MEDIA RELEASE

Inquest jury finds failures in mental health care of 17-year-old Lucy Curtis
10 July 2026

Before HM Area Coroner Dr Peter Harrowing
Avon Coroner's Court
22 June – 10 July 2026

Lucy Curtis died on 1 January 2024, following an incident of self-harm on 27 December 2023 whilst an inpatient at Riverside Adolescent Unit in Bristol. She was 17 years old.

An inquest jury has now concluded that there were multiple missed opportunities and failures in her care:

- The delay in direct engagement and acceptance onto CAMHS caseload meant that help was not available to Lucy until her decline was already advanced. This possibly contributed to Lucy's death.
- The effectiveness and communication about discharge from Wessex House, and the uncertainty caused by the process by which the discharge date was changed has been described as a turning point in Lucy's mental health. For this reason, there was a possible contribution to Lucy's death.
- The failure of Riverside to recognise the escalating situation (including concealment of ligatures and increasing intensity and frequency of self harm episodes, indicating increased risk) on 26th and 27th December 2023, and the subsequent failure to implement adequate observation

levels (in line with previous occurrences) probably contributed to Lucy's death.

- Given the uncertainty over the precise time Lucy applied the fatal ligature, we find that the failure of Riverside to adhere to Lucy's observation levels on the morning of 27th December possibly contributed to Lucy's death.
- The time lost, due to various factors, in the delivery of emergency treatment until the arrival of paramedics possibly contributed to Lucy's death.

Lucy's contact with mental health services started in January 2023, when she presented to her GP for anxiety, low mood, and self-harm. Later on, Lucy would disclose bullying that she had experienced at school, and professionals would go on to note that Lucy showed signs of a social communication disorder or autism, although that was not known at the time. At the end of January 2023, the GP made a referral to Child and Adolescent Mental Health Services (CAMHS), although the referral was declined the next day.

Lucy was referred back to CAMHS for a second time on 24 April 2023, following her presentation at hospital following self-harm, however the referral was closed shortly afterward. By this time Lucy was experiencing thoughts to end her life.

A third referral was made on 19 May 2023, after which Lucy was added to the waiting list on 25 May 2023. The inquest heard evidence that the waiting times for routine referrals were 3-4 months for an assessment, and a further 3-4 months for therapy following the assessment. In the meantime Lucy's mental health continued to deteriorate, and concerns raised by Lucy's parents and her school did not lead to her case being reviewed or expedited.

On 14 July 2023 Lucy attended hospital due to self-harm, during which time medication was found in Lucy's room along with a note which revealed she had planned to end her life. Following this, Lucy was eventually accepted into CAMHS for an initial appointment on 2 August 2023. She had two more weekly CAMHS sessions before a serious risk incident occurred on 21 August 2023, when she went missing from the family home overnight.

At this stage, due to Lucy's risk and in view of limited capacity with the CAHMS Intensive Outreach Team (who could have otherwise provided intensive support over and above the weekly sessions being provided by CAMHS), professionals felt that admission to an inpatient mental health unit

had become necessary.

Lucy was admitted to Wessex House in Bridgwater as a voluntary patient on 25 August 2023. Wessex House was operated by Somerset NHS Foundation Trust. It was during this admission that Lucy started engaging in the form of self-harm which would ultimately cause her death.

At the inquest, the jury heard about serious risk incidents which occurred when Lucy was permitted out of the unit on unsupervised leave. The first of these took place on 6 September, when Lucy had been permitted out with a peer, despite her parents having contacted Wessex staff to relay concerning comments Lucy had made about being able to access the train tracks nearby. Whilst on leave, Lucy experienced a traumatising event with the peer; the police were called; and staff ultimately returned both young people to the unit. On a second occasion, on 27 October 2023, Lucy was permitted unsupervised leave despite having had serious self-harm incidents the night before. These incidents had involved a new form of self-harm which Lucy had not been using previously. Whilst out on leave, Lucy took an overdose. When she was found, she was conveyed to hospital for treatment where she stayed for two nights. On a third occasion, on 21 November 2023, Lucy overdosed again whilst out on unsupervised leave. She was conveyed to hospital and was treated there for two nights before being returned to Wessex.

The jury heard how Lucy's parents had been told by staff that staff could not stop Lucy from going out because she was a voluntary patient, although at the inquest staff gave evidence that emergency holding powers were available if they thought Lucy was at immediate risk. In the event, these holding powers were only used once, in the final days of the admission.

The jury also heard that it had been staff practice not to remove risk items if they encountered Lucy using them in the course of self-harm if she was not considered to be at immediate risk of serious harm. This led to an incident on 4 November 2023, where the risk item was left on Lucy for over an hour, causing significant distress and physical injury to Lucy.

Although there had been some positive early signs in the first few weeks of her admission at Wessex, Lucy's risk incidents increased in October, following a meeting held about her care. The jury heard Lucy's mother describe this meeting as 'hostile', and Lucy and her family were given a discharge date without any prior notice and without efforts being made to agree that date with Lucy, the community team or her parents. The jury heard

evidence that Lucy felt rushed and not listened to, and that there were concerns on the part of the community mental health teams as to whether Lucy's level of risk could be managed safely in the community. Although the discharge date was then moved, Lucy was ultimately discharged back home on 27 November, having acquired a more dangerous method of self-harm.

Although the plan had been for Lucy to receive intensive support and treatment in the community, due to a traumatising risk incident in the family home late on 8 December 2023, Lucy was admitted as a voluntary inpatient to the Riverside Unit in Bristol on 12 December 2023. Riverside was operated by Avon and Wiltshire Mental Health Partnership NHS Trust.

The consultant psychiatrist with responsibility for Lucy's care developed a plan for the admission with Lucy and her family: for a short admission, to be followed by transition to day patient status. Later, and in the absence of the psychiatrist who went on leave over Christmas, the jury then heard how Lucy's parents received a call informing them that the unit were concerned about an increase in risk incidents and felt they may be running out of legal powers to manage Lucy's risk given she was a voluntary patient and not detained under the Mental Health Act. Between 18 and 20 December, Lucy was placed on 1:1 observations by the nursing team on three separate occasions in order to keep her safe.

Despite contacting the Approved Mental Health Professional (AMHP) service with a view to arranging an assessment under the Mental Health Act, no assessment was convened following liaison with the AMHP service. Riverside staff spoke to Lucy about this 'dilemma' in her care, and when Lucy was informed that no MHAA would take place, she was incredibly distressed and engaged in a number of self-harm incidents in quick succession. On 22 December 2023, Lucy told staff she wanted to be discharged and that staff couldn't keep her safe at the unit. Lucy's parents were ultimately able to persuade her to go home on leave, however they returned to the unit within a few hours after a number of serious self-harm incidents at home, in which her parents had to intervene. Over the next few days at Riverside, self harm incidents continued for Lucy.

On the morning of 27 December 2023, Lucy had self-harmed in the early hours of the morning, and again at 9.16am. Despite this, the jury heard that a decision was made not to increase Lucy's observations to 1:1 continuous observations. Instead staff decided to remain on 15 minute intermittent observations, but agreed between themselves that they would do extra checks to make sure Lucy was safe. Ultimately, these extra checks did

not occur after Lucy was last seen alive and well at 10.20am. On the next observation, which fell due at 10.30am but took place at approximately 10.43am, Lucy was found unresponsive.

The jury heard evidence that initially Lucy was thought to have a carotid pulse, although when checked again it was ‘very weak’. Despite policies requiring escalation to the ward doctors, and the administration of oxygen and CPR in these circumstances, no treatment was administered until around 10.52am.

Lucy was conveyed to Southmead Hospital by ambulance, where she died on 1 January 2024.

The Riverside Unit closed in January 2024, as a result of an internal review triggered by Lucy’s death. Senior management at Riverside concluded that they ‘were concerned that they could not deliver high quality safe and consistent care’.

In evidence, one witness described the ward as ‘chaotic’, and that they had raised concerns about Lucy needing a more intense level of observation on many occasions. Another witness said that they had raised concerns about staffing levels and that the ward felt unsafe due to the number of high risk patients. When asked, they said that they had not felt listened to by management.

Wessex House also closed following Lucy’s death.

Two independent reviews were commissioned following Lucy’s death, which identified a number of issues across the delivery of her care, as well as cultural issues within the inpatient teams.

Speaking after the inquest, Lucy’s family said: *Although fatal mistakes were made on 27 December, we don’t blame the staff on the ground. To understand what happened that day, you need to look at the wider picture.*

First, we need to look at the wider picture of conditions at Riverside, and the findings of an independent review which took place following Lucy’s death, which brought to light a culture of bullying and of management not listening to staff who raised safety concerns.

Second, is the story of Lucy’s catastrophic journey through mental health services. From January until August of 2023 Lucy did exactly what we teach

young people to do when they’re struggling. She reached out to adults and professionals around her, and shared with them her darkest thoughts. Instead of delivering support, the system seemed focussed around gate keeping and waiting lists. When help finally came, it was too late.

What we didn’t know then was the harm that Lucy would be exposed to on a mental health ward, and the possibility that a young person may emerge from hospital so much worse than when they first arrived. We feel strongly that more should be done to warn other families about this and to prevent it from happening.

It is no coincidence that both of the units where Lucy was admitted in 2023 have been closed following her death. For us, questions as to how the units came to be the way they were remain. Why were unsafe cultures permitted to develop like they did? Who knew about it and when? Why did no one intervene?

Today, we turn another page in the long process of healing. We miss Lucy every day. Not only for the big milestones she should have experienced, but also for the countless small moments that made her who she was.

Lucy deserved so much more. If love could have saved her, she would have lived forever.

ENDS

NOTES TO EDITORS

Lucy’s family are represented by Amy Ooi of Bhatt Murphy and Ruby Peacock and Jamie Burton KC of Doughty Street Chambers. They are supported by INQUEST caseworker Kate Litman.

For further information, a photo of Lucy, and interview requests please contact katelitman@inquest.org.uk. The family's full statement is available here.

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suicide and self-harm and guidance for reporting on inquests.

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