The Girls on the Bridge

A Scottish Review special investigation

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by Kenneth Roy

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Part I

The basic facts are these. Naimh Frances Bysouth (or Lafferty), born on 18 June 1994, and Terrie Faye Oliver (also known as Georgia May Rowe), born on 13 February 1995, walked a distance of three miles from the Good Shepherd Centre, in Bishopton, Renfrewshire, to the Erskine Bridge, arriving near the centre of the bridge just before 9 o'clock on the evening of Sunday 4 October 2009. They had walked for about an hour to their pre-planned destination.

When they arrived at the barrier, the two girls took off their training shoes and put them on the ground. Georgia – we shall call her Georgia – left a photograph of herself and her half-brother and sister in one of her shoes. One of the girls draped a scarf over the barrier. They sat briefly on the barrier with their backs to the water, linked arms, and fell backwards. The force of the impact killed them instantly. Naimh – who preferred to be called Neve; so we shall call her Neve – was 15 years old; Georgia 14.

A fatal accident inquiry heard by Sheriff Ruth Anderson QC decided that they took their own lives. Why they chose to do it together, and why they chose to do it that night, will never be known. Neve had just returned to the Good Shepherd after weekend home leave; Georgia had been out for a meal with her aunt. Neve came back at 7pm, Georgia 10 minutes later. They appeared to be in good spirits: there was nothing in their behaviour which gave any cause for concern. At 7.30, a member of staff saw both girls in their night clothes. Fifteen minutes later they had changed into outdoor gear and were on their way out of the building. By 9 o'clock they were dead in the waters of the Clyde.

Other than the basic facts, what do we know of this case? There are several misconceptions, some more serious than others. We have been told that the girls were close friends. A minor matter: but they weren't. An impression has been given that, although both were in care, their backgrounds were relatively normal. On the contrary, their personal histories were shocking. The outcome of the inquiry into their deaths, as reported in the press, was grossly simplistic: if there had been more staff on duty in the Good Shepherd Centre on the evening the girls absconded, or if they had been accommodated more securely, their deaths that night might have been avoided. Is that it? Far from it.

The true story is one of systemic failure, a reluctance to confront official shortcomings, a judgement of extraordinary passivity about the culpability of one of the key players in the unfolding tragedy, and two needless deaths.

Neve's story

Neve's parents separated when she was two years old. She lived with her mother, Colette, a caring person by all accounts, but went on seeing her dysfunctional father, Paul Lafferty, a man with a violent past and a record of illegal drug-taking. The turning point in her life came when she witnessed an incident involving Lafferty and another man which led to her father's trial for murder. He was acquitted in November 2006, but Neve's life was permanently affected. Her behaviour deteriorated abruptly.

In 2007, she told her mother that she had swallowed an overdose of herbal tablets. In April 2008, she cut her wrists. She was taking drugs, drinking heavily, shoplifting and associating

with delinquents; she was reported for assaulting a fellow pupil at school. She was now spending more time with her father, who had no money to eat or to heat his house. Lafferty decided that he could no longer cope with Neve, but she refused to live with her mother.

In June 2008 she became a client of Argyll and Bute Council, and was in and out of the open unit of the Good Shepherd Centre at Bishopton, where absconding could not have been easier. The unmanned fire exit door was the usual escape route.

Neve had a boyfriend, Jonny McKernan, who was as messed up as she was. On 19 February 2009, Jonny appeared in court on a charge. Two days later he killed himself. On 3 March, the day of his funeral, Paul Lafferty was admitted to a psychiatric unit (he committed suicide in 2010, after Neve's death). Neve had now lost her boyfriend and, effectively, her father. Her fragile life degenerated into chaos.

On 5 March she self-harmed by scratching her face and the following day, in the open unit, she drank a 200ml bottle of witch hazel. She was taken to the Royal Alexandria Hospital in Paisley but 'required no treatment'. Eight days later she went missing from the unit for a full weekend, which she spent with a man, sleeping in a car.

On 19 March, she was finally transferred to the secure unit at Bishopton for her own protection. For a few months she was closely supervised. During this period, she repeatedly told staff that, if she could, she would 'go mad' with drugs and drink. She talked about ending her life. She talked about 'wanting to be with Jonny'. She told a case worker that she would take loads of 'blues' (street valium), mix it with vodka, go to sleep and not wake up. Neve was 'calm and focussed' when she said these things.

A place of safety?

On 26 June, there was a serious breakdown in communications at Argyll and Bute Council. A man named Roger Wilson, 'resources services manager', told the head of the children's department, Douglas Dunlop, that Neve's social worker, Deborah Wicks, had recommended that she should be transferred from the secure unit at Bishopton to the open unit. Dunlop, without seeing the case papers, decided that Neve should be transferred instead to one of Argyll and Bute's own children's homes.

Deborah Wicks had not recommended that Neve should be transferred from a secure unit to an open one or to a children's home. She was firm in her belief that Neve required the safety of secure accommodation, and refused to attend the children's panel hearing at which she would have been expected to recommend the move.

Despite her implacable opposition, the move was duly ratified on the recommendation of another social worker who took over responsibility for Neve and would continue in that role until Neve's death.

A case worker at East King Street, the children's home in Helensburgh where Neve was sent, prepared a note: 'Niamh self harms – cutting wrists, taking paracetamol, drank half a bottle of witch hazel, and has threatened to hang herself – numerous sucide attempts'. Was this a suitable environment for Neve? The staff were doubtful, to say the least.

Neve plastered her bedroom wall with large laminated photographs of Jonny. According to one care worker her room 'resembled a shrine'. She absconded on several occasions, took drink to the home, and on 27 July was found semi-conscious in bed after a valium overdose. She again said she wanted to be with Jonny. She said she was sorry to have wakened up.

Neve was seen by two GPs in Helensburgh. Neither was of the opinion that she required to go to hospital, though one thought that she needed a psychiatric assessment.

It was obvious that East King Street could not keep Neve safe. It should have been obvious before she was referred there.

The journey

On 28 July, her carers decided that she should go back to the open unit – repeat, the open unit – at Bishopton as an emergency measure. When Anne Berry, a case worker at East King Street, was helping Neve to collect her belongings for the transfer, she found a letter lying beside her bed.

Anne Berry, having glanced at the final line, quickly put the letter in her pocket. Neve was taken to the open unit in her night dress and with vomit stains on her clothes. During the car journey she said several times that she wanted to be with Jonny and 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 to the Erskine Bridge because the staff would not chase anyone there – in case they jumped.

At reception, Anne Berry gave the letter to a case worker named Marjory Thomson, who copied it and returned the original to Anne Berry. When Anne Berry told a social worker about the letter, she was advised to put it in Neve's file at East King Street. The letter remained there unread – until the police discovered it after her death.

The existence of the letter was, however, brought to the attention of the head of the Good Shepherd unit, a man named Sandy Cunningham. He did not ask to see it. Nor did he discuss its contents with the social work department.

Neve's move from East King Street to the open unit should have been formally considered by the children's panel. It wasn't. The panel should have reviewed the transfer. It didn't.

When Neve's response to the transfer was to take another overdose, she was again seen in A & E at the Royal Alexandria Hospital where she 'required no treatment'. No further assessment was ordered by the duty doctor. The case worker who accompanied Neve had not been told about the letter.

Two days later Neve tried to break into the secure unit at Bishopton. She was so distressed that she had to be physically restrained. She cut the inside of her wrist with a razor, and was taken once more to the Royal Alexandria Hospital. Sixteen stitches, but no further assessment recommended. The old story.

On 5 August, Neve saw a locum to have the stitches removed. The locum was concerned about her mental condition. As a result, Neve was referred to the NHS's Child and Adolescent Mental Health Service (CAMHS) on 7 August 2009.

On the day she died two months later, she was still waiting for an appointment.

The letter

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 hut I don't need tae deal wae anythin anymore. Tell my dad I love him.
Lov Yaz all Neve XXX
Don't grieve for me for now I'm free.

At the inquiry, Marjory Thomson denied ever having seen this letter – a denial which the court rejected. Sandy Cunningham, the head of the unit, was reluctant to accept it as a suicide note. Roger Wilson, the manager who apparently misrepresented the wishes of the dead girl's social worker, left for New Zealand a week before the inquiry began. The court asked him to provide an affidavit. He failed to respond.

Part II

Georgia's story

There was a possible explanation for the degeneration of Neve Lafferty's fragile life into chaos. She witnessed a violent incident involving her dysfunctional, drug-addicted father in which a man died. Neve's father went on trial for his murder. Paul Lafferty was acquitted, but the trauma left a permanent impression on Neve.

There was no life-changing event in the case of Georgia Rowe: she was a deeply vulnerable child from the start. Born in Hull to a single mother, she was the subject of a care order within 10 months of her birth in 1995. The order (granted by a family court) remained in place until her death 14 years later.

Around the time of her first birthday, Georgia was sent to Scotland to be cared for by her maternal aunt, Tanya Oliver, in the Ayrshire village of Sorn. Tanya treated Georgia as her own daughter.

From the age of seven, there was a steady deterioration in Georgia's behaviour. She lied, she was aggressive and sometimes violent, and as she grew older she was sexually precocious. In 2008 Tanya decided that she could no longer cope. Georgia was placed with successive foster carers in Jedburgh and Hull, the Hull placement breaking down because of persistent absconding, Georgia's use of drink and drugs, and her liking for high-risk sex.

In March 2009 it was agreed that she should be transferred to the secure unit at the Good Shepherd Centre. It was thought to be sympathetic to Georgia's own wishes: she had

indicated a desire to return to Scotland. But there was no improvement in her behaviour. She lashed out at staff, shouted and swore, squealed and made strange animal-like noises. She had to be physically restrained on a number of occasions. When she recovered, Georgia said she had no memory of these outbursts.

On 7 May 2009, she ripped up a pillowcase and formed a ligature. She put it round her neck and attempted to strangle herself. This was interpreted by the staff not as a serious suicide attempt but as a 'cry for help'.

Inexplicably, her carers decided that Georgia was fit to be transferred from the secure unit at Bishopton to the open unit, where absconding through the fire exit door was routine and easily accomplished. Her aunt was appalled. There was a heated discussion between Tanya Oliver and the staff, but Georgia was moved anyway. It was not long before she absconded.

The bully

There was a very good reason for Georgia's desperation to leave the open unit. She was being badly and systematically bullied by another of the girls in the unit, a girl from Fife known only as 'AM'.

The first time she absconded, Georgia refused to return to Bishopton voluntarily. She jumped repeatedly in front of moving cars, and when the police arrived she ran into a garden making animal noises. She had to be handcuffed for the journey back.

The bullying continued. It was a daily occurrence. On one occasion, AM intimidated Georgia by hiding a pair of scissors in the waistband of her jeans, making it known to Georgia that they were there. Another time, when the girls were heading for the swimming pool, AM told Georgia that when they got there she was going to drown someone – there was no doubt who she had in mind. Georgia refused to go to the pool that day.

Georgia absconded many times. Just as a distressed Neve Lafferty once tried to break into the secure unit for her own protection, so independently did Georgia. She was again physically restrained and in a condition of extreme distress as she was returned to the open unit. She told staff that AM was planning to stab her in the face with a piece of glass.

Nothing was done to stop the bullying. Nothing was done to remove the bully.

When Sandy Cunningham, the man in charge of the unit, gave evidence at the inquiry into the deaths of Georgia Rowe and Neve Lafferty, Sheriff Ruth Anderson formed the impression that he was seeking to minimise the 'extremely serious nature of the bullying in an establishment for which he had overall management responsibility'. Mr Cunningham is no longer employed at the Good Shepherd; he is listed in the court papers as an education officer with Glasgow City Council.

A day out

On 26 September 2009, eight days before she killed herself, Georgia responded to a further threat from AM – to put her head through a ******* window – by absconding. She met up with another girl – not Neve Lafferty – and they boarded a train at Bishopton for Glasgow.

The two girls hung about the city centre, where they were picked up by an older man who took them to a block of flats and plied them with alcohol and drugs. They spent the night with this man and had a conversation about committing suicide. Neither girl thought that she had anything to look forward to in this life.

The following morning they went to a police station and were returned to the Good Shepherd. In the car on the way to Bishopton, Georgia repeated that she did not want to go back to the open unit to be bullied by AM.

On 4 October, Georgia went out for a meal with her aunt, Tanya Oliver. She returned to the unit at 7.10pm and changed into her night clothes, as did Neve Lafferty who had got back from weekend home leave 10 minutes earlier. Both seemed cheerful and gave no cause for concern.

No-one knows what happened next – what passed between the girls. But by 7.45, unseen by anyone except CCTV, they were dressed in outdoor gear and on their way out of the building. They walked together for three miles to the Erskine Bridge. By 9 o'clock they were dead.

A & E

Between the stories of Neve Lafferty and Georgia Rowe there are many striking similarities. A failure to listen by those caring for them is the most obvious and disturbing one. How many more times did Neve and Georgia have to exhibit signs of suicidal intent before someone took them seriously?

But there was one important difference.

In Part I we described how on three separate occasions in the months leading up to her suicide, Neve Lafferty was admitted to the A & E unit of the Royal Alexandria Hospital in Paisley. In March, she was taken there having swallowed a 200ml bottle of witch hazel. She 'required no treatment'.

On 29 July, she was there again after another overdose. Again she 'required no treatment' and no referral was made by the duty doctor.

The following day, 30 July, she entered the A & E unit a third time having cut the inside of her wrist with a razor. The wound required 16 stitches, but again there was no referral.

Three suicide attempts; two visits to A & E within 24 hours; but still no referrals. This neglect of Neve's mental welfare would not have been permitted south of the border. When Georgia Rowe was admitted to the A & E unit of Hull Royal Infirmary after an overdose, she was referred to the psychiatric service as a matter of course. She was seen by a mental health specialist, who carried out an assessment despite the patient's reluctance to co-operate. The referral did not save Georgia's life – but it might well have done.

The automatic referral of young self-harmers which is policy in England should be adopted without delay in Scotland. It is more than a little surprising that Sheriff Anderson did not see fit to make this a recommendation in her judgement.

Part III

Ten weeks before she finally succeeded in killing herself, Neve Lafferty made another of her many suicide attempts. On the morning of 27 July 2009, she was found semi-conscious in her bed in a Helensburgh children's home.

Throughout that day, Neve repeatedly told anyone who would listen that she wanted to die (or 'to be with Jonny', her dead boyfriend – it amounted to the same thing) and that she could not understand why she was still alive.

Neve was seen by two local GPs, Dr Jason Fang and Dr William Brown. It seems that Dr Fang did not ask Neve why she took the tablets, and there is an implied mild criticism in the inquiry report that he did not think of referring her to CAMHS (Child and Adolescent Mental Health Service), a specialist branch of the NHS.

Neither doctor thought that Neve needed to go to A & E. Could she, however, have been referred to the psychiatric unit at Gartnavel Royal Hospital in Glasgow? Dr Brown was well-informed about the pressure on beds there, and the particular shortage of beds for 14 to 16-year-old children. He was not hopeful about the chances of Neve being admitted.

Nevertheless, he felt that Neve should be given a psychiatric assessment. But by the time he saw her on the evening of 27 July, CAMHS had closed for the day. Emergencies in the lives of chaotic young people occur at any time, often at night, yet CAMHS observes the hours of a small town solicitor – 9 to 5.

Other than recording the fact, Sheriff Ruth Anderson had nothing to say in her judgement about this serious defect in the care of children at risk.

Neve, clearly still unwell, was eventually taken to A & E on 29 July. Nothing was done. Determined to die, she then cut her wrist and was re-admitted to the same A & E department 24 hours later. The wound was stitched, but no further action was deemed to be necessary. Did the duty doctors not detect some connection between these events or discern their significance? The hospital in Paisley escapes without censure in Sheriff Anderson's report – a report rightly critical of many other agencies and individuals.

The most the sheriff suggested – and it was only a suggestion – was that 'consideration should be given' to introducing a system of automatic referral to a psychiatrist when a young patient in A & E exhibits symptoms of self-harm. Although this sensible policy – which is common practice in England – should be introduced without delay, there appears to be no urgency to do so on the part of the Scottish Government.

It was only when Neve's stitches were being taken out – she required 16 for the wrist wound – that a locum became so anxious about the patient's mental health that Neve was finally referred to CAMHS. Caring though this action was, the locum might as well not have bothered. Two months later, on the day she died, Neve was still waiting for an appointment.

Had she lived, she would have gone on waiting, perhaps for many months. We understand

that, in March next year, there will be a new, improved waiting time target for CAMHS appointments. Scotland's most vulnerable young people should then be seen within 26 weeks.

Does Sheriff Anderson think this is acceptable? Does the Scottish Government think it is acceptable? Would any minister dare to justify a waiting time of half a year for severely damaged young people?

'Probably not'

The Crown asked Stephen Platt, professor of health policy at Edinburgh University, to prepare a report on the deaths of Neve Lafferty and Georgia Rowe. To the question, 'Were their deaths preventable?', Professor Platt replied: 'Probably not'. It would be interesting to have the justification for this conclusion. Having studied the evidence, we have come to the opposite conclusion.

1

No therapy of any kind was ever given to Neve or Georgia, despite the frequently expressed view of Neve's mother and Georgia's aunt that therapy would be helpful, and there was no stability in their care. They were treated as human parcels: Neve was moved no fewer than five times in seven months, and between June 2008 and August 2009 Georgia lived at nine different addresses, mercilessly bullied at the last of them. Had there been both therapy and stability, their deaths might have been prevented.

2

Georgia's unsuccessful attempt to strangle herself, not long before her final walk to the bridge, was treated by staff at the Good Shepherd Centre as a 'cry for help' – a phrase that ought to be expunged from the language. Had her suicidal intentions been taken seriously, her death might have been prevented.

3

In February 2009, a team leader in Argyll and Bute Council's social work department, Adah Lambie, recommended that Neve should be returned to the care of her father, Paul Lafferty, a man with a violent past and a record of illegal drug-taking. The social work department knew of Lafferty's appalling lifestyle, yet the move went ahead. Predictably, it was a disaster. Neve wrote: '…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'. Had Neve been removed from the malign influence of this man at an earlier stage, her death might have been prevented.

4

Neve's social worker, Deborah Wicks, knew that her client required to be looked after in secure accommodation. Both girls also instinctively knew this. It is a distressing though largely overlooked fact that, in the last months of their lives, Neve and Georgia independently tried to break into the secure unit at Bishopton, knowing it to be a place of safety. Neither succeeded, and Deborah Wicks's sound professional judgement was disgracefully undermined by her employers, Argyll and Bute Council. Had Deborah Wicks been listened to, Neve's death might have been prevented.

For all these reasons, we do not share Professor Platt's pessimism. In our view, both deaths could and should have been prevented.

Epitaph

'Dont grieve for me,' said Neve Lafferty in her suicide letter, 'for now I'm free'. She would not have been surprised to learn that this desperate letter, leaving specific instructions for her funeral, was so little regarded that it was consigned to a file unread. 'No one gave a shit,' she wrote in the same letter. Two months later she left the Good Shepherd Centre for the last time, and walked with Georgia Rowe three miles to the Erskine Bridge, where the two girls linked arms on the barrier, their backs to the water.

Have their deaths changed anything? Does anyone give a shit now?

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