Re : Locket Ure Williams, Deceased

Regulation 28 Report to Prevent Future Deaths

	Regulation 28 Report to Prevent Future Deaths This Report is being sent to: [redacted], **The Chief Executive Officer of Surrey and Borders Partnership NHS Foundation Trust**
1	**CORONER** I am Richard Travers, HM Senior Coroner for Surrey.
2	**CORONER'S LEGAL POWERS** I make this report under paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.
3	**INVESTIGATION and INQUEST** I commenced an investigation into the death of Locket Ure Williams. The inquest concluded on the 31st May 2024 when I found that the medical cause of death was: Ia Multiple Injuries and my conclusion as to the death was that: Locket Ure Williams died as a result of Suicide. Their death was more than minimally contributed to by Surrey and Borders Partnership NHS Foundation Trust's Children and Adolescent Mental Health Service's: (i) delay in assessing Locket's condition and needs, (ii) underestimation of Locket's risk of suicide, and (iii) failure to deliver necessary therapeutic treatment to Locket in a timely manner. I subsequently held a hearing to receive evidence relating to the prevention of future deaths and this was concluded on the 26th September 2024.
4	**CIRCUMSTANCES OF THE DEATH**

	Locket Williams was 15 years of age when they died. They had a history of self-harm, suicidal ideation, and suicide attempts. This history included a referral to Surrey and Borders Partnership NHS Foundation Trust's Children and Adolescent Mental Health Service, with a report of self-harm and suicidal ideation, in October 2020, and three subsequent suicide attempts, in February, June and July 2021. Locket was suffering a Depressive Disorder and Emotional Dysregulation and, in April 2021, they were placed on the waiting list for Cognitive Behaviour Therapy, which was expected to be effective in treating their conditions and controlling their suicidal ideation. Although Locket was prescribed medication and received some monitoring and support from the Children and Adolescent Mental Health Service, the Cognitive Behaviour Therapy did not commence until very shortly before their death, and no effective treatment had been provided prior to their death. On the night of the 27th September 2021, Locket left their home and walked to [redacted], from where they jumped to the road below. Locket's death, from consequential injuries, was recognised at 00:01 hours on the 28th September 2021. Full details of the events and failings which lead to Locket Ure Williams' death are set out in my "Findings and Conclusions" document, a copy of which is sent with this report.
5	**CORONER'S CONCERNS** The evidence received at the prevention of future deaths hearing showed that a number of the issues and concerns raised at and following the inquest hearing have been addressed. However, in my opinion the following concerns remain and give rise to a continuing 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 : **Concern 1** The evidence at the inquest hearing revealed that, at the time of Locket's death, there were no psychiatric in-patient beds available for children in Surrey. It was recognised in the evidence that sending children out of the County, and sometimes to hospitals at a great distance away from their home, may be detrimental to their overall welfare, including their suicide risk, and may militate against their admission at all.

At the prevention of future deaths hearing, I was told that a new, 12-bedded, unit named Emerald Place has since been opened by the Trust in partnership with a private provider. However, a concern about the level of in-county psychiatric in-patient beds for children continues because (i) the unit is not fully open and there is no fixed date for such opening, (ii) even when fully opened, it seems that the unit's 12 beds will be insufficient to meet the probable need at any one time, and (iii) even when fully opened, the unit will not be able to treat children with eating disorders or children needing psychiatric intensive care.

Concern 2

On the basis of the evidence I heard at the inquest hearing, I found that Locket's death was contributed to by the Trust's underestimation of their risk of suicide.

At the prevention of future deaths hearing, I was told that the Trust has introduced a new risk assessment system. The new system is in accordance with NICE guidelines and relies on a fuller description of the nature and level of the risk rather than its classification as low, medium, or high.

It is clear from the evidence that there is good reason to move away from the three-tier classification, but I am concerned that the new system does not include any clear and obvious alert, on the medical records, that there is a risk of suicide in relation to the child in question. Although the intention of the new system is to encourage each clinician to read the narrative of the fuller risk assessment, there is currently a risk that, if they do not do so (and it is foreseeable that they will not always do so or be able to do so), they will be unaware of the risk of suicide.

It was accepted in the evidence that an alert for a risk of suicide could be included in a child's record without undermining the move away from the three-tier classification of that risk as low, medium or high.

Concern 3

I also heard that a child at risk of suicide may now be provided with a document, called "My Safety Plan", one purpose of which is to help the child to communicate with others (including for example family members, teachers, and social workers) about their condition and risk. I was told that, if a child does not want to refer in the document to the risk of suicide, other terms such as "distress" may be used.

To the extent that part of the purpose of the My Safety Plan is to enable the child to communicate their risk of suicide and thereby receive help to stay safe, I am

	concerned that by substituting the word "distress" for "suicide", some plans may not refer to suicide and may not therefore ensure that the nature of the risk is clearly conveyed to those from whom the child may seek support, and to the responsible adults in their life. **Concern 4** From the evidence I heard at the inquest hearing, it was apparent that staff within CAMHS did not always attend or engage with Core Group Meetings to which they were invited by children's services. At the prevention of future deaths hearing, it was accepted that, for those children under Children's Services, active involvement in Core Group Meetings by all agencies involved with the child was of real importance. This was so, because the meetings were the means by which information was shared by different agencies and an informed plan was made to protect the child's life (including from suicide) and welfare. Failure by Trust staff to attend or otherwise to engage with the meetings, and the other agencies involved with the child, may therefore raise the risk to the child and undermine their protection. I was also told that there is an expectation that Trust staff should prioritise attendance / involvement in Core Group Meetings but, it seems, that no monitoring takes place to assess compliance with that expectation, including no systematic recording of the receipt of invitations to attend Core Group Meetings and no systematic recording of the response by the staff who have been invited, or otherwise.
6	**ACTION SHOULD BE TAKEN** In my opinion action should be taken to prevent future deaths by addressing the concerns set out above and I believe your organisation has the power to take such action.
7	**YOUR RESPONSE** You are under a duty to respond to this report within 56 days of the date of this report, namely **by the 9th December 2024**. I, as coroner, may extend the period. Your response must contain details of action taken or proposed to be taken, setting out the timetable for action. Otherwise, you must explain why no action is proposed.
8	**COPIES and PUBLICATION** I have sent a copy of my report to the Chief Coroner and to the following Interested Persons:

	(i) [redacted], (ii) [redacted], (iii) [redacted], and (iv) Surrey County Council. I am also under a duty to send a copy of your response to the Chief Coroner. 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 by the Chief Coroner.
9	**14th October 2024** **Richard Travers**