MISS N PERSAUD
HER MAJESTY'S CORONER
EAST LONDON
Walthamstow Coroner's Court, Queens Road Walthamstow, E17 8QP
[redacted]

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS (1)

Ref: 110868

	REGULATION 28 REPORT TO PREVENT FUTURE DEATHS ***THIS REPORT IS BEING SENT TO:*** 1. [redacted], **Royal College of Paediatrics & Child Health, NHS England** Email: [redacted] 2. [redacted], **Medical Director, Health Education England** Email: [redacted] 3. [redacted], **President, Royal College of Psychiatrists, London Office, 21 Prescot Street, London, E1 8BB** Email: [redacted]
1	**CORONER** I am Nadia Persaud area coroner for the coroner area of East London
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. http://www.legislation.gov.uk/ukpga/2009/25/schedule/5/paragraph/7 http://www.legislation.gov.uk/uksi/2013/1629/part/7/made
3	**INVESTIGATION and INQUEST** On the 13th June 2019 I commenced an investigation into the death of Lily May Girton. Lily was 17 years old when she passed away on the 1st June 2019. The investigation concluded at the end of the inquest on the 9th August 2022. The conclusion of the inquest was a narrative conclusion:

	Lily Girton took her own life whilst suffering from a mental illness. Her death was contributed to by a failure of the community CAMHS team to expedite an assessment by a psychiatrist; to carefully and robustly assess and manage her risk to self and by a failure to titrate up her anti-depressant medication to an effective dose.
4	**CIRCUMSTANCES OF THE DEATH** Lily Girton suffered from anxiety, depression and emotional dysregulation. She sought assistance from the Child and Adolescent Mental Health Services in December 2018. She was asked to register with a new GP before she could access the service. On 12 March 2019 she was seen for her first assessment with the team. Later the same day, Lily presented in distress at Euston station and required detention under section 136 of the MHA for her own safety. She was taken to University College Hospital where she was admitted to a paediatric ward and where she received care from the psychiatric liaison team. Following this brief admission, Lily was prescribed antidepressants by her GP who expected the community CAMHS team to continue monitoring and prescribing this medication. The community team did not do this and Lily was not seen by a psychiatrist within the community CAMHS Team. Lily was seen by a social worker within the CAMHS team, who had been appointed as her care co-ordinator. The care co-ordinator provided cognitive behavioural therapy. She did not take steps to expedite the psychiatric appointment; did not take steps to ensure that Lily's medication was appropriately titrated and did not carefully assess, document and communicate Lily's risk to self. On the 29 April 2019, Lily was admitted to University Hospital again, requiring a longer admission and presenting with higher risk. The concerns of the hospital team were communicated to the community CAMHS teams, but Lily's care plan was not materially altered. On the 31 May 2019, Lily was involved in an altercation with a group of males in a kebab shop. She was mocked by the males and she reported that one of the males had hit her. In the early hours of the 1 June 2019, Lily was discovered [redacted] partner's home address. Her life was pronounced extinct on scene. Police attended and deemed the circumstances as non-suspicious. The altercation in the kebab shop is likely to have contributed to a decline in Lily's mental state on the 31 May 2019. The failings in the care provided to her by the community CAMHS team left Lily without the resilience to manage the decline in her mental state.
5	**CORONER'S CONCERNS** During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you. The **MATTERS OF CONCERN** are as follows. – The Inquest heard that CAMHS services nationally have a lack of adequate staffing levels in the form of doctors, in the form of psychiatrists, registered mental health nurses and psychotherapy staff. The Inquest heard that consultants often have an average of 130 to 150 active cases on their caseloads. This is substantially higher than the recommended caseloads by the Royal College of Psychiatrists. The lack of staffing and resources contributed to Lily's death and there is a concern that the ongoing shortages of suitably trained staff within CAMHS teams poses a risk of future deaths of young people.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths and I believe you [AND/OR your organisation] have the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report,

	namely by **5th October 2022,** I, the coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner, to the family of Lily Girton, to the other Interested Persons, to the Care Quality Commission (where the deceased was under 18)]. I have also sent it to [redacted] the local director for public health who may find it useful or of interest. I am also under a duty to send a copy of your response to the Chief Coroner and all interested persons who in my opinion should receive it. I may also send a copy of your response to any other person who I believe may find it useful or of interest. The Chief Coroner may publish either or both in a complete or redacted or summary form. He may send a copy of this report to any person who he believes may find it useful or of interest. You may make representations to me, the coroner, at the time of your response, about the release or the publication of your response.
9	**[DATE] 11th August 2022 [SIGNED BY CORONER]**