

FATAL ACCIDENT INQUIRY

Under the Fatal Accidents and Sudden Deaths
Inquiry (Scotland) Act 1976

Determination by Sheriff Ruth Anderson QC Sheriff of North Strathclyde following an Inquiry held at Paisley into the circumstances of the deaths of **Niamh Frances Bysouth** (also known as Niamh Frances Lafferty) Date of Birth 18th June 1994 and **Terrie Faye Oliver** (also known as Georgia May Rowe) Date of Birth 13th February 1995.

Note: Other than in my formal determination, I shall refer to Niamh Frances Bysouth (also known as Niamh Frances Lafferty) simply as Niamh. I am aware that at one point she intimated a desire for her first name to be spelt 'Neve'. However most of the productions refer to her as Niamh, and I intend to use that form.

Terrie Faye Oliver (also known as Georgia May Rowe) will be referred to as 'Georgia'. Although 'Terrie' was the name chosen by her natural mother, throughout the thirteen or so years that she lived in Scotland she was known as 'Georgia'. It was only between the months of July 2008 and April 2009 when she lived in a variety of foster placements and children's homes in England that she expressed a wish to be known as Terrie. When she returned to Scotland in April 2009 she chose to be called 'Georgia' once more.

The Sheriff, having resumed consideration of the cause, DETERMINES that in terms of Section 6(1) of the Fatal Accidents and Sudden Deaths Inquiry (Scotland) Act 1976:

(a) Niamh Frances Bysouth (also known as Niamh Frances Lafferty) and Terrie Faye Oliver (also known as Georgia May Rowe) died in the waters of the River Clyde below the Erskine Bridge Renfrewshire shortly before 2100 on Sunday 4th October 2009.

(b) (i) Niamh Frances Bysouth (also known as Niamh Frances Lafferty) died as a result of 1a Multiple Injuries due to

1b Fall from a height

(ii) Terrie Faye Oliver (also known as Georgia May Rowe) died as a result of 1a Chest and abdominal injuries due to

1b Fall from a height

(iii) There was no accident. Both deaths were suicides.

(c) the deaths of Niamh Frances Bythsouth (also known as Niamh Frances Lafferty) and Terrie Faye Oliver (also known as Georgia May Rowe) may have been avoided had the following reasonable precautions been taken:

i. had the number of staff members on duty at the Good Shepherd Open Unit on 4th October 2009 been at least four in terms of Regulation 13 of SSI 114/2002, the agreement between the provider and the Scottish Commission for the Regulation of Care ('the Care Commission'), and in light of the prevailing dynamics within the establishment.

ii had Niamh Frances Bysouth (also known as Niamh Frances Lafferty) and Terrie Faye Oliver (also known as Georgia May Rowe) been accommodated in October 2009 on the first floor of the Good Shepherd Open Unit rather than in the self-contained flat on the ground floor directly opposite an unalarmed fire exit door

(d) There were no defects in the system of working which contributed to the deaths

(e) The following facts are relevant to the circumstances of the deaths:

1. there was a need for a more robust approach to the issue of absconding linked to the security of the premises at the Good Shepherd Open Unit

2. (a) management at the Good Shepherd Open Unit in August, September and October 2009 should have given proper regard to the serious nature of the bullying of Terrie Faye Oliver (also known as Georgia May Rowe) by AM (a young person resident in the establishment at the time) and its impact on Terrie Faye Oliver (also known as Georgia May Rowe) and (b) management should have taken appropriate steps to ensure the removal of either Terrie Faye Oliver (also known as Georgia May Rowe) or AM from her placement at the Good Shepherd Open Unit

3. the failure of placing authorities to hold detailed, comprehensive, concise and readily accessible information relating to an individual child to include the recommendations of the child's social worker/key worker and any psychological assessment, and to ensure this information was copied to the residential establishment on any placement of the child.

4. there was a need for systems of communication (both verbal and documentary) to be set up and adhered to by all staff responsible for the care and safety of young persons to ensure that accurate and up-to-date information relating to an individual child was available to decision makers and to those responsible for day-to-day care

5. the need for a 'stand alone' risk assessment in documentary form for each young person in the care of a residential institution with separate consideration given to the issues of 'self-harm' and 'suicide'.

The Statutory Framework

The Purpose and the Parameters of a Discretionary Inquiry

This Fatal Accident Inquiry has attracted considerable public interest. It might be helpful if the purpose and remit of this Inquiry and the parameters which apply were to be set out here.

Section 6 of the Fatal Accident and Sudden Deaths Inquiry (Scotland) Act 1976 Act ('the 1976 Act') sets out the purpose of an Inquiry such as this in the following terms:

“at the conclusion of the evidence, and in submissions thereon, as soon as possible thereafter, the Sheriff shall make a determination setting out the following circumstances of the death, so far as they have been established to his satisfaction

(a) where and when the death, and any accident resulting from the death, took place

(b) the cause, or causes, of such death, and any accidents resulting in the death

(c) the reasonable precautions, if any whereby the death, and any accident resulting in the death, might have been avoided

(d) the defects, if any, in any system of working which contributed to the death, or any accident resulting in the death

(e) any other facts which are relevant to the circumstances of the death.

The purpose of a discretionary Inquiry

Where in relation to any death, there is a public interest in inquiring into the circumstances surrounding the death and those do not, as a matter of law, require the holding of a mandatory Inquiry, the Lord Advocate, in the public

interest, may apply to the court for the holding of such a discretionary inquiry. The Inquiry into the deaths of Niamh and Georgia is a discretionary one.

It is well settled that it is not the purpose of a fatal accident inquiry to determine any question of civil or criminal fault or liability. In *Black –v- Scott Lithgow Limited* 1990 SLT 612 Lord President Hope stated at page 615 G-H:

“There is no power in this section [s6] to make a finding as to fault or to apportion blame between any persons who might have contributed to the accident.....It is plain that the function of the sheriff at a fatal accident inquiry is different from that which he is required to perform at a proof in a civil action to recover damages. His examination and analysis of the evidence is conducted with a view only to setting out in his determination the circumstances to which the subsection refers, in so far as this can be done to his satisfaction. He has before him no record or other written pleading, there is no claim of damages by anyone and there are no grounds of fault upon which his decision is required.”

Assistance in identifying the purpose of such an Inquiry as this may be found in the words of Sheriff Brian Kearney, in his Determination after the Inquiry into the death of Mildred Allen 14th November 1985 in which he states:

“The essential purposes are the enlightenment of those legitimately interested in a death, ie the relations and dependants of the deceased, as to the cause of death (and of any accident resultant of the death), and the enlightenment of the public at large, including the relations, as to whether any reasonable steps could or should have been taken, whereby the death might have been avoided, so that lessons may be learned.....”

Sheriff Charles Stoddart in his determination following the Inquiry into the death of Christine June Foster (25 February 2002) said the following:

“An Inquiry under the 1976 Act is an exercise in fact finding and not fault finding, and so it would be quite wrong for me, in the context of these proceedings to ascribe directly to any one named individual or body blame for the death. Section 6 of the Act does not permit me to do that, but it does

entitle me to set out in my determination the reasonable precautions whereby her death, and the accident which resulted in it, might have been avoided. An FAI does not empower a Sheriff to make “a finding as to fault” or to apportion blame between any persons who might have contributed to the accident....[the Sheriff’s] examination of the evidence is conducted with a view only to setting out in his determination, the circumstances to which [Section 6(1)] refers in so far as this has been done to his satisfaction (Lord President, Hay Black –v- Scott Lithgow Ltd. 1990 SLT at 612.) As Sheriff Principal Mowat expressed in his Determination, following upon the Lockerbie disaster:

“in terms of Section 6(2) of the Act, a sheriff’s determination may not be founded upon in any other judicial proceedings arising out of the death, and by this method, Parliament has indicated that the finding of fault is not intended as the purpose of the Inquiry.”

Determination under Section 6(1)(a) and Section 6(1)(b)

All parties with the exception of Hull City Council (see my note below) were agreed that the determination under the first two subsections of Section (6)(1) should be as stated in my formal determination above.

Determination under Section 6(1)(c)

‘the reasonable precautions, if any, whereby the death, and any accident resulting in the death, might have been avoided’

What is a ‘reasonable precaution’? Carmichael on Sudden Deaths and Fatal Accident Inquiries (3rd ed) at paragraph 5-75 p. 174 states:

“what is envisaged is not a ‘probability’ but a real or lively possibility that the death might have been avoided by the reasonable precaution’.

What constitutes a 'lively possibility' has been considered in other determinations. In the Fatal Accident Inquiry into the death of James McAlpine (October) 1985) Sheriff Kearney gave some guidance where the deceased, a 7 year old boy, died during what was presented to his parents as a straightforward medical procedure.

".....in relation to making a finding as to the reasonable precautions, if any, whereby the death and any accident resulting in the death might have been avoided it is clearly not necessary for the court to be satisfied that the proposed precaution would in fact have avoided the accident or the death, only that it might have done, but the court must, as well as being satisfied that the precaution might have prevented the accident or death, be satisfied that the precaution was a reasonable one."

In the Fatal Accident Inquiry into the death of Marion Bellfield (April 2011) Sheriff Braid also gave consideration to what a reasonable precaution might involve. The deceased was admitted to hospital for endoscopy and she died two days post operation.

".....that is not to say that every single thing which might have been done and which might have avoided the death should, if it was a reasonable step to have taken, make its way into a finding under section 6(1)(c). Not only would that not be helpful in avoiding future deaths, but it would involve placing unjustifiably wide construction on the word "precaution". Whatever that word means, it must place a limit on the sort of acts or events which should be included in a s6(1)(c) finding. The natural meaning of "precaution" is an action or measure taken beforehand against a possible danger or risk.....since one purpose of a fatal accident inquiry is to inform those with an interest of what actions should be taken in future, a finding under section 6(1)(c) must carry with it the implication that the precaution ought, with the benefit of hindsight, to have been taken in the case which resulted in death, albeit without the necessary implication that the failure to take it was negligent."

Sheriff Holligan in his Determination arising out of the death of John Kelly, states:

“It is not the function of an inquiry to make findings of any fault or to apportion blame.....Causation does have a role. In particular the provisions of Sections 6(1)(c) and (d) seem to me to proceed on the basis there will be, in most cases, a process or event which falls to be examined in order to see what led to an accident. Having established such process or event, it is then possible to see what steps might have been taken to avoid the outcome or what defects there were. In my opinion, the provisions of Sections 6(1)(c) and (d) fall to be applied objectively and with the benefit of hindsight. Section 6(1)(e) gives some support to this interpretation. There might be circumstances that might be relevant to the death but might not have been established to have a causal link.”

Finally, in the Rose Park Inquiry Determination (20th April 2011) Sheriff Principal Lockhart said the following:

‘The question of reasonableness is directed to the precaution which is identified. The issue is not whether an individual or an organisation behaved in a reasonable or unreasonable way, but whether or not there is a precaution which is a reasonable one and which might have made a difference’

Taking guidance from all of the above, and reflecting on all of the evidence led in the course of the Inquiry, I have come to the view that the two matters I have determined in terms of Section 6(1)(c) are both reasonable precautions which each contain that ‘real or lively’ possibility that the deaths of Niamh and Georgia might have been avoided at that time.

Determination under Section 6(1)(d)

I have made no finding under this subsection. I was not asked to do so by any party represented at the Inquiry.

Determination under Section 6(1)(e)

In considering the scope of Section 6(1)(e), in the Inquiry into the death of John Kelly, Sheriff Holligan had this to say:

“The provisions of section 6(1)(e) are still wider and, in my view, entitle and indeed oblige the court to comment upon, and where appropriate make recommendations in relation to any matter which has been legitimately examined in the course of the inquiry as a circumstance surrounding the death if it appears to be in the public interest to make such comment or recommendation.”

Sheriff Reith QC in her determination arising out of the Inquiry into the death of Sharman Weir (23rd January 2003) stated:

‘In my opinion, the purpose of a Fatal Accident Inquiry is to look back as at the date of the Inquiry to determine what can now be seen as the reasonable precautions if any, whereby the deaths might have been avoided and any other facts which are relevant to the circumstances of death. The purpose of the conclusions drawn is to assist those legitimately interested in the circumstances of the death to look to the future. They, armed with hindsight, the evidence led at the Inquiry, and the Determination of the Inquiry, may be persuaded to take steps to prevent any recurrence of such a death in the future.’

The Inquiry

Evidence in this Inquiry began on 15th June 2011 and the Inquiry heard from the last witness on 19th December 2011. Evidence was heard over some 65 days. Written submissions from all parties were lodged by 7th February 2012 and oral submissions were heard on 8th and 9th February 2012. Because of the wide-ranging scope of the issues examined during the course of the Inquiry, the Findings in Fact have been set out under individual headings although there is some unavoidable overlap and occasional necessary

repetition. Brief biographical details of Niamh and Georgia are contained in the Note and events prior to 18th June 2008 in the lives of each of the girls which are considered of significance have also been covered in the Note. Coincidentally events took place quite separately in the lives of Niamh and Georgia around 18th June 2008 which resulted in each of them being taken into care at that time. They proceeded on individual paths, and by September 2009 were sharing accommodation at the Good Shepherd Open Unit in Bishopton. It was from there that on the evening of Sunday 4th October 2009 Niamh and Georgia absconded together and later fell to their deaths from the railing on the west side of the Erskine Bridge. The relevant events between 18th June 2008 and 4th October 2009 which impact on the determination are set out in the Findings in Fact.

Finds in Fact

(a) The events of 4th October 2009

1. Niamh (born 18th June 1994) and Georgia (born 13th February 1995) died after falling from the Erskine Bridge into the waters of the River Clyde some time around 2045 on Sunday 4th October 2009. Their deaths were suicides. The girls, having walked from the Good Shepherd Open Unit ('the Open Unit') stopped at a point near the centre of the Bridge, at the barrier on the west side. They removed their training shoes and placed them on the ground. Georgia left a photograph of herself and her half brother and sister in one of her shoes. A scarf was draped over the barrier by one of the girls. The two girls sat briefly on the barrier with their backs to the water. They linked arms just before falling backwards. Both girls died on impact with the water.

2. Niamh's body was recovered about 2135 on 4th October and Georgia's body was recovered about 2200 on 4th October. At post-mortem examination on 8th October Niamh's death was certified as being caused by Multiple

Injuries due to a fall from a height, and Georgia's by Chest and Abdominal injuries due to a fall from a height.

3. At the time of their deaths, both girls were resident in the Open Unit situated some 3 miles from the Erskine Bridge and approximately an hour's walk away. The authority responsible for the placement of Niamh was Argyll and Bute Council, ('Argyll and Bute') and the authority responsible for the placement of Georgia was Hull City Council ('Hull') (formerly Humberside County Council).

4. Niamh had been resident at the Open Unit since 28th July 2009. She had been on Home Leave from 2nd October 2009 until she was returned by her mother Colette Bysouth to the Open Unit at around 1900 on 4th October. She had spent, with her mother's permission, the night of 3rd October at the home of Dee Dee, a friend, and the sister of Niamh's deceased boyfriend Jonny McKernan.. Niamh was in good spirits and her behaviour over the weekend had given her mother no cause for concern.

5. Georgia had been resident in the Open Unit since 21st August 2009. On Sunday 4th October 2009 she had gone out for a meal and a visit to a local equestrian centre with her maternal aunt Tanya Oliver and one of her aunt's friends in the late afternoon and had been dropped off by them sometime around 1910. Georgia gave the impression of having enjoyed her time out and had given no cause for concern during her time away from the Open Unit that day.

6. From sometime before 12 noon on 4th October 2009 only two members of staff had been on duty in the Open Unit. These were Mary Stewart, Senior Care Worker and Night-Shift Coordinator, and Martha Fraser, who had retired after being employed at the Open Unit as a Care Worker for more than thirty years and who in 2009 continued to work there on a sessional basis.

7. At some time shortly after the girls' respective returns to the Open Unit, Martha Fraser, who was the only member of staff in the Open Unit at that time, saw Niamh and Georgia in their night-clothes, possibly around 1930.

8. At 1943 the two girls, wearing outdoor clothes, were captured on the unmonitored CCTV system located in the Good Shepherd Secure Unit (the 'Secure Unit') leaving the campus by the main driveway. These images were first viewed after their deaths.

9. In connection with her duties of collecting girls from weekend leave, and going out to buy take-away meals, Mary Stewart left the unit at about 1740. Between 1740 and 2040 she came back to the Open Unit for around 20 minutes but otherwise remained away from the Open Unit. From Georgia's return at around 1930, until approximately 2040, Martha Fraser was left in charge of 7 girls, 2 of whom, Niamh and Georgia, were in 'the wee flat'

10. Some 10 minutes after the return of Mary Stewart, at around 2050, it was discovered that Niamh and Georgia were missing. Their night-clothes were found lying on the floor of the bedroom accommodation in the 'wee flat'. By the time it was appreciated that the girls had absconded, they had fallen to their deaths from the Erskine Bridge. Their absence from the Open Unit had gone undetected for approximately one hour and ten minutes.

11. Nine girls were resident in the Open Unit as at 4th October 2009. There should have been at least 4 staff on duty on 4th October 2009 between 4 pm and midnight. That evening there were two members of staff on duty. A third member of staff who had attended for duty earlier in the day had gone home sick before noon. The Head of Service Alexander Cunningham ('Sandy Cunningham') was aware from sometime in the morning 'when the girls were still all sleeping' that there were only two members of staff on duty. He had been unable to find another member of staff to replace the member of staff who had gone home sick. Although he kept in touch with the Open Unit by

telephone, he chose not to go into the Open Unit. He knew that at certain times on the Sunday evening there would be only one member of staff on duty in the premises.

The Open Unit

12. In 2009 a non-profit making organisation called CORA provided administrative and financial services to four residential units in the central belt of Scotland – the Good Shepherd Centre, Springboig St. John's (now closed) St. Philip's Plains and St. Mary's Kenmure. CORA operated under a board which comprised the chair person of each of the Boards of Management for the four residential schools, and Monsignor Peter Smith, a Catholic Priest, who represented the Bishops' Conference of Scotland. The members of the Board of Management for each school, including the Good Shepherd Centre, were appointed by the local bishops of the Catholic Church. The CORA Board had no responsibility nor input into the day-to-day running of the Open Unit.

13. On 1 April 2002 the Good Shepherd Centre was deemed registered with the Scottish Commission for the Regulation of Care ('the Care Commission') by virtue of the provisions of Articles 3 and 4 of The Regulation of Care (Scotland) Act 2001 (Commencement No. 2 and Transitional Provisions) Order 2002 (SSI 2002/162). The registration as a care service fell within the definition of 'school care accommodation service' as then defined in Section 2 (1)(c) and (4) of the Regulation of Care (Scotland) Act 2001. A Certificate of Registration dated 14th October 2008 (GS100/9) was issued by the Care Commission to the Open Unit. The National Care Standards published by the Scottish Ministers in September 2005 under Section 5 of the Regulation of Care (Scotland) Act 2001 were applicable to the Open Unit from September 2005 until its closure. Regulation 13 of SSI 114/2002 applied to the Open Unit. Its terms were set out in the certificate of Registration as follows: "*A provider shall.....ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate*

for the health and welfare of service users” Overall responsibility for the Open Unit lay with a Board of Management and day-to-day responsibility with Sandy Cunningham as Head of Service and his deputy Liz Anne Davenport. Care Manager at the Open Unit.

14. The building was situated in a semi-rural area just outside Bishopton. In 2008-9 on the same campus, but run completely separately, were two other facilities viz. the Good Shepherd Secure Unit ('the Secure Unit') and the Good Shepherd Close Support Unit ('the Close Support Unit').

15. In addition to residential accommodation, the Open Unit premises provided educational facilities for those girls who were resident, as well as other girls not in mainstream education who would travel to the facility on a daily basis during term-time. In 2008, parts of the building occupied by the Open Unit had been closed off, due to a down-turn in numbers. In the summer of 2009 there were plans for expansion in the form of demolition of the existing building and the construction of new premises on the site, but in the event these did not materialise.

16. The Open Unit closed in 2010 and the registration with the Care Commission of the school care accommodation service provided at the Open Unit was cancelled at the request of the Open Unit's Board of Management on 5th July 2010.

17. From first registration the Open Unit was inspected twice each year by the Care Commission. Reports were produced after each inspection and available for public perusal. There was an inspection between 10th December 2008 and 13th February 2009, and an inspection between 18th May 2009 and 24th July 2009.

18. As part of the inspection in 2009, at a meeting on 18th May 2009 between Jane Weir, the Care Commission Inspector, and Sandy Cunningham, there was discussion of staff/resident levels, dependent on anticipated resident numbers and dynamics as well as on the accommodation being utilised.

Taking those factors into consideration, on 4th October 2009 between 4 pm and midnight, the minimum number of staff on duty should have been four.

19. The living accommodation on the first floor at the Open Unit consisted of a large living area, a number of bedrooms as well as a kitchen and ancillary facilities and an office. There was a separate self-contained unit on the ground floor of the building known as 'the wee flat' where there were two bedrooms (one single and one twin) as well as a bathroom and a sitting area. On 4th October 2009, Niamh and Georgia, along with a third girl, were accommodated in 'the wee flat'. Niamh and Georgia shared a bedroom.

20. Immediately opposite the main door into 'the wee flat' there was an unalarmed fire exit door, giving direct access to the external area at the front of the building and from there direct access to the main drive and the public road at the top of the drive.

21. There were no locks on the windows nor on the various doors (both internal and external) in the Open Unit. There was no alarm system connected to any external door. There was no system whereby residents were expected to check-in or out of the premises. In June 2009 an alarm had been connected to the fire exit door outside 'the wee flat' but around July 2009 Sandy Cunningham instructed that it be disconnected because the girls tended to use that fire exit as a means of leaving the Open Unit and staff were being interrupted each time the alarm in the form of a bell which rang in the upstairs accommodation went off. Staff were unable to stop the girls using the fire exit. No sanctions were put in place to prevent its use. There was no CCTV system directly linked to the Open Unit. There was CCTV placed in the main driveway but this was not monitored by staff in the Open Unit. The monitoring facility was situated in the Secure Unit but it was not continuously monitored.

22. The sole means of monitoring the whereabouts of each of the girls was 'staff awareness'. There was no additional security. If a girl wished to leave

the Open Unit without permission, she could do so. Staff were not allowed physically to restrain any girl intent on leaving and could only try to persuade a young person not to leave the campus. If staff became aware that a young person had left the premises, they would try to trace the girl, could follow a child in a vehicle, and would try to persuade her to return to the Open Unit.

23. It was the policy of the Open Unit to accommodate known self-harmers on first floor bedrooms as near to the upstairs office as possible. Niamh was a known self-harmer and should not have been accommodated in 'the wee flat'.

24. It was the policy of the Open Unit to accommodate girls who were assessed as presenting a high risk of absconding on the first floor. The 'wee flat' was suitable only for the accommodation of girls who were assessed as being at very low risk of absconding. Georgia was categorised as a high risk of absconding and should not have been accommodated in 'the wee flat'.

Niamh

19th June 2008 until 28th July 2009.

25. Prior to her going into care on a voluntary basis in June 2008, Niamh had lived for a time between 2007 and 2008 in Helensburgh with her father Paul Lafferty although there were times during that period when she would return to her mother's home. Her father and her mother Colette Bysouth had separated when Niamh was two years old. Niamh then lived in Helensburgh with her mother, and eventually her mother, stepfather and two half-sisters. She had contact with her father, and her paternal grandparents who also lived in Helensburgh. In 2006, when she was spending time at her father's home, Niamh witnessed the aftermath of a very violent incident involving her father, and a local man called Brian Fallon. In the course of that incident Brian Fallon was killed, and Paul Lafferty sustained multiple stab wounds. He spent time

in intensive care. He was subsequently tried for the murder of Brian Fallon and was acquitted in around November 2006.

26. Sometime in 2007 Niamh told her mother that she had taken an overdose of 25 herbal tablets. In April 2008 Niamh self-harmed by cutting her wrists. She associated with delinquent young people in the local community who took drugs, consumed alcohol when underage and were involved in criminal behaviour. Niamh was drinking alcohol, shoplifting and truanting. When she was at secondary school she assaulted a female pupil. In June 2008 Paul Lafferty concluded that he was unable to look after his daughter. Niamh refused to return to live with her mother and her immediate family. On 19th June 2008 Niamh was received voluntarily into the care of Argyll and Bute. She was initially placed at East King Street Children's Unit, ('East King Street') a residential facility owned and run by Argyll and Bute. Almost immediately some of her friends in Helensburgh tried to remove her from the unit. At that time Argyll & Bute recognised that East King Street could not keep Niamh safe and on 23rd June 2008 she was transferred from East King Street to the Open Unit.

27. On 8th August 2008 at a Children's Panel she was placed under the supervision of Argyll and Bute with a condition of residence at the Open Unit. She remained under the supervision of Argyll and Bute until her death.

28. Sandra Leonard was Niamh's Social Worker from 19th June 2008 until the end of May 2009. She was at that time employed by an agency who provided staff to Argyll and Bute. The Senior Social Worker, Team Leader and Miss Leonard's Line Manager was Adah Lambie. Adah Lambie's Line Manager was the Area Manager Joy Daniels. Colette Bysouth worked closely with the Social Work Department both before and throughout all the time Niamh was in care and presented at all times as a loving, committed and sensible mother, who always had Niamh's best interests uppermost. Niamh however remained consistent in her wish to live with her father, at least until the summer of 2009 and was steadfast in her refusal to live with her mother,

stepfather and two half sisters and was not prepared to accept the appropriate boundaries her mother and stepfather attempted to place on her behaviour.

29. Paul Lafferty took drugs, including heroin. He associated with others who took drugs, and he had a violent past in addition to the incident when Brian Fallon was killed. He was unreliable in his contact with the Social Work Department and in 2008/2009 he did nothing to discourage Niamh in her sexual relationship with Jonny McKernan, a 16 year old local boy who took drugs and who had a criminal record. Colette Bysouth was at all times very worried about Niamh's relationship with Jonny McKernan who was also a violent young man. Paul Lafferty was at no time a suitable full-time carer for Niamh.

30. On 30th November 2008 a family group conference arranged by the social work department was held in Helensburgh to plan for Niamh's future care. Amongst others Paul Lafferty and Colette Bysouth attended. It was agreed that the long-term plan was for Niamh's eventual return to the care of her father. This was to be via a spell of residence at East King Street and a variety of supports had to be in place prior to Niamh's anticipated eventual return to the care of her father. At the meeting those in attendance thought that Paul Lafferty was under the influence of drugs. Colette Bysouth was very worried at what was being proposed.

31. A Children's Panel was fixed for 16th January 2009. Sandra Leonard prepared a report in which her recommendation was that Niamh's supervision requirement be continued and that a condition of residency naming East King Street should be made as per the plan formulated in November 2008. Adah Lambie told her to amend her report to make no recommendation regarding residence. Sandra Leonard was unhappy about that instruction and took legal advice.

32. On 16th January 2009 there was a Children's Panel. No one who gave evidence was clear as to what the decision of the hearing was. In any event

Niamh did not move to East King Street at that time because the Social Work Department were of the opinion that the mix of children resident in East King Street would not have been conducive to Niamh's best interests. That assessment had not been placed before the panel on 16th January 2009.

33. On 9th February 2009 Adah Lambie completed a supplementary report amending the care plan and recommending that, while remaining subject to supervision, Niamh should be returned to the care of her father. This was contrary to the January recommendations of Sandra Leonard. Adah Lambie's recommendation to the panel on 13th February 2009 that Paul Lafferty was a suitable carer for his 14 year old daughter was not supported by the knowledge that the Social Work Department had of his abilities and his life-style.

34. On 13th February 2009 a panel met to consider Niamh's case. Sandra Leonard was on holiday and Adah Lambie attended. On Adah Lambie's recommendation the panel returned Niamh to the care of her father, with the condition that she continue her education at the Open Unit. There was confusion between the social work department and the Open Unit as to when the order was to be implemented. Despite that confusion, neither Adah Lambie nor any one from the Open Unit thought to have the situation clarified and the order was implemented immediately. The recommendation of Sandra Leonard for Niamh to return to her father by means of a planned transition period involving a stay at East King Street was not put before the panel nor were the essential supports which had been identified by Sandra Leonard and agreed by Adah Lambie prior to any move from the Open Unit followed up or put in place by Adah Lambie.

35. Between 13th and 19th February 2009 when Niamh was in the care of her father, no social work visit was made nor was any contact attempted. Niamh did not spend every night at her father's home, with her father's knowledge and approval. Paul Lafferty was unable to care for his daughter and the placement broke down by 19th February 2009.

36. At a LAAC Review on 18th February 2009 in Helensburgh Niamh appeared, unkempt and very distressed. She spent that night in the care of her father, though not at her father's house.

37. On 19th February 2009 there was a planning meeting in Helensburgh. The decision of the meeting was that Niamh should return to the Open Unit. Paul Lafferty phoned Niamh to tell her of the decision and when her mother went to collect Niamh she ran away. She was retrieved by her mother and taken to the Open Unit after she had been allowed to say 'goodbye' to her boyfriend Jonny McKernan who had appeared as a naccused person in the sheriff court at Dumbarton that day. That was the last time Niamh saw him.

37. On 20th February 2009 Niamh absconded from the Open Unit, and was returned there later that day by her mother.

38. On 21st February 2009 Jonny McKernan died of a drugs overdose. His funeral took place on 3rd March 2009.

39. On 3rd March 2009, Paul Lafferty was admitted to a local psychiatric unit. Later that month, after his discharge from hospital, he left to live in Denmark. Subsequently Niamh's Supervision Requirement Order included a condition that Paul Lafferty should have no direct contact with his daughter and that any telephone contact had to be supervised. Paul Lafferty committed suicide in September 2010.

40. On 3rd March 2009 Niamh was seen in the street in Helensburgh by Sylvia Rennie, the Operational Manager of Up 2 Us. Niamh was heavily under the influence of drugs and/ or alcohol.

41. Between 20th February 2009 and 13th March 2009 Niamh absconded from the Open Unit on a number of occasions and when at large consumed both alcohol and drugs. On 5th March 2009 she self-harmed by scratching her face and on 6th March 2009 she drank a 200 ml bottle of witch hazel when in the Open Unit. She was taken to the Royal Alexandria Hospital in

Paisley. She required no treatment. In particular, between 9th and 11th March 2009, Niamh absconded from the Open Unit on three separate occasions.

42. At a panel hearing on 13th March 2009 Niamh's condition of residence at the Open Unit was confirmed - on a 'last chance' basis - with a condition *inter alia* of no contact with her father. Immediately after the panel Niamh absconded and again consumed alcohol and drugs. She was absent for the whole weekend. During that time she had been in the company of an older man, had slept in a car which had then been involved in a road traffic accident and was subsequently deliberately set on fire.

43. On 16th March 2009 on the authority of Douglas Dunlop Head of Service for Children's Services Argyll and Bute Niamh was admitted to the Secure Unit. She was taken there by Sandra Leonard. She remained in the Secure Unit until 3rd July 2009.

44. The criteria for accommodation of a young person in conditions of security are to be found in Section 70 of the Children (Scotland) Act 1995. Subsection (1) sets these out in the following terms:

(a) that the child, having previously absconded, is likely to abscond and, if he absconds, it is likely that his physical, mental or moral welfare will be at risk;
and

(b) that the child is likely to injure himself or some other person

45. On 19th March 2009 the panel granted a warrant for Niamh's placement in the Secure Unit. The warrant was renewed on 9th April 2009. She was placed initially in Unit 1 and was moved to Unit 2 on 12th May 2009. During her time there Niamh complied with the rules and did not require secure holding. During her time in the Secure Unit Niamh refused to cooperate with the any counselling which was offered to her.

46. In the Secure Unit, all doors are kept locked, including bedroom doors which are locked overnight. There is a viewing panel into each bedroom. A young person in secure conditions is not able to leave a room without the permission of a member of staff and young persons are accompanied by a staff member at all times.

47. Between 16th March and 3rd July 2009 Niamh was allowed out of the Secure Unit only on a supervised basis. She went on a variety of outings with members of staff. All such outings passed without incident. On her 15th birthday on 18th June 2009 she had a supervised visit lasting half an hour to see her mother, stepfather and half-sisters in Helensburgh, as well as her paternal grandparents who lived in the town. That was her only visit to Helensburgh during her time in the Secure Unit.

48. Between March and July 2009 Niamh repeatedly advised the staff in the Secure Unit that whenever she was able to do so she would 'get mad' with drink and drugs. She talked about how she would end her life. She told Duncan Shaw, a care worker in the Secure Unit, that she would take loads of 'blues' (street valium), vodka, go to sleep and not waken up. He described Niamh as being very calm, and focussed when she spoke about killing herself. She repeatedly indicated a wish to 'be with Jonny'. By that she meant she wanted to die.

49. On 11th June 2009 Deborah Wicks was appointed Niamh's social worker in place of Sandra Leonard who had ceased working for Argyll and Bute at the end of May 2009. Deborah Wicks had no opportunity of speaking to Sandra Leonard about Niamh's case. She met Niamh for the first time on 11th June 2009. She attended a 'Looked After and Accommodated Child' Review on 15th June 2009 ('LAAC Review'). The Reviewing Officer and Chairperson of that meeting was Mary Walker. Those in attendance included Deborah Wicks, Edward ('Ted') Jeffries, a psychologist employed by Argyll & Bute, and Colette Bysouth.

50. The conclusion of the meeting of 15th June 2009 was that Niamh no longer met secure criteria and referral was to be made to two options (1) the Close Support Unit (the 'CSU') and, if no place was available at the CSU, (2) 'the wee flat' at the Open Unit with additional supports. No consideration was given by the meeting to a placement at East King Street. No accommodation at the CSU was available until some time in August 2009. No investigation was made into the availability of accommodation in 'the wee flat'. Deborah Wicks was of the view that prior to any move from the Secure Unit to the community a transition period was essential so that Niamh's behaviour could be tested outwith the Secure Unit.

51. After the LAAC Review on 15th June 2009 Deborah Wicks had further opportunity to consider Niamh's case. She prepared a report dated 23rd June 2009 for the panel on 3rd July 2009. She recommended that Niamh should remain in the Secure Unit until accommodation in the Close Support Unit was available. She considered that a great deal of work still had to be done with Niamh before a successful transition from secure conditions could be made. She recognised that Niamh had not been tested in conditions affording her any degree of freedom, and was concerned about Niamh's regularly stated intention to drink alcohol and take drugs whenever she had the freedom to do so.

52. On or about 26th June 2009 Roger Wilson, Resources Service Manager, Argyll and Bute spoke to Douglas Dunlop, Head of Service for Children and Families and Criminal Justice on the telephone and told him that the recommendation from Deborah Wicks was that Niamh should be referred to the Open Unit. That information was not accurate. Douglas Dunlop did not ask who Niamh's social worker was. He did not ask to see the social worker's report nor the papers from the LAAC Review. He did not speak to anyone directly involved with Niamh's care. On the basis of what he had been told by Roger Wilson, Douglas Dunlop directed Roger Wilson to draw up an alternative plan for Niamh recommending one of Argyll and Bute's own children's homes. William Moore was the Accomodations Manager with Argyll and Bute and the person responsible for identifying a potential suitable

placement. A place was available at East King Street. Douglas Dunlop instructed that the alternative plan of East King Street should be drawn up in the form of a supplementary report from Niamh's social worker containing that recommendation.

53. As at the end of June 2009, the view of Deborah Wicks, Adah Lambie and Joy Daniels was that Niamh should move from the Secure Unit to the CSU, prior to any further move. Adah Lambie, Deborah Wicks and staff at the Secure Unit thought that Niamh should remain in the secure unit until accommodation was available at the CSU. None of this information was ever communicated to Douglas Dunlop. Had Douglas Dunlop been privy to the views of other professionals familiar with Niamh's case, specifically those of Deborah Wicks, he would have played no part in the decision-making process regarding Niamh's future placement. He would not have instructed Roger Wilson as he did had he known that Deborah Wicks was recommending that Niamh remain in secure accommodation, until such time as a place in the CSU became available.

54. An Argyll and Bute Resource Management Meeting was held in Inveraray on 29th June 2009. Its remit was to make decisions on community based packages of care. Discussion of Niamh's case was not on the agenda. After the formal part of the meeting, Niamh's case was discussed by Joy Daniels, William Moore, Placement Manager with Argyll and Bute, and Alexander Taylor, Social Work Manager with Argyll and Bute. None of these had seen any papers in relation to Niamh nor had any one of them spoken at any time to Deborah Wicks. They were aware of the involvement of Douglas Dunlop and the recommendation that a suitable place be found for Niamh within one of the children's units run by Argyll and Bute. They decided that the recommendation of Argyll and Bute Social Work to the Children's Panel on 3rd July 2009 should be that Niamh should go directly from the Secure Unit to East King Street. The discussion of Niamh's case without papers at the end of a Resource Management Meeting was unique. This was not the appropriate forum for such a discussion to have taken place nor for this kind

of decision to have been made without the decision-makers having full information. No Minutes were taken at this meeting.

55. On 2nd July 2009 a meeting took place at East King Street to discuss Niamh's case. Present at that meeting were Adah Lambie, William Moore, Deborah Wicks, staff from the Open Unit, and from East King Street. By that time the decision had been made by management at Argyll and Bute that the recommendation to the panel on 3rd July 2009 was to be for accommodation at East King Street.

56. A note was prepared by Lisa Wilson Senior Social Care worker at East King Street about the meeting at East King Street on 2nd July 2009 (erroneously dated 1st July 2009) which contained *inter alia* the following:

*Risk factors – Niamh has a history of drug and alcohol misuse.....
She places herself in dangerous situations in the community i.e. frequenting households where drugs/alcohol is (sic) being misused. She has also suffered the recent loss (Feb. 2009) of her boyfriend to a drugs overdose.*

Niamh self-harms – cutting wrists, taking paracetamol, drank half a bottle of witch hazel, and has threatened to hang herself – numerous suicide attempts.

Staff at East King Street expressed reservations as to the suitability of Niamh's placement there, and the capacity of the unit to keep her safe.

57. When Deborah Wicks realised at the meeting on 2nd July 2009 that the recommendation to the panel was to be that Niamh be transferred from the Secure Unit to East King Street, she told Adah Lambie that she was refusing to attend the Children's Panel on 3rd July 2009 to put forward a recommendation with which she did not agree. She went on sick leave on 3rd July 2009 after an accident at home. She did not return to work until 5th October 2009.

58. On 2nd July 2009 Colette Bysouth was advised by Adah Lambie that Niamh's continued stay at the Secure Unit followed by a period of time at the Close Support Unit was no longer an option being considered. She was told that Niamh would be going to East King Street. Colette Bysouth was very concerned that East King Street would not be able to keep Niamh safe and expressed those concerns to Adah Lambie.

59. On 3rd July 2009 Adah Lambie took on the role of Niamh's social worker in the absence of Deborah Wicks. She remained in that role until Niamh's death.

60. At the Children's Panel on 3rd July 2009 the recommendation for East King Street was made by Adah Lambie. The Panel followed that recommendation. On that date Niamh transferred to East King Street. Staff at the Secure Unit had not anticipated that Niamh would be leaving the unit that day. No paperwork went with Niamh when she moved. The only information available on Niamh was that given at the meeting on 2nd July. From the outset, Nancy Porter, Unit Manager at East King Street, had concerns for Niamh's safety, particularly relating to the transfer from secure accommodation to a very open unit in the community where Niamh would have access to her peers. East King Street was not equipped to accommodate any child who was a persistent self-harmer and/or in respect of whom there were issues in regard to a potential risk. Niamh was both. East King Street was not appropriate accommodation for Niamh at that time. She should not have been transferred there on 3rd July 2009.

61. Niamh resided at East King Street from 3rd July 2009 until 28th July 2009. Her bedroom walls were covered with large laminated photographs of Jonny McKernan, described by a member of staff as 'resembling a shrine'. She spoke often of her wish to 'be with Jonny'. She returned to the home under the influence of drink. On one occasion she brought alcohol into the home. On the morning of 27th July 2009 she was found in bed in a semi-conscious state under the influence of some substance. After investigation it transpired that she had consumed a large quantity of Valium, with the intention of ending

her life. She thought she had taken in excess of 90 tablets. It is likely that she had consumed around 20 before passing out. She told the staff on duty that she 'wanted to be with Jonny' and that she was angry that she had wakened up. She was staggering, and her speech was slurred.

62. During the course of 27th July 2009 despite her condition, Niamh absconded on two occasions from East King Street. On one occasion she was returned by the police and on the second occasion she was returned by a member of staff to whose house in Helensburgh she had gone. She was also seen by Dr. Fang and then by Dr. Brown, two local general practitioners. Neither was of the view that Niamh required to be seen at a hospital though Dr. Brown concluded that she 'may well have needed a psychiatric assessment'.

63. Colette Bysouth spent much of 27th July 2009 at East King Street. She was due to go on holiday to Spain with the rest of her family the next day and wanted to cancel that. A ticket had been bought for Niamh. However she had made it clear to her mother that she was not prepared to adhere to any restrictions on her behaviour while abroad. Collette Bysouth had reluctantly concluded that she could not risk Niamh absconding from her care in a foreign country and had decided prior to 27th July 2009 that Niamh should not join the family holiday. On 27th July 2009 Collette Bysouth received assurances from Adah Lambie that Niamh would be accommodated in a safe respite facility in Ayrshire and that she should continue with her holiday plans. Had she not had that assurance, she would have cancelled the family holiday. Dr. Brown understood that Niamh was to be taken by social workers that same evening to a place of safety in the country. East King Street could not keep Niamh safe.

64. Despite the understanding of Colette Bysouth and Dr. Brown and the assurances given by Adah Lambie, Niamh remained at East King Street until 28th July 2009. That morning, an emergency meeting took place at East King Street. The meeting was attended by Roger Wilson, Joy Daniels, Adah Lambie and Anne Berry, a care worker at East King Street. The decision of

the meeting was that Niamh should be transferred to the Open Unit on an emergency basis. Roger Wilson contacted William Moore by telephone and later that morning Paul Crombie, placement officer with Argyll and Bute telephoned Sandy Cunningham who agreed to accept Niamh at the Open Unit.

65. After the meeting, when Anne Berry was helping Niamh to collect her belongings for her removal to the Open Unit, she found a suicide letter lying beside Niamh's bed. At that time Niamh had emptied out her belongings which had just been packed. Anne Berry saw the words 'Don't grieve for me' on the note and quickly put it in her pocket.

66. Niamh was taken to the Open Unit, still in her night attire and with vomit stains on her clothes, by Anne Berry, a male careworker, who drove the car, and Veronica Mahoney, Acting Team Leader with Through Care Team, Argyll and Bute who had called into East King Street that morning on an unconnected matter and had volunteered to assist with Niamh's transfer. Adah Lambie did not accompany her, nor did any paperwork go with her. In the course of the car journey, Niamh said on several occasions that she wanted to be with Jonny. She tried to get out of the car. She said that if a young person wanted to run away from the Open Unit, she just had to go on to the Erskine Bridge because staff would not chase anyone there in case she jumped. She was in a state of considerable distress on her arrival at the Open Unit. Such was her distress that the staff from East King Street who took her there had to leave eventually without her knowledge. Veronica Mahoney told staff at the Open Unit about Niamh's reference to the Erskine Bridge.

67. At the Open Unit, in the course of Niamh's reception, Anne Berry gave the suicide note to Margory Thomson, a care worker at the Open Unit, who copied it and returned the principal to Anne Berry. That was the only document given to the Open Unit on Niamh's transfer there on 28th July 2009. Anne Berry took the principal back to East King Street. Later that day in the course of a telephone call she read its contents to Adah Lambie and on Adah

Lambie's instructions put the note in Niamh's East King Street file where it remained unread by anyone until it was recovered by the police on 5th October 2009.

68. Between around noon and 1730 on 28th July 2009 Sandy Cunningham became aware of the existence of the suicide note but did not ask to see it, nor did he discuss its contents with the social work department.

69. The Open Unit was not equipped to accommodate any child at risk of suicide. As at 28th July 2009 Niamh was at risk of suicide. She was not appropriately placed at the Open Unit on 28th July 2009.

Niamh – 28th July 2009 – 4th October 2009

70. During her time at the Open Unit until her death Niamh's key worker was Karen Kydd and her co-key worker was James Boyle.

71. It was the responsibility of Adah Lambie to arrange for Niamh's case to go before a children's panel. Between 28th July and 4th October 2009 no such arrangement was made by her. The transfer of Niamh from East King Street to the Open Unit should have been considered and reviewed by such a panel with the necessary reports and information before it. That did not happen because of Adah Lambie's omission.

72. On 29th July 2009 Sandy Cunningham went on annual leave. A meeting took place at the Open Unit that day attended by Liz Anne Davenport, the Deputy Head of Service at the Open Unit, and in the absence of Colette Bysouth, by Niamh's maternal aunt, Ashleigh Bysouth. At the meeting Lizanne Davenport told Ashleigh Bysouth about the suicide note. As the note was addressed to Niamh's mother, Ashleigh Bysouth was not permitted to read it.

73. On 29th July 2009 staff at the Open Unit were concerned about Niamh's continued presentation of drowsiness as a result of the overdose and she was taken to the Royal Alexandria Hospital where she was seen by Dr Fiona Brenna. She required no treatment. James Boyle, care worker at the Open Unit, accompanied Niamh. He had not been told about the suicide note. No further assessment was ordered by the doctor.

74. On 30th July 2009 Niamh absconded from the Open Unit and made her way to the Secure Unit. She was in a state of considerable distress and tried to get into the Secure Unit beyond the reception area. Staff from the Open Unit followed her. She had to be physically restrained before being taken back to the Open Unit. Shortly after her arrival there, she cut the inside of her left wrist with a razor. She was taken by James Boyle to the Royal Alexandria. He did not inform the doctor of the overdose of Valium and was still unaware of the existence of the suicide note. Niamh's injury required 16 stitches. No further assessment was ordered by the doctor who attended Niamh.

75. On 5th August 2009 Colette Bysouth took Niamh to Dr. Anne Fraser, a locum working in Bishopton at the time, to have the stitches on her arm removed. She told the doctor of her concerns about Niamh's mental state and as a result a referral was sent by the doctor to CAHMS on 7th August 2009. No appointment was offered prior to 4th October 2009.

76. On 7th August 2009 in the course of a telephone conversation with her mother Niamh asked her where her jugular vein was and also made reference to jumping from the Erskine Bridge. Her mother reported this conversation to staff at the Open Unit.

77. Between 28th July 2009 and 4th October 2009 Niamh's mood fluctuated. She cried often but could also be positive on occasion. She made frequent references to wanting to be with her dead boyfriend and some members of staff at the Open Unit thought that she should be psychiatrically assessed. Niamh told her father during a telephone call that she was going to kill herself.

Colette Bysouth continued to be extremely worried about her daughter and thought that she was very depressed.

Georgia

19th June 2008 – 24th August 2009

78. Georgia is the fifth child of Mandy Oliver. Her maternal aunt is Tanya Oliver. In November 1995 when Georgia was 10 months old she was placed in the care of Tanya Oliver and her husband Clark Rowe who lived in Sorn, Ayrshire. Georgia's twin half-brothers had by that time been adopted outwith the family and another half brother, and her half-sister had already been adopted by Tanya Oliver.

79. From 16th November 1995 until her death Georgia was subject to a Care Order granted by Kingston-upon-Hull Family Court in terms of Section 31 of the Children Act 1989 initially in favour of Humberside County Council (predecessor of Hull City Council). The Order authorised the local authority to refuse contact between Georgia and her natural mother.

80. Throughout Georgia's time in Ayrshire, Hull delegated responsibility for the practical arrangements regarding their statutory obligations in respect of her as a 'looked after' child firstly to Strathclyde Regional Council and thereafter to East Ayrshire Council.

81. From around the age of seven, Georgia's behaviour began to give cause for concern. She lied, was sometimes aggressive and violent and as she grew older, went missing on occasion from her home, and began to display sexually precocious behaviour. By 18th June 2008 Georgia's behaviour at school and in the home had deteriorated to such an extent that Tanya Oliver felt she was not able to cope with Georgia's behaviour. She was particularly concerned about Georgia's increasingly violent behaviour towards her and

towards her sister and thought that a period of respite might alleviate the very difficult situation.

82. On 19th June 2008 prior to Georgia and her sister leaving for school in Glasgow, an argument in the family home over Georgia's use of hair-straighteners led to her assaulting her brother and having to be restrained. That same day Tanya Oliver saw the headmistress at Notre Dame, the secondary school in Glasgow which Georgia attended, and also had a long consultation with a locum General Practitioner in Ayrshire. The doctor contacted the school, Hull and East Ayrshire Council.

83. On 19th June 2008 Georgia absconded three times from her school and arrangements were made by Hull in consultation with East Ayrshire Council for Georgia to spend time away from her home. Georgia's social worker in Hull was Lydia Jackson. Tanya Oliver anticipated that this time apart from her family would be a period of respite for everyone involved and that Georgia would be returned to her care very soon. She did not anticipate that Georgia would be taken to Hull.

84. On 19th June 2008 Georgia was collected from Notre Dame at the end of the school day and by arrangement was taken to Darvel to spend the night with a friend of Tanya Oliver.

85. On 20th June 2008 Georgia returned to the family home to collect items for the weekend. On that occasion Georgia told Tanya Oliver that she could not wait to see her with blood coming out of her eyes, ears and mouth and that she wanted to see her dead. Social workers from Hull took Georgia away. They did not inform Tanya Oliver where Georgia was going.

86. On 20th June 2008 Georgia was placed with short term foster carers in Jedburgh. She remained with them until 24th June 2008, although she could have stayed with them for two weeks. Georgia advised Tanya Oliver by text of her placement in Jedburgh.

87. On 24th June 2008 Georgia was taken from Jedburgh by Lydia Jackson to Mr & Mrs. Norris, foster carers in Hull. She stayed with them until 11th July 2008. The placement broke down because of Georgia's behaviour, which included repeated absconding.

88. From 11th July 2008 until 21st September 2008 Georgia lived with Mr. & Mrs. Postill, foster carers in Hull. The placement broke down as a result of Georgia's persistent absconding, drinking and drug taking, and her high-risk sexual activity. The social work plan in July 2008 was to work towards Georgia's eventual return to Scotland after a period of time with Mr. & Mrs. Postill.

89. On 2nd August 2008 Georgia went missing and her disappearance was reported to the police.

90. On 3rd August 2008 Georgia was taken to Hull Royal Infirmary after she had been drinking 'a bucket' that is, a combination of alcohol and pills in a container which is passed round a group for consumption. She had been in a highrise block of flats somewhere in the area of her foster home.

91. During the summer of 2008 and despite the terms of the Section 31 Care Order from Kingston-upon-Hull Family Court Georgia was able to make contact with her natural mother and met her on several occasions. These meetings continued after the social work department became aware of them.

92. In September 2008 Mr. & Mrs. Postill went on a pre-arranged holiday. While they were on holiday, their daughter Rebecca, an approved carer, became responsible for Georgia. On 15th September 2008 Georgia was out drinking in the street. She was brought back to the house but ran away again. She was found unconscious in the street and an ambulance was called for.

93. On 16th September 2008 Georgia was taken to Hull Royal Infirmary when it was suspected she had glass in her foot as a result of running away the day before, and because she had been unconscious. After leaving the hospital,

Georgia ran away again and was found later in the house of a stranger, in a very drunken condition.

94. On 18th September 2008 Georgia ran away. The police were contacted and when she was traced, she was in a very drunken condition. She was taken to Hull Royal Infirmary. She was kicking and screaming and had to be held down by security guards. Georgia said that she wished she was dead.

95. On 21st September 2008 Georgia was taken into Merlin Bridge Children's Home in Hull. Between 21st and 28th September 2008 Georgia ran away from Merlin Bridge several times. On one occasion she was seen in the street, banging her head on the pavement.

96. Mr. & Mrs. Postill returned from holiday towards the end of September. They were willing to have Georgia back with them but Georgia made herself scarce when Mrs. Postill visited Merlin Bridge on 1st October, and did not attend a meeting at Merlin Bridge on 2nd October which had been arranged with a view to her returning to the Postills. No further consideration was given by Hull to returning Georgia to Mr. & Mrs. Postill's care.

97. After 28th September 2008 and while she was resident at Merlin Bridge, Georgie continued to run away, drink alcohol, take drugs and have further contact with her natural mother.

98. On 27th October 2008 Georgia returned to Merlin Bridge having smoked cannabis and taken two tablets of an unknown substance. She collapsed. She was taken to Hull Royal Infirmary by ambulance. Police had to assist to get her into the ambulance because of her failure to co-operate.

99. On 28th October 2009 Georgia was discharged from Hull Royal Infirmary and returned to Merlin Bridge. That same day Lydia Jackson made arrangements for Georgia to be placed in secure accommodation at the

Secure Unit at Levertonhall in Essex on a 72 hour Place of Safety Order. She was in considerable distress throughout the journey from Hull to Essex.

100. Between 24th June 2008 when she left Scotland and 28th October 2008 Georgia's behaviour had deteriorated significantly.

101. On 31st October 2008 Hull & Holderness Family Proceedings Court made an order authorising Hull City Council to keep Georgia in secure accommodation. Further orders were made on 22nd January 2009, 6th April 2009 and 27th May 2009.

102. On 31st October 2008 Georgia was transferred from Levertonhall to Sutton Place Secure Unit ('Sutton Place') in Hull. She remained there until 17th April 2009. Georgia's case manager at Sutton Place was Barbara Rutherford. Prior to Georgia's placement in Merlin Bridge there had been no contact between her and Tanya Oliver. Contact was restored while Georgia was in Merlin Bridge. During the time Georgia was resident in Sutton Place Barbara Rutherford assisted in fostering the relationship between Georgia and Tanya Oliver and Tanya Oliver was kept informed as to Georgia's progress by staff at the unit. Lydia Jackson did not keep Tanya Oliver informed about Georgia as often as she should have done and a great deal of what happened to Georgia was never communicated to her aunt.

103. In November 2008 Barbara Rutherford prepared a report on Georgia. She identified a variety of issues for Georgia which had to be addressed and recommended psychological therapy as essential if progress was to be made. She envisaged Georgia's placement at Sutton Place 'not being short term'. Georgia wanted to return to Tanya Oliver and Scotland. During her time at Sutton Place Georgia never wavered from that. As early as November/December 2008 the plan as far as Sutton Place was concerned was for Georgia's eventual return to Scotland. Lydia Jackson had a similar long-term plan for Georgia.

104. Between 1st December 2008 and 31st January 2009 on an unspecified date a meeting took place in Newcastle between staff from the Good Shepherd Secure Unit and staff from Sutton Place regarding the eventual return of Georgia to Scotland. Hull considered the facilities offered by both the Secure Unit and the Open Unit as suitable for the future placement of Georgia. No one from Hull visited the campus at Bishopton. Hull had identified the Good Shepherd Centre from their website and had read the Care Commission Inspection Reports. Hull did not consider any other residential establishment for Georgia at any time. As Barbara Rutherford put it 'there was no Plan B'.

105. Although psychological therapy was considered essential if Georgia were to make any progress, while in Sutton Place she saw the psychologist Patrica Ross on only three occasions and refused to work with her. Thereafter her case was taken over by Dr. Lynsay Coxhall who prepared a report around the beginning of March 2009. Georgia did not engage fully with the preparation of this report. Dr. Coxhall's recommendation was that Georgia required psycho-therapy and she anticipated that at least a year would be needed for this work to be done with Georgia.

106. During her time at Sutton Place Georgia needed to be restrained on several occasions.

107. On 10th March 2009 a multi-agency meeting took place in Hull. Dr. Coxhall's report was available for that meeting. It was Dr. Coxhall's opinion and recommendation that if Georgia were to be moved from Sutton Place to the Secure Unit at Bishopton, then the transition had to be done slowly over a period of four months. She also recommended therapeutic work to assist Georgia specifically with the transition process itself. The meeting agreed that Georgia would remain at Sutton Place for a further four months to prepare her for her anticipated transition and eventual transfer to the Secure Unit. Some time after the meeting, Tanya Oliver left for a pre-arranged ten day charity trip to China.

108. Towards the end of March 2009 staff at Sutton Place were advised that due to lack of funding, the facility would be closing down within a few months. Sutton Place closed at the end of June 2009.

109. At the beginning of April 2009 Lydia Jackson was on leave. At that time, Roy Walker, manager of Sutton Place, Barbara Rutherford and Karen Robinson, Senior Social Worker, made a preliminary decision that Georgia would transfer from Sutton Place to the Secure Unit in Bishopton. No one from Sutton Place or from the social work department contacted or attempted to contact Tanya Oliver to advise her of this change of plan. The terms of Dr. Coxhall's report were not taken into consideration when that decision was made nor was Dr. Coxhall contacted for advice either before Georgia's transfer to the Secure Unit or after her transfer either by those who took the decision or by any member of staff at the Secure Unit. Her report was never sent to the Secure Unit or the Open Unit.

110. Georgia made one overnight visit to the Secure Unit on 9th/10th April 2009. After that single overnight visit, the decision was taken that Georgia would move to the Secure Unit on 17th April. Part of the rationale for that decision was that Georgia wanted to move, although she had been very distressed when she was told initially of the move. She was transferred to the Secure Unit on 21st April 2009. No therapeutic work was done either to assist any transition period nor in relation to the move itself. Dr. Coxhall was not told about Georgia's move on 21st April 2009 and when she did find out about it, was disappointed to discover that the move had been undertaken without any of her recommendations being acted on. On her return from China Tanya Oliver was advised of the imminent move, and visited Georgia at Sutton Place the evening before her move to Scotland.

111. Georgia remained at the Secure Unit until 24th August 2009. After an initial settling-in period of around ten days when there were no difficulties, her behaviour deteriorated and there were a variety of outbursts from Georgia when she needed to be restrained. During these times, she was agitated, tried

to lash out at staff, and thrashed around. She was abusive, shouted and swore, refused to listen to staff, and squealed and made strange noises, described as 'animal-like'. Restraints lasted anywhere between ten and thirty minutes, and on one occasion she was restrained for forty five minutes. During these times, her eyes were closed and her hands sweaty. Afterwards she said she had no recollection of these outbursts nor any awareness of where she was during them.

112. On 7th May 2009 Georgia ripped up a pillowcase and put the ligature she had formed round her neck in an attempt to strangle herself. This was viewed by staff at the Secure Unit as a 'cry for help'.

113. On 19th May 2009 a Secure Accommodation Review was held at the Secure Unit. Various representatives from Hull attended this meeting and reports were available from staff in the Secure Unit. The meeting concluded that Georgia continued to meet the criteria for secure accommodation.

114. Jill Neil was one of Georgia's care team at the Secure Unit. In a report dated 24th June 2009 she stated that Georgia continued to meet secure criteria. Further he opinion was that on 23rd July 2009, the date of the next Secure Accommodation Review, Georgia continued to meet secure criteria.

115. Sometime between 24th June 2009 and the end of July 2009 a decision was taken by Hull that Georgia should be moved from the Secure Unit to the Open Unit, and that no application would be made to Hull & Holderness Family Proceedings Court for a further secure order. The order granted on 27th May 2009 was due to expire on 27th August 2009.

116. On 3rd July 2009 a heated discussion took place between Tanya Oliver and Lydia Jackson at the Secure Unit during which Tanya Oliver expressed her serious concerns to Lydia Jackson about any proposed move for Georgia from the Secure Unit to the Open Unit.

117. On 10th July 2009 Tanya Oliver received a letter from Lydia Jackson advising her that notwithstanding her concerns, the plan to move Georgia to the Open Unit would be implemented, prior to the expiry of the existing secure order on 27th August 2009.

118. On 23rd July 2009 a Secure Accommodation Review concluded that criteria for Georgia's accommodation in secure facilities continued to be met. At the meeting Tanya Oliver was vocal in advising the meeting of her concerns about moving Georgia to the Open Unit. She expressed her opinion that none of the issues identified as being essential for Georgia's progress had been addressed. She wanted Georgia to move to the Close Support Unit as a stepping-stone from secure to open conditions, when the time came that she no longer met secure criteria.

119. A transition plan was worked out between Sue Ainley, Team Leader at Hull and Lydia Jackson to accommodate Georgia's anticipated move from the Secure Unit to the Open Unit. This was the first time that such a transition had taken place between these two units. Neither Sue Ainley nor Lydia Jackson visited the Open Unit prior to drawing up the transition plan and there was no discussion with the Open Unit as to where Georgia would be accommodated on her transfer there.

120. At the start of the transition period on 4th August 2009 Georgia absconded from the Open Unit after another resident at the Open Unit AM had behaved aggressively towards her. Staff followed her to Bishopton, but she refused to return to the Open Unit. In Bishopton, she jumped repeatedly in front of moving vehicles. Staff were unwilling to attempt to take hold of her because of safety issues. They called the police. Georgia was in considerable distress, making 'animal noises' and running into a garden. She had to be handcuffed before being taken back to the Secure Unit by the police. Staff at the Open Unit thereafter expressed serious concerns to management about the advisability of Georgia's move to the Open Unit. Although in light of the events of 4th August 2009 the transition plan was revised slightly in that the date for the actual transfer was brought forward by

three days, the decision to move Georgia from the Secure Unit to the Open Unit before the last secure order expired on 27th August 2009 was not changed.

121. Between 23rd July and 23rd August 2009 Georgia was visited by Tanya Oliver who thought that Georgia had regressed.

122. Georgia was transferred to the Open Unit on 21st August 2009. Her placement at the Open Unit at that time was not appropriate. She continued to meet the criteria for secure accommodation.

Georgia at the Open Unit

21st August 2009 – 4th October 2009

123. From August 2009 until her death, Georgia was the victim of a sustained and increasingly violent campaign of bullying by another resident AM. The incidents of which staff became aware or witnessed were recorded in the Unit Log to which all staff had access. On 1st September 2009 when Liz Wilson a care worker at the Open Unit was told by Georgia of an incident that had happened on 31st August she reported the matter to Liz Anne Davenport. Management were aware from the outset of the escalating situation.

124. As a result of episodes of verbal intimidation and physical violence directed at her, described by a member of staff as being 'a daily occurrence', Georgia was frequently very upset and anxious. She absconded from the Open Unit on many occasions.

125. She absconded on 7th September but did not leave the grounds. On 8th September when the girls were in the school, AM intimidated Georgia by hiding a pair of scissors in the waistband of her jeans but ensuring that Georgia knew the scissors were there. AM was excluded from the classroom. She was abusive to staff.

126. On 8th September 2009 Liz Anne Davenport requested of and was granted additional funding by Fife Council, AM's placing authority, for additional funding to enable AM to be monitored and supervised on a one to one basis for a period of 5 to 6 days.

127. On 9th September AM screamed at Georgia and accused her of something which she had not done. On 10th September a further incident occurred when AM behaved in a threatening and aggressive manner to Georgia.

128. On 13th September 2009 when the girls were going to the swimming pool AM told Georgia that when they got to the pool she was going to drown someone. The clear implication was that AM was going to try to drown Georgia. Georgia was very upset and refused to go on the outing. When staff were made aware of the situation, AM became exceedingly aggressive and abusive towards them. She started to smash Georgia's bedroom window in 'the wee flat', shouting that she was going to kill her. It took staff approximately 45 minutes to contain AM and ensure her return to the building. Georgia absconded from the Open Unit and made her way to the Secure Unit, trying to get back in. She was returned by a member of staff. She was extremely distressed. This incident was reported to the police. Later that evening Georgia again left the Open Unit, saying that she was not going to remain in the unit for AM to stab her in the face with a piece of glass.

129. On 15th September 2009 AM accused Georgia of having 'grassed' her for having 'hash' on 14th September. There was no truth in the accusation. Georgia was intimidated by AM on this occasion.

130. On Sunday 19th September 2009 at around 2000 Georgia absconded with AM while on an outing to Paisley with staff from the Open Unit to buy carry out meals. She went to a house in Ferguslie Park, Paisley. She was returned to the Open Unit by the police at 0050 on 20th September 2009.

131. At approximately 2330 on Saturday 25th September 2009 Georgia placed items under her duvet to give the impression she was in bed, and absconded. She was returned to the Open Unit the next day by the police whom she had contacted. She had gone allegedly to Greenock to meet up with friends.

132. On 26th September 2009 AM threatened Georgia and told staff that she would have put Georgia's head 'through a fucking window' if a certain member of staff (Karen Kydd) had not been working a long shift. Some 45 minutes later Georgia absconded. On this occasion she met up with CMS a resident in the CSU. Both girls ran to the railway station at Bishopton and boarded the train for Glasgow. They hung about the centre of Glasgow and were then approached by an older man in a car who took them to a block of flats (location unknown). He gave them alcohol and drugs. Both became extremely intoxicated. They spent the night in the flat and during the night they had a conversation about committing suicide as neither girl thought that she had anything to look forward to in her life. CMS would have been too scared to kill herself but she thought that Georgia was serious about wanting to die. CMS knew that Georgia was being bullied by AM in the Open Unit.

133. The following morning (Sunday 27th September 2009) at their request the unknown man drove them to Alloa, where CMS had family. He left them at the bus station and they subsequently went to the police. Standby Social Work were contacted and the two girls were taken back to their respective units at the Good Shepherd. In the course of the journey, Georgia expressed a desire to be back in the Secure Unit. She said she had felt safer there. Georgia said she did not want to go back to the Open Unit because of AM's bullying and because she was unhappy with the way staff were treating her.

134. On arrival at the Open Unit, Georgia said to CMS that she would not see her again. CMS asked Georgia to promise that she 'wouldn't do anything stupid' but Georgia refused to give her that promise. CMS told staff at the

CSU about this conversation. There was no evidence that this information was communicated to any one at the Open Unit.

135. When CMS returned to the CSU after this period of absconding, she was almost immediately thereafter transferred to the Secure Unit where she remained until April 2010.

136. After Georgia's return on 27th September 2009, Karen Kydd, made an entry in the Unit Log that Georgia needed to be moved from 'the wee flat' to accommodation upstairs the following morning i.e. Monday 28th September. Karen Kydd had wanted the move to take place that evening as a matter of urgency, but other residents were angry with Georgia because she had absconded and it was not considered appropriate to make the move that evening. Sandy Cunningham agreed that Georgia should be moved out of 'the wee flat' the next day. He did nothing to ensure that his decision was acted upon and subsequently acquiesced when it was not.

137. Georgia was not moved from 'the wee flat'. Between 28th September and 4th October 2009 no measures were put in place to address Georgia's increasing pattern of absconding, and high risk behaviour when she was at liberty.

138. On 28th September 2009 Georgia was subjected to a prolonged period of bullying and intimidation by AM. On Tuesday 29th September Karen Kydd noted in the Unit Log that there were concerns about child protection issues in relation to Georgia. She contacted Hull and advised them of Georgia's continued threats to abscond. Karen Kydd viewed the situation as untenable. Nevertheless no measures were put in place by management to end the bullying nor was any action taken by Hull at that time.

139. At 1110 on 29th September 2009 Georgia left the building, stating that she was going to Glasgow to meet friends. She boarded the 1205 train from Bishopton to Glasgow.

140. At around 0715 on 30th September 2009 police at Maryhill contacted the Open Unit to advise that Georgia had presented herself at Maryhill Police Office. Staff from the Open Unit collected her. Georgia had been away from the Open Unit for more than 20 hours.

141. On 30th September 2009 Karen Kydd spoke on the telephone to Sue Ainley at Hull and expressed her concerns about Georgia's behaviour. She was advised that a new social worker had been appointed for Georgia and that it was intended she would visit the Open Unit with Lydia Jackson within possibly the next two weeks.

142. In September 2009, staff at the Open Unit recognised that they could neither effectively contain AM nor keep Georgia safe. When faced with a situation of sustained bullying resulting in frequent and high risk taking absconding over the month of September 2009, management at the Open Unit were complacent. No steps were taken to request AM's placing authority to remove her immediately nor was Hull contacted by management with a request that Georgia be moved from the Open Unit.

143. During the month of September 2009 Tanya Oliver was never informed by any member of staff at the Open Unit of Georgia's repeated absconding nor of the bullying campaign by AM, nor did any member of the social work department in Hull alert her to the situation at the Open Unit.

Risk Assessment

144. No 'stand alone' risk assessment was ever done on either Niamh or Georgia by their placing authorities nor by any of the residential establishments in which they were placed. Had such an assessment been carried out, regularly updated, and accompanied each girl to the various establishments in which she was placed, then management and staff charged with their health and safety would have had a readily accessible and comprehensive document as a valuable tool to assist them in their

responsibilities and to alert them to the risks which pertained, whether those were in relation to absconding, self-harm or suicide.

Personae

Evidence at the Inquiry was led on behalf of the Crown for the public interest by John Watt, Area Procurator Fiscal. The following parties were represented:

1. Transport Scotland by Mr. Watt, solicitor.
2. Social Care and Social Work Improvement Scotland (known as such at the outset of the Inquiry, then as The Care Inspectorate, having been formerly called The Care Commission) by Mr. McClure, solicitor. For the purposes of this Determination I have chosen to refer to the body as The Care Commission
3. Hull City Council (formerly Humberside) by Mr. Pollock, Solicitor
4. East Ayrshire Council by Miss Gilmore, Solicitor
5. Argyll and Bute Council initially by Miss McGowan, Solicitor and latterly by Miss McFarlane, Solicitor
6. The Board of Management, Good Shepherd, by Mr. Jackson, Advocate
7. Tanya Oliver, maternal aunt of Georgia, by Mr. Cheyne, Advocate
8. Colette Bysouth, mother of Niamh, by Mr. Gilbride, Advocate.

In addition, at a later stage in the Inquiry, Lydia Jackson, Social Worker, Hull City Council, was represented by Mr. McNair, Solicitor, though in the event he asked no questions and made no representations.

I am grateful to the procurator fiscal and to counsel and solicitors for their assistance throughout the Inquiry and for the submissions provided after the conclusion of the evidence.

Witness who gave evidence

1. Colette Bysouth, mother of Niamh
2. Ashleigh Elanor Bysouth, maternal aunt of Niamh
3. Tanya Rowe, maternal aunt of Georgia
4. Yvonne Bailey, Foster Manager, Merlin Bridge Children's Home, Hull
5. Barbara Lucy Rutherford, Retired, former Deputy Manager of Sutton Place Secure Unit, Hull
6. Tina Lowther, formerly Family Support Worker, now Social Worker with Hull
7. Janice Barmby, formerly Team Manager, now Professional Development Manager with Family Unit, Hull
8. Susan Ainley (referred to as Sue Ainley), Team Manager, Child and Young Person Services, Hull
9. James O'Kane on the Erskine Bridge on 4th October 2009
10. Irene Livingston on the Erskine Bridge on 4th October 2009
11. Gordon Andrew Eastwood on the Erskine Bridge on 4th October 2009
12. Beverley Susan Cotterel on the Erskine Bridge on 4th October 2009
13. Margaret Lavain (known as Dawn), Retired, formerly Social Work Assistant, East Ayrshire Council
14. Alison Jane Wallace, Team Manager, Social Work, East Ayrshire Council
15. Lisa Miller, Social Worker and Family Therapist, North Ayrshire Council
16. Ami Jane Parsons, Mental Health Nurse Humber NHS Trust
17. Patricia Ross Clinical Psychologist, Humber NHS Trust
18. Sandra Leonard, Social Worker, formerly with Argyll and Bute
19. Deborah Wicks, Social Worker with Argyll and Bute
20. Gary Cronin on Erskine Bridge on 4th October 2009
21. Adah Lambie, formerly Team Leader, now Social Worker with Argyll and Bute
22. Joy Daniels, Area Children's Manager, Argyll and Bute
23. William Moore, Children's Placement Manager, Argyll and Bute
24. Lisa Patricia Wilson Senior Social Care Worker at East King Street Children's Unit, Argyll and Bute

25. Thomasina Park, Acting Senior Social Care Worker at East King Street Children's Unit. Argyll and Bute
26. Veronica Mahoney, Acting Team Leader with Through Care Team Argyll and Bute
27. Anne Berry, Social Care Worker Argyll and Bute
28. Sylvia Anne Rennie, Operations Manager, Up2Us
29. Dorothy Richmond Counsellor
30. Rosemary Murray, Worker with Who Cares? Scotland
31. Lynn McDonald, Social Care Worker, East King Street Children's Unit Argyll and Bute
32. Loren Ford, Social Care Worker (bank), in East King Street Children's Unit, Argyll and Bute
33. Sarah Middleton, Retired, formerly Social Care Worker (bank) in East King Street Children's Unit Argyll and Bute
34. Mark Edward Lines, Social Work Manager, Argyll and Bute
35. Catriona Thomson/Taylor, Retired, formerly Senior Social Care Worker, East King Street Children's Unit Argyll and Bute
36. Nancy Porter, Unit Manager at East King Street Children's Unit, Argyll and Bute
37. Sarah Jane Menzies Social Work Assistant Argyll and Bute
38. Mary Walker, formerly Independent Reviewing Officer, now Team Leader Argyll and Bute
39. Alexander McKenzie Taylor, Social Work Manager, Argyll and Bute
40. Douglas Dunlop, Head of Service for Children and Families and Criminal Justice, Argyll and Bute
41. Peter Smith, Minister of Religion, Chairperson of CORA
42. Roisin McGoldrick, Lecturer and Chairperson (since October 2009) (formerly Vice-chairperson) of the Board of Management at the Good Shepherd Open Unit
43. Maria Harte, Head of Secure Unit, at the Good Shepherd Centre
44. Maxine Barr, formerly Residential Service Manager at the Good Shepherd Centre Secure Unit
45. Kathleen Anne McAuley, Unit Manager, Good Shepherd Secure Unit

46. Clare McCormack, Assistant Manager Unit 1, Good Shepherd Secure Unit
47. Duncan McDougall Shaw, formerly Residential Worker at Good Shepherd Secure Unit
48. Jill Melvin Neil, Residential Social Care Worker Good Shepherd Secure Unit
49. Louise Morrison, Acting Unit Manager, Unit 1 Good Shepherd Secure Unit
50. Wilma McEwan, Support Worker, Unit 2 Good Shepherd Secure Unit
51. Karen Lapsley, Service Manager at Hansel Alliance, formerly at Unit 1 Good Shepherd Secure Unit
52. Craig Evans, Residential Social Care Worker, Unit 1 Good Shepherd Secure Unit
53. Tracy Margaret McNab, Programmes Worker, Good Shepherd Secure Unit
54. Lee Fuller, Residential Social Care Worker, Good Shepherd Secure Unit
55. Lynn Carol McDonald, Social Care Worker, Unit 2, Good Shepherd Secure Unit
56. Liz Anne Davenport, Social Worker, Inverclyde Council, formerly Care Manager Good Shepherd Open Unit
57. Marjory Thompson, Support Worker at St. Mary's Kenmure, formerly Residential Care Worker at Good Shepherd Open Unit
58. James Boyle, Social Care Worker at Good Shepherd Secure Unit, formerly in the Open Unit
59. Cher McCarthy, Residential Social Care Worker at St. Mary's Kenmure, formerly at Good Shepherd Open Unit
60. Helen Boyle, Support Worker at Stepdown Community Services, formerly Residential Care Worker at Good Shepherd Open Unit
61. Georgina McBean, formerly sessional Support Worker at Good Shepherd Open Unit
62. Margaret Docherty, formerly Team Leader at St. Francis' Day Unit Good Shepherd Centre, now Social Worker with Simon Community, Glasgow
63. Karen Kydd, Shop Assistant, formerly Senior Social Care Worker at Good Shepherd Open Unit

64. Elizabeth Patricia Wilson, Residential Child Care Worker with Glasgow City Council, former at Good Shepherd Centre Open Unit
65. Martha Fraser, Retired, formerly Social Care Worker at Good Shepherd Open Unit
66. Mary Stewart, Residential Child Care Worker, formerly at Senior Social Care Worker and Night-Coordinator, Good Shepherd Open Unit
67. CMS, young person, formerly resident at Good Shepherd Close Support Unit
68. Geraldine Foley, formerly Residential Care Worker Good Shepherd Open Unit
69. Carol Dearie, Deputy Head, Good Shepherd Secure Unit
70. Ashleigh Gray, formerly Residential Social Care Worker
71. Alexander Cunningham, Education Officer Glasgow City Council, formerly Head of Open Residential and Community Centre at Good Shepherd Open Unit
72. Lydia Anne Jackson, Complaints Co-ordinator, formerly Social Worker Hull
73. Kirsty Bremner, Chartered Forensic Psychologist, formerly at St. Mary's Kenmure and Good Shepherd Secure Unit
74. Donna Gillespie, Nurse Therapist, CAMHS, Renfrew
75. Gillian Fraser, Consultant Clinical Psychologist, CAHMS, Renfrew
76. Fiona Brennan, A & E Doctor at Royal Alexandra Hospital in 2009
77. William Brown, General Practitioner, Helensburgh
78. Lynsey Coxhall,, Clinical Psychologist, Humber NHS Foundation Trust
79. Edward Jeffries, Retired, formerly Principal Educational Psychologist with Argyll and Bute Council
80. Jason Fang, General Practitioner, Helensburgh
81. William Valentine, Chief Bridge Engineer with Transport Scotland
82. Jane Weir, Retired, formerly Care Commission Officer
83. Lawrence O'Connor, Retired, formerly Educational Psychologist at St. Mary's Kenmure
84. Stephen David Platt, Professor of Health Policy at the University of Edinburgh

85. Anne Sheila Fraser, General Practitioner, Lochwinnoch, formerly locum at Bishopton

Affidavit evidence was also received from the following:

- 86. Sheila Ingram
- 87. Patricia Jarvis
- 88. Heather Fisher
- 89. Diane Ayre
- 90. Patricia Ann McKee
- 91. John Matthew Dunn
- 92. David Norris
- 93. William Chippendale
- 94. Jacqueline Postill
- 95. Rebecca Blampley

NOTE

Although this Inquiry arose out of the deaths of Niamh and Georgia on 4th October 2009, the evidence covered events in both girls' lives for some years prior to that date. Niamh had lived with either her mother or her father until she went into care on a voluntary basis in June 2008. On 8th August 2008 she was made subject to compulsory measures of care and apart from a few days in February 2009, Niamh remained in care until her death. Although since the age of 10 months until June 2008 Georgia had lived in family with her maternal aunt and two of her four half-siblings, she had for all of her life been subject to court orders and under the care of Hull City Council (formerly Humberside). From 19th June 2008 until her death Georgia remained in care at a variety of foster homes and residential establishments. As a result of these arrangements for both Niamh and Georgia, the Inquiry heard from many witnesses whose involvement ranged from the day-to-day care of the girls in residential establishments, to responsibility for management of such establishments.

Evidence was led from social workers, and management from both Argyll & Bute and Hull. In additions, the Inquiry heard from psychologists, general practitioners, hospital doctors, and from Professor Platt, Professor of Health Policy at the University of Edinburgh who had prepared a report at the request of the Crown. The Inquiry heard evidence from Niamh's mother and her maternal aunt, and from Georgia's maternal aunt who had looked after her for most of her life prior to June 2008. Given the breadth of the evidence before the Inquiry, I have attempted in what follows to focus on evidence in relation to the matters raised in the formal determination and to expand as appropriate on those matters in respect of which I have made Findings-in-Fact.

Although the Inquiry examined the lives of Niamh and Georgia in some detail, the determination under Section 6(1)c is restricted to two reasonable precautions which, had they been taken as at 4th October 2009, may have avoided the deaths of these young girls on that day. The matters which I have listed under Section 6(1)(e) relate broadly as to how Niamh and Georgia came to be in the Open Unit in October 2009 and also to specific issues e.g. the bullying of Georgia by AM, which arose during their accommodation there. Had different decisions been taken at earlier stages, it may have been that neither Niamh nor Georgia would have been accommodated in the Open Unit on 4th October 2009. Indeed, it is perfectly possible that had other decisions been taken in relation to their time in care, they would never have met. The fact is however that they did meet, were living in 'the wee flat' at the same time, and on the evening of 4th October 2009 chose to leave there and walk the three miles or so to the Erskine Bridge. After sitting briefly on top of the barrier on the west side of the bridge, facing away from the water, they linked arms and fell backwards into the water. With the exception of Mr. Pollock on behalf of Hull who submitted I should not hold Georgia's death to be suicide, all parties were agreed the deaths to be suicides. I had no hesitation, in light of all the evidence, in concluding that Niamh and Georgia were well aware of what they were doing, and the consequences for them. They chose on 4th October 2009 to take their own lives, although the reasons for doing so on that particular day, and together, will never be known.

The matters under Section 6 (1) (e) I consider both relevant and material, but without that necessary causal connection which is required for any matter to come within the ambit of Section 6 (1) (c).

Some weeks after the conclusion of the evidence, I was provided with written submissions on behalf of all parties represented, with the exception of Miss Lydia Jackson. Those submissions I found of assistance and I gave consideration to appending them to this determination. However, I decided against that. Despite the wide-ranging nature of the evidence, the focus could only ever be on the latter part of the lives of Niamh and Georgia, not on the whole. However, I hope that any person reading this determination will be able to follow the particular sequence of events in the lives of Niamh and Georgia which led to the tragedy of 4th October 2009.

I have covered what I consider the relevant issues in what I trust is sufficient detail to enable the reasoning behind my findings and conclusions to be understood. I have chosen not to rehearse the evidence in great detail and have left out many incidents in their entirety. Some details I have included where I consider them of significance, but I have tried to be selective in my general approach to the issues I considered relevant. Where there were disputes in the evidence which were material to this determination, I have set out my reasons for preferring one version over another.

I hope too that those responsible in whatever capacity for the policy and practice of the care of young persons in Scotland may find something of value in this determination which will assist them in their task of caring for the most vulnerable, complex and challenging of young people who become looked after and accommodated children in our society.

First of all I set out some brief biographical notes for Niamh and Georgia, from birth until June 2008 and thereafter in a series of headings provide some discursive material arising out of the evidence before the Inquiry.

(1) Short biography of Niamh

Niamh was born in Alexandria on 18th June 1994. She was the daughter of Colette Alison Bysouth and Paul Lafferty (also known as Paul Szeles). Her father died on 3rd September 2010 at his own hand. Niamh's parents separated when she was about 2. Part of their time together was spent in London. For the next few years, Niamh stayed with her mother and remained in regular contact with her father and her paternal grandparents. Her mother formed another relationship, as a result of which Niamh has two half-sisters. Niamh lived in family with her mother, her step-father and her two sisters. Niamh's mother was at all times a loving and concerned mother who always had her daughter's best interests at heart. Niamh had a close bond with her father and as she grew older was consistent in her wish to live permanently with him. At least part of her disruptive behaviour at home, at school and in the community had as its aim a desire for her mother to 'throw her out of the house'. Her mother was never prepared to do that. Niamh, whether in care or at home, could be difficult and demanding. She did not make life easy for those involved in her care. She could also be good company and fun. Niamh lived with her father between 2007 and 2008. In 2006, when she was at her father's house, she witnessed the aftermath of an extremely violent incident in which her father was repeatedly stabbed and ended up in intensive care, and another man Brian Fallon was killed. Paul Lafferty was subsequently tried for the murder of Brian Fallon and was acquitted. At the time Niamh was traumatised by what she had witnessed. That extremely violent incident and its aftermath (Niamh was cited as a Crown witness in her father's murder trial though in the event not called to give evidence) undoubtedly impacted on Niamh's future behaviour. It was unfortunately never properly investigated principally as a result of her failure to engage with any therapeutic work available to her. She became a friend of the daughter of

the man whom her father had killed and she also started hanging about with a group of young people in Helensburgh who were known for drug taking, underage drinking, and generally delinquent behaviour.

As well as being a man of violence, Paul Lafferty took illegal drugs, including heroin. He was never at any time able to provide the appropriate guidance to his daughter or establish boundaries for her behaviour. One stark example is his encouragement of his young daughter in her sexual relationship with Jonny McKernan who took drugs, was attracted to violence and had faced criminal charges. He was dismissive of Niamh's mothers concerns about the relationship. Although Colette Bysouth also had very serious and justified concerns about Paul Lafferty's ability to care for Niamh properly, she also recognised that Niamh loved her father and that her preference was to live with him, where the discipline was effectively non-existent and she would have the opportunities to live the lifestyle she wanted. Niamh's often expressed determination to live with her father was a matter to which unfortunately Argyll and Bute Social Work Department for a long time gave unjustified credence.

When he came out of hospital in March 2009, having presented himself to the psychiatric unit on the day of Jonny McKernan's funeral, Paul Lafferty left Scotland to live in Denmark. Niamh had telephone contact with him after that when she was in the Secure Unit, but no direct contact. It was a condition of her supervision requirement order that she had only supervised telephone contact with her father. The fact that shortly after March 2009 the decision was taken that Paul Lafferty was to have no direct contact with his daughter is eloquent of the wholly unrealistic assessment of his abilities as a father made by Argyll and Bute, during the course of 2008, and in particular when Adah Lambie recommended to the panel on 13th February 2009 that Niamh return to his care.

Niamh commenced her secondary education at Hermitage Academy, Helensburgh in August 2006. On 19th June 2008 after a period of time when she had been living at her father's house, she went into the care of Argyll and

Bute Council voluntarily. She was admitted to East King Street Children's Unit Helensburgh. From that date until her death she was with the exception of a few days in February 2009 never out of residential care.

(2) Short biography of Georgia

Note: I will refer to Tanya Oliver as Tanya in this section of my note. She was often referred to simply by her first name in the course of the evidence and to refer to her as Georgia's maternal aunt does not accurately reflect her role in Georgia's life.

Georgia was born in Hull on 13th February 1995. She was the fifth child of Mandy Oliver. The identity of her father is not known. Male twin half-siblings were adopted outwith the family. Her older half brother and older half sister were adopted by her maternal aunt Tanya Oliver prior to Georgia's birth. In around the summer of 1995 Tanya who was married to Clarke Rowe at that time received a telephone call from Hull Social Work Department advising her of the existence of Georgia (then called Terrie). She did not hesitate to offer her a home. On 16th November 1995 Kingston upon Hull Family Court made a Care Order in respect of Georgia in terms of Section 31 of the Children Act 1989 in favour of Humberside County Council (predecessor of Hull City Council) and made an order authorising Humberside County Council to refuse contact between Georgia and her natural mother. Both orders remained in force at 4th October 2009. At the age of 10 months Georgia was placed in foster care under that order with Tanya and her husband who lived in Sorn, Ayrshire. This marriage was a second one for Tanya's husband and he had three children from his first marriage. Those three plus Georgia's half-brother and half-sister as well as Georgia all classed themselves as brothers and sisters.

Tanya and her husband separated in August 2002 and were subsequently divorced. They had been together for eighteen years, and the separation and

the time which followed it was a difficult one for the whole family. Georgia took the separation badly as she had been very attached to her Dad and she tended to blame Tanya for the break-up of the marriage. It was Tanya's intention to adopt Georgia, as she had her two half-siblings. Their natural mother had contested the adoptions and Tanya was anxious not to go through that difficult process (which had been resolved not that long before Tanya was told of Georgia's existence) again. She wanted Hull to arrange for Georgia to be freed for adoption but, for reasons that never became entirely clear in the course of the inquiry, that did not happen. Certainly Tanya did not push for the adoption, and Hull in turn took no legal action to change Georgia's status. However at home, Georgia was treated no differently from her two half-siblings and she was loved and cared for by Tanya, and indeed other members of the extended family, often in very trying and difficult circumstances. As far as Tanya was concerned Georgia was her daughter.

Georgia, like her brother and sister, was brought up in the knowledge of her origins and how she came to be with Tanya in Ayrshire. She knew that Tanya was not her birth mother. Georgia became aware for the first time that she had not been formally adopted by Tanya during the course of a meeting with a social work assistant in Hull when she was about seven. The assistant, without ascertaining beforehand what Georgia knew of her origins or status, asked Tanya in the presence of Georgia whether she intended to proceed with Georgia's adoption. The Inquiry heard evidence that on occasion Georgia could be upset and angry that she had not been adopted. She was not averse however to telling professionals involved in her care and assessment that she had not known that Tanya was not her mother until she was older. It was clear that Georgia had been brought up in full knowledge of her origins and Dawn Lavain who worked with Georgia on her 'Life Story Book' gave evidence of how cooperative Tanya Oliver had been with this process, and how much information and material she had given to the exercise. There was also evidence that Georgia could be manipulative and be prepared to tell lies when she thought that might be to her advantage e.g. she told her foster-carers Mr. & Mrs. Postill that unlike her sister she had not been sent to a private school, which did not accurately reflect the true

situation. Georgia benefitted materially from the allowances which Tanya received for her from Hull. She enjoyed many activities such as ski-ing, horse-riding and drama lessons, and as time passed with no movement on the adoption, it may well have suited Tanya Oliver to leave matters as they were. There was no evidence that Georgia was treated differently from her brother and sister.

Georgia attended primary school in Sorn. After the separation in 2002, her behaviour, which Tanya described as having always been 'a little different but nothing to worry about', changed. She started to tell lies and she went missing on a few occasions. At a young age she started to show an interest in boys. She commenced her secondary education at Notre Dame High School in Glasgow in August 2006. Her sister attended Glasgow Academy and Georgia was offered the opportunity of attending there but deliberately did badly in the entrance examination and as a consequence was not offered a place.

Georgia's difficult behaviour continued. She truanted from school, was violent and aggressive in her behaviour at home and was also sexually precocious. Complaints were received at her secondary school about her behaviour. Tanya sought and received support from social work staff at East Ayrshire Council throughout these difficulties. At different times, referrals were made to CAMHS (Child and Adolescent Mental Health Service) and Georgia and Tanya attended some appointments. East Ayrshire Council carried out their duties in respect of Georgia diligently and with care. They communicated information as appropriate to Hull and Dawn Lavain in particular provided support and assistance to both Tanya and Georgia when appropriate. She was aware of how difficult and challenging Georgia's behaviour could be and was worried about the aggression being shown by Georgia to Tanya and to her sister in particular. Dawn Lavain described Georgia's increasingly difficult behaviour as resulting in Tanya, who was working full-time and did not always enjoy the best of health, being 'at the end of her tether'.

A crisis point was reached in June 2008. Tanya had a meeting with the headmistress of Georgia's school and also with a general practitioner. As a result of grave concerns over Georgia's violent behaviour, directed especially towards her, as well as to her brother and sister, Tanya decided that she needed some respite and on 19th June 2008 Georgia was removed from Sorn. She spent that night at the home of a friend of Tanya in Darvel. The next day she returned to her home in Sorn to collect some personal items. She was then taken to Jedburgh. She never returned to her home in Sorn.

In June 2008 Tanya did not consider the possibility of Georgia being taken from Ayrshire to Hull, nor did anyone from Hull discuss that with her. Georgia had no relatives in the Hull area who were in a position to care for her. She had no links to that area. She had spent practically all her life in Ayrshire. She spoke with a Scottish accent. What Tanya had hoped for was a short period of respite for her and also Georgia's brother and sister, and for Georgia to have the opportunity of spending a short time away from the family home. Prior to the move on 19th June 2009, Tanya had been looking at various options for Georgia to spend some time over the holiday period at a residential summer camp and had discussed this possibility with Hull. When Georgia was taken from Ayrshire after her overnight stay with a family friend in Darvel, no one from Hull informed Tanya of where Georgia was to be taken. When Georgia was moved from Jedburgh after her weekend stay there, Tanya Oliver was given no information by Hull as to Georgia's next move.

(3) Role of East Ayrshire Council

Hull made arrangements for Strathclyde Regional Council and thereafter East Ayrshire Council as successors to Strathclyde Regional Council to undertake the day to day supervision of the placement of Georgia on their behalf. The original plan had been for adoption but that did not happen and Georgia remained 'looked after' by Hull by virtue of the Section 31 Care Order. East Ayrshire Council were never legally responsible for Georgia as a 'looked after' child in terms of Section 25 of the Children (Scotland) Act 1995. The only

statutory obligation that East Ayrshire Council had in relation to Georgia was the duty to promote her welfare, as a child in their area, in terms of Section 22 of the 1995 Act

Although there was no impediment to the transfer of social work responsibility, which could have been done in accordance with The Children (Reciprocal Enforcement of Prescribed Orders etc. (England and Wales and Northern Ireland) (Scotland) Regulations 1996 (SI 1996/3267) such a request was never made by Hull. Had such a transfer taken place Georgia would have become a 'looked after' child in Scotland by virtue of Section 17(6)(d) of the Children (Scotland) Act 1995 and would have become subject to a supervision requirement in terms of section 52(2) of the 1995 Act. No explanation was given to the Inquiry as to why such a transfer did not take place. It is unfortunate that no steps were taken by Hull to transfer responsibility. East Ayrshire Council were 'on the doorstep' and throughout had provided a high standard of care and commitment to Tanya and Georgia. Referrals were made to CAMHS as appropriate and staff visited more than the statutory requirement of every three months. Had such a transfer taken place, then Georgia would never have gone to Hull – a move which it was accepted by Lydia Jackson and was clear from the evidence was an unmitigated disaster for Georgia. The Inquiry heard evidence that no suitable foster placement was available in Ayrshire in the middle of June 2008, but the Inquiry was also advised that Mr. and Mrs. Chippendale, the foster-carers in Jedburgh, could have kept Georgia for two weeks. That 'breathing space' would have given Hull time to analyse the whole situation and continue to look for an appropriate placement for Georgia in Scotland. The move to Hull in June 2008 may have been taken initially on a misunderstanding of Georgia's connections with the area, though it is hard to know how that could have happened, given the long involvement Hull had had with Georgia's care. There was also perhaps undue weight given to Georgia's wish to go there. However, within a short period of time, Hull should have re-assessed the situation, especially when the first foster placement in the area broke down so quickly. Lydia Jackson was aware at the time that Georgia was being moved from what she described as a 'high-end' lifestyle to inner-city living and inner-

city opportunities for alcohol/drug abuse and meeting up with delinquent young people. Hull also became aware in the summer of 2008 that somehow Georgia had managed to make contact with her birth mother – something that Hull had not wanted to happen for thirteen years. Despite the good work that East Ayrshire Council had done for all that time, within less than a week of Georgia leaving Ayrshire, their involvement was at an end, the case was closed, and Hull never contacted East Ayrshire Council again.

(4) The Good Shepherd Open Unit at Bishopton

Finding in fact 16 refers to the cancellation on 5th July 2010 of the registration of the Open Unit with the Care Commission. The Open Unit closed in 2010. Although there was evidence that as far back as 2008/2009 plans were being considered to build a completely new facility on the Open Unit site at Bishopton, and that certain funding was available, the plans have so far not materialised. The Secure Unit and the Close Support Unit do however continue to operate on the existing campus. Much therefore in this determination will be of no practical application as far as the Good Shepherd Open Unit is concerned.

Prior to the summer of 2009, a large section of the building in which the Open Unit was housed was closed off, and by the summer of 2009 the residential facility was contained in a flat on the first floor which comprised the living/dining/kitchen accommodation, as well as the bedrooms and bathroom and toilet facilities. There was also an office on the first floor. The laundry facilities were contained in another part of the building. There were additional bedroom and toilet facilities in a self-contained unit known as ‘the wee flat’, which was on the ground floor of the same section of the building

Many of the staff who gave evidence to the Inquiry had worked on the campus for many years, working long hours, and often faced with very difficult situations arising out of the volatile and often abusive behaviour of the young girls for whom they were providing care. Martha Fraser, for example, prior to

her retirement, had worked there in excess of thirty years, and had chosen to return to work on a sessional basis after all those years of service.

(5) Recommendations made and Decisions taken by Argyll and Bute Council in relation to Niamh until from 18th June 2008 until 27th July 2009

(a) 18th June 2008 until 13th February 2009

Niamh went into care on a voluntary basis on 18th June 2008 and was initially placed in East King Street. Almost immediately however it became apparent that she could not be kept safe there, given her links to a group of young people in Helensburgh who tried to 'get her out' of the home. She was therefore moved to the Open Unit where she remained until February 2009. During that time, Argyll and Bute's long term plan for Niamh was that she be returned to the care of her father. At best, the social work department had a totally over-optimistic view of his capabilities. Given the evidence heard, it is exceptionally difficult, if not impossible, to understand the thinking which led to the belief that Paul Lafferty was ever going to be a suitable carer for his young daughter.

There is no doubt that Niamh had a very strong and often expressed wish to stay with her father but at no time did Argyll & Bute Social Work Department carry out a risk assessment in relation to Paul Lafferty. That might have been a sensible starting point and had they carried out such an assessment, it would have been clear to them at a much earlier stage than February 2009 that he was not and was never going to be a suitable carer for his teenage daughter. By the time of the Family Conference in November 2008 on which too much weight seems to have been placed by the social work department (it was no more than a 'round the table' meeting of those with an interest in Niamh's welfare), it should have been obvious to the social workers that Paul Lafferty should no longer have been considered as a potential carer for Niamh. Although on occasion he would attend meetings and 'say the right

things', there were many times when he did not attend appointments, and at the Family Conference in November 2008 there was at least the suggestion that he was under the influence of drugs. The social work department were well aware of his background and his behaviour, and yet they persisted in considering him as a potential carer in their plans for Niamh.

Sandra Leonard impressed as a thoughtful and caring social worker who recognised in her evidence the unsuitability of Paul Lafferty as a carer for his daughter. She accepted that he had never been someone who would have been a suitable carer for his daughter. It is unfortunate that at the time when she was working with Niamh she had not been able to 'take a step back' from the situation and appreciate the reality of Paul Lafferty's lifestyle, personality and commitment to his daughter. When faced with Niamh's determination to live with her father, she gave undue weight to the wishes of the young person and not sufficient weight to the realities of the situation. There were several examples of witnesses placing far too much emphasis on what either Niamh or Georgia wanted, rather than exercising their own professionalism by carrying out a proper assessment of a situation. Sandra Leonard acknowledged that 'Colette was very much a constant, she had a very good working relationship (with the Social work Department) and was very committed to her daughter's wellbeing...' It was Niamh's return to the care of Colette that the social work department should have been working towards. If that was not going to be a possibility because of Niamh's determination to live with her father, then the only option was for Niamh to remain in care until she was old enough to live independently.

Nevertheless, the plan at the beginning of 2009 was for Niamh's eventual return to the care of her father. Before that could happen, Sandra Leonard had identified necessary supports to help Niamh's anticipated placement and was well-aware that these had to be in place prior to any move being made. She had discussed them with her senior Adah Lambie and had also communicated her recommendation that the move to her father should proceed via a time spent at East King Street. In the face of Niamh's determination, Sandra Leonard did her best to identify safeguards for her.

The panel on 16th January 2009 ended in some confusion. No one who gave evidence to the Inquiry was clear as to what the decision of the panel had been, given the concerns over Niamh's placement at East King Street at that time, and the fact that Sandra Leonard had been told by her senior not to make a specific recommendation as to residence. It is sufficient to say that in practical terms nothing happened, in that Niamh remained at the Open Unit until the next panel meeting on 13th February 2009.

Unfortunately, Sandra Leonard was on holiday at the crucial time in February 2009. The essential supports which had been identified by her as having to be available before there could be any move by Niamh to live with her father and which she had discussed with her senior had not been put in place. Adah Lambie was well aware of what Sandra Leonard considered essential before any move from the Open Unit could happen. Colette Bysouth who attended the hearing on 13th February 2009 gave evidence that Paul Lafferty who was also present told Adah Lambie prior to the meeting that he was not ready to care for Niamh at that time. Even Paul Lafferty seems to have recognised that he was not fit to look after Niamh. Despite this, and despite being aware that no supports were in place, Adah Lambie went into the meeting and recommended that Niamh be returned to the care of her father. This wholly unsatisfactory situation was made worse by the fact that there was confusion between the Open Unit and the Social Work Department about when the order made by the panel on 13th February 2009 was to commence. Unfortunately, due to lack of communication, no one took it upon himself/herself to try to find out when the move was to take place and Niamh left the hearing with her father, and without any supports to assist them. Sandra Leonard was very surprised indeed on her return from holiday to discover that the move had been recommended and made without the 'very very intensive phased transition'; which she had contemplated.

(b) 13th February until 3rd July 2009

Colette collected Niamh from her father's house on 18th February 2009 to go to the LAAC review. Niamh was in a state of distress and unkempt. In an essay written many months later which was read to the Inquiry Niamh described what her life had been like during those few days she was back in her father's care. The essay contained the following:

Sadly when I was at my laac review I was in a state. I had been out for the past 5 nights drinking and taking drugs and I was worried about my boyfriend who was at Court later that day. At the date of the laaac review I was staying at home with my dad. I had gone home in the morning to get him to come to the laac review, but he was in his bed, complaining of not being well and being sick, pains in his stomach and the shakes. Sadly, my dad is a recovering herion addict and was not able to make it to the laac review.

.....I didn't want to tell them that my dad had no money and that he was back on drugs.I had to say my dad had no money, both me and my dad had no money to eat, no electricity and not even any money for hot water to go for a bath.

Thereafter things moved very quickly. On 19th February 2009 at a planning meeting in Helensburgh, the decision was taken that Niamh should return to the Open Unit. When Niamh was advised of this decision by telephone by her father, she ran away when her mother went to collect her to take her to the Open Unit. She finally agreed to go with her mother to the Open Unit, but only after she had said 'goodbye' to her boyfriend Jonny McKernan. Two days later Jonny McKernan died of a drugs overdose and Niamh was overcome with grief and loss. Up until she died, she continued to grieve for her dead boyfriend and repeatedly expressed the wish to be with him, by which she meant that she wanted to be dead, not simply that she missed him.

Niamh attended the funeral on 3rd March 2009 and consumed both alcohol and drugs. Her father, having threatened to kill himself with a knife, was admitted to the psychiatric unit at Vale of Leven hospital that same day.

Niamh had to be returned to the Open Unit by police. Thereafter she started to abscond from the Open Unit. She blamed her mother for the death of Jonny and she was upset that her father was in hospital. She was depressed and was without doubt in a state of crisis. An emergency panel sat on 13th March 2009 which continued Niamh's supervision requirement of the Open Unit. Shortly after the hearing, Niamh absconded from the Open Unit and remained at large for the whole weekend. She returned to the Open Unit on Monday 16th March and was transferred to the Secure Unit on a 72 hour order. Her accommodation in the Secure Unit was confirmed by a subsequent panel and Niamh remained in secure accommodation until 3rd July 2009. Secure accommodation was clearly the right place for Niamh between March and July 2009. She coped well with the secure regime and her times of mobility, although always closely supervised, caused no difficulties. However she refused to participate in any psychological therapy and although she completed a programme about the dangers of alcohol and drugs, her participation was merely superficial. She repeatedly told staff in the Secure Unit that whenever she had the opportunity, she would be 'getting mad with drink and drugs' again.

The aims of the secure placement had been five fold:

1. to provide a nurturing environment with consistent age appropriate boundaries and routines
2. for Niamh to build trusting relationships with maternal family and other appropriate adults to enable her to explore her emotions in a safe and secure place.
3. to explore Niamh's loyalty to her paternal family and peer group and assist her to develop realistic expectations in relation to contact with same
4. to address Niamh's alcohol and drug misuse and assist Niamh to develop strategies to keep herself safe in the community
5. to provide opportunity for Niamh to explore her feelings of attachment and loss and assist in developing more positive relationships with others

By 3rd July 2009 only the first aim had been achieved, and that effectively 'came with the territory'.

The fact that Niamh had been placed in secure accommodation in March 2009 demonstrated how serious the situation had been. Professionals had to be satisfied that the purpose of secure accommodation had been served and that Niamh was ready to be given more freedom. When on 11th June 2009 Deborah Wicks became Niamh's social worker in place of Sandra Leonard who had left at the end of May 2009, she spent time familiarising herself with the papers and met Niamh before the LAAC Review on 15th June.

She was of the view that 'a lot of work had to be done before a successful transition from secure could be actioned'. She was aware that Niamh allied herself to a group of young people in Helensburgh with whom she had some history and who all took drugs and participated in under-age drinking and criminal behaviour. While Niamh had been in secure accommodation she had not been presented with any temptations and as a result of her very restricted mobility, she had not been tested in any situation where she would be able to make choices. When Niamh had last been out in her community, she had taken drugs, and drunk alcohol. As Deborah Wicks wrote in her report at the time:

The test will be when Niamh has freedom to make her own decisions and at this time the writer is not confident that Niamh is capable of making positive ones; she has talked to staff and her mum about wanting to meet up with her pals to 'get mad with it' and she still finds it difficult to accept compromise in relation to what she wants to happen'

Deborah Wicks was an impressive witness who within a matter of two or three weeks of familiarising herself with Niamh's case, had accurately assessed the situation and produced a report dated 23rd June 2009 which contained *inter alia* the following under the heading of Conclusion and Recommendation:

Neve (sic) has been unable to discuss her feelings in relation to her situation and so the writer cannot evidence if Neve has any insight into her life and the impact that her choices have had on it and how she has ended up where she

is currently. The reasons for Neve being where she is right now may be more complex than we think but until she has the opportunity to open up to an adult that she trusts and starts to explore her emotions and understand why she is here the writer is concerned for Neve's long term welfare and safety.

Neve has done very well in secure and on the surface it would appear that she no longer meets the criteria for a secure placement. The writer is concerned that Neve has not had the opportunity to explore her emotions and feelings in relation to loss and attachment. Had she been able to do this we may be at a point where we could evidence, even in part, a successful transition programme and seen the impact of this on her relations with others. In addition the writer is unable to answer the question as to whether or not Neve can successfully keep herself safe in the community by making responsible decisions in relation to her peer group and the activities in which to engage.

With consideration to these concerns and in consultation with family, colleagues in social work and Good Shepherd Centre the recommendation is that Neve remain on a S70 supervision requirement naming Good Shepherd Centre secure placement and that an immediate transition programme be implemented until a placement becomes available in the GSC close support unit where Neve's commitment to a successful transition can be tested out in a supported and planned way.

Deborah Wick's recommendation was over-ruled by management in relation to the situation at the end of June 2009 and it is difficult to understand why the recommendation to the panel on 3rd July 2009 was for Niamh to move from the Secure Unit directly to East King Street, when in the course of their evidence to the Inquiry both Adah Lambie and Joy Daniels said that Niamh continued to meet secure criteria at that time. Failures in communication must have played a significant part, given that those at the Inveraray meeting had seen no papers in respect of Niamh's case, and that Douglas Dunlop

was given inaccurate information from Roger Wilson as to the contents of Deborah Wick's report.

Unfortunately, and unhelpfully, by the time Adah Lambie came to give evidence to the Inquiry, she had great difficulty in remembering much of what had happened during those crucial months in 2009 and her response to many questions put to her was that she could not remember. I simply express surprise that an experienced professional had apparently forgotten in their entirety some of the important meetings which she had attended and the crucial discussions in which she had participated. The following are some examples.

- a. She knew in February 2009 that Sandra Leonard had wanted supports in place prior to any move by Niamh to her father's home, but in Sandra Leonard's absence she did nothing to facilitate those supports. She was not able to assist the Inquiry as to why there had been that omission.
- b. No explanation was given by her as to why she did not go with Niamh to the Open Unit on 28th July 2009 nor why no papers went with Niamh that morning.
- c. While she accepted that she should have arranged for Niamh's case to go back to a panel after her change of residence at the end of July 2009, she was unable to give any explanation for that omission.
- d. It was also never explained why she chose to do nothing in response to Anne Berry reading to her the contents of the suicide note other than to instruct that it should be filed. She failed to treat the contents of the letter and the whole incident as seriously as she ought to have done. Had she done so, then Niamh at the end of July 2009 would have been identified as the suicide risk that she clearly was, and would not have been accommodated in the Open Unit, an establishment which was neither equipped for nor had staff appropriately trained to deal with a young person in Niamh's critical state.

e. Despite her evidence to the Inquiry that as at 3rd July 2009 Niamh continued to meet secure criteria, she attended the panel that day and put forward the recommendation that Niamh should be transferred to East King Street. Why she should have recommended one thing while holding a different view was never explained.

f. There was a dispute in the evidence as to the circumstances in which Deborah Wicks did not attend the panel meeting on 3rd July. Deborah Wicks had an accident at home on the morning of 3rd July as a result of which she was off work for many weeks. She told the Inquiry that she had informed Adah Lambie on 2nd July 2009 that she was refusing to attend the hearing on 3rd July. Adah Lambie said that conversation had not taken place. However, I preferred her evidence on the disputed matter and am satisfied that she told Adah Lambie that she was not prepared to attend a panel to put forward a recommendation with which she did not agree.

It is difficult to understand in the face of all the evidence pointing towards a different recommendation why Argyll and Bute chose to recommend to the panel on 3rd July 2009 that Niamh should transfer straight from the Secure Unit to East King Street. They were fully aware of all the background and of the dangers and temptations available for Niamh within the community. Niamh herself had repeatedly and without equivocation expressed her intentions in relation to drugs and alcohol to staff within the Secure Unit. Niamh was an absconder, a self-harmer and a young girl who had repeatedly expressed her wish to be dead. She had undergone no therapeutic work to address her attachment to her father, her bereavement after the death of Jonny or her determination not to live with her mother. She had not been tested in the community. The three social workers involved at the time i.e. Deborah Wicks, Adah Lambie and Joy Daniels all gave evidence to the Inquiry that Niamh as at 3rd July continued to meet secure criteria. Had there been proper communication among all those involved in this decision-making process, then one can conclude with confidence that Niamh would never have been transferred straight from the Secure Unit to East King Street on 3rd July 2009. Had staff autonomy, on which Douglas Dunlop told the

Inquiry he placed such importance, been allowed to play its proper part, then the recommendations of Deborah Wicks would have been given their proper weight. In addition, had Joy Daniels felt confident in her autonomy, then at the Inveraray meeting she might not have allowed herself to be persuaded by Alex Taylor and William Moore against her better judgement to accede to the instruction from Douglas Dunlop that the panel was to have a supplementary report recommending East King Street.

In the course of their evidence, social workers emphasised that the decisions made at the Children's Hearings were panel decisions and of course that is correct. However, panel members rely on receiving comprehensive information from social work departments and it would be disingenuous to suggest that panel members are not influenced in their decision-making by the recommendations put to them by those with direct involvement in the care of an individual child, and who in their professional capacity are taken to be fully informed as to all the circumstances.

Because of its pivotal role in Niamh's transfer to East King Street on 3rd July, it is important to appreciate that the decision-making nature of the meeting which took place after the Resource Management Meeting at Inveraray was unique. According to Mark Lines, Social Work Manager, Argyll and Bute, it was not the appropriate forum for such a discussion. Three senior managers were prepared to take a decision in the absence of any papers, and in a situation in which there could therefore be no proper analysis of Deborah Wick's recommendations. The point made by Mr. Gilbride, Counsel for Colette Bysouth, is well founded – the meeting became in effect a contest between the Open Unit and an Argyll and Bute resource with a support package, done in a vacuum with no papers and no discussion whatsoever, as Joy Daniels told the Inquiry, of the contents of Deborah Wick's report.

All of this arose apparently out of inaccurate information being communicated by Roger Wilson to Douglas Dunlop. Given the information that he had, Douglas Dunlop based his instruction at least in part on financial considerations and it is recognised that decisions concerning the best use of

resources are at the best of times difficult ones. Given the fine balancing called for, it would have made sense for Douglas Dunlop to have satisfied himself that he had given proper consideration to the competing alternatives and for him to have done that he should have asked to see the available papers, and also spoken to Deborah Wicks.

Roger Wilson did not give evidence to the Inquiry. He left to live in New Zealand around a week prior to the commencement of the Inquiry. A request was made for him to provide affidavit evidence, as others have done, in which certain matters could have been addressed, but no response was received from him in this connection. The Inquiry therefore had only Douglas Dunlop's version of the telephone call from Roger Wilson and its contents. I had no difficulty in holding Douglas Dunlop credible on that matter and was satisfied that I could rely on his evidence as to what he had been told by Roger Wilson.

There is one other matter in relation to the decision taken on 29th June 2009. Ted Jeffries the psychologist who knew Niamh was present at the Resource Management meeting when Niamh's case was first raised. He told the Inquiry that he had voiced his opposition to a move to East King Street. He was the only person in Inveraray who had been at the LAAC Review on 15th June 2009. Unfortunately, he did not ensure that his opposition was minuted, and there is no reference to his views in the note prepared by Alex Taylor after Niamh's death. Ted Jeffries regretted this omission, but in fairness to him, the Inquiry heard of many instances of proceedings at meetings not being minuted, of minutes containing inaccuracies, as fundamental as not noting correctly who attended them, and of minutes being prepared but not circulated for approval. Some failures in communication can be crucial. However, there was nothing to suggest that the decision of 29th June 2009 would have been different had Ted Jeffries' opposition been more vociferous or had his opposition been minuted.

(c) 3rd July 2009 to 28th July 2009

Niamh moved from the Secure Unit to East King Street on 3rd July 2009. Initially she was kept on a very tight lead. She had contact with her mother and the rest of the family and to begin with there were no major difficulties. She had additional support from Sylvia Rennie of Up 2 Us. Her room at East King Street was full of large laminated photographs of Jonny. Within a short time however Niamh started to strain against the restrictions placed on her movements and on her contacts. She found a part-time job in a local café which concerned Sylvia Rennie greatly as it meant that Niamh would have access to cash. Niamh candidly told her that she was going to spend all the money and 'have a party'. During her short time at East King Street she tried to bring alcohol into the home on one occasion and she also returned under the influence on another.

She continued to express her wish to be with Jonny and at least one member of staff took these expressions as evidence of suicidal intentions. The member of staff did not however enter these in the appropriate log. On the morning of 27th July 2009 Niamh was found in her bed in a semi-conscious state. She was incoherent and later seen bouncing from one wall in a corridor to another. Staff realised that she was under the influence of drugs and took appropriate action. She was seen by Dr. Fang and Dr. Brown, two general practitioners during the course of the day. Her mother spent most of 27th July at East King Street and Adah Lambie also attended. During 27th July 2009 Niamh repeatedly said to those in attendance that she wanted to be with Jonny and she told Dr. Fang that she would not understand why she was still alive. Despite this information, Dr. Fang did not ask Niamh why she took the tablets, nor did he think of referring Niamh to CAMHS. Dr. Brown, like Dr. Fang, did not think it necessary that Niamh attend Accident and Emergency. He did conclude however that she may well have needed psychiatric assessment. He told the Inquiry that there were great difficulties in having a child between the ages of 14 and 16 admitted to a psychiatric unit, given the limited number of beds available in the area. He described Gartnavel Royal Hospital in Glasgow as being under huge pressure because of having only a

small number of beds for that age-group. He had attended East King Street in the evening and as CAMHS runs a 9 to 5 service, that option was not available at the time either.

He considered that East King Street could not keep Niamh safe. However, he was privy to the discussions about where Niamh should go and when he left the home sometime later, he was under the impression that Niamh would be moving that night to a more secure place in the country. That was the same impression that Colette Bysouth was given by Adah Lambie, as a result of which she somewhat reluctantly decided to continue with her holiday plans with the rest of the family. Had she not thought that Niamh was being moved that night to a safe place in Ayrshire, she would not have gone on holiday the next morning.

Niamh did not go to Ayrshire. She remained overnight in East King Street and was taken in a state of considerable distress to the Open Unit late on the morning of 28th July 2009. The decision to move Niamh to the Open Unit was taken by Roger Wilson at a meeting convened at East King Street earlier that morning. William Moore was contacted by telephone by Roger Wilson who made no mention of there having been a suicide attempt. Following on that, Paul Crombie phoned Sandy Cunningham who agreed to accommodate Niamh. Apparently no consideration was given at the meeting as to whether Niamh's overdose might have been a suicide attempt. No one asked the simple question 'Was this a suicide attempt?' That omission I consider extraordinary. Had the question been asked and answered correctly in the light of all the available information, then the Open Unit would not have been considered as an appropriate placement for Niamh.

Later that day, a further opportunity presented itself to the professionals responsible for Niamh's care and her safety when the existence of the suicide note was made known to both Sandy Cunningham and Adah Lambie. Had either or both of these individuals given appropriate weight to the significance of the contents of this note, and the circumstances in which it had been found, then Niamh should have been taken from the Open Unit that same day. Why

Sandy Cunningham did not read the note nor act on it was never made clear. He was very reluctant in his evidence to accept that the note was a suicide note (see later in this note). Why Adah Lambie also did nothing in response to learning of the note's existence and its contents, other than to tell Anne Berry to file it is beyond my understanding.

(6) Recommendations made and Decisions taken by Hull City Council in relation to Georgia

(a) No explanation was given as to why no consideration was given by Hull to the transfer of responsibility for Georgia if not in the early stages to Strathclyde Regional Council, then at a later stage to East Ayrshire Council. By 2008 Georgia had been in Scotland for 13 years. It must have been clear to Hull that the adoption of Georgia by Tanya Oliver for whatever reason was not going to proceed. A freeing order could have been applied for in Scotland had the case been transferred. The supervision of Georgia was being done by social workers in Ayrshire who were having to communicate with Hull. Looking at the situation from a purely logistical standpoint, a transfer should have been proceeded with. There seems to have been some confusion in the minds of the social work department in Hull as to what the legal possibilities and procedures might be if the matter were to have been raised in a Scottish court. There was nothing to prevent Hull from drawing their long and geographically distant responsibility for Georgia to an end.

(b) Hull acted prematurely in removing Georgia from Scotland on 24th June 2008. While there was on that date no foster placement available in East Ayrshire, there was evidence that Georgia could have remained with the foster carers in Jedburgh for two weeks, which would have allowed other options to be explored. Other reasons for the move to Hull were that Georgia wanted to go to Hull and that Hull thought that there was family in Hull who might be able to offer a home/support to Georgia. There was no considered response to the crisis situation which had developed. No

consultation took place with Tanya Oliver, who in the initial days after Georgia's removal from Ayrshire, was not kept informed by Hull as to Georgia's whereabouts. This information was communicated to her in text messages from Georgia. In the light of her long commitment to Georgia, that is an extraordinary position for Hull to have adopted. The move took Georgia from a rural area to an urban one, involved a change of school and two foster placements in Hull which broke down. Georgia was able to contact her natural mother and she had the opportunity to fall in with 'the wrong crowd' in the neighbourhoods in which her foster placements were. It is not possible to state with any confidence that a move within Scotland would necessarily have had a better outcome, but the fact is that the move to England was a disaster for Georgia. She derived no benefit from it and her behaviour deteriorated. Lydia Jackson candidly accepted that disaster was an accurate description, and that was not challenged.

(c) Initially Hull were under the impression that Georgia had family contacts in the Hull area who might have been able to provide care for her. It was never made clear on what that thinking was based. However, within a very short period of time Hull knew that no such supports/connections existed. The plan in the summer of 2008 by which time Georgia was living with Mr. & Mrs. Postill was to get Georgia back to Scotland and returned eventually to Tanya Oliver. By that time Georgia was absconding regularly, taking alcohol and drugs, and involving herself in high risk sexual behaviour. These incidents were all reported to the social work department who must have realised that the opportunities for high risk taking behaviour and absconding had multiplied on Georgia's arrival in the Hull area. Georgia had also, despite the terms of the court order that there was to be no contact between her and her mother without the agreement of the social work department, made contact with Mandy Oliver. Mandy Oliver had chronic addiction issues and had been unable to care for any one of her 5 children. The social work department became aware of this contact. The Inquiry heard no evidence of any action taken by Hull which stopped this contact, prior to Georgia being taken into secure accommodation. Mandy Oliver had played no part in Georgia's life for almost 13 years. She chose not to attend the Inquiry of which she had been

made aware. While at first Georgia was keen to establish some kind of relationship with her natural mother, she realised soon after establishing contact that her mother could offer her nothing. That must have been a severe disappointment to Georgia at a time of such upheaval in her young life. Mr. Pollock on behalf of Hull submitted that Georgia's behaviour had stabilised during her time with Mr. & Mrs. Postill and that it deteriorated only when they went on holiday. The evidence did not support that submission. Georgia was drinking, indulging in high risk sexual activity and taking drugs on occasion before the holiday in September 2008. The fact that Mr & Mrs. Postill's daughter Rebecca Blampney was prepared to shoulder the responsibility for Georgia while her parents were on holiday, and the fact that the Postills were willing to have Georgia back with them after she had been admitted to Merlin Bridge says much about their willingness to shoulder a continuing responsibility to Georgia and is very much to their credit. There was however no stabilisation in Georgia's behaviour from the day she left Ayrshire till the day she went into secure accommodation at the end of October 2008. Rather, the opposite was the case. Her behaviour deteriorated and her risk-taking increased.

(d) During her brief stay at Merlin Bridge, Georgia was able to abscond regularly and also have contact with her natural mother. Her behaviour deteriorated to such an extent that a 72 hour place of safety order was made on 28th October and on 31st October 2008 a secure order was obtained. Georgia was thereafter accommodated at Sutton Place Secure Unit until her transfer to Scotland in April 2009. From an early stage in her stay at Sutton Place, the plan was for Georgia's eventual return to Scotland, and Barbara Rutherford did much to encourage the revival of the relationship between Georgia and Tanya. In June 2008 Tanya had sought counselling about the breakdown of her relationship with Georgia, and had been given professional advice to stand back at that time and wait for Georgia to make the first move towards reconciliation. By October 2008 while Georgia was at Merlin Bridge contact had been re-established.

(e) Soon after Georgia's arrival at Sutton Place, Hull started looking for suitable accommodation for her in Scotland. The Secure Unit was identified as a possibility and arrangements were made for a meeting in Newcastle on an unspecified date. The Secure Unit had advantages i.e. there was a Close Support Unit and an Open Unit on the campus, it was near to Georgia's home, and apparently it had contacts with suitable foster homes (though apart from a passing reference, this last advantage was not explored in the evidence). After the meeting, Hull did not consider any other potential placements for Georgia in Scotland or elsewhere. The Inquiry heard that while Georgia was accommodated in the Secure Unit, Hull also paid the Open Unit a negotiated weekly rate to keep a place open for her there.

(f) Around February 2009 Hull requested Dr. Lynsay Coxhall to prepare a psychological assessment of Georgia. Dr. Coxhall's report was available for the meeting on 10th March 2009. The recommendations of Dr. Coxhall's report included the following:

'In my opinion (Georgia) would benefit from a long term residential placement with educational and therapeutic provision that incorporate the family, therefore ideally placed in Scotland. I understand a place has been tentatively identified in Scotland which appears to be very appropriate in meeting (Georgia's) needs. It became clear during the assessment that (Georgia) struggled with separations and therefore I would strongly recommend that her transition from Sutton Place is managed very carefully. My suggestion is that her Order is extended by four months as this will allow such a plan to be drawn up and gradual steps undertaken to make the transition as smooth and therefore less threatening/disruptive to (Georgia) as possible. This gives the opportunity of providing (sic) (Georgia) with a model of a "good ending" rather than an experience of – as she may perceive it – abrupt separation/rejection. This may involve gradual steps such as staff from the identified placement making contact – telephone and visits – with (Georgia) and likewise (Georgia) having the opportunity to visit the placement with Sutton Place staff. Gradual exposure may reduce her anxieties and make the idea of moving less scary in her mind. I would also recommend

time limited therapeutic work on helping (Georgia) manage and explore her feelings around the transition, and developing more helpful coping techniques to deal with the anxieties/negative thoughts that may well arise. Such work could be done during her remaining time at Sutton Place with myself in my role as Psychologist at Sutton Place.

Due to early experiences and subsequent stressful life events, (Georgia) displays psychological difficulties such as challenging behaviour, low self esteem, vulnerability to risk, and attachment difficulties. Although not officially assessed, I suspect she may be experiencing trauma symptoms due to negative life events and poor ability to cope.

My opinion is that she requires a containing, structured environment which provides clear boundaries and expectations. This gives “psychological safety” for (Georgia) and will allow her to safely begin to explore her psychological difficulties and address them. Her family in Scotland are very important to (Georgia) so I encourage them to be an active part of (Georgia’s) care plan through Family Therapy. My concern at the current time is that if (Georgia) is not in a residential unit providing such a contained environment, the lack of boundaries and therefore perceived lack of security may increase her risk of placing herself in further vulnerable situations. This is indicated by previous evidence of (Georgia’s) reactions when she has similarly felt insecure.

I would support a further order of four months as this gives the opportunity to:

Officially identify an appropriate placement

Begin a gradual, planned transitional period

Allow therapeutic work to be done on endings and moving on”

Despite having instructed this report, in the weeks that followed Hull singularly failed to act on those recommendations.

Staff at Sutton Place were put in a difficult situation when it became known that the place was to close in the summer of 2009. The remaining residents had to be accommodated elsewhere and the atmosphere within the home was no doubt unsettled as a result of the uncertainties for both staff and young people. Nevertheless more time was available for the transition of Georgia to the Secure Unit to have been paced. This was Georgia's ninth move since June 2008. Change of any sort can be difficult for anyone. For someone with Georgia's history and difficulties, as Dr. Coxhall pointed out, change can be particularly traumatic. Given the very clear recommendations set out in Dr. Coxhall's recent report, it would have been of benefit to Georgia if more time had been taken over the move and in the light of those recommendations it is difficult to understand why the move took place when it did. In addition, there was no discussion with Tanya Oliver prior to her leaving on her trip to China about the possibility of an early move, and there was no effort made to contact her when the decision was taken that Georgia would be moving. She was therefore not involved in this decision. Nor was there any attempt by Hull to look at other possible placements for Georgia. As Barbara Rutherford so succinctly put it – there was no Plan B.

No one in authority from Sutton Place visited the Secure Unit prior to Georgia's move there nor as it transpired did any social worker from Hull responsible for Georgia's care take the trouble to inspect either the Secure Unit or the Open Unit. For example, when Sue Ainley visited Georgia on 6th September 2009 by which time Georgia was living in 'the wee flat', she did not ask to see Georgia's bedroom or living accommodation. She did not leave the reception area prior to taking Georgia out on a shopping-trip.

(g) After her transfer to the Secure Unit, for a period of some 7 to 10 days there were no difficulties with Georgia's behaviour. Thereafter, her behaviour deteriorated and she had to be restrained on several occasions. After some time however there were improvements but during all the time in the Secure Unit, no meaningful therapeutic work was undertaken and there remained concerns about Georgia's ability to cope outwith a secure environment.

(h) When a secure order is made in respect of an individual child, there is a legal requirement for a review within 28 days. In Georgia's case, the first review took place on 27th November 2008 following on the court order of 31st October 2008. Secure accommodation reviews require to be held periodically while a secure order remains in place. The main purpose of such a review is to identify whether secure criteria continue to be met. At the review on 23rd July 2009 at the Secure Unit it was the general view of the meeting that although Georgia had made some progress, secure criteria continued to be met. Physical holds were still necessary on occasion and there remained what are referred to as 'behaviour management issues' to be addressed. In spite of that assessment, a transition plan devised by Sue Ainley and Lydia Jackson, after discussion with Liz Anne Davenport, was commenced shortly thereafter. No transition plan involving a move from Secure to Open conditions had ever been prepared or attempted in relation to any other child. What was planned for Georgia therefore was unique and required monitoring with the utmost care, given Georgia's history of absconding and risk-taking. Further, Georgia had been in secure conditions since the end of October 2008 and her ability to cope with conditions of the utmost security had not been tested in any way.

(i) Taking all of what is contained in **(h)** there was a very strong argument for an application by Hull to the court for a further secure order towards the end of August 2009. Such an order is 'permissive' in nature and had a further order for another 3 months been sought and granted in August 2009, this would have allowed for testing of Georgia in conditions of less security and would have allowed Hull the opportunity of taking up some of the recommendations in Dr. Coxhall's report which had been effectively ignored up until July 2009. There was no analysis of how Georgia might cope with yet another move nor was there any assessment or analysis of what progress had in fact been made by Georgia between 23rd July 2009 when she still met secure criteria and 21st August 2009 when she apparently no longer did. The person who made the decision that Georgia no longer met secure criteria in August 2009 was Karen Robinson, Sue Ainley's Line Manager, but there was no evidence as to the reasoning behind that decision. Barbara Rutherford in

November 2008 assessed that Georgia's stay in secure accommodation would not be short-term. In April 2009 Georgia had been transferred to a different establishment at very short notice, without any therapeutic work to assist her. In July 2009, despite the fact that she had been assessed as continuing to meet the necessary criteria, she was going to be moved yet again, without any therapeutic work.

(j) There was a failure on the part of Hull to recognise that Georgia had not been prepared properly nor tested for the amount of freedom she would have at the Open Unit. During her transition period Georgia went on two outings, had tea at the Open Unit on two occasions and spent a total of ten nights at the Open Unit. On 4th August 2009 she absconded from the Open Unit and had to be returned to the Secure Unit in handcuffs. Despite that, and the views of members of staff in the Open Unit, particularly Karen Kydd, that Georgia was not ready for transfer to open conditions, the transition plan was allowed to continue, with only minor amendment to the practicalities. With her history of absconding, risk-taking and self-harm, and strange behaviour which required restraints, and in the latest episode police assistance and the use of handcuffs, it should have been obvious to Hull that a move from conditions of 24 hour security to an open unit where the only form of security was 'staff vigilance' was not appropriate for Georgia at that time. That finding is based not on hindsight, but on what was known of Georgia's history, her behaviour while in the Secure Unit and the events of 4th August 2009. At the very least, Hull should have put the transition on hold and gone to the court at the end of August for a further secure order. Such an order is permissive, so that if during the three month period thereafter Georgia no longer met secure criteria, then she could have been moved at that stage. On 21st August 2009 she continued to meet secure criterion in relation to absconding and given her behaviour in Bishopton, there is a sound argument that she also met the criterion in relation to risk/harm. Tanya was particularly concerned about the proposed move from secure to open conditions. She would have preferred that consideration be given to accommodation in the CSU as a stepping stone, but her concerns were overridden.

(k) There was a failure on the part of Hull to appreciate the nature and intensity of the bullying by AM and the high risk nature of Georgia's absconding behaviour. Given the level of Georgia's absconding in September 2009, taken in conjunction with her history, especially since leaving Scotland in 2008, it is hard to make out a case for her **not** meeting secure criteria in September 2009. It is worth repeating part of Dr. Coxhall's report:

My concern at the current time is that if (Georgia) is not in a residential unit providing such a contained environment, the lack of boundaries and therefore perceived lack of security may increase her risk of placing herself in further vulnerable situations. This is indicated by previous evidence of (Georgia's) reactions when she has similarly felt insecure.

The Open Unit was not a contained environment. The lack of physical security within the unit provided Georgia with opportunities to abscond. She had a long history of doing so. Within days of her transfer to the Open Unit, the same pattern emerged. She placed herself in vulnerable situations, the details of only some of which were known to the Open Unit and to Hull. She absconded on more than one occasion when she remained at large overnight. The sustained campaign of bullying by AM must have contributed to Georgia's lack of psychological security, as well as a lack of physical security. She could not have known when the next episode of bullying would occur nor what form it would take.

(l) Management at Hull knew of the difficulties of the relationship between Lydia Jackson and Tanya Oliver. Lydia Jackson was very open in her acceptance that she had a problem in relating to Tanya and that she often felt intimidated by her. This resulted in her not being in contact with Tanya as often as she should. To give one example already referred to: no one from Hull contacted or attempted to contact Tanya to advise her of the closure of Sutton Place and of the decision to transfer Georgia to the Secure Unit. Tanya obtained this information from Georgia and was in Lydia Jackson's words 'very, very angry and justifiably upset about not being contacted'. A better relationship with Tanya Oliver would have been of benefit to Georgia.

Management failed to address this difficulty. Lydia Jackson continued as Georgia's social worker up till her death.

(7) Appropriateness of Niamh's placement at the Open Unit on 28th July 2009 including her accommodation in 'the wee flat'

The Inquiry heard evidence that on a number of occasions Niamh had self-harmed. The fact that she was a self-harmer was well-known to staff at the Open Unit. Two days after her return to the Open Unit on 30th July 2009, Niamh had caused serious injury to her wrist with a razor and had needed medical attention in the form of 16 stitches.

The Open Unit were aware of the circumstances which resulted in the transfer of Niamh from East King Street to the Open Unit on 28th July 2009. Had there been at that time full communication between all of those concerned with Niamh's care and safety, including Adah Lambie, Sandy Cunningham and staff at East King Street, then staff at the Open Unit would have appreciated, as management should have done at the time, that Niamh presented as a suicide risk. Armed with all of the circumstances of her overdose, her repeatedly articulated desire to 'be with Jonny', her expressions of 'wishing to be dead' together with the terms of the suicide note as well as her previous history, no one could have doubted that the ingestion of valium was a serious suicide attempt. Had there been appropriate collation and communication of all available information, then it would have been clear that the Open Unit was not an appropriate placement for Niamh at the end of July. In addition, had the correct steps been taken by Adah Lambie, the senior social worker, to bring the matter before a Children's Hearing, as ought to have been done but was not, then that would have presented an opportunity for a considered and comprehensive assessment of Niamh's situation. In addition, no paper work arrived with Niamh, as should have happened, on her transfer on 28th July 2009. It was also normal practice for the social worker to accompany a child on such a transfer. This did not happen on 28th July 2009. the responsibility

was placed on Anne Berry, a care worker, accompanied by Veronica Mahoney, who just happened to have called in to East King Street that morning on an unrelated matter. Anne Berry gave evidence that she was so upset by the events of that day that she 'just wanted to get home' at the end of her shift.

While Argyll and Bute should not have placed Niamh in the Open Unit on 28th July 2009, it is also the case that had Sandy Cunningham made the necessary enquiry of the placing authority of the whole circumstances of Niamh's overdose and given the appropriate significance to the suicide note and its contents, then he would have refused to accept the placement, or having accepted the placement and then made further inquiry, would have taken. The primary responsibility for the placement lay with Argyll and Bute but the Open Unit also had a duty of care to Niamh and to any other resident. That duty of care included a responsibility for assessing the risk presented by any placement against the facilities offered by the establishment and advising a placing authority if the placement was no longer considered appropriate.

Niamh was a known self-harmer, and also had a history of absconding from the Open Unit as well as from other places. Two days after her transfer from East King Street, a serious incident of self-harm had taken place, after Niamh had tried to get back into the Secure Unit. In September 2009 staff at the Open Unit thought that Niamh was making progress. Notwithstanding that perception, she had been bereaved only six months earlier and her father for whom she had in Sandra Leonard's assessment an anxious attachment had been in a psychiatric unit after threatening to harm himself. He was now out of the country and Niamh was allowed only supervised telephone contact with him. Furthermore, in August 2009 Niamh had made references to her jugular vein, the Erskine Bridge and had told her father she wanted to kill herself. All of those factors militated against her being accommodated in 'the wee flat' immediately adjacent to an unalarmed fire-exit door

(8) Appropriateness of Georgia's placement at the Open Unit from 21st August 2009, including her accommodation in the wee flat

The Open Unit

Management at the Open Unit knew or should have known that Georgia was not appropriately accommodated and that the facility at the Open Unit was not equipped or staffed to deal with Georgia's placement there. If the events of 4th August 2009 did not provide sufficient warning to management of what might lie ahead, then the subsequent level of absconding, difficult behaviour and the impact of the sustained bullying by AM should have made it abundantly clear that Georgia's continued placement within the unit was totally inappropriate. Karen Kydd was particularly anxious about Georgia's continued accommodation at the Open Unit at this time and contacted Hull to advise them of what she termed 'child protection issues'. No action was taken to remove Georgia either from the wee flat or from the Open Unit altogether. By way of contrast, there was evidence that CMS with whom Georgia absconded on 27th/28th September 2009 had been accommodated in the Secure Unit from 2nd April 2009 until 19th August 2009. On that date she had been moved to the Close Support Unit. On 29th September 2009 after her return from absconding she had been transferred back to the Secure Unit where she remained until 14th April 2010.

The wee flat

Sometime after Georgia was transferred to the Open Unit, Liz Anne Davenport decided that she be accommodated in the wee flat. Georgia wanted to be there. At that time, various members of staff including Mary Stewart raised objections to that decision. Mary Stewart sent an e mail voicing her concerns to the entire staff team and copied Sandy Cunningham into it. It was well known that Georgia had a history of recent violent behaviour, which had necessitated physical restraint, and a long history of absconding. A girl accommodated in 'the wee flat' was harder to monitor.

Because she was at high risk of absconding Georgia should not have been accommodated in the wee flat.

After the absconding episode with CMS, on 29th September 2009 Sandy Cunningham decided that Georgia was to move upstairs. The girls on the first floor were not happy with Georgia because she had absconded. They did not want Georgia upstairs and it was thought by Sandy Cunningham that the 'dynamic' upstairs might prove difficult and furthermore Georgia did not want to move and was refusing to do so. It was suggested by a member of staff that her belongings be moved upstairs and she would have had to follow. That eminently sensible suggestion was never acted upon. Given much of the evidence heard in the course of this inquiry it is hard not to come to the conclusion that in the face of opposition from the young people, staff and management at the Open Unit often gave in and allowed what the girls wanted. This is one such example.

(9) Security at and Absconding from the Open Unit

There was a commendable desire among management and staff for there to be in the Open Unit as homely an atmosphere as possible. However the Open Unit was not a family home, nor were the young persons there living with members of their families. They were being looked after by paid care workers, doing a very difficult job for modest financial reward. Niamh and Georgia were in care because of extremely worrying and risky behaviour. Both had spent time in secure accommodation. The Open Unit in August 2009 accommodated also AM, a girl whose behaviour was aggressive, threatening and violent towards Georgia, as well as abusive and intimidating towards the other girls. She was aggressive towards staff and often refused to follow instructions. She also absconded on at least one occasion during September 2009. Niamh, Georgia and AM were also self-harmers, and Niamh was a suicide risk. At least one other resident at the time was described by staff as exceptionally volatile.

Given that dynamic, something more than 'staff vigilance' was necessary if there was to be any realistic hope of keeping each girl safe from herself and from others. Some of the more minor types of absconding may have merited the description of 'St. Trinian's' behaviour suggested by Mary Stewart but the nature of the absconding the Inquiry heard about in relation to both Georgia and Niamh as well as CMS was of a far more worrying kind. Niamh and Georgia's absconding on 4th October 2009 had of course the worst of consequences.

Young persons in the Open Unit could not be locked in, and could be physically restrained only under certain very limited conditions. There was no physical security on the premises. Doors and windows were unlocked, and there was no system in place for keeping track of the whereabouts of any individual girl, except that of the vigilance of staff. For example, Mary Stewart thought that Georgia was to be monitored regularly when she was in 'the wee flat', as she was on 4th October, but that evening only Martha Fraser was in the building and was not in a position to monitor Georgia properly. Martha Fraser through no fault of her own was completely unaware of any special monitoring conditions which might have attached to Georgia that day. There was no way of knowing when a girl left the premises without permission, unless she was seen leaving, or staff were alerted by other girls to the fact that someone had gone.

In any open unit, absconding will always be an issue for management and staff to deal with. The strategy for dealing with absconding from the Open Unit comprised trying to persuade a child not to leave or if that failed, following the child when out of the campus and continuing to try to negotiate a return. This strategy could be adopted only if the staff actually knew about the intended absconding or became aware at the very earliest stage that the absconding has taken place.

Apart from staff vigilance, there was also a system known as the Traffic Light System in place, agreed between the Open Unit and Strathclyde Police. The

system allocated a colour to each child i.e. red, amber, green, with red being the most serious category of absconding behaviour. If two girls absconded together, the incident was coded according to the more serious category. This system was not preventative. It was a reactive measure by ensuring that whenever the absconding was identified, Open Unit staff alerted the police and the type of absconding was categorised by means of this colour-coding.

There were two types of absconding: (1) when a child on leave failed to return at the agreed time from time out or home leave and (2) when a child left the Open Unit without permission. In either of these situations the police would be alerted and the incident coded in relation to the agreed colour coding. Because of her history, Georgia was coded 'red'. If a child coded 'red' absconded with another child, regardless of the second child's personal coding, the incident would be coded 'red'. This system applied only to situations where staff knew that someone had absconded. It did nothing to prevent absconding. Staff and management were aware that Georgia did not always abscond on her own e.g. she absconded with AM on one occasion from a trip with a member of staff to buy take-away meals and she absconded with CMS towards the end of September.

In June 2009 the fire-door directly adjacent to 'the wee flat' was alarmed. However, the girls used that door as a thoroughfare, and this unsanctioned use resulted in the alarm being activated regularly, which caused disruption to the staff who had to check the situation each time. Sandy Cunningham in July 2009 authorised that the fire-door alarm be de-activated. The Inquiry heard no evidence of any attempt by management to tackle the problem of unauthorised use in a way which would have ensured that the fire-door remained alarmed. The wishes of the girls were accommodated rather than any attempt by management to make the girls follow any rule that might have been imposed for their safety.

The CCTV system in place was monitored by the Secure Unit and the Inquiry heard no evidence of how consistent that monitoring was. The system did not cover the building which housed the Open Unit. The Secure Unit and the Open Unit were entirely separate entities and the one was not responsible for the other.

The Inquiry heard of no analysis in relation to any absconding figures directed to the precise circumstances, if known, in which absconding had taken place, or to where or for how long the absconding had lasted. On the limited figures available, there was no distinction made between failures to return and abscondings from the Open Unit itself. In relation to Georgia, some limited information was available about where she might have gone on the various occasions when she absconded from the Open Unit, but even by the end of September 2009 there was no evidence of any structured approach being taken by staff to find out if the bullying by AM contributed to Georgia's absconding (given some of the things which Georgia had said, that could not have been in doubt), nor was there any attempt to carry out a proper risk assessment to determine the Open Unit's ability to keep Georgia safe. Management was aware of the high risk situations into which Georgia was putting herself and effectively did nothing.

The levels of absconding at the Open Unit were never raised with the Board of Management in terms of any report and Sandy Cunningham gave evidence that the issue of absconding did not merit greater consideration than it was given in 2009. It was submitted by Mr. Jackson on behalf of the Good Shepherd Board of Management that it was quite conceivable that Georgia's absconding behaviour might have modified with time. I do not agree with that submission. Georgia had a long and worrying history of absconding. As far as her stay at the Open Unit was concerned, the evidence was that the frequency of her absconding was increasing and the level of risk-taking escalating. No inference to support a proposition of modification of her absconding over time can be drawn. Further given the events of 4th October 2009, there could never have been an evidential basis for that submission.

The Inquiry heard no evidence of any consideration being given to the suitability of placing certain combinations of girls in the wee flat. There was no evidence of any analysis of the dynamics which prevailed within the wee flat nor as to why Niamh a self-harmer who had repeatedly threatened suicide and whose high risk-taking behaviour was well known, should have been placed in the wee flat at the same time as Georgia, a serial absconder who also had a history of self-harm and high-risk taking behaviour. Despite both girls having been in secure accommodation only weeks before they were placed in the wee flat, no assessment seems to have been made by staff in the Open Unit as to the suitability of putting the girls in 'the wee flat' together. The conclusion that neither should have been in the wee flat in October 2009 does not require hindsight. Neither fitted the criteria of suitability for accommodation in this separate unit. Management decided on 29th September 2009 that Georgia was to be moved upstairs, one assumes on the basis that she was not suitably accommodated there, and then chose not to act on that decision.

(10) Staff Levels at the Open Unit

In their evidence, Roisin McGoldrick, Sandy Cunningham and Jane Weir all asserted that the best form of security was vigilance on the part of the staff. If that was the case, then the obvious starting point would be to have staff on duty in sufficient numbers. On 4th October 2009 that vigilance singularly failed to materialise because of inadequate staffing levels. I want to be clear that there is no criticism of either Mary Stewart or Martha Fraser in what either did or did not do that particular evening. I was impressed by both women and by the many years each had devoted in their working lives to looking after difficult and troubled girls. Mary Stewart had raised the issue of staffing and monitoring in an email to staff and to Sandy Cunningham. It was the responsibility of management in the knowledge that staffing levels on 4th October 2009 were inadequate to take steps to ensure that the appropriate number of staff were on duty.

One inference that can properly be drawn from the evidence is that Niamh and Georgia took advantage of the fact that there was only one member of staff in the Open Unit when they returned on the Sunday evening. They appear to have deliberately deceived Martha Fraser by appearing upstairs in their nightclothes immediately before going back downstairs, changing into their outdoor clothes, and absconding from the Unit.

(11) Bullying of Georgia at the Open Unit

From August 2009 until her death on 4th October 2009 Georgia was subjected to a sustained and often violent campaign of bullying at the hands of AM. The Unit Log held in the Open Unit and available for all members of staff to read, and contribute to, catalogued a series of disturbing instances of AM's behaviour towards Georgia, as well as references to her behaviour towards other girls in the Open Unit, and her abusive and uncooperative attitude towards members of staff. Karen Kydd, Senior Care Worker, had a close relationship with AM – in her own words 'I wore her like a scarf. If I kept her with me, I knew she was not getting into bother.' There is no doubt that her special relationship with AM went some way in preventing difficult situations arising. However, there was evidence that this relationship blinkered Karen Kydd to the reality of the bullying situation and it was with considerable reluctance and only at a very late stage in her evidence, that she finally accepted that there **had** been bullying. Mary Stewart was similarly reluctant despite the evidence in the Unit Log to accept that bullying had been taking place, though she too eventually conceded that it had.

Sandy Cunningham while recognising that the situation with AM was never going to improve, was nevertheless content in September 2009 that her removal from the Open Unit should be a planned one, and he anticipated that it would take a month or more from the end of September 2009 for that to be achieved. In his evidence he appeared sanguine about that time-tabling,

despite his evidence that he was becoming increasingly concerned for the physical security of Georgia. His evidence never explained that contradiction. He accepted that he could simply have told Fife Council to remove AM forthwith from the Open Unit, but he did not do that. In the course of his evidence he described Georgia as a 'resilient character' whom he did not think was 'overly intimidated' by AM's bullying. How he could have come to that view is, in the face of all of the evidence about the bullying and its effect on Georgia, beyond comprehension. In the course of giving evidence, Sandy Cunningham gave the distinct impression that he was seeking to minimise the extremely serious nature of the bullying that was going on, more or less on a daily basis, in the establishment for which he held overall management responsibility.

Liz Anne Davenport in September 2009 knew that AM was no longer appropriately accommodated in the Open Unit but did not take steps to have her removed. However, she did make arrangements with AM's placing authority Fife Council for additional finance to support one-to-one monitoring for a time in September 2009. It was never made clear when that one-to-one monitoring ceased, if it did, nor indeed if it was always in place when it should have been. If it was in place for several days after 8th September 2009 when Miss Davenport noted in the Unit Log that arrangements had been made for such monitoring and supervisions, then it must have become obvious that it was not effective, given the number of incidents which took place around that time and subsequently. AM was throughout September 2009 able to bully Georgia regularly, whether she was subject to additional monitoring or not.

(12)Communication

While Hull, Argyll and Bute and the Secure Unit and Open Units generated together a veritable mountain of paperwork in relation to Niamh and Georgia, it became apparent in the course of the Inquiry that there were many instances where there were failures among professionals to communicate

information in a cogent, straightforward, and common sense way. Some of these failures taken on their own were not of particular importance but taken as a whole they suggested a lack of professionalism and a tendency to view form-filling as an end in itself, without considering such matters as the value or the relevancy or accuracy of the information contained in all this paperwork. The following list contains a few general examples, as well as some specific ones.

- i. documents were often undated
- ii. documents were often unsigned
- iii. documents were on occasion signed by someone who was not the author and had no way of knowing if the contents were accurate
- iv. forms were often incomplete. Mary Walker the Reviewing Officer at the LAAC reviews for Argyll and Bute had a particularly relaxed approach to the forms she was required to complete. She often left whole sections of forms blank, or incomplete. She did not give the impression of being particularly troubled by these omissions.
- v. forms were sometimes used where the circumstances did not meet the criteria e.g. a form used in the Secure Unit called 'an Asset Risk Assessment' applied to young people who had committed offences but was used also for young people who had not offended. Similarly a form used by the psychologist Dr. O'Connor during his limited work with Niamh was one formulated for offenders, not for someone with Niamh's background.
- vi. forms failed to be precise in the way they called for information e.g. failure to distinguish between self-harm and suicide
- vii forms e.g. Individual Crisis Management Plans (ICMPs) often repeated information contained in previous similar forms, with no attempt made to

update information or analyse what the contents of the form might actually mean.

viii forms which should have been completed on a regular basis were not

ix meetings took place without the participants having the necessary documentation before them. The informal meeting after the Resource Management meeting on 29th June 2009 at Inverary is an obvious and concerning example

x. Meetings took place at which no Minutes were taken and no follow up confirmation was made. Two examples are:

(1) the meeting on 18th May 2009 between Jane Weir and Sandy Cunningham. When Jane Weir gave evidence she was unable to tell the Inquiry with any confidence what she meant by the notes she had made about the meeting, with specific reference to staff levels.

and

(2) the Resource Management Meeting on 29th June 2009 when no Minutes were taken, despite the irregularity of having such a meeting in the circumstances, and the importance of the decision which was taken. What was produced to the Inquiry was a note dated 5th October 2009 prepared by Alex Taylor at the request of Douglas Dunlop, after the deaths of Niamh and Georgia and at the start of the police investigation.

ix Minutes regularly contained inaccuracies and ambiguities.

x. Dr. Coxhall's report on Georgia of March 2009 was not sent on to the Secure Unit nor to the Open Unit

The above are only some of the many failures in communication about which the Inquiry heard evidence. As well as the suicide note of July 2009 the Inquiry heard evidence about an earlier suicide letter written by Niamh sometime in the early part of 2008. Her mother found the letter, considered

its contents 'very worrying' and handed it into the Social Work Department in Helensburgh. Thereafter it disappeared. Sandra Leonard never saw it during the time that she was Niamh's social worker and the letter was neither contained in nor referred to in any of the voluminous paper work generated by Argyll & Bute in respect of Niamh. What was before the Inquiry was a scanned copy retained by Niamh's mother when she handed the principal to the Social Work Department. In her evidence Joy Daniels spoke of a range of measures which had been implemented by the Social Work Department in Helensburgh following on a review of practices which took place after the deaths of Niamh and Georgia. One can only hope that improvements have indeed been made to communications in the department.

The Suicide Note

One of the starkest examples of these general failures in communication relates to the suicide note written by Niamh towards the end of July 2009. Its contents which were read to the Inquiry are now set out:

Dear Mum

Sorry about this but no one gave a shit what was best fur me. Don't know if you still have my old letter but I want tae be buried wae my neclace Jonny bought me. I want buried next tae Jonny and my name spelt Neve Lafferty and can you play P.diddy and Faith Evans missing you at my funeral once again I'm sorry but I don't need tae deal wae anythin anymore. Tell my dad I love him.

Luv Yaz all Neve XXX

Don't Grieve for me for now I'm free

I was satisfied that Marjory Thomson was the member of staff at the Open Unit to whom Anne Berry gave the note, and who copied it and returned the principal to her. At the Inquiry Marjory Thompson denied ever having seen the note. I did not accept that evidence. Anne Berry gave a very graphic

description of how at the Open Unit she had put her hand in her pocket and found the note which she had hastily put there when helping Niamh to gather her belongings from her bedroom at East King Street. The person to whom she gave the note at the Open Unit was the member of staff who was noting information from her about Niamh. The staff member who took the information from Anne Berry and noted it was Margory Thompson. Further, between Niamh's reception at the Open Unit at around noon on 28th July 2009 and 17.30 that same day Sandy Cunningham became aware of the note's existence, although he never took it upon himself to ask to see the note at any time. He told the Inquiry that the existence of the note had been communicated to him either by Marjory Thompson or Helen Toner. Helen Toner was not on duty at the material time. The person who told him about the note was Margory Thompson.

Had Sandy Cunningham read the note which in the course of his evidence after much dissembling he finally and reluctantly accepted **was** a suicide note, then he would have appreciated that the Open Unit was not the appropriate place for Niamh at that time and Argyll and Bute would have had to have made alternative arrangements for her. Had Adah Lambie taken the trouble to see the note and consider its contents in the light of what had happened to Niamh, she too would have realised that the decision made that morning to place Niamh in the Open Unit required immediate review.

On 29th July 2009 Sandy Cunningham went on leave. That morning a meeting took place at the Open Unit attended by Liz Anne Davenport and Ashleigh Bysouth, Niamh's maternal aunt who was there in place of Colette Bysouth who had gone on holiday. Ashleigh Bysouth gave evidence which I accepted that at that meeting she was told by Liz Anne Davenport of the existence of the note but was advised that she could not see the note as it was addressed to Niamh's mother. Liz Anne Davenport told the Inquiry that she had been unaware of the existence of the note until 5th October 2009 and had not seen it before giving evidence. It may be that she had in fact not actually seen the note but I am satisfied that at the very least she knew of its existence on 29th July 2009. I preferred the evidence of Ashleigh Bysouth. In

the absence of Sandy Cunningham and in the knowledge of the limitations of security at the Open Unit, Miss Davenport should have made familiarised herself with the contents of the note, if indeed she did not do so.

The Inquiry heard of many occasions on which staff at the Open Unit and at Argyll and Bute failed to communicate information either internally or externally. Given that much of their work involved 'talking' and 'supporting' it was remarkable how many times basic information was not communicated. I have selected randomly only three examples from many.

(1) James Boyle was the member of staff from the Open Unit who took Niamh to hospital when the Open Unit very properly wanted her examined after her transfer on 28th July 2009. He did not give the doctor who attended Niamh any information about the circumstances in which Niamh had been found, nor about what she had been saying about wanting to be dead. He may not have known about the suicide note at that time, but he should have made it his business to know as much as possible about the circumstances to relay these to the doctor. He was also the member of staff who took Niamh back to the hospital three days later after she had injured her wrist with a razor. Remarkably, he chose not to mention the overdose of three days before, despite the fact that Mary Stewart had emphasised to him the importance of doing so. He ignored that instruction.

(2) Douglas Dunlop's failure to contact anyone within Argyll and Bute to discuss Niamh's case after Roger Wilson gave him what is now known to be inaccurate information about the recommendations of Deborah Wick's report.

(3) On 4th October Mary Stewart was unaware of the existence of Niamh's suicide note and Martha knew of neither the existence of the suicide note nor about Georgia's recent history of absconding, nor the bullying campaign of AM.

(13) Risk Assessment

At the Open Unit there was no specific risk assessment document, and in order to assess what risks a particular child might pose, it was necessary for a member of staff to look at a number of different documents. Sandy Cunningham expressed surprise that no analysis was done in relation to risk on any child though he accepted that he had never examined logs or any paperwork to satisfy himself that information was being accurately recorded and analysed. He suggested that was Liz Anne Davenport's responsibility. He confirmed that after 4th October 2009 and following a Care Commission inspection a document had been produced which bore to be a risk assessment document although the topic of risk of suicide was not covered. Professor Platt gave evidence that children in care are at elevated risk of suicide, from the very fact of being in care, and that elevated risk increases where there are additional factors. As has been noted above, he expressed surprise that despite the voluminous papers from the Open Unit relating to Niamh and Georgia, it was impossible to know if any judgement had been reached about their levels of risk, and if so what that judgement amounted to. Without individual risk assessments, it is impossible for there to be a care plan tailored appropriately to an individual child's needs and it also makes it impossible for any one responsible for the health, welfare and safety of a child to know what risks there actually are. Ploughing through collections of documents, many of which contain out-of-date information, needless repetition and on occasion wholly inaccurate information is not the proper or professional way of approaching such a crucial matter.

(14) Psychological Therapy

It was clear from the evidence that both Niamh and Georgia had very serious behavioural difficulties. Niamh was grieving over the death of her boyfriend, and had what was described as 'anxious attachment' towards her father. That may well have had at its heart her experience of witnessing at least in part what happened when her father was repeatedly stabbed and Brian Fallon

was killed. Although always in Tanya Oliver's description 'slightly different' Georgia had first embarked on worrying behaviour after Tanya and her husband separated when she was around 7. Georgia always knew, as did her half-brother and half-sister that Tanya was their maternal aunt and not their natural mother. She was treated no differently by Tanya. It may be however that the fact that she, unlike her half-siblings, had not been officially adopted by Tanya caused her difficulties. In addition, although it was a specific order of the English court that Georgia's natural mother was to have no contact with Georgia, the fact that Georgia was able to meet Mandy when she was in care in Hull must have added to her confusion. Finding that her natural mother was inadequate and with addiction problems must have had an adverse effect on a thirteen year old.

Although Niamh remained at all times within less than an hour's travel from her home in Helensburgh, she was moved no fewer than 5 times in just over 7 months. Georgia, from June 2008 until August 2009 lived at 9 different places while in care. Particularly in the case of Georgia, those moves must have caused psychological upheaval as well as physical disruption. Dr. Coxhall's evidence made that clear.

The Inquiry heard from several psychologists and all were agreed that both girls might well have benefitted from therapy of one kind or another. However, it was clear that for whatever reason or reasons neither was willing or able to participate in any meaningful way in any of the therapies that were or might have been offered to them. Dr. Coxhall, with whose evidence I was impressed, explained that where there was reluctance to engage, there were a number of different ways that might be explored to encourage someone like Georgia to engage with any therapy considered appropriate. However, all the psychologists were agreed that a young person could not be forced to undertake psychological work and that to attempt to force such therapy on an individual could well be counter-productive.

During her time in the Open Unit from the end of July 2009 until her death, Niamh had a few sessions with Dr. O'Connor, a psychologist employed by

CORA. These resulted from a chance meeting between Dr. O'Connor and Niamh in the Open Unit. They were not part of any plan. At one of these sessions Niamh informed Dr. O'Connor when they were completing a form together that she had felt suicidal that summer. Unfortunately, Dr. O'Connor chose not to ask Niamh anything about that statement. He was unaware of the overdose of 27th/28th July 2009 and of the existence of the suicide note. Why that vital information had not been communicated to the in-house psychologist I cannot understand. Had there been proper communication among staff, and had a risk assessment existed, then Dr. O'Connor would have been provided with fuller information which one hopes would have prompted him to explore the significance of 'feeling suicidal that summer'. Niamh had agreed with Dr. O'Connor towards the end of September 2009 that she would participate in a programme to commence in late October. Dr. O'Connor thought that was a positive sign. Whether at the time Niamh agreed to commence the programme she anticipated being in a position to undertake it cannot be known.

Put broadly, there were various attempts made over the years, when the girls were in care and also at home, for CAMHS and assorted counselling services and psychological services to become involved. Both Tanya Oliver and Coletted Bysouth expressed their concerns to Hull and Argyll and Bute respectively, as well as to others, about the lack of any progress in relation to therapies that might have been available. Given the refusal of Niamh and Georgia to cooperate, and the potential dangers in trying to force cooperation however, it is not possible to conclude that the lack of psychological input was relevant to the deaths of Niamh and Georgia. It is nevertheless of concern that despite all the potential input from a variety of psychologists the Inquiry heard of no structured and sustained therapy being undertaken by either girl.

Towards the end of October 2008 when Georgia was in care at Merlin Bridge and had returned from one of her absconding episodes under the influence of an unknown substance, she was taken by staff to Hull Royal Infirmary. As a

matter of practice in England then and now, in circumstances such as these there is an automatic referral to psychiatric services, and on 28th October 2008 Georgia was visited at Merlin Bridge by Ami Parsons, a member of the Mental Health Team based at Hull Royal Infirmary. She carried out an assessment of Georgia, despite Georgia not being willing to engage fully in the process. In contrast, Dr. Brown told the Inquiry that when he saw Niamh on 27th July 2009 at East King Street he considered the possibility that Niamh should be psychiatrically examined. Given the limited number of beds available in the area, he did not think she could have been accommodated in a psychiatric ward that evening, and as CAMHS operated a 9 to 5 arrangement, that option was not open to him to explore. At the end of July 2009 Niamh presented at the Royal Alexandra Hospital in Paisley on two occasions, the first as a result of the overdose of valium she had taken when in care at East King Street, and the second after she had self-harmed by cutting her wrist badly, on neither occasion was it suggested by the medical practitioners who attended to her that Niamh should be seen by either a psychiatrist or a psychologist for assessment. When young people such as Niamh attend Accident and Emergency departments of hospitals in Scotland presenting with histories suggesting serious self-harm, or suggestive of a suicide attempt there must be value in having a psychiatric/psychological assessment carried out as near to the time of presentation as possible. At present, that option is not available automatically. Consideration should be given to making it so.

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(15) Role of the Care Commission

It was unfortunate that Jane Weir was not as focussed in the giving of her evidence as one might have hoped, and Mr. McClure on behalf of the Care Commission very fairly accepted that she struggled to recall the detail of her interactions with the Open Unit in 2009. It was also apparent that there was no consensus as to what had been agreed in relation to staffing levels at the meeting she had with Sandy Cunningham on 18th May 2009. A follow-up letter or a simple minute would have clarified the situation. In other circumstances

this lack of consensus might have been of more significance, but the fact was that on 4th October 2009 the planned number of staff who should have been on duty that evening was four, and that number would have adequately met the responsibility on the Open Unit in terms of their Certificate of Registration dated 14th October 2008.

“A provider shall..... ensure that at all times suitably qualified and competent persons are working in the care service in such numbers as are appropriate for the health and welfare of service users” (SSI 114/2002 Regulation 13)

The wording of Regulation 13 lacks precision as to the test to be applied when determining what in any set of circumstances would be deemed an appropriate number. Given the increasing numbers of our population who are spending time in a variety of care and nursing homes, I am of the view that there is a public interest in a need for more certainty homes about staffing levels necessary to meet the requirements of Regulation 13. Determining how that might be achieved e.g. by the stipulation of minimum staffing levels or by the application of a ratio is for other to decide but a regulation such as this which is lacking in precision is not helpful.

The format of the document which comprised a Care Commission report was not always as precise and focussed as it might have been and there may be merit in the Care Commission reviewing what is a public document to ensure that the information contained in it accurately reflects the situation at any establishment subject to registration. It transpired from the evidence that many of the headings in the document are followed not with an inspector's assessment but with what amounts to some kind of aspirational mission statement from the establishment itself. This state of affairs runs the risk that someone reading such a document may be misled as to the reality of the situation. The contents of these reports can often be an important factor on which decisions are taken in relation to the placing of people, whether young or old, mentally or physically handicapped, and it is essential that what is in any report is not only completely accurate, but also completely comprehensive. For example, in the latest Care Commission report on the Open Unit there was a reference to CCTV being in place throughout the

campus. That statement was not an accurate one. There was no CCTV in place in the Open Unit, and the CCTV in place in the communal driveway was operated by the Secure Unit, and not continuously monitored. Further, the latest care commission report available to the Inquiry in respect of the Open Unit referred to measures being in place to deal with absconding. This was misleading in that it referred only to measures put in place after absconding had happened i.e. the Traffic Light System, and not to any measures or strategy to prevent it happening.

(16) Transport Scotland and The Erskine Bridge

There was in the course of the Inquiry no criticism of Transport Scotland or any evidence to suggest that any reasonable precautions might have been taken by Transport Scotland whereby the deaths might have been avoided. On the contrary, there was evidence from William Valentine that all reasonable precautions had been taken by Transport Scotland to prevent people committing suicide from the Erskine Bridge. As at October 2009, the parapet height met the UK national standards as contained in the Design Manual for Roads and Bridges published by the Highways Agency. It is however appropriate to note that since 2009 further assessment has been carried out and work is now taking place whereby further and higher barriers of anti-climb design and material are being erected along both sides of the bridge.

(15) Professor Platt's Report and Evidence

The Inquiry heard from Professor Stephen Platt, Professor of Health Policy Research at the Centre for Population Health Sciences at the University of Edinburgh. He had – at the request of the Crown – prepared a report dated 30th May 2011 in which he addresses the two issues on which he had been asked to comment viz;

1. were the deaths preventable?

2. could anything have been done to mitigate the (suicide) risk? If so, how?

His answer to the first question posed is in the following terms. *'If forced to give a one word answer to the question 'where the deaths of GR and NL preventable?' the most honest answer has to be 'Probably not'.*

In dealing with the second question, he raised a series of questions which he very properly did not attempt to answer. Many of the questions he posed in his report were asked in the course of the evidence and this determination has attempted, on the basis of the evidence heard or agreed, to answer such questions as are considered relevant to the deaths of Niamh and Georgia.

Professor Platt's evidence was measured and helpful to the Inquiry. One area of concern for him, shared by me, was why, given the case histories of both Niamh and Georgia, no judgement as to the risk of suicide was ever reached by those in the Open Unit and reference has already been made to that issue in this Note. In his conclusion he makes three preliminary recommendations which I repeat here for the benefit of those responsible for the welfare and safety of young persons in their care.

Three preliminary recommendations by Professor Platt

1. *Local authorities should commission a set of guidelines for staff working with looked after and accommodated children about recognising and mitigating suicide risk in this client group. These guidelines should include the requirement to develop a detailed management protocol.*

2. *The management protocol should set out the procedures to be implemented when a looked after and accommodation child is considered to be at risk of self-harm or suicide e.g. by making suicide 'threats', by*

expressing suicidal thoughts or by making preparations for suicide. The protocol should cover inter alia the allocation of duties and responsibilities, effective methods of communication, within the establishment, liaison with other professionals and techniques for preventing contagion/spread of suicidal behaviour within the establishment.

3. Professionals working with looked after and accommodated children, either directly (e.g. in residential establishments) or indirectly (e.g. local general practitioners or employed in the local CAMHS team) should have a sound understanding of the risk of self-harm and suicide among their clients and of appropriate interventions to mitigate that risk. Appropriate training should be provided on starting employment in a residential centre and at regular intervals thereafter (as part of continuing professional development).

In conclusion

It is appropriate at the end of this Determination to express my condolences formally to the family of Diane McGowan partner in Messrs. Simpson & Marwick who represented Argyll and Bute Council in the early weeks of the Inquiry and who died of cancer in November 2011.

I also wish to express again my condolences to John Watt, Area Procurator Fiscal, whose elderly mother died in September 2011 .

Finally, I would wish once more to express my sympathy to the families of Niamh and Georgia and to put on record how grateful I am for the way in which those who attended the Inquiry conducted themselves throughout, both in the giving of evidence, and in the way they conducted themselves during

the many days of evidence, much of which must have been distressing for them all. They behaved with dignity and restraint throughout.

Ruth Anderson QC

Sheriff of North Strathclyde at Paisley

27th April 2012