidence base for the proposition that adolescents with ADHD showed a higher incidence of suicidal ideation compared to adolescents without that diagnosis (at 57% versus 28%) and that there is also a higher incidence of death by suicide. She agreed that young people with both autism and ADHD are at even more risk. Dr Zoric was asked whether, in those circumstances, anxiety and depression are part and parcel of the neurodevelopmental conditions or are additional psychiatric conditions. She said that it could be extremely difficult to disentangle where a neurodevelopmental condition ends and a psychiatric condition starts, but that it would be wrong to assume that low mood, excessive anxiety, and suicidality were simply the result of the neurodevelopmental conditions, because a mental health condition could also have materialised.

13. Dr Zoric said that whatever the cause, if low mood and suicidality develops, the child needs treatment and, in her view, treatment from mental health services. She said,

"*When there is evidence of self-harming, suicidal thoughts and general stress of functioning in school or at home, substance abuse, those are pointers towards*

mental health conditions. And that group of young people I would say are the ones that should be under the children and adolescent mental health services. Paediatric expertise does not stretch to manage mental health disorders. Once anxiety and depression occurs, I feel that regardless of what may have been the reason, that is where the expertise of people who know how to deal with anxiety and depression can come in".

Howard of Effingham School

14. I received oral evidence from **Amanda Collyer**, and written evidence from **Julie Menhennett**, both from the Howard of Effingham School ("HofE"). Jen was on HofE's roll from September 2015 until July 2020, between the ages of 11 to 16 years. Ms Collyer was Jen's "Year Manager", which is a pastoral role, and Ms Menhennett was the school's Assistant Principal and SENCo at the time.

15. Amanda Collyer explained that the school has around 1,500 students, aged 11 to 18 years, with class sizes of about 30 pupils. It is a mainstream school but it has some capacity to provide individually targeted additional support to meet the extra needs of students, for example through the use of Learning Support Assistants ("LSAs"). This was managed by the SENCo and the school's Inclusion Department.

16. Dr Fernandez' diagnosis of ASD coincided with Jen's move to HofE and, on the 28th September 2015, he wrote to Julie Menhennett, stating,

    "*I have given Jennifer a formal diagnosis of autism as she has significant difficulties with social interaction and social communication. She also has difficulties with higher language function and at times struggles with social use of language. I understand that Jennifer is currently still in her "transition group". However as time progresses Jennifer will need to be monitored fairly closely and if any difficulties arise she will need to be provided with appropriate support in keeping with her diagnoses and difficulties (eg Linden Bridge School outreach services).*
    I understand that the SEND team is well equipped to support pupils with autism and ADHD and I believe that the school will do its best to support Jennifer in order for her to develop holistically."

17. Ms Menhennett stated that Jen was not on the Special Educational Needs ("SEN") register at "SEN Support", and there was no written plan for her, but she was coded by the school as "Be Aware", so that her teachers were aware of her needs and could make reasonable adaptations to meet them (and, for example, she was timetabled so that she could share the LSA support that was in place for students with Education, Health and Care Plans). She said that Jen also received regular one-to-one support in managing her anxieties from Amanda Collyer.

18. Ms Collyer confirmed that she held weekly counselling sessions with Jen through which she came to know her well. These provided support with bereavement (in relation to the death of a family member) and, more generally, self-esteem, for which she used a "*very low-level cognitive behaviour therapy approach*". Ms Collyer said that Jen was immature and had difficulties with organisation, concentration, and friendships with children her own age. From the school's point of view, she managed quite well in her first two years, with some LSA support in class, although they were aware that the effort needed for Jen to cope at school caused her to have "*meltdowns*" at home.

19. Amanda Collyer said that it was in Year 9, which started in September 2017, that they saw a sudden decline. Jen became very worried about her GCSEs, her anxiety and sensory issues increased, and her attendance started to drop. In October 2017, the school sought advice from Limpsfield Grange, its ASD outreach service, and their recommendations were subsequently implemented. However, the concerns continued and Ms Bridges later reported that Jen was giving up on her personal care, spent a lot of time crying in her bedroom, and had stopped sleeping and eating properly, such that she lost seven kilos in weight within a few weeks; she also told the school that Jen was sleeping with objects which she hoped would strangle her in the night.

20. Consequently, on the 14th May 2018, Ms Collyer made an urgent referral to the Children and Adolescent Mental Health Service ("CAMHS"), which is provided by Surrey and Borders Partnership NHS Foundation Trust. She set out Jen's diagnoses and her complex needs, her history of increasing

difficulties with coping with school leading to angry outbursts, her not eating and sleeping, and her not wanting to live any longer. She stated,

"*Jenny will say she wants to die, she wants to do this by strangulation and will take to bed items that she hopes will get tangled around her neck such as dressing gown cords, ear phone wires – this has been reported to school by Mrs Bridges who removes these items when Jenny is asleep. … If Jenny becomes very angry about something she will lash out – in general she can manage this but behaviours recently mean this risk is heightened*."

21. On the 15th May 2018, Jen was extremely stressed at school; she told Ms Collyer that if she had any more stress, she would "*give in*" and do what was inside her head, meaning killing herself. Jen expressed ideas of stabbing herself with her Swiss Army Knife, hanging herself with a rope, overdosing on her own ADHD medication, drowning herself, or poisoning herself, and the witness said that Jen had researched some of these methods. Ms Collyer immediately telephoned CAMHS to pass on this further information.

22. Ms Collyer said that Jen did not attend school again that term. It became clear that Jen's suicidal thoughts were connected to the stress of school and HofE considered that, until she received therapeutic help, they could not meet her needs. Ms Collyer made an application for a temporary place for Jen at St Peter's Centre, which is a short-term educational provision for children who are unwell. Jen was accepted, and started to attend in September 2018, but she stayed on the roll at HofE, with the expectation that she would return in the summer term of 2019, after receiving treatment and therapeutic support from CAMHS.

The Application for Jen's Education, Health and Care Plan

23. Amanda Collyer told me that HofE did not apply for an Education, Health and Care Plan ("EHCP") for Jen, but when she started at St. Peter's Centre the Headteacher, Jo Ashworth, considered that Jen ought to have one and she supported Ms Bridges in applying to Surrey County Council.

24. I heard evidence about the statutory obligations upon a Local Education Authority in relation to the education of children with SEN from **Tracy Sanders** who has been the Inclusion and Additional Needs Assistant Director for the South West quadrant of Surrey since August 2021. So far as the statutory system in place is concerned, Ms Sanders stated that :

(i) There is a statutory framework in place as a result of the Children and Families Act 2014, and this is covered by a Code of Practice, and together they set out a Local Authority's relevant responsibilities,

(ii) Strategically, the Local Authority must work with partners (including other state agencies) to ensure that provision is jointly commissioned to meets the needs of children with SEN; necessary services will include "*specialist support and therapies, such as clinical treatments, delivery of medications, speech and language therapy, assisted technology, personal care, child and adolescent mental health services, occupational therapy, physiotherapy and others*",

(iii) The Code of Practice specifies that, "*A child or young person has special educational needs if they have a learning difficulty or a disability which calls for special educational provision to be made for him or her*." If relevant needs are identified, then the Local Authority must issue an EHCP for the child,

(iv) As the name suggests, an EHCP must set out the child's educational, health and care needs, together with planned outcomes, and the specific provision which must be provided to that child to meet those needs and achieve those outcomes. The focus will be on the provision needed in an educational setting, but if a health need is also identified, the provision which is required to address that need (such as a medical or therapeutic treatment) should also be included in the EHCP, so that an integrated approach can be put in place. This can include provision which is required to address emotional or mental health difficulties, such as anxiety or depression,

(v) A pupil with an EHCP may be placed in a mainstream school or a special school; either way, he/she must receive the provision identified in the Plan. Following its issue, an EHCP must be reviewed at least annually and further reviews may be triggered by certain events,

(vi) So far as capturing children with SEN is concerned, the Code states, "*Local authorities must carry out their functions with a view to identifying all the children and young people in their area who have or may have special educational*

needs or have or may have a disability. Local authorities may gather information on children and young people with special educational needs or disabilities in a number of ways. … Anyone can bring a child or young person who they believe has or probably has special educational needs or a disability to the attention of a local authority. And parents, early years providers, schools and colleges have an important role in doing so."

(vii) Ms Sanders agreed that the intention is that, one way or another, those involved should all work together so that any child in the area who has SEN is identified as early as possible so that those needs are met as early as possible. She also stated that, for a child with a life-long condition such as autism, identifying the child's needs early, and supporting the child's understanding, and that of their family and all those who work with them, "*is the critical factor*"; she agreed that early provision would be aimed at support of the child in order to avoid (amongst other things) damage to self-esteem, rising anxiety, mental health problems, and self-harm and suicidal ideation developing, and

(viii) If a child is diagnosed with autism before the age of five years, the diagnosing paediatric team will draw that child to the attention of the Local Authority's "*Early Years Group*" and referral may be made to the SEN team for assessment of SEN needs. However, if autism is diagnosed over the age of five years, the diagnosing team will not usually alert the Local Authority at all; rather, it will be for others (primarily parents or school) to decide whether to ask the Local Authority for an assessment of SEN. Ms Sanders said that in Surrey about two-thirds of applications for assessment for an EHCP are made by schools and colleges and about one third by parents.

25. Sharren Bridges told me that she is critical of HofE for not applying for an EHCP for Jen at an earlier stage, and for failing to inform her that she could make such an application herself. In response to the latter point, Julie Menhennett stated that she understood Amanda Collyer would have informed Ms Bridges that she could apply, although Ms Collyer accepted that she could not be sure that she did so. As for the school not making an application, Ms Menhennett said that she believed Jen's needs were being met by HofE until 2018, when they escalated and it became clear that she required support with physical and sensory needs, and social, emotional and mental health needs. Further, she said that, "*We are required to prove*

that we have put up to £6000 of support in place before applying. This is guidance that we are given by Surrey. We also need to have two sets of reviewed targets." She said that HofE did not have this level of support in place for Jen because, prior to 2018, they did not believe that it was needed to meet her needs.

26. Ms Sanders was asked about the school's understanding of the system and agreed that it reflected the contents of the Code which indicates, she said, that, "*The criteria for an assessment is that the school have tried everything they can, including seeking advice from outside agencies, and used all their ordinarily available provision in order to meet needs. If they cannot then meet need, and the young person does not make the progress that they are expected to, then they can apply for a needs assessment. The ordinarily available provision does, of course, include an element of funding, which is the £6,000 that was being referred to. But it is not the single only criteria that we would use in determining whether or not a needs assessment was required*". She emphasised, however, that this did not mean that a school must not make an application for an EHCP assessment unless the child's provision is costing them more than £6,000 a year. Ms Sanders agreed that the system which is in place nationally (and not just in Surrey), which requires a child's school to identify SEN and then attempt to meet it before applying for an EHCP, can result in some variation in outcome, depending upon the level of SEN skill and experience within the school. Ms Sanders said that all schools have a responsibility to ensure that their staff are properly trained for this purpose, and that support for this is available, but she acknowledged that this aspect of the system, which depended on an individual school's judgment, could be seen as a weakness in achieving the stated aim of the Code, namely to identify all children with SEN and meet their needs at the earliest opportunity.

27. As I shall come to below, Jen was issued with an EHCP, without resistance on the part of the SEN Team, on the 20th July 2019. The plan contained lengthy provision which was judged to be necessary to support Jen at school.

28. Comment: By way of comment and findings, I will add at this stage the following. I am satisfied that Jen's needs had not arisen for the first time in 2018, even though their impact on her presentation at school may have become more obvious at that time. Rather, the fact that she had SEN had been apparent since primary school. Whilst HofE may have believed that Jen's needs were being adequately met by the additional support they were providing in years 7 and 8, I am satisfied that her needs were not being fully met, and that this probably contributed to her rising anxiety and deteriorating self-esteem and mental state, including her suicidality, much of which was focussed on her school attendance. In this regard, it is telling that Jen's state of mind improved when she was subsequently placed in a more appropriate setting (as I shall come to below). Clearly, there was a misunderstanding on the part of HofE and the school could have requested an assessment of Jen's SEN far sooner, and closer in time to her diagnoses being made. Further, I find that HofE did not make it clear to Ms Bridges that she could make a request for assessment herself. In the circumstances, there were missed opportunities to put in place an EHCP for Jen at a significantly earlier stage; these were missed opportunities to ensure Jen was placed in an appropriate educational setting and that she received the specific and targeted support she needed. It is likely that she would have benefitted from this in a relevant way; as Ms Sanders explained, the reasons the Code emphasises the need for identification and meeting of needs as early as possible, include the fact that it is early intervention which is expected to be more effective in reducing the risk of damage to self-esteem, rising anxiety, mental health problems, and self-harm and suicidal ideation developing. I should emphasise that, in reaching these views, I do not find that those involved at HofE were doing other than trying to help and support Jen within the system in place, as they understood it to be. I accept that there was a genuine misunderstanding as to the financial criteria and, having heard the evidence of Ms Sanders, I can see that there is room for confusion. Further, I understand the misunderstanding may be shared by others. Finally, I note Ms Sanders' recognition of some weakness in the system, in that it requires a school to attempt, and fail, to meet need before bringing a child to the attention of the local authority, this being in contrast to the system in place for a child who is diagnosed with a neurodevelopmental condition before the age of five years.

CAMHS' Response to the May 2018 Referral

29. I heard oral evidence from **Dr Phillip Ferreira-Lay** who is a Consultant Adult and Child Psychiatrist and a Consultant Medical Psychotherapist employed by Surrey and Borders Partnership NHS Foundation Trust. He told me that his clinical roles focus on community CAMHS work and neurodevelopmental services. From 2015 until recently, he was also Clinical Director for Surrey & Borders Mental Health Services. He is now the Associate Medical Director.

30. The witness explained that the way in which services are provided to children in Surrey has changed over the years since 2015. In 2016, the provision became more comprehensive with the intention of supporting not just mental health but also, more broadly, emotional health and wellbeing. It was intended that this would be delivered not only by CAMHS, but through a variety of stakeholders, including education, and the voluntary sector. CAMHS' services were commonly known as Mindsight CAMHS at that time. Later, in 2020, a further evolution of that was known as Mindworks. So far as children with suspected or confirmed mental illness was concerned, he said that CAMHS has a number of different services, including outpatient teams, such as the Crisis Team, the Hope Service Team, and the Community Team, and in-patient services in hospital.

31. Dr Ferreira-Lay said that Jen was in fact referred to CAMHS for the first time in 2015. That had been by the family GP and was because she was self-harming by cutting her hair with a razor. Dr Ferreira-Lay himself triaged that referral and referred it on to Relate counselling services because no moderate to severe mental health issues were identified.

32. He confirmed that on 15th May 2018, CAMHS received the referral from the HofE. Ms Bridges and Jen also attended CYP Haven in Epsom, CAMHS' drop-in service, where Jen said that the likelihood of her acting on her suicide plans was "*nine and a half out of ten*". The referral was triaged as urgent and an assessment of Jen took place on the 17th May 2018, followed by a multi-disciplinary discussion. He said it was decided that

CAMHS needed to liaise with HofE to understand more about Jen's needs, because suicidal ideation in an autistic child did not necessarily suggest a mental illness. He accepted that the risk and incidence of suicide is higher in autistic children, in comparison with neurotypical children, but said that sometimes an autistic child,

"… might say they are suicidal, sometimes a family member might report that a young person is suicidal; a school may do similarly. … that's a term that has both specific and general usage, by which I mean it is not uncommon for an autistic child … to have limited use of language and we heard earlier on today, or I heard that in some ways Jen was functioning perhaps not as she might have done in terms of her expected ability, in terms of her age. So what we will often do is try and work out, when it's a report of suicidality, is that literally, "I am suicidal, I am going to kill myself in relation to a specific mental health need," or is it an expression of distress that may be attributable to other needs, for example insufficient school support or other contextual factors."

Dr Ferreira-Lay said that the answer to that question was indicative of where future help should lie.

33. On the basis of the records, Dr Ferreira-Lay told me that on the 29th May 2018, a CAMHS' Primary Mental Health Worker, Yasmin Rahemtulla, visited Jen at home. Jen described school as "*hell*" and Ms Bridges stated that she did not consider that Jen was receiving the support she needed. Jen said she was happier now she was not attending school. On the 29th June 2018, there was a meeting attended by Yasmin Rahemtulla, Amanda Collyer of HofE, and Ms Bridges who reported that Jen's anxiety has decreased, but she was still worrying at night, having panic attacks, and talking about drowning herself. It was agreed that Jen needed different educational provision and that St. Peter's Centre would be suitable. The witness said that Dr Aylett, from the paediatric team at Epsom Hospital, saw the family on the 2nd July 2018, and rang CAMHS that day to chase for their report and to ask which Consultant Psychiatrist was responsible for Jen, as she intended to write to him; she was told it was Dr Naidoo. She did then write to Dr Naidoo saying that she would, "*be very grateful if you could copy me into any reports so that we can liaise with regard to Jennifer's medical needs and in particular her ADHD medication*". Later that day,

CAMHS' Hope Service, which provides crisis support, received a telephone call from a distressed Ms Bridges, saying that Jen reported trying to strangle herself with her dressing gown cord whilst in the shower. Jen sought urgent help from CYP Haven where it was recorded,

"*… she almost passed out and went purple. And she didn't know what led her to do this, nothing significant has happened. She said her rational brain stopped her from doing it. She rated her intent of suicide as 11 out of ten. I asked Jenny how she knew her neck had turned purple, she said she did it in front of a mirror, although there were no visible marks around the neck…. Jenny said she'd been feeling good until yesterday then suddenly felt low, couldn't attribute this sudden mood change to anything tangible but did note the thought of going back to school made her feel suicidal*."

34. On the 4th July 2018, Yasmin Rahemtulla reported to Dr Naidoo a call in which Ms Bridges was distressed and saying that Jen, "*Does not know why she did it but she is an impulsive girl and this has happened before where she has told mum she is worried that she might do something to herself. Mum has removed pills, knives, plugs from the bath, et cetera, and would like her to be seen by a doctor for assessment.*" As a result of these events, a further home assessment visit was planned by Ms Rahemtulla and Dr Naidoo recorded, *"… please … do discuss with me if you feel she needs to be seen by a medic*.' The visit took place on the 5th July 2018, when Jen was found to be in good spirits and not suicidal, and was planning to be away on trips over the summer.

35. **Dr Kashmeera Naidoo** gave oral evidence about these matters. She was a Consultant Psychiatrist in the Community Team. She was asked whether she was Jen's "*named psychiatrist*" and said it was "*hard to answer*"; case allocation was governed by geographical "*patch*", but lack of capacity had resulted in a lack of clarity. In any event, the allocated psychiatrist would be consulted about that child only as required, as caseload meant that individual monitoring of progress was not possible, and that the doctor would not necessarily be consulted before the child was discharged from the service. So far as her involvement with Jen was concerned, Dr Naidoo said that she never met her and she could not recall any correspondence with Dr Aylett. As for the reported strangling incident, Dr Naidoo agreed

that this had been drawn to her attention. She agreed that Ms Rahemtulla's assessment suggested a risk that was unpredictable and which, by its very nature, could rise again at any time. But, she said, the note made following her visit suggested that the acute crisis and risk had by then resolved and there was a crisis plan in place. She believed that would have been why she did not ask to see Jen, and did not have any further involvement.

36. Jen's records show that on the 18th September 2018, there was a consultation between Yasmin Rahemtulla and Joanne Taylor, a Psychologist within the Community Team, as a result of which Jen was placed on a waiting list for therapy with a Psychologist, "*with medium priority due to risk and impact on accessing St. Peter's Hospital School placement*". On the 21st September 2018, Ms Rahemtulla informed Ms Bridges of this, saying that she could not give a time for the start of the treatment but, "*… Jenny's a priority as she will be attending St. Peter's and it would be good for education and our services to be working together*".

37. Julie Menhennett, the SENCo at HofE, told me they became concerned about the delay in Jen's psychological support from CAMHS starting, especially once Jen was attending St. Peter's Centre, and on the 15th October 2018, she wrote to Dr Ferreira-Lay, saying Jen was one of HofE's two "*high-profile cases"* and stating,

"*Jenny has complex SEN. She has diagnoses of ADHD and ASD and has been school refusing since May 2018. She has been assessed by CAMHS, told that she needs ongoing therapy, and nothing is in place. She hasn't been able to step through the school front door for 5 months. We've managed to get her a place at St Peter's Hospital School. However, they will stop working with her if therapy isn't put in place and they are therefore able to work alongside a therapist for Jenny. Again, please can you look into this as a matter of urgency? Phil, I'm sure you're aware that this is just the top of the iceberg for our school. These are our high-profile cases and I have real concerns for these students in terms of risk to life. I look forward to hearing from you*."

Ms Menhennett said that this did not result in therapy starting. She also sought advice from David McKie from the clinical psychology service employed by the Howard Partnership Trust, but she was told that they

could not work with a student who was open to CAMHS, as this would be contrary to policy.

38. Dr Ferreira-Lay gave evidence about his response to Julie Menhennett's email and what followed. He agreed that the reference to "*risk to life*" was to a risk of suicide, although he said that the "*use of language needed to be understood fully*". He asked Dr Fivos Cacoullis, Lead Consultant Psychiatrist for CAMHS, to review Jen's notes to find out what had been done. **Dr Fivos Cacoullis** gave evidence and told me that he did review CAMHS' SystmOne electronic records. He said the risk assessments showed a variable pattern, with risk escalating and settling, depending on her circumstances and support. He said he found all the documentation of CAMHS' management to be appropriate and up-to-date. He said he saw evidence of a comprehensive mental state examination, good evidence gathering, consideration by the Community MDT, and two home visits, and that Jen had been placed on the waiting list for therapy.

39. Dr Cacoullis wrote to Dr Ferreira-Lay, stating, "*I also think that there might be a perception of therapy being able to minimise things, which seem to be as a consequence of ASD and emotional anxiety dysregulation. Once again demand capacity is an issue. In conclusion, this is about expectations on one hand versus resourcing to meet demand on the other. My view is serious discussion with CCG and other stakeholders need to move forward about what is realistic within the financial envelope they have provided*". Dr Cacoullis said that he meant that there may be an incorrect perception by outside bodies that immediate therapy "*would somehow solve the issue*", when in fact other support and changes would also be needed. He said, "*… therapy doesn't involve just sitting in a room with a young person talking. But it might involve parental management, support, liaising with school, psychoeducation, and all of those things may not be delivered by a therapist but they have therapeutic value and they would form a core part of any CAMHS work*". He said that a perception that, "*you're getting either nothing or you're getting therapy and there isn't anything in between*" would be wrong. He said that Jen had "*got through the door*" and was awaiting therapy, but a limit on resources meant that it could not yet be provided.

40. Dr Ferreira-Lay said that Dr Cacoullis was flagging up a reality, which was that they had to, "*do the best we can for young people, but this is in a context of an ever-evolving conversation with commissioners and stakeholders around how do we best deploy our resources*". He said that he therefore wanted to know what the HofE psychology support team, led by David McKee, was doing. He understood that HofE expected CAMHS to provide therapeutic support to Jen at St. Peter's Centre, but that did not match his understanding of how the services were expected to work together. The witness said it was important to obtain a comprehensive overview of what the child's needs are and then, together with others, decide "*how best to deploy our resources collectively*" to meet those needs. On the important question of who should provide the "*comprehensive overview*" of the child's needs, he said,

    "*So the danger might be, and especially with neurodevelopmental disorders, to think that the assessment of needs is purely the business of a specialist mental health provider. We have a role, but we will have a role alongside school and other stakeholders. So that is what I am trying to demonstrate*".

41. The witness was asked, though, to explain what assessment CAMHS had made of Jen's mental health needs at that time. He said that CAMHS' own assessment, for deciding whether there was a clinical mental health need, was a longitudinal process which would not necessarily be completed at an initial stage, but may need to involve drawing information from others over time. He said that on the basis of Dr Cacoullis' response, he understood that, in addition to her neurodevelopmental diagnoses, Jen was suffering emotional anxiety and dysregulation, although he accepted that this diagnosis did not appear elsewhere in her notes. He said it was also his understanding that, "*… the plan from our bit of the service at that point was to earmark for therapeutic intervention. And I was still going to clarify … to explore, can we meet needs even faster in school, because I had developed a programme with him [*the school psychologist*], at his request, around how we might work together*".

42. On the 19th October 2018, Dr Ferreira-Lay sent an email to Julie Menhennett asking whether David McKie had been supporting Jen. Ms Menhennett responded immediately, saying that David McKie had not been involved, "… *as we have high level of need in non-mental health areas that have taken priority. … As I am sure you are aware, his remit is not to replace CAMHS provision*", and she asked Dr Ferreira-Lay to continue to look into Jen's case. The witness said that what he could and should have done was contact David McKie, to express his view that, "… *your team at school is best placed to meet this sort of profile of young person*", but he did not do so. On the same day, he received a message from St Peter's Centre to say that Jen was "*making huge strides*" but that they were "*very keen for her to have a CAMHS appointment / assessment asap to help facilitate her EHCP application*". Dr Ferreira-Lay forwarded this to Yasmin Rahemtulla and to Joanne Taylor, the Psychologist in his team. Ms Rahemtulla responded by asking Ms Taylor when Jen might reach the top of the treatment waiting list, and was told of the "*loose plan*" for Linda Bayliss, who was also a psychologist, to "*pick up JC when she returns in November …If you're concerned, Phil, we could take it to the team for allocation sooner*". Dr Ferreira-Lay agreed that he had not responded to that.

43. On the 20th October 2018, Dr Ferreira-Lay did send an email to Yasmin Rahemtulla and Joanne Taylor, stating,

"*I want to strike the right balance between clinical need and service limitations. Wonder if a team discussion and/or telephone clarification with Julie at the school would be helpful. Have tried clarifying what input David McKie is or can give to this yp as he is now employed by the school. Have attached the school's response. They are aware of how stretched we are and yet appear to be missing the point as I flag up what options they might have locally in the school.*"

However, Dr Ferreira-Lay told me that he did not communicate further with the schools and this was then the end of his involvement. In answer to questions from Ms Sikand KC, he accepted that he ought to have asked his team to respond to Julie Menhennett and that he had never informed her a that, in his view, it would be more appropriate for David McKie's team to be supporting Jen. By way of comment, it seems to me that Dr Ferreira-

Lay's response shows that he was focussing persistently on the school and thereby lost sight of the vital role that CAMHS itself should have played in managing the risk to Jen's life.

44. Dr Bozena Zoric, to whom I have already referred above, succeeded Dr Aylett in the paediatric team at Epsom Hospital and then had responsibility for Jen. She told me that following her ADHD diagnosis, Jen had been treated with medication and had remained under the paediatric team for monitoring. When she first saw her in November 2018, Jen had stopped taking her ADHD medication, but remained on drugs for sleep difficulties which, the witness said, are common in children with ADHD and autism. Dr Zoric said that her assessment was that Jen's condition was very complex and that she needed the involvement of CAMHS. She stated,

    "*From the first time I saw Jennifer, I … obviously, her mood fluctuated. There were times when her mood was better, depending on what was happening to her. But from the first moment I met Jennifer, I felt that due to the complexity of her presentation, she would have been better off in a CAMHS ADHD clinic compared to paediatrics*."

45. Dr Zoric explained that, in her view, supporting Jen was not as simple as prescribing medication for her ADHD, which was primarily to assist with concentration problems. For a child as complex as Jen, a more holistic input was needed to deal with anxiety and low mood. She was aware of Jen's self-harm and suicidality in May and July 2018, and she told Jen's mother that CAMHS would now be the right team to see her because she was complex. Dr Zoric told me that treatments options included cognitive behaviour therapy and medications for anxiety and depression, and these could be delivered by CAMHS, and that it would have been better if the specialist ADHD service within CAMHS, "*with their expertise and resources that can manage mental health issues*", had taken over management of Jen's ADHD at that point. However, at Ms Bridges' request, she had agreed to continue to following up Jen in relation to her ADHD, but in the knowledge that the self-harming behaviour and risk was being addressed by CAMHS.

46. On the 5th November 2018, Ms Bridges telephoned CAMHS to ask where Jen was on the waiting list, saying she had only a term and a half left at St. Peter's Centre, and she would then be back where she started. She said Jen needed coping strategies and currently, "*just shuts herself away when she gets home from St Peter's*". This was passed to Joanne Taylor, the psychologist. A note on the 7th November 2018 records that there had been an MDT discussion and the outcome was, "*To allocate to Bernadette Mulhern for treatment intervention*". On the 20th November 2018, Amanda Collyer telephoned CAMHS saying that HofE were concerned about Jen returning to the school, that an EHCP process was underway, and requesting contact.

47. I heard oral evidence from **Bernadette Mulhern**, a Registered Mental Health Nurse with 40 years' experience. In 2018, she was working as a Clinical Nurse Specialist for CAMHS. She said she had some experience of working with children with neurodevelopmental conditions, but no specific training. She said that CAMHS developed its own neurodevelopmental service with specialist clinicians, psychologists and doctors, who would work with those young people, and she was not part of that service.

48. Ms Mulhern said that in November 2018, she received an email asking her to meet Jen and review her case. She noted that the initial review referred to Jen needing help "*containing ASD needs*" which, she said, meant she required support with managing and living with the challenges that ADHD and ASD present. The witness said that she met the family on the 3rd December 2018. She recorded a full review of Jen's history and current state and circumstances. This included that Jen herself was saying, "*I turn into a psycho when a lot of people around, ten or more*", and that she would become scared and anxious. She also described murderous thoughts, including "*plotting to kill anyone around me*" and said she believed she would act on this, so far being stopped by "*common sense and being distracted by someone*". Jen said these thoughts had been there for about the last five years, but had come to the surface since she had not been preoccupied with the stress of school. Ms Mulhern agreed that affected Jen's ability to cope with ordinary, everyday life, significantly and particularly with her education. She said Jen felt less stressed at St Peter's

and her current suicidal ideation and risk was low, and Jen was saying that her brain had now said she could seek help and she wanted help, although she did not know in what form. Ms Mulhern recorded the outcome of her assessment to be as follows:

"*Due to the complexity of this young person's needs and her mother's own disability and her struggle to cope with the psychological aspects of Jen's complex needs, I will review this case with the multidisciplinary team as I believe she needs more specialist input than I can provide. I had a brief discussion with my clinical supervisor Claire Hartshorn who recommended a referral to MASH. Case will be reviewed at our team MDT on 12th Dec to decide if role for CAMHS. I will then phone mum to feedback.* "

Ms Mulhern said that, in her view, Jen needed help from someone with expertise in autism in particular. She said she knew there were other clinicians in the team who were more experienced with ASD, and there were CAMHS neurodevelopmental services, so appropriate resources were there. The witness said that she made the referral to MASH, which is the multi-agency safeguarding hub, thereby bringing the family to the attention of Surrey Children's Services, as she thought they may also be able to provide support to the family.

49. The outcome of the CAMHS MDT meeting on the 12th December 2018 was that Bernadette Mulhern was directed to hold two more sessions with Jen, "*…to help us all get a better sense of what Jennifer wanted before the team could have a view*". The clinical note recorded, "*Work on re-imagining her identity. Thinking about a continued assessments, giving her the opportunity to off load and explore what she wants to take forward. Developing emotional literacy. Formulating whether there is a clear piece of work to complete*." Ms Mulhern said, "*I still held the view that this was something that was beyond my expertise but I was willing as a clinician, to follow the advice and guidance of the multidisciplinary team in helping them to decide if, what therapy, if there was therapy still to be offered from CAMHS. So I felt it was the right thing to do to offer those sessions*". The witness was asked whether she had been persuaded that she could do something helpful and worthwhile in gathering further information from Jen, or whether she still considered that she was not the right person to be dealing with Jen but had agreed to

continue simply because she had been directed to do so, and she said it was the latter.

50. Bernadette Mulhern saw Jen again on the 8th January 2019. Jen was speaking openly and was calmer; she said her negative thoughts had not been telling her to kill herself, which she put down to not having so much pressure over the school holidays. Ms Mulhern asked Jen to think about what she wanted help with and write it down for discussion at their next meeting.

51. On the 14th January 2019, Ms Mulhern received an email from Amanda Collyer asking, " … *where Jennifer is with regards to therapy within CAMHS and whether you would be able to attend the next review meeting on the 11th February here at Howard of Effingham. It would be extremely useful for a representative from CAMHS, who has been working with Jennifer to be at the meeting as we are looking to start the reintegration process into school for Jenny, and St. Peter's and ourselves have so far had no input to guide us to enable the transition back into school to be a success for Jennifer*".

52. Ms Mulhern's third meeting with Jen took place on the 15th January 2019. Jen told her that she needed "*coping strategies to help me cope with the rest of the world*" and help with her low self-esteem. Ms Mulhern noted that her overall risk to herself was low but recognised that it could "*quickly flip*" if she became stressed again. She recorded that she was told by Ms Bridges that Children's Services were going to provide a Youth Support Worker and had recommended a ten week Barnardo's course; and that there was also some counselling being provided at St. Peter's Centre. The witness recorded the outcome of her meeting as being:

"*The things Jen identified as wanting help with, ie managing stress and improving self-esteem, are the areas that she is getting some help with in St. Peter's School and that will be addressed in the 10 week Barnardo's course with Early Help. In light of this and the current low risk, I explained that there did not appear to be a role for therapeutic input from CAMHS at this time.*
I will liaise with Donna Nwufo S/W, with school and with my CAMHS colleagues to confirm this and then phone mum with feedback and discharge".

Ms Mulhern said her manager, Claire Hartshorn, agreed with her plan to discharge Jen, and so she informed the family and HofE accordingly, and she indicated she would not be attending the review meeting at the school.

53. Bernadette Mulhern said she did not know the nature of the counselling being provided at school and she did not know the content of the Barnardo's life skills course. Further, she accepted that Children's Services, had told her that their funding panel had not yet approved any support. (In this regard, I will note here that the evidence of Jan Smith from Children's Services, to which I shall refer later, was that the application for support was declined on the 7th January 2019, on the basis of capacity and because Jen was already receiving help from other sources, including CAMHS.) Ms Mulhern was asked, therefore, on what basis she had been satisfied that Jen's complex needs, which she still considered required specialist input, were going to be met by those other sources. Ms Mulhern said that she "*anticipated*" that the help being offered would meet Jen's needs, but she did not know. She was also asked how it was, conversely, that she reached the view that there was no ongoing role for the Community Team, when the expertise Jen needed existed within it, and she said, "*I'm sorry, I cannot clarify that for you*". The witness was asked whether the outcome decision, to pass Jen on to other agencies and discharge her from the Community Team, had been discussed in December 2018, when she had been directed to see Jen twice more. She said she was not able to answer as she could not recall. The witness was asked, "*Was there a pressure on you to pass referrals on to other services if you possibly could*?", and she said,

"*I wouldn't say there was a pressure to pass referrals on. I would say we were always encouraged to think about, you know, the wider, other resources other than CAMHS. You know, referrals would come into CAMHS and be assessed and put on a treatment waiting list. … the young person's needs can change from the point of referral and assessment, to when they're seen. And so there is guidance to look at and review those cases to see whether CAMHS is still the right service or whether another agency would be able to help. So that would be in one's thinking when reviewing*".

54. Ms Mulhern said that both Ms Bridges and HofE asked for Jen to be kept open to CAMHS and Ms Mulhern agreed to do so. There was a miscommunication which left Ms Bridges believing that Jen had been discharged and as a result she wrote a letter to Ms Mulhern, in which she said that Jen was,

"*… far from ready to be back in a mainstream environment. She has only made the amazing progress that she has as she has been protected from the stress that made her want to end her life in May 2018. Both myself and Jenny are very concerned about transition back to mainstream education without much needed guidance and support from CAMHS. The only reason there is not currently a risk to Jenny's life is because she has managed life within the confines of St Peter's and home. The idea of suicide is not currently in the forefront of Jenny's mind. Most of the time, however, I feel that without the necessary support from CAMHS and St Peter's the risk to her life rapidly increases again. … As a parent I feel Jenny needs the support from both school and CAMHS to hopefully enable her to return to mainstream school. Without the correct support there is still a significant risk to her life*".

55. On the 25th February 2019, Amanda Collyer wrote stating that Jen was due to return to HofE after Easter and, "*… we are concerned that her anxieties and suicidal thoughts may return when she is again subject to the 30 students in a class, moving around a school which holds in excess of 1000 students*". Two days later, Ms Collyer wrote again saying that Jen had reported becoming so frustrated with some homework set by St. Peter's, that she had slashed paper with a Swiss Army Knife and stabbed boxes in her bedroom with a pair of scissors, indicating a high level of unmanaged anxiety. Ms Collyer said, "*… our concerns remain extremely high about how she will cope when back in mainstream school*". Ms Mulhern was asked whether that development had caused her to re-consider whether CAMHS ought to be allocating someone with expertise immediately. She said that it had not, as this was an acute episode that then settled, which was Jen's usual pattern. She did, however, write a short letter supporting the suggestion that Jen required a smaller, alternative educational placement.

56. Amanda Collyer confirmed that Jen had done well at St. Peter's Centre as it was a small setting, for between 9 and fifteen students, and Jen had been

happy and relaxed there. However, her problems re-emerged when attempts were made to reintegrate Jen to HofE in the summer term of 2019. When she visited HofE, even for short periods, her anxieties quickly and obviously increased. Ms Collyer said that the therapeutic work needed to help Jen cope with the stresses of HofE had not taken place and she felt that the concerns she had raised with Bernadette Mulhern had not been taken sufficiently seriously. In the event, Jen never returned to HofE as a full-time student. In about the May of 2019, she attempted a part-time return with the help of a support worker, but her anxieties increased very quickly and she was then off sick again until the end of term.

57. On the 29th April 2019, Ms Bridges telephoned Bernadette Mulhern to tell her that Jen's phased return to HofE was causing Jen distress. This was followed by a further acute crisis on the 23rd May 2019, when Jen went to the Emergency Department to report thoughts of harming herself or others with a knife, which she handed to hospital staff. She punched the wall in frustration and reported feeling unsafe to return home, as there were things there she could use to end her life. The precipitating factor was said to be her struggling to return to mainstream school, although she later also reported an upset with her father.

58. In response, Ms Mulhern said a plan was made by CAMHS for her colleague, Sharon Allen, who had experience and expertise with young people with ASD, to consider seeing Jen. She said this was done in response to Jen's distress and raised risk when she attempted a return to HofE which, she accepted, was precisely what had been predicted by the school and family. On the 11th June 2019, Sharon Allen met Jen for the first time and agreed to arrange three sessions with her over the summer, with Bernadette Mulhern remaining the case holder. Ms Allen's next meeting with Jen was on the 29th August 2019, and I shall come to that further below.

The Contents of Jen's EHCP

59. Following evidence gathering and drafting by the SEN team at Surrey County Council, Jen's EHCP was finalised and issued on the 25th July 2019. It contained details of her special educational needs flowing from her neurodevelopmental conditions and the provision which was required to meet those needs. There were also entries concerning Jen's emotional health, with some reference to her history of suicidality, but these did not reflect the extent and seriousness of that history. Tracy Sanders was asked about this and agreed that the history ought to have been better captured. She agreed that the SEN team had been made aware that Jen had developed anxiety, low mood, and suicidal ideation in relation to which she was open to CAMHS. She said that in these circumstances, statutory advice ought to have been obtained from CAMHS to establish Jen's mental health needs and any provision required to meet those needs, but that had not happened. Statutory medical advice had been sought from the responsible clinician in the paediatric team at Epsom Hospital, as the Designated Medical Officer ("DMO"), and this had been provided by Dr Zoric who gave details of Jen's neurodevelopmental diagnoses and their effect, but this did not cover matters in CAMHS' remit.

60. Ms Sanders said that, at that time, it was the responsibility of Dr Zoric, as DMO, to obtain all relevant input from CAMHS and include it in her statutory advice on Jen's health needs. Dr Zoric accepted that she did not do that, and that she could have included reference to Jen's history of low mood, self-harming and suicidal ideation. She said she did not do so because, at the time she completed the advice, Jen was doing really well and not suffering low mood or thoughts of self-harm.

61. I do note, however, that on the basis of the Educational Psychologist's advice which had been obtained by the SEN team, the EHCP included a requirement for Jen to be provided with "… *support from a professional who can provide a suitable therapeutic intervention, intended to address her anxiety, for example, through the use of cognitive behaviour therapy, adapted for use for young adults with autism and she will be provided with weekly sessions for at least 16 weeks …*".

CAMHS' Further Response

62. I heard oral evidence from **Sharon Allen** who is currently a Trainee Counselling Psychologist and Group Lead in CAMHS' Epsom community-based Treatment Team. Ms Allen said she is a Chartered Psychologist, experienced in delivering cognitive behavioural therapy group programmes, and has been trained to assess autism. In 2019, she was working for CAMHS as a Targeted Youth Support Officer, working primarily with young people with autism or ADHD in a therapeutic context, around psycho-education, thoughts, feelings, behaviours, and how to manage emotional dysregulation.

63. As stated above, Ms Allen said she first met Jen in June 2019, when she was asked to meet with the family to see if she could offer some specific support around Jen's neurodevelopmental difficulties. She said that initially, as with all forms of therapy, that would be about building a rapport and a relationship, which can take longer with a neurodivergent child, and then using her Dialectical Behavioural Therapy ("DBT") skills, in which she had been trained, to help Jen manage emotional dysregulation. She said that DBT is an evidence based therapy to teach skills to young people who have suicidal ideation or self-harm. Ms Allen said that in the June, it had been agreed that she would meet Jen for three sessions over the summer to see if she could engage with her, and to assess whether the work required was within the scope of her experience and training. As such, she became a joint care-co-ordinator with Ms Mulhern.

64. Ms Allen said she was unwell over the summer and so the first of her three sessions with Jen was not until the 29th August 2019. Prior to that, on the 20th August, Jen had attended the CYP Haven in Epsom, reporting that she had been fishing with her father, there had been an altercation about smoking, and she was now "*having constant flashbacks of past episodes of verbal aggression, and vivid nightmares of him dissecting her, peeling skin off, causing Jen to become very agitated*". Ms Allen accepted that this was a new aspect to her presentation and could be seen as a red flag for something that would need to be monitored.

65. The witness recorded that at the meeting on the 29th August, Jen said the nightmares were a little bit better but that she still felt scared sometimes. "*We talked about the programme she watches Shadow Hunters, as I know there was a storyline in it whereby a boy's skin was being peeled away and so I pointed out this seemed to correlate with her recent nightmares and flashbacks. We talked about how we sometimes need to protect ourselves from things in our imagination. We drew a shield to represent the people or things that Jennifer could draw on to help her when she's scared, this included mum, her boyfriend and her dog. We talked about how the people in the programme protect themselves and she said they use runes, these are symbols that the cast use like magic tattoos to protect themselves. Jennifer said she had drawn runes before and she designed a rune to protect her".* Ms Allen said this was a relationship building exercise. She wrote too that, *"Jennifer expressed that she is worried about her boyfriend and will only say how she feels once she knows he is okay. Mum agreed that Jennifer has black and white thinking … becomes fixated on things and it's hard for her to deviate from this".* Ms Allen noted that Jen seemed better at the end of the session and that the flashbacks seemed to be anxiety related, and they agreed to meet again on the 9th September 2019.

66. Ms Allen said she expected to have the two further planned sessions with Jen, and then she, "*would have taken it back and discussed with Bernadette following what mum and Jen wanted*" and therapy would then usually begin. However, she did not, in fact, see Jen again. On the 9th September 2019, she received a telephone call from Ms Bridges to say that Jen did not want to come into CAMHS as she was starting her new college that day and it was all too much. She said she had seen an improvement in Jen compared to the previous week. Ms Allen recorded that she agreed that she would email Jen to ask her if she could visit her at home, and "*leave the door open for mum or Jennifer to contact me should she change her mind*". Sharon Allen did send an email to Jen to that effect, indicating that Jen could choose whether to continue with the sessions or not. The witness said this was because it was important to empower the young person, although she accepted that she had a professional obligation to continue to engage with her, even if Jen was reluctant. In the event, Ms Allen did not take any steps to progress her work with Jen over the following two months, and the witness said she could not explain this.

67. Dr Zoric told me that she reviewed Jen on the 4th November 2019. She noted the May 2019 episode of suicidality and that Jen had not had input from CAMHS recently, and so she wrote to the GP suggesting that, as her mood was still continuing to be low, Jen should see someone from the CAMHS therapy team for cognitive behaviour therapy and should ask to see a child psychiatrist who could prescribe antidepressant medication. Jen's CAMHS records note that on the 14th November 2019, Ms Bridges called CAMHS asking for, *"… an update moving forward. Not urgent but could you call …"*. On the 25th November 2019, Sharon Allen spoke on the telephone to Ms Bridges. She recorded,

"*Mum said paediatrics have sent a letter asking for Jennifer to be considered for medication for depression as she is not sleeping well and reports low mood. Mum also reports however that Jennifer is still attending college and has a new boyfriend following a recent breakup with her old boyfriend. Mum said she had one meltdown but this could be because mum had an episode whereby she had quite bad tremors due to her ongoing ill health, which Jennifer witnessed. ... Mum did report however that although Jennifer has not been self-harming or talking of suicide she has been cutting her own hair and drawing on her. Mum said Jennifer has agreed in principle to taking antidepressants. I explained that the paediatric letter needed to be looked at and then she would be advised if an appointment had been scheduled with a psychiatrist. This may need to go to MDT for a decision. I advised that I would see if there was a letter awaiting scanning and then take Jennifer's case for discussion to the MDT*".

68. In the course of the hearing, Ms Bridges produced an email sent on the 9th December 2019, under which she had sent Dr Zoric's letter to Ms Allen, who accepted that she must have received it, although she could not recall this. Ms Allen said that, at the time, she had asked the medical secretaries and administrative team to look for the letter and, a month later on the 20th December 2019, was told that there was no letter on the system. Ms Allen accepted that she did not take any action to obtain a copy and could not recall why she had not done so. On the 5th February 2020, Ms Bridges telephoned chasing a "*review appointment*" with a psychiatrist for which, she said, they had been waiting for two and a half years, and she rang again on the 25th February 2020. On the 10th March 2020, Ms Allen recorded that the paediatric letter had been sent to her by Ms Bridges and

uploaded on to the system; she wrote, "*Letter suggests requesting to see a psychiatrist for medication*". Ms Allen was reluctant to accept personal responsibility for the nearly four-month delay in obtaining the letter, and sought to blame the medical secretaries, the psychiatrists and Bernadette Mulhern, but eventually stated, "*I do accept overall in hindsight I should have followed it up sooner*".

69. On the 25th November 2019, Ms Allen had told Ms Bridges that she would take the paediatric letter and Jennifer's case to an MDT meeting for discussion, but she did not do so. Rather, on the 10th March 2020, shortly after uploading the letter onto the system, she discussed the case with Bernadette Mulhern. Ms Mulhern's note stated, "*Sharon Allan and I had a case review discussion today to decide if there is a further role for specialist CAMHS. Sharon met with Jennifer for a session in August 2019, further planned sessions were cancelled by Jennifer as she wanted to focus on settling into college and did not feel need for CAMHS sessions*". When pressed, the witness accepted that this was not an accurate reflection of what had happened and that the further planned sessions had not been cancelled by Jen. Ms Mulhern's note continued, "*Telephone liaison between mum and Sharon continued from September 2019 to update and monitor. Mum said that there were no episodes of self-harming behaviour, nor were there any expressions of suicidal ideation*". Again, Ms Allen accepted that this was inaccurate in that there had only been one telephone call, that being on the 25th November 2019, and Ms Bridges had been expressing concern about the way in which Jen was cutting her hair and drawing on herself, in the context of self-harm. Ms Mulhern's note went on to reference the paediatric letter, but stated that Jen is attending college, has a new boyfriend, and appears to be functioning quite well at the moment. The plan was:

"*It is our view that Jennifer appears to be functioning well at the moment and the reported low moods referred to in the paed's letter are likely to be part of her normal reactions to external stressors of day-to-day life events, bearing in mind her diagnosis of autistic spectrum disorder (her rigid thinking). In light of this we agreed to write to mum and Jennifer to invite them to review apt with Sharon and I to review her mental state to establish if there is need for a psychiatric review with one of our Child Psychiatrists. We will consider a referral to Surrey Care Trust for mentoring*".

70. Ms Allen told me that they would have decided to organise a review so that they could get an up-to-date presentation to take to the team and to the psychiatrist, for their consideration. She said she could not recall why, if that were the case, a referral to Surrey Care Trust was mentioned. She also agreed that the letter sent to Ms Bridges referred to holding an assessment to see, "…*if there is a need for a psychiatric review with one of our child psychiatrists, or if discharge from CAMHS is now indicated*" [emphasis added]. It was put to Ms Allen, and she agreed, that there was an outstanding treatment plan which she had not yet progressed for Jen, and she was asked how there could be any question of discharge in those circumstances. Ms Allen responded, "*This is our usual procedure. When we're doing a review, we're looking at what the current presentation is, what the current need is and how that need could be best met, whether that's with us or with another service*". She was asked whether discharge from CAMHS and referral to the Surrey Care Trust was, in fact, the plan at this point, and Ms Allen said, *"I don't recall. Sometimes we have a mentor in place as well alongside us. So that doesn't always mean that they can't remain open to us if there's a mentor in place".*

71. On the 14th April 2020, Ms Bridges emailed Bernadette Mulhern, saying,

"I received a letter about what to do next with Jen. She's been getting on really well at college. However, unfortunately Jen, alongside not eating and biting herself when she can't cope or is finding things overwhelming, she has now started smoking and cutting to deal with stress, she started with smoking back in November and cutting started in early March, Jen is now cutting daily. I don't feel that now is the right time to discharge Jen as I think she is needing more support than ever. Jen has a social worker from the Early Help Team at Social Services, after an Instagram issue and some "friends" asking for inappropriate photos which thankfully she didn't send. However, when she spoke to her college driver about her friends, alarm bells started ringing for the driver. He's an ex-policeman so he was probably the right person for her to open up to. And when I spoke to her about it she got very aggressive and ended up running away. This is all now settled and being dealt with. The police were meant to be in touch with you, but I doubt they were. The chats with the social worker were starting to have a positive impact but now as covid-19 has landed, this is just a phone support and isn't as effective. I think that

Jen still needs some therapeutic intervention of some sort. She has been prescribed 20 mgs of fluoxetine via the GP now as she is 16, but she has only been on them for five weeks so it's early days, but as I am sure you are both aware medication is a plaster and not a long-term solution. Hear from you soon so we can make a plan to move forward with Jen's recovery."

Ms Allen agreed that this email provided concerning information, including in relation to Jen's mental health and risk of self-harm. However, she did not raise its contents with any further members of the team, but simply proceeded with the plan which had already been made with Ms Mulhern, to see Jen for a review. That review took place two months later in June, and I shall return to that, below.

Children's Services

72. Children's Services had become involved in December 2019. In this regard I heard evidence from **Jan Smith** who is employed by Surrey County Council as their Targeted Youth Support Service Manager. He explained that Targeted Youth Support ("TYS") is a level three service, supporting young people with multiple and complex needs, working closely with colleagues at level four. He said these teams are in-house, with Surrey commissioning Early Help Services for level 2 need from, for example, Surrey Care Trust and East Surrey YMCA. Mr Smith said that the TYS has a multi-disciplinary team which includes social workers and others with specific expertise. The team uses a range of tools to support and encourage the young person to identify solutions for themselves. The average time of being open to TYS is about six months. TYS does not have a specialist autism service. The witness said that approximately 30% of TYS' caseload were self-harming to some extent and, in this regard, the team rely on "*our CAMHS colleagues to assess and treat and make discharge and safety plans. If assessment or therapeutic work for mental health is needed, that would come from CAMHS, but we would always continue to be involved while we are still doing our work*". Mr Smith said that TYS would organise a Team Around the Family ("TAF") Meeting, to monitor progress on any plan made, and if mental health is an issue, CAMHS would be invited and involved as part of the plan; this would be to meet "*Working Together*" obligations on state agencies, to avoid passing the young person from one agency to another,

and to recognise the collective responsibility to support and progress the needs and issues of the young person in question.

73. Jan Smith said that two referrals relating to Jen were made and accepted by TYS, the first in December 2019 and the second in December 2020. He said that he certainly saw Jen's needs as multiple and complex and, from the outset, requiring level 3 provision. Jen was allocated to Tiffany Cherry, initially in January 2020, and, he said, she made a very good, robust plan, and had a lot of contact with the family; she built a good relationship with Jen and it felt like there was progress being made.

74. **Tiffany Cherry** said that she was a Targeted Youth Support Worker, who had some training and experience of dealing with autistic children who were expressing suicidal ideation. She said her role was to work one to one to try and make a positive impact and to build their resilience for moving forward with their life and with their family; the specifics would be need led. She did not, however, provide any specialist input or therapeutic treatment. The first referral was triggered by Jen's involvement on-line with a man in the United States, thought to be grooming her, and her aggressive response to her mother when she intervened. Ms Cherry met and assessed Jen and noted she was keen to learn coping strategies. She told me she was in regular contact with Jen between January and October 2020. She said that Jen found it really difficult to meet new people and it took some time to build a rapport. She said that Jen was quite good at masking, so people that did not know her well might not appreciate all her complexities and vulnerabilities. In the February and March of 2020, she found Jen to be overwhelmed by anxiety and there was conflict with other students at college. Ms Cherry recorded that she discussed with Jen, "… *self-esteem, self-worth. I asked her to identify areas she needs to improve on. She said her personal hygiene. She would like to get to showering every other day and brushing her teeth twice daily. She's going to build this up slowly over the next two weeks, trying different methods to see what works for her*." Ms Cherry said this was significant; "*I found when working with children with autism and ADHD that how they feel in their brain comes out physically. For some that may be their bedroom and how messy it is. Some it may be in presentation within themselves. So if they are feeling overwhelmed and cannot cope, doing the basics … is just too much. … That was why I wanted her to focus on that before*

anything else, because if she cannot look after herself, how is she going to be able to change anything else that everyone else is worried about?". She said she reminded Jen that no one could do it for her and she needed to make the changes herself, with support and advice from others.

75. Ms Cherry said that on the 31st March 2020, Ms Bridges reported that Jen had self-harmed and Jen said she had "*flipped*" without a specific trigger, but with a feeling of "*emptiness*". The self-harming by cutting continued into April and Ms Cherry spoke to Jen about the support being given by her mother and by TYS, to emphasise that, "… *it is important that she tries the things that are being suggested to her as in the future she will need to be managing her emotions in a healthy manner on her own. There is only so much mum and I can do for her in the short-term*". She said she later changed her approach, to planting a seed and letting it be Jen's idea, rather than telling her what to do. A few weeks later, Jen was working on a farm with animals, which was her "*happy place*", and she had stopped cutting herself and her personal hygiene had improved. Further, a new medication helped significantly with her mood. However, when they met in June 2020, Jen, "… *explained she spends most of her time trying to not cut, to self-harm, and watching Netflix. … She made a comment about drinking her blood as a way of coping. She said she pricks her finger and drinks it that way. She explained that she told CAMHS this but they still discharged her. And she also called 111 but they never called her back. … She was laughing and mentioned that it's a sensory thing*". The witness said that she continued to work on strategies for Jen to manage her stress. It became apparent that Jen's state could vary and that there was ongoing emotional dysregulation at times; she said she found it difficult to work out whether Jen was "*mentally unstable*" or not. Later in the summer she recorded that Jen was managing her emotions and behaviours well, was able to see this progress in herself, and was looking forward to going back to college. Jen felt that she would now be better able to cope with relationships at college, although Ms Cherry said she had a concern about this; she was aware that Jen developed intense feelings for boyfriends very quickly, and said her autism meant that she did not always understand what was a healthy relationship. In the October 2020, TYS decided that their involvement should end and Ms Cherry recorded that Jen was then working with a Surrey Care Trust mentor every two weeks, and that she had "*come a long way with her coping strategies and feels ready to move forward*". She said

Jen and Ms Bridges agreed, as Jen was experiencing stress, but at a lower level and it was not overwhelming her to the extend it had done when they first met.

76. As stated above, Sharon Allen's review appointment took place on the 15th June 2020 and was held via video link. Ms Allen said that she had not obtained any further information from the GP, the paediatric team, or children's services, prior to the meeting. Both Sharon Allen and Bernadette Mulhern met Jen and her mother on-line. The record made by Ms Mulhern states,

"Currently mood about 5 and she is eating and sleeping well.

The cutting mum reported … has now stopped however recently Jennifer had started pricking her thumb with a pin and then sucking the blood. She says she thinks this was due to her taking medication for anaemia, iron tablets which she doesn't like. She said when she was taking the iron tablets she would prick her thumb about 15 to 20 times a day however when she was not taking them it was much less about 4 or 5 times a day. This medication now stopped.

No reports of any DSH [direct self-harm] or suicidal ideation.

Jennifer continues on Fluoxetine 20mgs px GP about 14 weeks ago and they both feel it stabilises her mood.

Jennifer has settled well into college in Guildford before Lockdown and will continue when it reopens. She is enjoying starting to meet up with friends who are mainly male.

She continues to have support from Tina at Early Help Support, this is weekly telephone contact at moment which she finds very helpful.

We discussed discharge from CAMHS as no significant mental health concerns and refer her to Surrey Care Trust where she will have a mentor for unlimited period. We also encouraged to seek support as required from college. …

OUTCOME

Discharge from CAMHS
Referral to Surrey Youth Support Service."

77. Ms Allen was questioned about the decision to discharge Jen from CAMHS, without consulting the MDT, as had been planned. First, I asked her whether she and Bernadette Mulhern had the expertise and authority to discharge Jen from CAMHS without consulting the MDT, and she said that they did, although she added that, "… *more recently we have a new procedure implemented that cases would all go to the MDT*…" before discharge. I shall return to this issue further, below. Secondly, Ms Allen was asked whether Jen was discharged because the decision to discharge had already been made, in her conversation with Ms Mulhern in the March. The witness denied this and said the decision was made at the time of the assessment and was based on the current presentation, which was that Jen had no significant mental health concerns, was being prescribed anti-depressants by her GP, was receiving helpful support from social care, and would be referred to the mentoring service. She said if Jen or Ms Bridges had not agreed, "…*we would have taken the case back to the MDT*". Finally, the witness was asked to explain the basis upon which she and Ms Mulhern had concluded there was no role for CAMHS; she accepted that Jen had been with CAMHS for over two years, awaiting therapy and none had been provided, and she was asked why she had not liaised with the other agencies involved to check that Jen's mental health needs were in fact being met. The witness said that Jen appeared to be stable and sufficiently supported by social care; further, she intended to refer to Surrey Care Trust and "*we would have given them some information around what had been happening, what we thought would help going forward*".

78. Sharon Allen was then taken to the Request for Support Form she had completed in order to seek a mentor for Jen from the Surrey Care Trust. Ms Allen agreed she had provided sparse information in the form and that she did not mention, at all, Jen's neurodevelopmental conditions, her autism and ADHD, her history of self-harm and suicidality, her prescription of antidepressants, the fact that she had an EHCP in which her needs were set out, or the fact that others agencies and clinicians were involved. She did not give proper details of Jen's family, and included no information about the recent tensions Jen had displayed with both her

parents, and she did not include information about Ms Bridges' disability, which was relevant. The witness accepted that she had not completed the form properly and, when pressed, that she had comprehensively underplayed the complexity and seriousness of Jen's condition. Ms Allen said this was because she had recently taken on an additional managerial role, because the service was short-staffed, and she had not had the time to complete the form properly.

Surrey Care Trust

79. **Emma-Louise Lowe** told me she was working for the Surrey Care Trust ("SCT") as its Assistant Mentoring Manager. She told me that SCT is a charity which seeks "*to empower individuals, families or young people to put positive changes in place and have support for them on a one-to-one basis*". She said that SCT had an "*Early Help Level 2*" contract with Surrey County Council, meaning that they provided a mentoring service for Level 2 needs, that is, those requiring some extra support but not specialist services, such as CAMHS. She said that SCT do support young people with neurodevelopmental conditions, depending on their severity.

80. Ms Lowe said Sharon Allen had sent the referral concerning Jen directly to her manager, Sian Jones, and it was then the witness' job to assess it. She said that it appeared to be a straightforward referral, with Jen just needing, "*…that little bit more support with life in general and having someone to confide in*". She said there was no mention of any mental health concerns or other diagnoses such as autism or ADHD, and no mention of self-harm or suicide, and the witness said she took the referral at face value and as a level 2 case. Ms Lowe said that, with the benefit of hindsight, she should have asked for more information. If she had considered that Jen's needs were greater than level 2, she would not have accepted the referral.

81. Ms Lowe told me that on the 9th July 2020, she and a colleague telephoned Ms Bridges and learned far more. They were told of Jen's diagnoses, mental health issues, history of suicidality, and current anti-depressant medication. Ms Bridges also told them about her time at St. Peter's Centre

and that she had just completed a course at Nescot College, and was due to start an animal care course there in September. She mentioned also Jen's disclosure to her driver about her interaction with the 32 year old man in the United States, and that a friend at college had persuaded her to give them £300 of her money, indicating that Jen was immature and vulnerable. Ms Bridges indicated that Jen needed help with understanding boundaries for her mobile phone use and, Ms Lowe said, she told her that an SCT mentor could help with that. The witness was asked whether the disclosed information had not suggested that Jen needs were at level 3, and she said that she, "*…still deemed this more as a level two as she was still trying to go into college, … regardless of there were some issues and more vulnerability but I was still regardless, I still believed this would be slightly on a level two just because it was more generalised support that we would have to personally be putting in and that was the support that seemed to be … required*". On the 13th July 2020, Ms Lowe said she spoke to Jen on the telephone; Jen was anxious and found it hard to talk, but indicated that she, "*… wants help and needs help but is unsure what*".

82. Ms Lowe explained that all the mentors provided by SCT are volunteers; they do not have any professional qualifications or training, and their role is simply to befriend and not, for example, to provide counselling or therapy. SCT provided the volunteers with training for one day, or over a few evenings. Ms Lowe said she allocated Jen's case to Sara Corker, and told her that, "*Jen is 16-years-old, she has ADHD and is high-functioning autism. She gets taken advantage of a bit. Follows suit with what her friends are doing, even if it is wrong and really needs some support and someone to speak with, to go through boundaries with, and also to realise that she does not need, when replying to someone, to be at their beck and call. Would be good for her to try and understand that sometimes people have a different agenda. She's very shy and at times will go quiet. Loves animals, especially horses, is due to go to college in September to complete an animal course*". Ms Lowe accepted that she did not pass on to Ms Corker all the information she had received from Ms Bridges, but said that she would not normally provide the volunteers with all the information, "*…just so they don't just assume and make any judgement before".* The witness said she was then aware of Ms Corker supporting Jen between August and December 2020. She was not aware of any problems

until she was asked, by Children's Services, for input in December 2020. I shall return to those events below.

Nescot College

83. I will now go back to 2019 to review what followed the breakdown of Jen's placement at HofE. Once it had become clear that Jen could not return to HofE, Ms Bridges had arranged a place for her at Nescot College ("Nescot"), and Tracy Sanders told me that this college was named as Jen's placement in her EHCP from September 2019. Ms Sanders described the system for information sharing in advance of the transfer. She said that the SEN team would provide a copy of the EHCP to a proposed school or college prior to admission, to ensure it could meet the student's needs, but the first school's safeguarding file and other relevant documents were passed by the school to the college, within five days of the student starting at the new placement. The witness described this as "*a disconnect*" between the SEND'S statutory code of practice and the safeguarding legislation, leaving the receiving college potentially without important information for the purpose of the assessment and early attendance.

84. I heard evidence from **Andrew Cowen** who told me that he joined Nescot in December 2022 and is currently the Deputy Principal. His evidence was based on Nescot's records. He said that Nescot is a Further Education college which also runs a 14-16 years provision, primarily for those who are struggling in a mainstream setting. In May 2019, the college had been provided with a draft of Jen's EHCP and was satisfied that it could meet her needs, and Jen started what proved to be a two year placement at Nescot in September 2019. He said that Nescot is not registered by the Department of Education, and so school-aged children must remain on the roll of a registered school; for that reason, Jen stayed on the roll of HofE for her first year at Nescot (and the first annual review of her EHCP was conducted jointly by HofE and Nescot).

85. Mr Cowen explained that Nescot's 14-16 provision was housed in a protected area, separate from its Further Education college. Jen was taught in very small groups with a high staff to student ratio. She was academically capable and there was no record of any specific incidents

causing any significant concern. Nescot used a system called ProMonitor to record staff comments, and this showed that in her first year, in the 14-16 provision, she was attending well and was progressing, and things seemed positive outside of college too.

86. In September 2020, by which time Jen was 16 years of age, she embarked on her second year at Nescot as a Further Education student and so was enrolled solely with the college. She started an Animal Care course which was based partly in the class room, with larger class sizes than the year before, and partly on a farm within Nescot's grounds. Andrew Cowen said that the campus was large and busy, with thousands of students, but quiet spaces were available. Jen soon started to have problems in her second year. On the 17th September 2020, it was recorded that she was distressed by her boyfriend and she reported having thoughts about hurting herself, although they passed. On the 16th November, Jen disclosed that she was suffering anxiety and panic attacks following the ending of her relationship with her then boyfriend. A short time later, Jen was in a relationship with another young man, whom she described as her fiancé. She stayed at his house for three nights and, on the 1st December 2020, refused to go home with her mother, who had attended the college to take her home. Jen reported this to the Nescot Safeguarding team, who made a referral to Children's Services, and she continued to stay with the boyfriend and his adult sister.

87. By this time, there was concern also that Jen was upsetting and disrupting her fellow students. Mr Cowen said that the records show that on the 7th December 2020, Jen was telling people, including staff, that she "*sold her soul to the devil and that her first born child belongs to the devil*", and that she had been pregnant on Friday and had a miscarriage on Saturday. A member of staff wrote that she was "*seriously worried about her need for constant drama and attention, especially the situation regarding the devil and her miscarriage – there was no joking about, she was 100% serious*". Whilst it was recognised that Jen's behaviour may have been a cry for help and attention, it was also causing "*chaos*" in the department, and Jen was placed on stage 1 of the disciplinary process which, Mr Cowen said, was really an intervention to support positive behaviour. A subsequent note recorded that staff spoke to Jen and her, "… *conversation did keep flitting to*

quite elaborate plans and events that have taken place. I feel Jen needs more specialised support to understand the world she lives in". On the 10th December, staff recorded speaking to Ms Bridges who was, "*… clearly very upset and feels that she has lost her daughter*". Ms Bridges subsequently emailed Nescot to report that Jen's relationship with her boyfriend had ended, that Jen had gone to live with her father, and that Jen had decided she did not want to return to Nescot, but wanted a "*fresh start*" elsewhere.

88. **Dr Noor Kafil-Hussain** is a Consultant Paediatrician who started working at Epsom Hospital in October 2020, when she inherited Jen's case from Dr Zoric. In November 2020, she was contacted by Jen's GP, Dr George, who wanted advice about Jen's ongoing prescription for sleep medication. Dr Kafil-Hussain arranged a telephone review with Jen, although she spoke only to Ms Bridges who, she said, was "*distraught*". The witness received a very full history from Ms Bridges and was told that Jen was no longer under CAMHS, that she had been on fluoxetine which helped with her mood, but had stopped taking it in October and her mood had deteriorated since. The witness said that she wondered whether there might be alternative medications which could be explored with a psychiatry specialist. She said it was not in her remit as a paediatrician to prescribe psychiatric medications such as antidepressants or anxiolytics. Her plan, provided to the GP, was for the sleep medication to be continued, and for a referral to be made "*to our new ADHD transition service which will be jointly conducted by a consultant paediatrician with an interest in neurodevelopment conditions and also an adult psychiatry consultant which I think will be beneficial for Jennifer*".

89. Dr Kafil-Hussain explained that the new clinic at Epsom Hospital was not yet running, but the lead consultant was accepting referrals. She made the referral to Dr Sharma and wrote, "*Her mother said she does not like taking capsules, fluoxetine is administered in capsule form, wonders whether this might also have been part of the problem. Unfortunately her mood since then has significantly deteriorated. She is said to have very low mood, very low self-esteem, reduced personal hygiene and difficulties with sleep. She ran away a couple of weeks ago, … boyfriend and his parents and subsequently moved in with her father. This was because her mother said she could not have a sleepover. She's currently at Nescot, having started in September, however, is already thinking about leaving and finding a different course. Continues to exhibit difficulties with her mood, also*

with impulsive behaviour and understandably her family are very concerned about this, mother's quite distressed and is receiving counselling herself. Previous inappropriate contact online with an older man, having Targeted Youth Service input. I feel that Jennifer would benefit from ongoing joint assessment and management of her ADHD and low mood. And as such, I think your joint transition clinic with adult psychiatry would be the ideal setting for this. I do wonder whether she should be encouraged to restart on antidepressants as her mother said her mood was much better with this. She has not been taking her ADHD medications for a couple of years now". She also discussed Jen with Dr Sharma who agreed that she would be a good candidate when the clinic opened in the summer / autumn of 2021, because they could provide the psychiatric input she needed and the management and monitoring of her ADHD, as well as assisting with transitioning into adult psychiatric services. The witness was asked why she had not made a referral to CAMHS, given that the new clinic was not due to open for six months or so, and she said that she had been told that Jen had not "*clicked*" with CAMHS and had disengaged, and that she had not viewed her need for input as urgent because the low mood was long-standing and there was no report of current suicidal ideation. The witness added that she knew that a routine referral to CAMHS took many months and she wondered if she had felt that Jen would probably be able to access the new service in a more timely manner.

90. Dr Kafil-Hussain said that Jen's profile was quite complex and, in her view, her problems could not be explained by her mood alone. She considered that there were "*many factors interplaying on the decisions that she was making there. For me as a neurodevelopmental paediatrician, I picked up on the fact that she has ADHD, one of the problems there is impulsivity. And, you know, and easy distractibility, getting bored very easily. … I was aware of many aspects from my discussion with her mother of these features. So impulsive decisions with regards to moving out and school*" which, she said, is why she thought she needed both medical input for management of her ADHD and psychiatric input for management of her low mood.

91. It was through these months, from August to December 2020, that Jen had been seeing **Sara Corker**, the volunteer mentor from SCT. Ms Corker told me she is an interior designer. She had received training over a few evenings and had mentored two adults, but Jen was the first child she had

mentored, and the first autistic person she was ever aware of meeting. She was given little information about Jen, so as not to pre-judge her. She was not told that Jen had recently been discharged by CAMHS, was taking anti-depressants, nor that she had a history of suicidal ideation. Ms Corker said they met in person a few times, and they spoke on the 'phone and exchanged texts, and nothing Jen said raised any real concern in the witness' mind. Ms Lowe said that in December 2020 she was asked by Children's Services to provide an update of SCT's involvement and she obtained this from Ms Corker, who called Jen and learned that she was no longer living with her mother, but was staying with her boyfriend, Chris. She recorded, "*Over the last few months, Jen has gone out with Chris and then broke up with him but then she'd spoken to the safeguarding team as there was an inappropriate FaceTime call between Chris and someone else, no action had been taken. She then went out with Alfie, broke up with him, also safeguarding team spoken to because she was reporting that he was effectively assaulting her. No action taken. Now is going back out with Chris and she's now living with Chris since last Saturday in a one-bedroom flat with his sisters*". This was new information to Ms Corker.

92. The evidence of **Lindsay Fryer**, a crisis call handler with CAMHS, was read. She stated that at 01.45 hours on Sunday, the 3rd January 2021, she received a crisis call from Ms Bridges and Jen. She spoke to Jen who said that she had tried to end her life earlier that evening by jumping off a balcony at her father's house, but she had been stopped by her sister. She said she still had the intention to end her life at the first opportunity, and she would be unable to keep herself safe from harm overnight. The witness asked Jen if she had any protective factors which may stop her from ending her life, and she replied, "*only if she was held down and forcibly stopped*". Jen also disclosed that, during the conversation, she had been self-harming by cutting her arms. Ms Fryer stated that she advised Jen's mother to take her to the Accident and Emergency Department if she felt that her daughter needed immediate and urgent support, and Ms Bridges replied that she would do so straightaway, as she was very concerned that Jen would act on the suicidal impulses.

93. I heard evidence from **Veronica Kararwa**, a Registered Mental Health Nurse working for the Community Crisis Intervention Service within

CAMHS. On the 3rd January 2021, following Jen's admission to Epsom Hospital, she saw Jen and Ms Bridges via video link. The notes indicated that Jen had tried to jump off a balcony with an intent to end her life. She had been seen by the Psychiatric Liaison Service who considered that she presented as still suicidal and unable to guarantee her safety at home. On the 4th January 2021, she said that Jen reported no improvement and stated that she went out of the hospital earlier for a cigarette smoke and "*felt like running in front of a car*". Jen's discharge was discussed at an MDT, including clinicians from Epsom Hospital, who said that Jen has disclosed that she had had a miscarriage last month but this assertion, and other things Jen was saying, appeared to have discrepancies and was thought to be untrue. Tiffany Cherry and Sara Corker also joined the meeting. Ms Kararwa said that it was decided that Jen would be discharged from hospital, to her mother's home, with a seven-day follow-up and a referral to Heads Together, a service which offers counselling to young people. Ms Bridges felt that she had no choice but to accept this.

94. The witness was asked why, given that Jen was suicidal, talking of a miscarriage which was thought not to have happened, and was autistic, a psychiatric assessment had not been planned. She said she did not know how to answer but none of the professionals had suggested a psychiatric review. Ms Kararwa said she conducted a review on the 11th January 2021, again by video link to Jen and Ms Bridges. She recorded that, "*Jen reports good progress. Stated feeling stable but not quite there. Gets urges to self-harm but is closely monitored so has not actually performed self-harm. Jen reported that she has enrolled in online classes… Described her mood as low, said it fluctuates. Rated it today as three out of ten. … Objectively appeared euthymic in mood. Mother reported sleeping and eating well. … Mother reported that Jen's mood fluctuates and that worries her. … Mother wanted to know what support we will offer. Mother wonders if we can get medication for her mood and therapy. Agreed will discuss the case with the team doctor. Currently in the process of referring her to Heads Together and will present her case to CT [Community Team] on Thursday. ….*". Ms Kararwa said that she spoke to Dr Oludare Asekun, a psychiatrist in the Crisis Team, on the 12th January. He advised her to discuss Jen's case with Community Team on Thursday, because she "*needed to be in tier three*" for medication review and monitoring. He also said he would be willing to offer a prompter review the following week if

there was going to be a delay. The witness said that Jen's case was discussed at a Community Team MDT on the 20th January 2021.The decision was that Jen was to be discharged from the Crisis Team and allocated to a clinician in the Community Team. She believed she was given the name of the clinician, although she could not now remember it, and that she had completed a handover form for them. Ms Kararwa was asked whether she had enquired when Jen was likely to be seen, given Dr Asekun's offer to see her quickly if there was to be a delay, but she said she had not done so because Jen was then no longer under the Crisis Team.

95. Jen did not return to Nescot after the Christmas holidays. The annual review of Jen's EHCP was brought forward and was held on the 8th February 2021. It was attended by Jen (referred to in the notes as "Jem") and her parents, and Nescot staff. Steve Mason from Surrey County Council's SEN team was invited but did not attend. Neither Tiffany Cherry nor CAMHS were invited. The update on Jen's social situation was recorded as follows:

"*Jem left home to stay with a boyfriend. This fell through and Jem came home and collected her things, but that fell apart. Since then she's been staying with her dad. In January she had a meltdown. Jem is apprehensive about returning to her mother. Subsequently her mental health has suffered. Mum and dad are keeping her busy*".

It was also noted that Jen had recently been re-referred to CAMHS. So far as her progress at Nescot was concerned, it was said that her academic work was satisfactory but that she was struggling with social situations, and she needed to stop sharing details of her private life, which was causing her problems. It was noted that Jen "*would benefit from a small group setting*" but otherwise there were very few proposed amendments to the EHCP. Finally, the review indicated that Nescot was no longer a suitable placement for Jen because, "*Jem has stated that she does not wish to continue at Nescot, but will remain for the academic year to gain her Maths and English qualifications*". The plan was for her to undertake this work remotely. The EHCP review document was sent by Nescot to the SEN team.

96. When questioned, Mr Cowen agreed that, given the information concerning Jen's living arrangements and mental health, Children's Services and CAMHS ought to have been invited by Nescot to the review meeting, or at least asked to make a written contribution. Tracy Sanders stated that the SEN team would normally attend a review meeting where there was a placement breakdown and the previous case officer had intended to do so, but Steve Mason, who was listed as having been invited, had only recently replaced the previous case officer and she assumed he had not attended due to late handover. Ms Sanders agreed that the changes in Jen's living circumstances were significant developments; Jen's safe place was no longer at home with her mother, and it seemed that she was a 17-year-old girl with complex needs who was sometimes living with a boyfriend, possibly without appropriate adult supervision, and this ought to have been reflected in updating amendments of the EHCP. The notes also recorded that there had been a re-referral to CAMHS and Ms Sanders said that she would have expected further enquiry to have been made by the SEN team, either with the college or directly through CAMHS and Children's Services, to obtain more information in this regard, as it was important for these matters to be reflected in an updated EHCP prior to transfer of placement.

97. **Grace Chikono** is a Registered Mental Health Nurse working for CAMHS' Crisis Team, and she told me that Jen was admitted to Ashford and St. Peter's Hospital on the 14th March 2021, which was Mothers' Day. She had been brought in at about 6.00 am by ambulance, stating that she had tried to stab herself with a peeling knife but managed to stop herself. She had then walked out of the house and for two miles before contacting the police for help. The witness spoke to Jen who said that, "… *her brain, her own thoughts, started to tell her that she should die. She informed me that she struggled with suicidal thoughts since 2015 but only opened up to talk about her thoughts in 2018. She described her mood as always been low and unable to feel happy, with associated feelings of hopelessness, worthlessness and emptiness*". Ms Chikono recorded her impression as, "*17-year-old presenting with suicidal ideation, background of ASD, ADHD, depression, anxiety, currently open to CAMHS community team. On assessment she presented as low in mood and may benefit from medication review*". She said she wrote this because her

assessment had clearly identified that there was low mood, described by Jen as 0.5 out of 10, and she had stopped taking her antidepressant and ADHD medications. She said that both Jen and her father were keen for her to be restarted on Fluoxetine; Jen said she had had difficulty swallowing them and the witness suggested it could be prescribed in liquid form. Jen's father complained that they had heard nothing from the Community Team since the January admission and, on the basis of CAMHS' records, the witness confirmed to me it had only recently been noted that Jen needed a medication review but she had not been properly allocated to a clinician to progress matters. She said that she emailed the Community Team to draw attention to this admission and to her impression and recommendations.

98. Dr Kafil-Hussain spoke to Jen and her father in April 2021 when, she said, her situation seemed "*fairly positive*". The witness did not know about Jen's admission to hospital in January 2021, but did learn of an admission in March when she had cut herself. She said that although the snapshot in April was positive, it continued to be her view that Jen would benefit from being under the care of a psychiatric team. She noted that Jen was now under CAMHS again, awaiting review, and she assumed that this would result in Jen being seen by a psychiatrist. Nevertheless, the witness said that Jen also remained on the waiting list for the new clinic in Epsom and, at the time of her death, was due to be seen in October / November 2021.

99. Tiffany Cherry told me about the further involvement of TYS. She said that on the 1st December 2020, Nescot had called Children's Services to say Jen was refusing to go home and, "…*wants to stay with boyfriend who is 16 and lives with adult sisters. Stayed there at the weekend. Mother does not want child to stay there, staying in one-bed flat with all these people. … Child has ASD and anxiety and wants to go back to boyfriend with whom she got engaged three weeks ago. Child does not like that mum has rules at home. Child is talking about getting married. School … are concerned about child returning to boyfriend's house*." Ms Cherry said she was surprised by this development, not so much that Jen had developed intense feelings for a boy quickly, but that she did not want to go home, as she had previously found the relationship between Jen and Ms Bridges to be a good one. Further enquiries showed that Jen had told the police that, "… *if she comes home, she will run away or try and kill herself. She*

said that both mum and dad are dead to her". Both parents were expressing shock at this sudden development and were opposed to her living in a one-bedroomed flat with boyfriend and two other adults. Ms Cherry said that Children's Services agreed that Jen needed protecting from herself at this point; she was extremely vulnerable because her autism meant that she had no understanding of the consequences of her actions. Other information received suggested that Jen was not eating, was self-harming, and was disappointed that a pregnancy test was negative. The case was allocated to Ms Cherry who said that it was thought that TYS would probably be involved for a short period only, in order to get Jen "*back on track*" and using the services that were available to her from SCT. She said she had not known about Ms Corker's lack of experience until she heard her evidence at the inquest, although she accepted that SCT had indicated, early in 2021, that they could not help Jen any further. By the January of 2021, Jen was back living with her mother, but her relationships at college had all broken down and she had stopped attending. A record made on the 11th February 2021, noted that Jen was telling, "… *stories about having had a miscarriage (not true). Otherwise quite settled at the moment, staying with dad and getting on well … Emotional wellbeing much more stable, no self-harm or talk of suicide. Some concern that this might be more about proving a point to mum. … Psychiatrists advise they won't allocate anyone else but we could re-refer. Will hold off doing this until we have finished the work planned to reassess needs and appropriate exit plan at that point*", and by March, Jen appeared to be settled living with her father, and a plan was made to discharge her and re-refer her to SCT.

100. However, Ms Cherry said that she then learned that Jen was taken to hospital by ambulance with a report that she had tried to stab herself with a blunt knife, although no wounds were found and no medical treatment was needed. She had left a "*suicide note*", and had left the house with the intention of killing herself, but rang a friend who convinced her to ring 999. Ms Cherry accepted that she had thought Jen's position was much better the previous October, and yet within weeks Jen's life had started to fall apart quite dramatically, with suicidal ideation and actions arising. The witness was asked what further help TYS considered they could now give Jen and whether they considered further and different intervention was required by others. She said she could not recall but that Jen's admission to hospital had led to CAMHS' Crisis Team involvement and TYS would look

to CAMHS for guidance on addressing the issues arising. However, she could not recall having contact with CAMHS to seek their advice. Ms Cherry arranged a Team Around the Family meeting for the 5th May 2021. She was asked why she had not invited CAMHS to attend and said, "*As far as I was aware, she wasn't open to CAMHS at this point*". She said that Jen was living with her father who stated that Jen was in a good routine, was becoming more independent, and was developing her social skills, and that she just needed to work on her bedtime routine and getting up at a reasonable time. Jen was not attending college but it was recorded that she was doing well with the online work and that she was due to start at Guildford College for a hairdressing course in September. Ms Cherry said that TYS were looking for an exit plan as Jen was progressing and was currently settled. So far as ongoing support was concerned, it was noted that SCT had refused the re-referral to them, considering Jen to be too high risk, and so a referral to Waves, which was a support group run by YMCA East Surrey, was proposed. It was also recorded that Ms Bridges had not seen Jen in a while, was very pleased that Jen seems to be doing so well, but was worried about the impact of the change of routine when Jen started at Guildford College.

101. I will note here that Emma-Louise Lowe of SCT confirmed that she had been invited to the Team Around the Family meeting organised by Tiffany Cherry for the 5th May 2021 but had declined to attend because SCT had, by then, refused to accept a further referral of Jen in view of her level of need. Indeed, Ms Lowe said that, on the basis of what she now knows of Jen's condition and history, she considers Jen had level 3 needs throughout and should not have gone to a level 2 service, such as SCT.

102. On the 9th June 2021, Jen was found to be missing from her father's home at night. He contacted the police. Shortly after doing so, Jen contacted her father and stated that she was on her way home. Jen told the police that she left home at approximately half-past midnight for a walk to clear her head; she felt anxious and her brain told her to get some air. She said she went out for a long walk and was speaking to inanimate objects about her problems. Eventually, she fell asleep behind a bus stop. This was reported to TYS but Ms Cherry said that, despite this incident, overall Jen seemed a lot more settled and able to manage her emotions, and she said

that in last few incidents, or slip ups as she would call them, Jen was reaching out for help, or trying to understand the impact of her behaviour, so there seemed to be some reflection on her part, which was positive. In the circumstances, she said, it was decided that Jen could be discharged from TYS on the 24th June 2021, with a referral to Waves. Jan Smith was asked whether TYS ought to have liaised with the other services before ending Jen's support from Tiffany Cherry. He said that TYS' closure was not contingent on what others were doing, because our work was finished, but he recognised that there could have been a TAF Closure Meeting with partners to assess the impact on Jen of all services ending at the same time.

103. So far as CAMHS' further management of the January 2021 re-referral was concerned, I then heard oral evidence from **Michael Oyadeyi**, who is a Registered Mental Health Nurse, then employed by CAMHS as a Senior Mental Health Practitioner in the Community Team. By reason of the pandemic, he was working from home at this time. He said that on the 20th May 2021, an appointment was placed in his diary for him to conduct a mental health review assessment of Jen, by video, on the 16th June 2021. He said Jen was awaiting allocation and, before a young person is allocated, it was normal process for there to be an initial assessment, and that is what he had been asked to conduct. He said she needed, "*… a comprehensive assessment of her mental health. So, meaning her mental state, as well as risk … so basically, initially an identification of her needs, her mental health needs and what services may potentially meet those needs*". He said he was also aware that, in March, the need for a medication review had been noted, which was not something he would have been able to do himself.

104. Mr Oyadeyi said he could not recall when he was first aware of the appointment. He said he did not speak to anyone else in the team about Jen before his assessment. He could not recall what he looked at, but said he would have looked at Jen's notes on the system, saying, "*I looked at all the notes that were available at the time*". The meeting with Jen and her father was booked to start at 10.00 am. He was asked how long the assessment was due to last, and said, "*at least one hour*". He said he spoke to them both via CAMHS' "*Attend Anywhere*" system although, when questioned by Ms Sikand, he accepted that this may have been with audio only because of the family's technical problems.

105. Mr Oyadeyi said he made his note of the assessment on CAMHS' electronic SystmOne record after the meeting had finished. He agreed that his entry was made between 10.41 am and 10.50 am. The relevant parts of his note reads as follows:

"Jennifer reports her mood has been fluctuating up down due to an accumulation of different things such as Grandmother not being well and being in and out of hospital and her dog dying, Dad reports Jennifer mood has been much improved recently as she is socialising more and making more friends and her mood has significantly improved during the evenings. She reports to struggle at times.

Presenting Complaint – 16/06/2021 (CAMHS Assessment)

Jennifer reports she was on Fluoxetine 20mg once a day however she states her body was not reacting well to the medication and it was causing her to throw up so she stopped the medication after advise from a telephone conversation as Jennifer was unable to keep down for 3 weeks.

Jennifer reports her mood has been fluctuating up down due to an accumulation of different things such as Grandmother not being well and being in and out of hospital and her dog dying. Dad reports Jennifer mood has been much improved recently as she is socialising more and making more friends. Jennifer is getting on well with her mother and Dad reports Jennifer is doing much better and there have been quite a few changes such as moving out of her mother house and staying with her father and stepmother which has helped her significantly.

Dad states Jennifer is still not where she wants to be. Jennifer reports she is not sure what help or support she needs as she is building up a support network with friends and she has the support from family.

School – Jennifer reports she is not enrolled in college however she has been given admission to Guildford College in September (2021). Jennifer reports she works better in one to one situation and she is doing a hairdresser's course.

…

Family mental health problems – No family mental health problems.

Medication – No medication.

Current Mental State –

Mood – Jennifer rates her mood currently … 8/10, 10 being the best.

Sleep – Jennifer reports to sleeping 8 hours a night minimum.

Appetite – Jennifer reports she has a good dietary and fluid intake.

Acute – Jennifer denies experiencing any acute symptoms and none evident during CAMHS Assessment.

Risk – Jennifer denies that she has any thoughts or intent of suicidal ideation and her protective factor being her family.

Presentation during the assessment – Jennifer participated in the CAMHS assessment.

Plan – I advised Jennifer and Dad that we will discuss the initial CAMHS assessment at a PAM (MDT) Meeting coupled with the background information and we will feedback them. I have had an MDT discussion with Sharon Allen (Lead) today (16/06/2021) and following our assessment it has been agreed to refer Jennifer through to Heads Together counselling for sessions around low mood management and to help her develop effective coping mechanisms to help manage her emotions.

Therefore, this patient will be transferred back into the care of the GP and discharged from CAMHS."

106. Mr Oyadeyi was asked about the PAM (MDT) Meeting, meaning Post Assessment Meeting (Multi Disciplinary Team) Meeting, and he said, that "*Sharon Allan was the Chair of this meeting, and so was Lead, … of this wider meeting, and that was the outcome of the wider meeting*". When pressed, the witness accepted that the PAM MDT meeting must have taken place

before he completed his entry in the records at 10.50 am. He was asked whether the discussion had involved only himself and Sharon Allen and he denied this, saying, "*…because for a PAM, for a PAM Meeting to take place, there would have to be more than two people*". He was asked how many others were present and who they were, and he said he could not recall. He was asked how this meeting was arranged and what took place and there were the following exchanges:

Qu. What was discussed about Jen at the meeting?
A. Her presentation. So, basically I had, this meeting wasn't specifically arranged for myself. I had joined a meeting that was already being conducted at that time. I had come into the meeting and there was availability to discuss Jen's case, hence I discussed it.

Qu. So you entered a meeting that was already going on?
Answer. Yeah.

Qu. It sounds as though you have a recollection of this, if you entered it. Is that right?
Answer. Yeah, yeah. Well, as we were talking about it. Yeah.

Qu. Did you have to wait until you had an opportunity to introduce Jen to the discussion?
Answer. There was … No. There was availability for me to discuss the case, for which I joined, and I was able to discuss that case.

Qu. And what did you convey to the meeting and those present about Jen?
Answer. Everything that was within my assessment. … commonly what I do, being Microsoft
Teams, I present the assessment on the screen. I share my screen. Which everyone, all the
professionals within the assessment can see my assessment as I'm going through it, for clarity
of mind and decisions. And that's what it was on.

Qu. And was there a Psychiatrist present at this meeting?
Answer. I can't recall, sorry.

Qu. And when you had given your presentation, what was the discussion, what were the views of those present, the multi-disciplinary presence?

Answer. That they agreed with, as a team we agreed with a decision that one of our partner agencies, a part of our alliance, Heads Together, would be the best outcome in terms of therapeutic approach in relation to NICE Guidelines, which say we should always try therapy first before medication.

Qu. And what was the rationale then for that decision? Why was that the conclusion and consensus?

Answer. Because at that time Jennifer presented as much improved in her mood from what was reported from herself and her father. There wasn't instability in her mental health in general. That this was an improvement compared to past episodes. And, yeah, there was no reason not to refer her to Heads Together for support. Because Heads Together have CBT therapists. So specifically we were looking at some low mood management work.

Qu. And you say, do you, all of that was discussed and considered at the MDT Meeting?

Answer. My case was presented on and shared on the screen and then, yes, that was discussed.

Qu. And discussed by those present and that was the consensus conclusion?

Answer. That's right.

107. As a result of these exchanges, I asked for disclosure of the minutes of the meeting at which Jen's case had been discussed and asked for the witness to attend on a subsequent day. On the following sitting day,

I was informed that Surrey and Borders Partnership NHS Foundation Trust considered that a conflict had arisen between themselves and Mr Oyadeyi. I granted Mr Oyadeyi Interested Person status and allowed time for him to seek his own legal representation should he wish to do so, which he did.

108. At my request, I was then provided with further witness statements and evidence by Surrey and Borders Partnership NHS Foundation Trust which were read. I will note in particular:

(i) I was provided with a witness statement from Dr Ferreira-Lay who stated that:

a. The CAMHS team offer specialist mental health assessment and treatment. A multidisciplinary team, typically made up of nurses, doctors, mental health practitioners and various therapists, will contribute their clinical expertise to formulate the care and treatment indicated for a young person further to assessment at different points in their journey,
b. The purpose of a post-assessment meeting or PAM was to review new cases with the clinical team; membership of the PAM would vary depending on the availability of staff but typically included registered mental health nurses, psychologists and psychiatrists. Emphasis is on a multidisciplinary conversation, it is not stipulated what disciplines will be required at any one meeting. PAMs were held frequently, typically three times a week, during COVID attendees would typically access PAMs via MS Teams from home or their Trust laptop/mobile phones. The aim of the discussion was to help the assessing clinician to complete an initial conclusion in respect of the assessment findings and plan any immediate next steps in the care arrangements for the child, young person and their family/carers. PAM meetings were not minuted, rather the record of the discussion on each case was entered onto SystmOne in that record,
c. In contrast, Multi Disciplinary Team Meetings were held weekly on a Wednesday afternoon; the membership consisted of clinical and operational staff and varied due to the availability/working

patterns of team members. The chair for the MDT was shared on a rota basis with staff members but was typically the general manager, deputy manager or a senior clinician. During COVID attendees would typically access via MS Teams from home on their Trust laptops/mobile phones. The agenda for the MDT covered core operational matters but was varied on the day to ensure that staff could bring other relevant matters to the meeting. The final agenda therefore was determined on the day. The agenda included clinical/case related matters, and operational items such as procedural concerns. Clinical discussions often concerned existing known cases with a current open episode of care; discussions often centred on the allocated clinical staff member, presenting issues and concerns regarding the care of the child or young person for discussion. The meetings were minuted, and

d. An MDT took place on the afternoon of the 16th June 2021 and the witness exhibited the Agenda

(ii) I was provided with a witness statement from **George Malpartida**, the Trust's Chief Technology Officer, who stated that,

a. Interrogation of the system showed that Michael Oyadeyi held an "*Attend Anywhere*" online video consultation call between 10.10 am and 10.25 am on June the 16th 2021,
b. There was no evidence found of a PAM meeting being held that morning, although there were limits on the investigation, especially in relation to the use of telephones,
c. In June 2021 it was not possible for a user to log into SystmOne in order to view a patient's notes without an electronic footprint of some form being created,
d. The audit log shows that Micael Oyadeyi accessed Jen's notes on the 16th June 2021 only, and that was in a period spanning one hour 49 minutes from 9.15 am to 11.04 am, and
e. The audit log shows that in 2021, Sharon Allen accessed Jen's notes on the 17th May 2021 for two minutes, but did not access them at all on any other day, including the 16th June 2021.

109. Prior to attending to give further evidence, Mr Oyadeyi provided to me a further witness statement in which he said that he wished to emphasise that he had no recollection of Jennifer, and no recollection of the assessment on the 16th of June 2021. He was asked whether he was now saying that he had no recollection of the post-assessment meeting he said had taken place with colleagues, and he repeated that he had no recollection. He was asked why he had not said that previously, and why he had given a detailed account of what took place at the meeting, if he could not, in fact, recall that. He said, "*I just want to make it clear at the time of me giving my first evidence I wasn't, obviously I was on the stand here, I wasn't able to sort of ... although I couldn't recollect then what had happened, I was more talking from the sense of what I would have done, so our usual practice at that time*". He was asked whether it was likely that the "*Attend Anywhere*" call which he held between 10.10 and 10.25 am on the 16th June 2021, which was his only recorded call that day, was his call with Jen and her father, but he was unwilling to "*validate the likeliness of that being accurate*". Mr Oyadeyi continued to say that he had conducted a thorough assessment and when asked whether that was feasible in a meeting of 15 minutes or so, he said, "*It may have been*".

110. The witness accepted that he did not have authority to decide to discharge a patient alone. Rather, there was a requirement for a case to be discussed at a meeting of at least three health care professionals before the patient could be discharged. In his original witness statement, he said that he had informed Jen and her father that there would be discussion at a PAM (MDT) Meeting comprising, "… *the consultant psychiatrist, psychologists, CBT therapist, nurses, psychotherapist and social workers ...*", but he said he added that to his draft statement because he had been asked by Trust legal services to explain what type of professionals there would have been in this meeting. He said that, in practice, decisions to discharge were sometimes made by three nurses. He said, "*Multidisciplinary meetings, we use the resources that are available at the time. At that time, there were quite a few nurses, locum nurses, within the service. So these professions, for example, doctors or psychologist may not be readily available to attend such meetings*". He said a meeting of three nurses would be a multi-disciplinary meeting because there would be three different health care professionals present. He was asked why he had not

presented Jen's case to the MDT which was held on the afternoon of the 16th June 2021, at which a range of disciplines were present, and he said, "…*we were encouraged by management within the team not to bring young people who were not in terms of great concern, where there was a routine referral, that we're not to bring it to the MDT meeting. Rather, use the other forum such as PAM discussions, for which I did on that day, to be able to discuss these assessments*".

111. Mr Oyadeyi was asked again about who had taken part in the discussion following his meeting with Jen. In his further statement, he said that the discussion was with, "*Sharon Allan and another colleague. I do not now recall who, but it would be usual practice for there to be three people in attendance*". When pressed, however, he said, "*I cannot specifically remember how many colleagues were present at this meeting*". He was asked whether he could assist in explaining how the meeting was arranged and took place given that he was working from home and there was no evidence of it from the technological searches conducted by the Trust, and he said he could not. He was asked whether there may simply have been a telephone call between himself and Sharon Allan, and he said could not recall how they made contact. He was asked why he had given a detailed description of a meeting and its decision making in his earlier oral evidence if, in truth, he had no recollection, and he said that after giving his evidence, "… *I was remembering there were several young people who I was assessing at the time. And it now sort of dawned to me that I couldn't actually remember the specific circumstances of that assessment and also the MDT discussion, PAM meeting that happened after. It now sort of dawned to me that actually my only recollection is based on the medical records*". The witness denied having lied to the Court and he denied having given his previous version of events because he knew that was what ought to have happened.

112. In relation to the decision to discharge Jen from CAMHS, Mr Oyadeyi said he could not recall what the reasoning had been. He agreed that Jen's neurodevelopmental conditions and her history of suicidality were not included in his assessment note, and he agreed that if they had not been taken into account in the subsequent discussion, then the decision to discharge would have been made on an insufficiently informed basis. He said he could not recall knowing about her need for a medication review.

113. Mr Oyadeyi was asked about his referral of Jen to Heads Together. He said it was made, "*…for support, meaning therapy, for low mood management, so specifically CBT, Cognitive Behavioural Therapy, for Jennifer to learn effective ways of managing her emotions*". He was asked why, then, he had in fact asked Heads Together to provide counselling and he said that therapy and counselling were words which could be used interchangeably. The witness was asked how he could have been satisfied that the support from Heads Together would be sufficient to meet Jen's needs, and he said he could not answer that question. He agreed that it would have been important for Heads Together to know of Jen's neurodevelopmental conditions and history of suicidality to enable them to assess their ability to meet her needs, but that he did not include this information in his referral which he sent by email at 11.02 am on the 16th June 2021, after closing Jen's case to CAMHS' Community Team.

114. Sharon Allen was re-called and asked about the matters which had been raised by Mr Oyadeyi's evidence. Ms Allen agreed that in her witness statement, she had stated that following his assessment, "*Michael had an MDT discussion, where I was also present, and this took place on the 16th June 2021. We agreed, following his assessment to refer Jennifer through to Heads Together counselling …*". She sated too that Michael had advised Jen that he would discuss his assessment at the MDT, "*…which consists of Consultant Child and Adolescent Psychiatrist(s), Clinical Psychologists(s), Cognitive Behavioural Therapist(s), Child and Adolescent Psychotherapist(s), Specialist Nurse(s) and Social Workers*", to develop and agree, a clinically informed and evidence-cased Care Plan. However, in her oral evidence, she said she had no recollection of the meeting or who was present, although when asked whether, at the meeting, she had recalled that she had had previous direct involvement with Jen and she said, "*…I didn't recall. I recognised the name but I didn't recognise what my prior involvement was*". She said she could not remember when she was first aware that Mr Oyadeyi wanted to speak to her about Jen, "*… but based on the information, it looks like it was post-assessment*". She said that, in a PAM, a case would be presented to the meeting by the assessor, and that all involved would have access to the electronic records. She accepted that the system showed she had not accessed Jen's records on the 16th June 2021, but she said someone else involved may have done so. She accepted that Jen's case ought to have been

discussed by at least three colleagues, and she was asked about the feasibility of that being arranged, and then properly conducted, in the period between the end of Mr Oyadeyi's meeting with Jen (at 10.25 am) and his completion of his record (at 10.50 am); in response, she said this time scale would not be usual but may be feasible, depending on how concise the presentation was. Ms Allen accepted that, given that she had discharged Jen a year earlier with a referral to SCT, she ought to have considered what had happened subsequently and why it was that Jen had come to hospital in January and March 2021 with further self-harm and suicidal ideation but, she agreed, there was no evidence in the records of that question having been considered.

115. Sharon Allen was also asked whether the decision to discharge Jen a year earlier had been made by herself and Bernadette Mulhern alone, without reference to an MDT, as was required. She said that in June 2020, it had been permissible for discharge to be authorised by only two persons, and that the requirement for three to be involved had been introduced between June 2020 and June 2021, although she could not recall precisely when or how she had learned about this change.

116. Following this evidence from Ms Allen, I received a witness statement from **Sharon Dean** who is a member of the Trust's senior leadership team. She stated that,

a. Standard practice across CAMHS provision supports that any qualified clinician/practitioner can independently discharge patients from their caseload. Alternatively, and in line with their skills and competencies, a practitioner may choose to seek advice which can come from their supervisor, or via discussion at PAM or MDT. In June 2020, practice was guided by these principles. There was no requirement at Divisional Level for a specific number of people to constitute a PAM,
b. Teams at local levels may, however, develop local protocols and her investigations had identified a local North East CAMHS Standard Operating Procedure, version 3 dated March 2019, which stipulated that PAMs should have a minimum of three practitioners from three different professional groups. The witness states, "*We have recovered evidence that it was intended to review this SOP at a team away day in*

November 2019, however we have not been able to recover clear evidence of the final approval of the SPO", and

c. The SOP was reviewed and updated to version 4 in March 2020, with the statements regarding quoracy for PAM and requirements for disciplines not changing, and no relevant changes were made thereafter prior to June 2021.

117. I heard evidence from **Sarah Kenyon**, Emotional Wellbeing and Mental Health Services Manager for the YMCA East Surrey. She said that YMCA is a charity with a wide remit and it provides counselling services to Surrey County Council under its "*Heads Together*" branch. They support mainly those with issues such as anxiety, low mood, low self-esteem at a mild to moderate level. She said, "…*as we do not offer specialist support for neurodiverse young people we will consider each referral individually to determine whether our generalist counsellors and practitioners can support the young person, having regard to their unique special needs*". She said when both a referral form and an assessment or a discharge letter is received from CAMHS, they would review those documents but would not normally undertake a further assessment of the patient see whether they could meet their needs. Rather, they would simply let the family know that the young person had been added to the waiting list, "… *which is what we did in this case*". Jen was told that Heads Together expected to be able to offer her counselling sessions within the next 12 to 16 weeks, although, in fact, she remained on the waiting list at the time of her death.

118. Ms Kenyon told me that the referral form had made no mention of Jen's neurodevelopmental diagnoses, nor her history of self-harm and suicidality, and these were matters they ought to have been told of and would have led them to make further enquiries. Further, had they known the fuller picture, of which she is now aware, they would have wanted to meet Jen for their own assessment of whether they could offer some support.

119. Comment: In relation to Jen's final discharge from CAMHS, I find as follows. When Michael Oyadeyi was asked to assess Jen, he was aware that she had been referred to CAMHS' Community Team, on this occasion, in January 2021 and that she had not yet been seen or assessed. He

knew that Jen needed a comprehensive assessment of her mental health, an identification of her needs, and an assessment of what services may meet those needs, and said as much in his evidence. He knew that his assessment should involve assessing Jen for not simply her current state and risk level, but also for her history and her longitudinal risk; he stated in his note that that is what would be done. He knew too that, following his assessment, he was required to present Jen's case to a multi-disciplinary post assessment meeting, consisting of at least three people. I find that Mr Oyadeyi failed to do what he knew was required of him. His assessment of Jen was wholly insufficient. It was undertaken by means of a 15 minute telephone call and included no consideration of Jen's neurodevelopmental conditions, the events which had led to her referral to the Community Team, or her wider history of suicidality. Further, he failed to take his assessment to a properly constituted multi-disciplinary post-assessment meeting, which he easily could have done. Rather, he discharged Jen from the Community Team having spoken only, I find, to Sharon Allen. I find that Mr Oyadeyi gave dishonest evidence to me in this regard. Initially, he gave a detailed account of interrupting a convened meeting which was being chaired by Ms Allen, and of the rationale for the consensus decision which was reached. The Trust's investigations found no evidence of any such meeting. Subsequently, in his further witness statement and oral evidence, he took up a contradictory position and asserted that he has no recollection at all of what occurred. Nevertheless, he told me that a third person, who he could not recall or identify, took part in the meeting because it would not otherwise have been properly constituted. I find that the witness sought to mislead me because he knew that Jen had been discharged, and referred to a level 2 service, without the assessment and MDT consideration of her condition and needs which ought to have taken place.

120. I reach similar findings in relation to the evidence of Sharon Allen. I consider that her reference to the range of health care professionals who may attend an MDT was included in her witness statement to give the impression that Jen's case had been considered by at least some of those clinicians at such a meeting, when that was not the case. Further, her written description of the decision-making at a meeting "*at which I was present*" was at odds with her oral evidence, in which she said she had no recollection of what occurred. I find that Ms Allen's evidence was misleading and

designed to suggest that that there had been proper consideration of Jen's case prior to her being discharged from the Community Team when, at best, she could not remember what had happened.

121. I find that the decision to discharge Jen in June 2021, and indeed the decisions to discharge her made in June 2020 by Ms Allen and in January 2019 by Ms Mulhern, all of which were made without adequate assessment and MDT consideration, stemmed at least in part from a working practice operating in the Community Team. On the basis of the evidence I heard from Bernadette Mulhern, Sharon Allen, and Michael Oyadeyi, I am satisfied that they worked under a degree of pressure to discharge patients and refer them on to a level 2 service, whenever possible, and regardless of the appropriateness of the decision. This was probably driven by the level of demand the service was facing compared to the resources available.

Summer of 2021

122. Mr Chalkley said that, although Jen was in a good place at the time of her CAMHS review in June 2021, over the following months, she was "*up and down many times, this was a tough time as we were trying to set up her further education at Guildford College, she was on and off with her boyfriend at this time, her mental state was up and down, I had not noticed any suicidal intentions but was aware that her mental health was not at its best…*". Ms Bridges told me that her relationship with Jen improved over the summer of 2021 and they met up and spent time together. She said that, towards the end of the holidays, she was aware that Jen's anxieties began to build in anticipation of starting at Guildford College. **DC Mark Rumbles** of Surrey Police told me that, following Jen's death, her mobile telephone was examined and a message was found which stated, "*If I'm gone, open the SC [snapchat] messages with myself to find out why*". The messages found included several messages which were composed and saved on the 7th and 14th July 2021, but were not sent. These messages, which clearly give a picture of Jen's state of mind on those dates, included the following statements, "*Who am I kidding? I should just end it all. No matter who I get close to, they end up hurt or dead*" and *"If I'm not allowed to end it normally, I will do it how it works. Starve myself or jump in front of something, maybe off of something. I just can't keep hurting people like this. It's killing me. Every time*

something fucks up, it's like I'm being stabbed. I don't know how much longer I can keep going with how I am now. I will be gone and forgotten within a week. Every time I try to be happy I end up worse, before or after dragging other people down with me, and it's not fair on them. … I should just end it. No one will care or cry. I don't know why I haven't succeeded before, but next time I try I promise I won't fail."

Guildford College

123. **Millie Ellis** told me that she is Group Designated Safeguarding Lead for Activate Learning, the group to which Guildford College belongs. She said that Guildford College ("GC") has about 2,000 students, with around 900 to 1,000 in the 16 to 19 years age bracket. It provides mainly vocational courses. Ms Ellis explained that the information which GC would receive about a potential student would come from their application form and, if they had one, their EHCP. Documentation from the previous school or college, including any safeguarding file, would not be received in advance of the student starting at GC. She said that the requirements of "*Keeping Children Safe in Education*" are for the feeder school to provide documentation within five days of the student joining GC. She acknowledged that there could be a difficulty if the former establishment was unaware of the new placement. Further, she recognised, as had Tracy Sanders, that for students with additional needs, including those with an EHCP, there was a danger that the new college would be missing important information for the purposes of assessing whether it could meet the student's needs before offering a place, planning the support which the student would need to have in place, and supporting and safeguarding the student from the moment they started attending.

124. **Harriet Catterall** is Group Learning Support Team Leader for GC. It was part of her role to check Jen's EHCP, prior to her starting, to ensure that GC was able to meet her additional needs and ensure provision was put in place to do so. She said she spoke to Jen on the 20th May 2021, to discuss the application form she had completed for a hairdressing course. She found Jen to be very articulate and bright, and very clear about what her learning support needs were. Ms Catterall concluded that GC could, broadly, meet her needs although she noted that the college could not

provide the "*suitable therapeutic intervention intended to address her anxiety, for example, through the use of cognitive behavioural therapy, adapted for young adults with autism*" required by her EHCP; she accepted that she had not conveyed this to Surrey County Council's SEN team. The witness said she recommended that Jen be offered a place, noting her need for smaller class sizes, and to be in a class with an LSA, albeit not on a one-to-one basis. Jen was also to have a learning mentor and a support plan, which would be monitored. Ms Catterall was aware of Jen's neurodevelopmental conditions and anxiety, and that she was awaiting treatment from CAMHS, although she did not seek details of that. She said, however, that Jen's EHCP did not reflect the complex nature of her mental health needs which, "*I am only now beginning to understand*"; she said that through attending the inquest and hearing the evidence of others, she had learned details about Jen which she had not known, matters which would have been relevant to her pre-admission assessment. She had not known, for example, about Jen's significant history of self-harm and suicidal ideation and, if she had, she would have put in place additional protective measures. The witness said that for students with mental health concerns, "*…we have a lot of handover from their previous school. We are very aware of what their triggers may be. … At the beginning of every academic year, I will send out to the faculties a list of the students … who are high need, and any specific notes that we have about those students that we are particularly worried about I would share with them at that point. …We also have weekly meetings, our learning support team, with the faculty managers, to discuss students and to reiterate those concerns that we may have*".

125. **Julie Barnet**, whose evidence was read, stated that she was Jen's tutor on the course. She said that, at first, Jen seemed fine and was making friends with her peers. She was chatty though she was struggling with the practical tasks that she set. However, she was told that Jen had disclosed to her English teacher that she had tried to commit suicide during year nine. On the 8th September 2021, she spoke to Jen who told her that she suffered very badly with anxiety and had also self-harmed. She said that Jen, "*…admitted during this meeting that she did not want to do hairdressing and would prefer to do performing arts*". She said Jen seemed overly anxious and just wanted to go to meet her boyfriend; she made a note of these matters on Jen's "*ProMonitor learner notes*" and made arrangements for her

to transfer to the performing arts course. The witness said that she did not see Jen again until October 2021, on a date she could not recall, when she was in a corridor with two other female students, and appeared to be in high spirits, full of energy, and happy. She said she asked Jen how she was finding the new course and if it was the right decision to change, and Jen said yes, she was having a good time.

126. **Katie Clark** told me that she was the Designated Safeguarding Advisor for GC. She said that, in her role, she would be aware if a student had an EHCP, but that would not be a reason, in itself, for them to be on her radar for safeguarding issues. The same was true for a neurodevelopmental condition. In contrast, if there was a history of suicidality, even if there was no current acute episode, it would be important for her to know about that, as it was part of her role , "*to make sure I contact that learner to see if there's any imminent risk at the moment, and to check on their welfare and see what support they might have in place already*". She said she had not known about Jen's history of suicidality before she started. Ms Clark said she was first aware of Jen on the 14th September 2021, after Jen had raised with her tutor an allegation of historic sexual assault. Ms Clark said she spoke to Jen who explained that she was not currently at risk and would access support as and when needed; Jen did not want to give any further details and was content for no action to be taken. Jen also told Ms Clark that she had, "*panic attacks so severe that she can pass out*", and the witness said she asked the faculty for a medical risk assessment so that Jen could be supported; this was, she said, "*something that the teaching team would take the lead on*". Ms Clark said that Jen also disclosed that she has been referred to Early Help, but was now discharged, and was on the waiting list to be seen by CAMHS. The witness said she provided Jen with an exit card, enabling her to leave a class if she felt overwhelmed or anxious, and she arranged to talk to her again on the 30th September. However, she did not make contact with CAMHS to investigate further Jen's mental health.

127. **Charlee Prentice-Raine** stated that he was Jen's tutor on her performing arts course. He said that Jen made him aware of some mental health issues and she mentioned low self-esteem, but her motivation for the course was very good and she loved being in lessons. He said he was aware of her self-harming and they spoke about this and coping strategies.

He did not consider she was a high-risk student because she was presenting well in class and was keen to learn. He did, though, refer Jen's self-harming to the safeguarding team. He said, "*I had daily interactions with Jen. … At the start of the academic year, Jen seemed well presented and emotionally sound. … As the second/third week came, exact date unknown, Jen started to come to college unwashed and in the same clothes as the previous day. We discussed this and Jen mentioned that she was staying at her boyfriend's a lot more. … Jen informed me that she was worried about her boyfriend's welfare and one day she came into class in hysterics because he had tried to take his own life. I took Jen straight to our safeguarding team, but I know that she was desperate to get to the hospital*". On the 28th September 2021, Ben Simms, Deputy Designated Safeguarding Lead, had made a note on Jen's records to say, "*Jen left college yesterday, the 27th, in the early afternoon, around 2 pm, due to her boyfriend feeling suicidal. Jen said she is the only one who could help. I did try to ask whether emergency services or the Mental Health Team would be more appropriate to call to help him. He was at home with Mum and his dog, so sounded safe at the time, but Jen was convinced she absolutely had to leave to support him as, to quote, "She was the only one who knew how to help him." Jen was extremely distressed and rushed off to catch the bus to see him*". Following this incident, Mr Prentice-Raine noted that, having worked on Jen's personal risk assessment the previous week, he believed "*there is much more detail needed about previous experiences and what support is needed going forward. And I would therefore like to have another sit-down with her and a member of safeguarding to agree on PRA*".

128. Lucy Barker, whose evidence was read, stated that, "*Jen attended my English classes from September 2021. I felt she was a bright, lively individual with an inquisitive and enquiring mind. She could always be relied upon to answer an open question and add a salient comment to a discussion. I found her creative writing particularly engaging. You knew when Jen was in the room and when she was absent. It became apparent fairly quickly, I would estimate around the middle to end of September, that Jen had some mental health and emotional issues. Her writing became darker and even though we were writing about gothic literature, I was concerned at to the nature of her narrative. … She also disclosed to me in an English lesson whilst she was sitting at the back of the class and I was moving around the room talking to students, that she had attempted suicide in year nine. I was also concerned about Jen's appearance as this seemed to deteriorate in terms of*

clothing and personal hygiene. At the lesson on the 30th September 2021, this was particularly evident where Faye Field was my learning support assistant. She was wearing clothing that seemed to be too big for her and poorly laundered. Faye and I asked if she was okay, and Jen became very upset. She said she was staying with her boyfriend but that her boyfriend's mother was not very keen on this arrangement. I stayed with the class and Faye followed her out of the classroom, after which she seemed to visibly collapse emotionally whilst in the corridor".

129. **Faye Field** gave oral evidence and recounted her recollection of the events of the 30th September 2021. She said she was working as a LSA, although she had previously worked as a teacher and a SENCo. She recalled that there was class discussion of "*Crime and Punishment*", and a reference to hanging was made, and Jen left the class. Ms Field said she followed and found Jen slumped on the floor, looking very vulnerable, lost, scared. She was teary-eyed but not crying, and wearing her boyfriend's dirty and worn out clothes. She said Jen opened the floodgate and was expressing a "*tremendous amount of trauma*" and it "*was quite horrible and horrendous to hear that a young person feels and is going through this*". In a note she wrote later that day, Ms Field recorded,

"*Jem was in a fragile and emotional state (the topic of the English lesson had triggered some memories). She currently resides with her father (previously her mother). After an argument on Monday evening Jen left her father's home and is currently staying with her boyfriend. She was wearing her boyfriend's clothes as she has none of her own clothes and was hungry. She feels she cannot return home following this argument. She was under Early Help until the beginning of the summer when she was discharged and she has felt unsupported since. She is a young carer and is registered with My Time. I suggested she register with Surrey Young Carers. She talked openly about being pregnant last year and unfortunately losing the baby (she named the baby Skye). This has had a huge impact on her mental well being as she feels no-one understands her pain. She currently has an implant as contraception as she felt ex-boyfriends tricked and used her. She spoke about whilst residing with her mother that she used to research self-harming techniques and could relay facts about hanging and cutting and felt at times this was her only option. She uses songwriting as her way to express her feelings, however, the songs are all very dark, she would be happy to share (it is an insight into how she feels). She stated that all the people around her*

are on antidepressants and she previously was on medication, She said that they made her ill but would like to return to GP to discuss this further as she feels it would help if she took antidepressants (she takes her boyfriend's when she is down, I informed her not to do this and visit her GP). She mentioned that her boyfriend was on suicide watch recently and she was given the responsibility to stay with him during this time. Her grandfather passed away a few years ago and he was her world and someone who understood her, she was still grieving this loss".

Ms Field said that during this conversation, when she was speaking of losing a baby, Jen had shown her an image of an ultrasound of a full term baby on her telephone. She said that Jen openly discussed taking her own life and how you would need a certain rope, length, width, to ensure that you could commit suicide; she said she had been researching this on YouTube and other websites, and this seemed to be recent. She also spoke about self-harming as a way to cope with the loss of her baby. Ms Field said Jen's relationship with her boyfriend did not seem particularly healthy, and it felt to her that it was a co-dependent relationship between the two of them.

130. Faye Field said she took Jen to her line manager, Harriet Catterall, and she spoke to Katie Clark because, she said, I just wanted it to be brought to her attention straight away because of the magnitude of what had been shared and disclosed. She said she felt very concerned and that she told Ms Clark not only about Jen not eating and needing money, but also about her references to the dead baby and suicidal ideation. She said that Katie Clark said, "*We cannot respond to everyone, we've got hundreds and hundreds of students here that present with self-harming and situations and therefore we need to do it on a risk basis*," and that they would move forward on that basis. Ms Field said that she was asked by Ms Catterall to make a note of what occurred, and that she later made the note set out above in Jen's ProMonitor learner record. The witness said she did not see Jen again.

131. Harriet Catterall recalled speaking to Jen and that she said she had not eaten, she did not have any money, and she was homeless. She said she asked her about the options and she said that she did not want to go back to live with her mum because when she was at home she felt suicidal. She said that she had asked Ms Field to raise a safeguarding concern, but she

had wrongly entered it in the learner section of ProMonitor, rather than using a safeguarding concern form. She said this was a matter for the Safeguarding Team and that she did not have any further involvement. Ms Catterall said she did not see Jen again. She said, "… *because I think this was a Thursday, and then on the Friday she wasn't timetabled to come into college. She came in on the Monday, I didn't get any feedback to say there were any difficulties on the Monday and I think the next day was the day that they went onto remote learning because her tutor had COVID*".

132. Katie Clark told me that she recalled Faye Field speaking to her but said that the only issues she mentioned were in relation to accommodation and money; she did not mention the dead baby or suicide. She said she explained that she could not see Jen immediately, as she was dealing with other safeguarding issues, but was already due to meet her at 1pm and would speak to her then. She said she did later meet Jen, alone, and Jen stated that she was having "*mental health problems*" which led to her living with her father, but due to arguments with him, she was now living with her boyfriend, Patrick, who is 19 and lives with his mother. She said that when she lived with her Mother she had tried to kill herself; "*Tried to hang myself and tried to slit my neck*." She didn't feel she was a risk to herself or others at the time. She said that her father kept trying to "*kick her out*" and that she had not heard from her Mother since January. Jen said she felt safe at college and is enjoying it, and said she did not want to explore any counselling or support, because she wanted to just enjoy being at college. She said that she had not eaten for two days and did not have any money. So far as her presentation was concerned, Ms Clark recalled Jen's hair being quite greasy, and that she was agitated, but also quite matter of fact. With Jen's agreement, Ms Clark telephoned Mr Chalkley. He confirmed that Jen was living with her boyfriend but said she had access to money and food. He said he was concerned about her lack of self-care as she was not washing and she smelled. Ms Clark said they talked about Jen's disclosure that she had tried to kill herself when living with her mother and, she said, Mr Chalkley said, "*It didn't happen like that*"; that Jen had told her mother that she wanted to do something and her mother had stopped her before she could try and hang herself. Her impression was that nothing had actually happened, and Mr Chalkley denied that Jen had tried to slit her throat. He said she was welcome to come home for food or

to live. Ms Clark said that she did not ask him about CAMHS, which she regretted. Ms Clark then wrote a note to Harriet Cattrell saying, "*Dad says this is a complete misunderstanding and that Jen is not kicked out. She has taken some of his words literally. He has also explained some of the background information. I will make some enquiries and create a file so we can log any concerns. If you notice anything else or have any worries, please give me a shout.*"

133. Ms Clark said that she wanted to understand the picture more fully and so, the next day, she contacted Nescot and spoke to Camilla Brown, and asked for Nescot's safeguarding files and sent her an email to follow up (although she accepted that she had not chased when they subsequently did not arrive). She had said earlier in her evidence that if there was a safeguarding event, including one involving suicidality, she would need to speak to the student and *"… consider contacting any external agencies that might be working with them to form a better picture to be able to safeguard them and to make sure they are safe. … and to make appropriate referrals to CAMHS, to Children's Social Care, to Police, but also to establish the family network and the support that that particular student has".* She said that she would also put in place, "*a safety plan, so a risk assessment for that learner, to ensure that all the relevant staff are aware of the concern that they are possibly feeling suicidal or have attempted to harm themselves previously. So it would be important that all the staff would be aware of that as a concern, so that we share in our responsibility of keeping that learner safe*". She accepted that she had not taken these steps following the incident on the 30th September. She said she should have contacted Jen's GP, Children's Services, and CAMHS, but she did not do so. She accepted that she ought to have reviewed Jen's risk assessment but she did not do so. She thought that her failure to take these steps may have been because she was the only member of the safeguarding team for GC and its 2,000 students and she was overwhelmed by the workload at times.

134. Katie Clark also told me that she had not seen Faye Field's entry in Jen's Promonitor learner record until after Jen had died. She said she felt shocked when she had read it because it contained important details she had not known at the time. She said she had not looked at that record because safeguarding reports were made on safeguarding concerns forms,

although she accepted that she ought to have looked at all the records to gather information about Jen. She said that if she had seen Faye Field's note at the time and had that fuller picture, she would, "*without a doubt*", have started with a referral to Children's Social Care and considered speaking to the GP and CAMHS.

135. For completeness, I will note that Lucy Barker recalls that, on the 7th October 2021, Jen attended an English session with her online. She said that Jen seemed very engaged, posting comments and voicing her opinion, and making her usual intelligent contributions. She gave no indication at that time that anything was troubling her. Charlee Prentice-Raine stated that he emailed Jen the day before she died, "…*to ask if she was okay, as she had not attended an online lesson and we touched base with students if they have been absent without an explanation. Jen replied to this email to say that she was okay, had something to sort tonight, but was fine*".

Events of the 11th and 12th October 2021

136. DC Mark Rumbles investigated the events of the 11th and 12th October 2021 and gathered evidence, including from Ms Bridges, which established that at about 22.45 hours on the 11th October 2021, Jen called her mother to say that Patrick, her boyfriend with whom she was staying, had ended their relationship and she asked Ms Bridges to collect her and take her home. Ms Bridges went to collect her, arriving home at about 00.30 hours on the 12th October. At about 03.00 hours, Patrick left a message for Jen on her 'phone stating that he missed her. On the morning of the 12th October, Jen awoke at about 10.30 hours, ate breakfast, and logged onto an online call with her college. Ms Bridges went out to buy her some chocolate and ice cream, and Jen then settled down to watch a film. Ms Bridges felt that Jen was in crisis and so she contacted the family GP and arranged an emergency telephone consultation for Jen which was to take place at 14.00 hours. At about 13.00 hours, Ms Bridges left for work. She told me that she offered to stay with Jen, but Jen said she was fine, and so she went to work. From that point onwards, Jen was alone in the house. I was told by DC Rumbles that Jen had replied to Patrick's message by sending him a

text to say that she missed and loved him and that she was going to return to his address later that day. The final exchange of messages on her 'phone were with Patrick. Jen sent a text at 13.41 hours asking, "*Are you okay*?", to which Patrick replied, at 13.59 hours, saying "*Kinda*".

137. The evidence of **Dr McCartney-Patel**, the GP, was read. He said that he tried several times to contact Jen, and left a message on her phone to say he was trying to contact her, but was not able to get through to the numbers provided.

138. DC Rumbles stated that at about 16.20 hours, Jen's maternal grandmother went to the house to check on her welfare. Very sadly, she found Jen hanging from a rope tied to a metal hook in the ceiling of her bedroom. She released Jen and summoned help but, despite resuscitation efforts, an attending paramedic pronounced life extinct at 16.40 hours. A post mortem examination was conducted by **Dr Biedrzycki**, Consultant Forensic Pathologist, who found no evidence of third party involvement. Toxicological testing found no alcohol in Jen's system, but did establish non-recent use of cannabis prior to her death. Dr Biedrzycki indicated that its effect on Jen's state of mind could not be determined conclusively. He proposed "Ia Suspension" as the medical cause of death.

C. CONCLUSIONS

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

140. In relation to the immediate circumstances of her death, I have considered whether Jen died as a result of suicide. This would be the case if I were satisfied that Jen died as a result of her own deliberate act and that she intended that act to end her life. There is no evidence of any third party involvement and I am satisfied that Jen was responsible for her own suspension. I am also satisfied of her intention to end her life; Jen had openly discussed her suicidal ideation and intentions on many occasions and to many people, and had expressed an intention to end her life in the notes found on her telephone; further, I find that she would have

appreciated that the nature of the act of her suspension was very likely to result in her death, and she was alone in the house and, therefore, unlikely to be found quickly. In the circumstances, I do find that Jen died as a result of suicide.

141. Jen had experienced persistent, albeit fluctuating, risk of suicidal ideation and behaviour for many years, and her death was preceded by signs of a crisis evident in her appearance, behaviour, and emotional state, and reports of her thinking. The scope of this inquest has included investigation of the extent to which Jen's needs and this 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. For the reasons set out below, I find that, despite the efforts which were made by some, Jen's needs which were relevant to her risk of suicide were not sufficiently or effectively met prior to her death.

142. Jen was a girl with complex needs arising from her dual diagnoses of ASD and ADHD and her associated excessive anxiety, low mood, and emotional dysregulation. This was recognised by a number of clinicians who met and assessed her, including Dr Zoric, Dr Kafil-Hussain, and Bernadette Mulhern. Her state of mind and presentation was variable, and was "up and down", to a large extent dependent upon her ability to cope with the pressure she felt from the demands of life, whether from school or college, or from managing her relationships with her family, friends, and boyfriends, especially in adolescence. By Jen's own account, she lived with thoughts of suicide for many years, although it is clear that they came to the fore periodically.

143. It is important to recognise, and I do recognise, that what underlay Jen's difficulties were neurodevelopmental conditions which could not be "*cured*". Autism, in particular, is a life-long condition which cannot be eliminated by medication or therapy. When Dr Ferreira-Lay gave evidence he emphasised this and I accept his evidence in that regard. However, it is clear that a child can be helped to manage the consequences of these conditions by, as necessary, appropriate educational placement and provision, medical management of ADHD and associated conditions such as excessive anxiety and low mood, and therapeutic interventions such as

cognitive behaviour therapy. The evidence shows, and I find, that Jen needed, and was recognised to need, help in all those forms.

144. In particular, I find that Jen had a clear need for specialist input from CAMHS which she did not receive. Jen was referred to CAMHS on three occasions and accepted by the Community Team twice. For much of the time between May 2018 and June 2020, she was on a waiting list for therapy from the psychology team and was awaiting assessment. Whilst she was waiting, the SENCo at her school wrote personally to Dr Ferreira-Lay, as Clinical Director, to express her view that Jen's life was at risk. Despite this, I find that no sufficient assessment ever took place and no diagnosis was made. I am aware that Dr Cacoullis formed a view that there was probably emotional dysregulation, following a review of the records; he may or may not have been correct, but we cannot know because neither he, nor any other appropriate clinician, ever saw and assessed Jen in order to diagnose her precise condition. I find too that Jen was not provided with any therapeutic treatment. Bernadette Mulhern and Sharon Allen both saw Jen but neither embarked on treatment. Further, no medication review, of Jen's ADHD or anti-depressant medications, was ever conducted. I accept the evidence of Dr Zoric, that these were all matters which could and should have been undertaken by specialists lying within the CAMHS' Community Team. I find that they were not, in part at least because there was a pressure on staff to refer patients on to level 2 services, and to discharge from the Community Team. This was the outcome for Jen, even though her needs were recognised to be complex and had not yet been fully assessed or met.

145. I reach similar findings in relation to Jen's second period with CAMHS' Community Team, between January and June 2021. Despite the referral relating to Jen's active suicidality, and despite express requests for a medication review, she was again discharged and referred to a level 2 service without proper assessment, diagnosis, treatment or medication review.

146. I find that the specialist input which the Community Team could and should have provided, and were being pressed to provide by Jen's family, school, and Paediatrician, were such that they would have been expected

to reduce the impact of her neurodevelopmental conditions and assist her in learning to manage that impact herself. I am satisfied that, had that specialist input been provided in a timely manner, Jen's final crisis would probably have been avoided or managed, such as to avoid her death.

147. I have already set out above my findings concerning delay in the provision of an EHCP and my view that there was a missed opportunity to issue a plan, and arrange appropriate educational placement and targeted provision, as soon as was practicable. In addition, I find that even when the EHCP was issued, the support and protection which it ought to have secured fell short because the plan, as originally drafted and as amended after review, did not properly convey her needs in relation to her mental health and her risk of suicide. This failure resulted in Guildford College being materially underinformed. I was told by the college staff, and I accept, that the college's preparation for Jen's arrival, and their safeguarding of her once she started to attend, would have been far more robust had they been provided with the full picture. There were admissions as to the inadequacy of the college's safeguarding response to the crisis Jen suffered in September and October 2021, but I am satisfied that a more effective response, including the involvement of crisis support, would have resulted if the college had fully understood Jen's vulnerabilities and risks at an earlier stage. For this reason, I find that the failure of the EHCP process to capture the full picture and convey it to Guildford College made a more than minimal contribution to Jen's death. I have noted too the inadequate system for information sharing between educational establishments and the delay in the sharing of safeguarding information between Nescot and GC; this will not have helped but the principal means by which all important information should be conveyed is the EHCP.

148. Finally, I agree with Dr Ferreira-Lay's view, which he expressed to me in his evidence, that the needs of a child or young person of Jen's complexity must be met by all agencies fulfilling their roles and working in unison. The requirement for this is recognised not only in the SEN Code, but also the national "*Working Together*" guidance. Dr Ferreira-Lay expressed a view that there is a chronic misunderstanding of the role of CAMHS by other agencies. If that is so, it is a serious systemic issue which

ought to have been addressed generally, and could have been addressed, in Jen's case, by proper communication between CAMHS and other agencies concerning Jen's needs, but that did not happen. I have already found that CAMHS did not do their part in meeting Jen's needs. Other agencies, including Children's Services, provided support to the extent that they considered they could. But I am satisfied that there was a failure of the agencies to work effectively together to ensure that Jen's needs were met, over the years and particularly from June 2021 onwards. At no point did any effective multi-agency meeting take place to achieve this and, to the extent that the EHCP could be expected to act as a multi-agency plan for this purpose, it failed to do so. Dr Ferreira-Lay stated that there is no system in place, nationally, for multi-agency care co-ordination, and I find that this was a systemic failure. The discharge of Jen from both CAMHS' Community Team and Children's Services in June 2021, left her with insufficient support between then and her death. I am satisfied that there was a multiagency failure to work together to ensure that Jen's needs were met and that this more than minimally contributed to her death.

D. RECORD OF INQUEST

Legal Submissions

149. 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 ECHR and (ii) Neglect.

150. Article 2: As stated above, I have previously issued a Ruling in which I set out my reasons for concluding that the procedural duty arising under Article 2 ECHR was engaged in this inquest and I will not repeat those reasons here. I indicated that I would reconsider the issue at the close of the evidence and I have now done, especially in the light of the submissions made on behalf of all the Interested Persons, save Jen's parents, which argue that I ought to find that Article 2 is not now engaged. However, I do not accept those submissions. Having now heard all the

evidence, I consider it reveals arguable systemic and operational breaches, as reflected in my factual conclusions set out above. As Ms Sikand KC submits, and I find, Jen's risk of death from suicide was a present and continuing risk throughout. Even though it may have fluctuated, the chronic and persistent nature of the risk is clear from the evidence. I accept Ms Sikand KC's submission as to the relevance of Johnson J's judgment in *Traylor v Kent and Medway NHS Social Care Partnership Trust* [2022] EWHC (QB) in this regard.

151. Neglect: Ms Sikand KC invites me to consider recording a finding that Neglect on the part of CAMHS contributed to Jen's death. I have considered whether there is any proper basis for doing so. 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 an opportunity to render care which would have prevented the death (see, *R (Khan) v HM Coroner for West Hertfordshire* [2002] EWHC 302 (Admin)). I have concluded that it would not be appropriate to record Neglect. Whilst I have found failings on the part of CAMHS, and I am satisfied that they can be characterised as serious failings, I do not consider that the nature of those failings is such as to be properly described as failures to provide basic medical attention in the face of an obvious need for the same, in the sense intended by the concept of "*neglect*", as set in *Jamieson*.

Entries on the Record Of Inquest

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

Box 1 :
Jennifer Sharren Chalkley

Box 2 :

1a Suspension

Box 3 :

When she died aged 17 years, Jennifer Chalkley was girl with complex special needs. She had been diagnosed with Attention Deficit Hyperactivity Disorder when she was 10 years of age and Autistic Spectrum Disorder when she was aged 11 years.

These two neurodevelopmental conditions, together with associated excessive anxiety, low mood, and emotional dysregulation which she suffered periodically, resulted in a persisting but fluctuating risk of suicide.

Jennifer was known to the Child and Adolescent Mental Health Service and to Children's Services, having been the subject of a number of referrals arising from her suicidal ideation and behaviour and her other vulnerabilities. She was also monitored under the Paediatric Team at a local hospital. An Education, Health and Care Plan was issued to Jen by the Special Educational Needs Department of her local authority when she was 15 years old, but she struggled to cope in mainstream school and experienced the breakdown of school and college placements. Jennifer also struggled to cope with personal relationships.

In September 2021, Jennifer enrolled in a course at a new college. Within weeks she experienced low mood and was expressing suicidal ideation. Late on the evening of the 11th October 2021, Jennifer returned to her mother's home, having separated from the boyfriend with whom she had been living.

On the 12th October 2021, Jennifer's mother feared that she was suffering a mental health crisis and arranged an emergency telephone consultation with the General Practitioner for later that day. However, at 16.20 hours, Jennifer was found hanging from a rope which she had tied to a metal hook in the ceiling of her bedroom. Despite resuscitation efforts from attending paramedics, she could not be revived and her death was pronounced at 16.40 hours on the 12th October 2021.

Box 4 :

Jennifer Chalkley died as a result of Suicide.

Her death was more than minimally contributed to by :

(i) A failure by Surrey and Borders Partnership NHS Foundation Trust's Child and Adolescent Mental Health Service properly to assess, diagnose and treat Jennifer following referrals made in May 2018 and January 2021 in order to manage her conditions and minimise her risk of suicide,

(ii) A failure by Surrey County Council's Special Educational Needs Department to ensure that Jennifer's Educational, Health and Care Plan contained sufficient and updated information about her mental and emotional health needs and her risk of suicide, such as to enable the college she attended from September 2021, to understand and meet her consequential needs and manage the consequential risk, and

(iii) A multi-agency failure to share information and work together to ensure that Jennifer was supported effectively to manage her neurodevelopmental and mental and emotional health needs, and her risk of suicide, especially from June 2021 onwards.

Box 5 :

(a) 2nd February 2004 in Epsom, Surrey

(b) Jennifer Sharren Chalkley

(c) Female

(d) -

(e) 12th October 2021 at Bookham, Surrey

(f) Student of Bookham, Surrey

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 Ms Bridges, Mr Chalkley, and Jen's wider family.

Richard Travers
HM Senior Coroner for Surrey
1st May 2024