

Statement from family of Lucy Curtis

Lucy was an amazing person: she was bright, sensitive, and fiercely loyal. She would do anything for her friends. She was also a massive Taylor Swift and Harry Styles fan, and a big animal lover.

We thank the jury for the care and attention they have paid to the evidence over the last few weeks. It has been a gruelling and painful process for us as a family, and it must have been very difficult for them too.

What is clear is that mistakes were made on the day of the incident which took Lucy's life. Given the level of risk Lucy was exhibiting, it is now clear she should have been on continuous observations. Instead, a risky decision was made to keep her on 15 minute observations. It was said that that decision was made in Lucy's best interest, but questions remain in our minds about whether it was influenced by staffing levels, or because of pressure on nursing staff from other members of the team.

Ultimately, despite the decision for Lucy to remain on 15 minute observations, her final observation was 13 minutes late.

What happened next is agonising for us to think about: despite being found unresponsive, CPR did not start and no oxygen was given for about 9 minutes. We thank the jury for their finding that the time lost could have made a difference. We know that every second counts in those situations, and we believe that the failure to train and prepare staff for this predictable scenario cost Lucy her life.

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, and it is clear from the jury's findings that there were failures long before that day.

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.

When Lucy was assessed by CAMHS in April 2023, the clinician recorded the view that she was clinically depressed. However, Lucy was also assessed as not meeting the criteria for CAMHS intervention, which makes no sense to us. She was advised to see her GP to discuss antidepressant medication and proactively did so. Her GP, however, advised that only CAMHS could prescribe this medication. As a result, Lucy was passed back and forth between her GP and CAMHS while trying to access psychiatric assessment and treatment. This was an extremely distressing experience for Lucy at a time when she was at her lowest ebb and most in need of timely support. Instead of receiving clear and coordinated care, she faced uncertainty and repeated delays in accessing the treatment she had been advised to seek. When antidepressant medication was eventually prescribed, we observed a noticeable improvement in her mood. As her parents, we cannot help but wonder whether earlier access to psychiatric care and appropriate treatment might have prevented her subsequent hospital admission and the events that followed.

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.

During the admission to Wessex House, Lucy learned a much more dangerous form of self-harm, and she was repeatedly allowed to come to harm. Although we heard evidence from one staff member in particular, whose compassion and dedication was clear, the Lucy who came home after that admission was much more difficult to keep safe. As parents, we were put in an impossible situation.

At the point of discharge from Wessex, Lucy was incredibly brave in clearly and repeatedly telling those involved in her care that she did not feel able to keep herself safe at home. She said she believed she would end up taking her own life and was extremely frightened about being discharged.

As her parents, we shared these concerns and were very anxious about our ability to keep Lucy safe, particularly as we felt her risk had increased rather than reduced.

We have since learned that there were differing professional opinions about Lucy's discharge. Some believed her risk was too high, while others felt that remaining in hospital was increasing her risk. Although these differing views were discussed in professional meetings, they were not shared with us.

As the people responsible for Lucy's care and safety after discharge, we believe we should have been informed of these differing professional opinions and their rationale so that we could make informed decisions about her care.

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.

Michelle Curtis & Barry Curtis, parents of Lucy Curtis