Bromley Safeguarding Children Partnership

Local Child Safeguarding Practice Review

Robert

Jane Wonnacott

MSc MPhil CQSW AASW

Director, Jane Wonnacott Safeguarding Consultancy Ltd

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1 BACKGROUND TO THIS REVIEW AND REVIEW PROCESS

1.1 This Child Safeguarding Practice Review has been completed following the death of a 16-year-old child in March 2025. The indications are that he died by suicide, although this has yet to be confirmed by the coroner.

1.2 The child is known in this report as Robert, a pseudonym chosen by his parents.

1.3 The initial decision of Bromley Safeguarding Children Partnership was that the criteria for a multi-agency learning review were not met, but after Robert's parents contacted the Partnership with additional information, a Rapid Review was carried out in September 2025. This concluded that there was learning for the safeguarding system and there should be a Local Child Safeguarding Practice Review. The national Child Safeguarding Practice Review Panel were notified of this decision.

1.4 An independent lead reviewer was appointed and a reference group identified consisting of senior leaders from safeguarding agencies within Bromley who had no prior involvement with Robert. The reference group was chaired by the Independent Commissioner Children and Young People, Bromley Safeguarding Children Partnership.

1.5 An early discussion took place with Robert's parents to understand more about Robert's life and the areas that they wished to be covered within the terms of reference for the review. Robert had contact with mental health services and his parents understandably want this review to consider whether the risk of suicide was adequately assessed and responded to. This will be an important question for this review to answer. His parents have also told us that they are not seeking to apportion blame but want to help the review identify where system safeguards may not have operated robustly, so that future children presenting with evolving suicidal ideation are helped. The independent reviewer and the reference group are immensely grateful for their willingness to share their memories of Robert, and their contribution to the development of the review's key lines of enquiry.

1.6 Documents prepared for the Rapid Review were considered alongside source material from the case files collated by Robert's parents. These files were shared with his parents following information requests to services in contact with Robert. The documents enabled the reviewer and reference group to identify practitioners who could help the review. Meetings were held with managers and practitioners from:

- Bromley mental health and emotional wellbeing service (under 18's)
- Robert's school
- Child and Adolescent Mental Health Service (CAMHS)
- GP representative
- London Ambulance Service (NHS111)
- Orthodontic practice
- The school counsellor

1.7 The review also consulted with the Emergency Department Safeguarding Lead regarding internal referral processes.

1.8 Drafts of this final report were discussed by the reference group as it evolved and a late draft also shared with Robert's parents. Their comments have informed this version of the review.

2 ROBERT

2.1 Robert was nearly 17 years old when he died. His parents have described him as an intelligent, thoughtful and caring young lad and all those that knew him have also spoken of him as being polite, courteous, hardworking, charming, modest and caring. He was known for his trademark smile which was commented upon by almost everybody in his memorial book.

2.2 His parents recall his early interest in sport when he played football for his local club whilst at primary school in goal and defence. They describe him as never flinching when the ball came at him in goal and never turning away when a larger lad came at him in defence. They believe this strengthened his character and he became a fearless team player.

2.3 From year seven, Robert attended a boys' selective grammar school in a neighbouring borough and at the time of his death was in the sixth form. He was academically very able, excelled at rugby and was liked and respected by his friendship group. He had several leadership roles in school, and his death was a profound shock to his school community who commemorated the anniversary of his death with a sponsored park run. A trophy is now given every sports day in his name to the most improved player in the rugby team.

2.4 Robert was a dual heritage Southeast Asian/White British child. He did not practise his Mother's Muslim faith or any religion, but his parents have described him as having a strong moral compass. At the time of his death, he was living with his grandmother close to the family home, having moved there to have more space to study. Although not sleeping at home, Robert saw his parents almost every day as his father worked from the grandparent's house.

2.5 Robert gave very little indication of mental distress to his peers and talked of plans for the future including going to university and possibly pursuing dentistry as a career. In conversations with some professionals Robert did speak of worries such as feeling lonely at times and that friends were less sociable since the pandemic. He had made a close friend online though the gaming community.

2.6 He was very concerned about his appearance, specifically his skin and the impact of orthodontic treatment on his smile. His worries about his appearance were such that his parents arranged for the mirrored door of his wardrobe to be removed to prevent undue distress. He was also very interested in remaining healthy, and he became meticulous about only eating protein and vegetables as well as working out to keep fit. His parents have shared with the review numerous internet searches relating to vitamins, skin and hair products and he was keen for his parents to be in their best health, buying them special glasses and supplements.

3 AGENCY INVOLVEMENT WITH ROBERT

Response to initial concerns in 2022

3.1 Until 2022 Robert had contact with the usual universal services. However, in May 2022 Robert's mother found a ripped up four-page handwritten note in the bin in his bedroom. This note acknowledged his love for his family and friends but also described feelings of wanting to die by suicide. His confusion as to why he felt that way is explored within the note which touches on being an "over thinker" and worried that there was "something wrong" with him. The note contained the password to his phone, the password to his computer and a friend's telephone number.

3.2 Robert's mother asked his father to talk with him, and when Robert spoke to Father, he handed him a printed letter. This also referred to his love for his family and plans for suicide. In the note he described researching methods of suicide which are similar to methods researched in the days before his death. The note referred to his concerns about acne and also said "*Everything is crashing down on me*"; "*I have everything yet nothing*"; "*I am just so tired, and I don't have the motivation to live*". The note gave more details about his wishes for his funeral.

3.3 Robert's father described his head spinning on reading the letter as this was the first time that his parents had any idea that all was not well. During his conversation Robert told his father that he had been thinking about taking his own life and had considered ways of doing so. His parents have told the review that this discovery had a profound impact on them, it was shocking and frightening and they realised that he needed professional help.

3.4 Robert's parents called their GP and NHS111 for advice. Mother spoke to NHS111 who, after an initial triage, arranged a call back when Father and Robert were there. There was then a telephone call which transitioned to a video call by a NHS111 clinician who spoke to Robert and Father. There was discussion regarding Robert's concerns about acne, mention of the suicide note and that Robert had accessed websites which described methods of suicide. The clinician completed the expected 111 assessment and sent a referral to the GP requesting an urgent mental health assessment and referral to a dermatologist. [1]

3.5 This NHS111 written assessment included reference to the suicide note (but not the websites) and the call resulted in the family being directed to visit the local Urgent Care Centre who "streamed"[2] Robert through to the Emergency Department. The Emergency Department then referred Robert to the CAMHS Liaison & Crisis Team. Standard practice was followed with a brief referral form capturing basic information but little detail being e-mailed to the CAMHS Liaison and Crisis team. The next day the

[1] The system today would allow NHS111 to access appointment slots at the GP surgery and book an appointment.

[2] Streaming is the terminology used within the Urgent Care Centre when referring a patient on to the Emergency Department.

Emergency Department sent notification to the GP of the visit and their referral to CAMHS. This sequence of events is discussed later in this section of the report and in more detail in Finding One of the review.

3.6 The CAMHS Liaison & Crisis Team provides emergency mental health services to children under 18 in three London Boroughs. Where a child presents to an Emergency Department they offer a same day emergency assessment and in situations of suicidal ideation or self-harm they will usually complete an assessment of risk before formulating and creating risk management plans with recommendations for follow-up. Safeguarding actions will be completed where required. Practitioners who spoke to this review described the usual process as information review and immediate risk being assessed via a phone call (tele-triage) and to decide whether a same day face-to-face appointment is needed.

3.7 Information given to the inquest was that where suicidal ideation is present tele-triage is not in line with protocol which stipulates that there should be a face-to-face assessment. This protocol was not followed for Robert as a member of the CAMHS Liaison & Crisis Team spoke to the Emergency Department Nurse in Charge and then had a phone call with Robert and Father. Although the referral did include mention of suicidal ideation, the detail of significant information that the parents gave to NHS111 about suicidal ideation including the content of the suicide notes had not been conveyed in the referral to the CAMHS Liaison & Crisis Team. The team have told the review that had there been a clearer account of suicidal ideation (as set out in the note) they would have immediately arranged a same day face-to-face meeting and made a safeguarding referral.

3.8 The main discussion during the tele-triage focused on Robert's concerns about acne scarring, low self-esteem and low confidence. and the clinician assessed that Robert could keep himself safe for the next week and that the parents would help to mitigate the risks. The outcome of the triage was that Robert was assessed as "Amber" and should return home with an agreed safety plan, have a duty CAMHS phone call every other day and be seen face to face by the CAMHS Liaison & Crisis Team within seven days.

3.9 Robert's father immediately spoke to Robert's school to advise them that he was concerned about Robert's mental health and that he was in contact with CAMHS. The school made an immediate referral to the school counsellor who saw Robert the next day, and then three more times between May and July 2022. This also triggered support in school if needed with a general "having a tough time e-mail" to relevant staff and "time out cards" for Robert to use should he need space during the school day. There was no communication between CAMHS and the school and the issue of communication between schools and mental health services is discussed in Finding Two of this report.

3.10 The plan was for the CAMHS Liaison & Crisis Team to follow up with regular duty calls to the family to continuously assess risk before the seven day follow up. However, due to missed calls or calls not taking place at all, there was only one conversation. At the

face-to-face seven day follow up with CAMHS it was noted that Robert's acne was healing, and he said his suicidal ideation had come from looking at himself in the mirror. As a result, mirrors had been removed from his bedroom. He also said that he had support from friends and family. There is no reference to the suicide note in the assessment report although Father recalls offering to show the note to the practitioner. From Father's perspective the suicide notes were one of the most disturbing things he had read and revealed a side to Robert that they had never seen before. The notes were the reason that Robert's parents had sought help in the first place and his father believed that their content and significance would remain a key part of understanding Robert's distress and assessing risk throughout his care. The CAMHS practitioner does not recall being told about the note and usual practice would be to take a picture of any suicide notes for further consideration as to the level of risk.

3.11 The seven-day follow-up resulted in a referral to the local mental health and emotional wellbeing service for psychological therapy. Robert was also given a safety plan with coping suggestions, a distraction booklet and signposted to the Kooth website[3] for online counselling support. The review has been told that referral to the local mental health and emotional wellbeing service was believed to be the most appropriate decision as Robert needed psychological therapy which was provided by this service. At that time the process for referral to both community CAMHS and the mental health and emotional wellbeing service was via the Single Point of Access (SPA). The SPA sat within the local mental health and emotional wellbeing service and the referral was accepted by them for psychological therapy. CAMHS crisis practitioners have told this review that a referral to the local community CAMHS team would have resulted in much longer wait times and that the mental health and emotional wellbeing service would always escalate back to CAMHS if necessary.

3.12 It is important to note at this stage that the emergency crisis CAMHS assessment was not a full biopsychosocial assessment[4] of the child within their wider context but rather an assessment of the presenting issue and immediate risks. It is necessarily time limited and focused on immediate safety and next steps.

3.13 Although it is not expected practice, the CAMHS practitioner was proactive in following up to ask for a copy of the assessment by the local mental health and emotional wellbeing service but was not forthcoming, despite chasing. The wait for the assessment appears to have led to the final CAMHS discharge letter not being sent to the GP and family until two months after the initial referral.

3.14 It is relevant to the final recommendations within this report that the system has now changed and the CAMHS Liaison & Crisis Team no longer indicate a pathway on the referral form to the SPA who make the decision as to whether the referral should be directed to CAMHS community services or the mental health and emotional wellbeing

[3] Kooth is commissioned by the NHS to provide free on-line counselling for children and young people.

[4] This is an holistic assessment which recognises that an individual's wellbeing is shaped by the complex interaction between their body, mind and social environment.

service. There is now an integrated team (iSPA[5]) jointly operated by the local mental health and emotional wellbeing service and the mental health trust. This is a triage service which determines the most appropriate pathway for the child. The triage and assessment process is further discussed within Finding Two of this report.

3.15 Following the CAMHS crisis assessment Robert saw a private dermatologist as he had expressed concern about his acne. The parents recall that at the appointment Robert was very concerned about the impact on his appearance and had researched possible treatments including the possibility of microincisions. He was informed that this was not possible and in fact the acne began to clear up of its own accord.

Evaluation of practice

This was the first opportunity to understand the depth of Robert's anxiety and the risk that he might take his own life.

There remain two important practice issues that emerge and are relevant to today's practice.

1. The significance of the information within the two suicide notes became lost.
   Although parents recall giving verbal information to NHS111 about the detail within the notes, the record simply noted that a suicide note existed, and this contributed to the overall assessment within NHS111 that Robert should attend the Emergency Department within one hour. This assessment recorded the fact that there had been a suicide note within a list of other concerns and risk factors. After being seen at the Urgent Care Centre, which is co-located with the Emergency Department, the NHS111 information was not passed on to the Emergency Department. This was in line with routine practice which did not involve the whole patient record (known as the Encounter History) being shared.
   The presence of suicide notes was not mentioned on the referral form to the CAMHS Crisis & Liaison Team and from that point there was no exploration of the detail of the notes which if seen would have been likely to increase the level of concern. Instead, anxiety was mainly attributed to acne and facial scarring and Robert's parents have stressed to this review that this was not their main concern, their main worry was the level of distress that it was causing Robert. There was insufficient curiosity at all stages about what had prompted the parents to contact 111. If that had been discussed in detail, important information would have been emerged. The not unreasonable parental assumption was that they had told 111 about the notes and information they had provided would then be available to all professionals involved in Robert's care. It is vital that the detail of referral information does not become diluted, and this informs Finding One of the review.

[5] iSPA is the integrated front door for mental health and emotional wellbeing and comprises of both CAMHS and Bromley Y practitioners. It formally launched on 1st April 2024.

2. There was a disconnect between mental health services and Robert's school. No contact was made with Robert's school in order to inform the initial analysis of risk and work together with them on a plan to help Robert. Robert's school were swift in arranging for support, including in-house counselling, but this was provided in isolation from health service provision.

Involvement of the mental health and emotional wellbeing service in 2022

3.16 The mental health and emotional wellbeing service for children in Bromley is provided by a long-established local charity. It has provided these services since 2014, and in 2021 was awarded a five-year contract (with built-in extensions) to continue their provision of advice, signposting, groupwork and short-term low to medium interventions to children/young people and their carers. When Robert was referred for psychological therapy in 2022 there was pressure on the service which needed to manage a considerable waiting list. As a result, it was not until July 2022 that an initial telephone assessment took place with Robert. There was insufficient "while you are waiting" support offered at this stage as would be expected practice. Although the case records describe this as an assessment, it was information gathering to build a bigger picture and understand expectations. The practitioner noted suicidal ideation was still present with "on/off thoughts" and Robert described method, but he denied likelihood or intention to do it. The practitioner stated to this review that the family called the sessions with the school counsellor 'check-ins', so she did not request a report from them.

3.17 Robert was then allocated to a practitioner in the mental health and emotional wellbeing service in August 2022 and in mid-September Robert and his family were contacted by e-mail and offered an appointment. This was four months after the initial referral. There was no response from the family and after one telephone call to Father in November, during which he reported that Robert was doing much better, it was agreed that an e-mail would be sent to Robert to ask if he would be willing to have a conversation. An e-mail was sent to Robert on the same day and having not received a reply an e-mail was sent in January 2023 to Father and Robert confirming the case would be closed if no reply was received within the next week. As no reply was received, the case was closed and a final e-mail sent explaining case closure and that the family could contact the service if needed in the future.

3.18 By the time an appointment was offered to Robert he felt that he had been waiting too long for help and no longer wished to take up the offer of an appointment.

3.19 At the point of closure there had been no communication with Robert's school. The school counsellor had offered to work with Robert from September onwards, but he did not avail himself of further counselling and the assumption was that either the issues were resolved, or he was receiving help elsewhere. Good practice would have been to explore this assumption further with either Robert or his parents.

Evaluation of Practice

This was an important opportunity for practitioners to work together with his family, to develop a holistic understanding of Robert, his inherent vulnerabilities and risks, and the causes of his anxiety and distress and to provide him with a timely response.

1. Practitioners in the local mental health and wellbeing service were unclear about the role of the CAMHS Liaison and Crisis Team and the purpose of their assessment. This led to a failure to undertake a robust biopsychosocial assessment within the local mental health and wellbeing service on which to base an assessment of risk. The CAMHS Liaison & Crisis Team are clear that they only assess immediate risk and expect a full biopsychosocial assessment to take place within the community. However, the mistaken view of practitioners in the local mental health and emotional wellbeing service was that a full robust assessment had been carried out by an "expert" CAMHS practitioner which had concluded that Robert was "low risk". Consequently, they did not plan to carry out a full assessment at this stage.

2. There was continued disconnect between Health and Robert's school. The school counsellor assumed that help provided by the health service was more specialist than they could provide. In fact, Robert was being referred for psychological therapy provided by therapists with very similar qualifications and approaches to that of the school counsellor. This confirms the importance of effective information sharing and liaison between child mental health services and schools.

3. The means used to communicate with the family is important. Most communication by the local mental health and emotional wellbeing service was via e-mail although Father had made it clear in initial documentation that he would prefer text or phone contact. The initial documentation (which has now changed) lacked clarity and rather than the service carefully considering the preferred communication method, the default option of e-mail contact was used.

4. The impact of long wait times on children and young people needs to be better understood. The effect of waiting lists on young people has been found to be linked to emotional distress and young people may feel ignored or abandoned. Waiting too long may also jeopardise their trust in services.[6] For Robert, the opportunity to help was at the point of crisis when he had clearly expressed suicidal ideation, and four months later that moment had passed. This was a lost opportunity to engage with him and explore the root causes of his anxiety, rather than a superficial assumption that acne was the main issue. His father believes that a faster response might have helped Robert to feel heard, understood and supported when he needed it most. Waiting times are

[6] NSPCC briefing 2026 https://acrobat.adobe.com/id/urn:aaid:sc:EU:51482be2-59c7-442e-9532-d1beefe0364c

a cause for concern and it is important that their effect is mitigated by keeping in touch with young people and making sure that they know they have not been forgotten.

5. When young people with suicidal ideation do not take up the offer of help there needs to be a formal management review and evaluation of risk. Within four months the concerns for Robert had moved from clearly expressed suicidal ideation to withdrawal from services. This warranted a review of the case file which could have identified the lack of assessment and whether there were other options to engage with Robert and the family.

Second contact with mental health and emotional wellbeing service in 2024

3.20 Robert's parents recall that after his worries about acne, Robert then had concerns about other factors that might be affecting his appearance. It was around this time that he changed his diet and would only eat protein and vegetables and began to work out excessively at the gym. He also bought a pull-up bar for his room.

3.21 He had also been referred to an orthodontist and was first seen in February 2023. He was assessed as having a clinical need for treatment as, although his teeth were straight, he did have a chewing and biting issue. Braces were fitted in April 2023.

3.22 By January 2024, Robert's parents were worried about Robert's anxiety and when he approached them for help his father referred directly to the mental health and emotional wellbeing service via an on-line form. This stated that Robert did have thoughts and plans of suicide.

3.23 The referral was sent directly for further triage to the SPA team. This team were responsible for initial triage and sat solely within the local mental health and emotional wellbeing service. In early 2024 this was in the process of becoming a joint service with CAMHS, becoming an iSPA (integrated Single Point of Access), but this was not officially launched until April 2024. An email was sent to the family to say that CAMHS would be consulted about the correct pathway for Robert. It was not clear to the family that although consultation would usually take place, final decisions were made within the mental health and emotional wellbeing service. The issue of triage and assessments at the point of referral and the SPA/iSPA service is discussed further in Finding Two of this report.

3.24 The referral was triaged/screened by a manager and a SPA assessment for further information gathering was booked. Due to team capacity, the assessment took place a month after the referral was received. The completed SPA assessment[7], was carried out over the telephone by a Practice Lead from the "Getting Risk Support Team" who was

[7] This was completed on an "iSPA" headed document as the service was in transition – although still technically the SPA, some new template documents were being used as part of the "soft launch".

assisting with assessments in the at that time. She noted positive family relationships, and enjoyment of learning at school. Previous suicidal ideation was noted and feelings of loneliness stemming mainly since the Covid pandemic. Standardised tests were carried out with scores which were out of expected range for low mood, obsessive compulsive disorder (OCD), anxiety and depression. These tests were used to provide a baseline and would be monitored during the course of therapy. The practitioner told the review that the OCD score of 69 (65 is the borderline clinical threshold) taken within the context of the assessment did not indicate an immediate referral to CAMHS and the test would be repeated during a subsequent appointment. Subsequent testing showed that his score was within the normal range. A Safety Plan was agreed and emailed the same day.

3.25 There was no contact with Robert's school or CAMHS prior to the assessment being concluded. Risk was assessed as moderate and a plan agreed with Robert for face-to-face therapy every two weeks. The issue of triage and completion of holistic biopsychosocial assessments for children and young people is discussed further in Finding Two.

3.26 After contact with SPA/iSPA there was a pathway planning meeting and management oversight by a member of the mental health support team in the local mental health and emotional wellbeing service. The decision at this stage was to transfer Robert's care to the "Getting Help" team.[8]

3.27 Robert was allocated to a therapist almost seven weeks later. Prior to this there were "waiting well" contacts with Robert and his family to provide information and support.

3.28 The therapist discussed Robert's needs in supervision before the first session which was six days after allocation. This first session is described as an "assessment session" and Robert was seen alone and also with his parents. The plan was for six to eight therapeutic sessions every two weeks. Information was also sent to the parents about local parenting courses aimed at parents of teenagers. The parents have informed this review that this was not a helpful approach for them but they would have welcomed more information about what to do when worried that a child is suicidal.

3.29 At the next session the standardised tests were repeated, and Robert was now within the normal range apart from a raised anxiety score.

3.30 Supervision notes after this session record an email to parents to confirm that all sessions need to be attended on a weekly basis for the work to be meaningful and have any impact and that if the therapist could not offer this then the possibility of reallocation might need to be explored. The notes also record that risk should be

[8] "Getting Help" is defined within the THRIVE assessment framework as being used where individuals need focused, goal-oriented clinical or specialised support. This includes short-term interventions where there is a clear expected outcome. The THRIVE framework is the national model and is used within the Bromley mental health and emotional wellbeing service.

checked at every session including how often Robert had suicidal thoughts, triggers for those thoughts and whether he had a plan.

3.31 Before the next session, Father contacted the mental health and emotional wellbeing service to ask that Robert's sessions were put on hold until the end of August due to GCSEs and a family holiday. The practitioner emailed Father to confirm that the referral had been put on hold and asked Father to make contact when Robert was ready to resume. There was a further follow up at the beginning of September via email and a response was asked for by 18th September. If nothing was heard by then the referral would be closed.

3.32 Before any further contact was made with the mental health and emotional wellbeing service, Robert visited a duty GP in August with anxiety related symptoms. Robert was noted to be under the care of a therapist, and the plan was for Robert to discuss the anxieties with them. The GP was not aware that Robert was open to the mental health and emotional wellbeing service and the previous history of suicidal ideation in 2022 was not flagged within the records.

3.33 On 9th September Robert's father had responded to the email from the mental health and emotional wellbeing service to ask for sessions to start again. Five sessions were offered every two weeks starting mid-September. Although earlier supervision records had noted a plan for weekly sessions, the review has been told that this was a typographical error.

3.34 On 25th September 2024 Robert registered at a new GP practice. The standard national registration form does ask about medication, health conditions and other aspects of the person's life including whether they have a social worker. It does include a box where the patient can enter information about "mental health conditions" but does not ask any specific questions about prior contact with mental health services. The GP records from the previous GP practice were transferred electronically. The NHS111 document from 2022 which was labelled "suicidal", and the discharge letter from CAMHS were not obvious within the records as they were attachments and there was no visible safeguarding flag or alert that would have brought this to the new surgery's attention. There was no correspondence from the mental health and emotional wellbeing service regarding the current counselling, although the consultation with the GP hub in August was present.

3.35 Robert attended four further sessions with the local mental health and emotional wellbeing service after resuming treatment. These sessions have been described as patient led, and the therapist therefore respected Robert's reluctance to talk in detail about some aspects of his mental wellbeing. Before the fifth planned session Robert sent a text message to the therapist saying "I wanted to let you know that I'd like to discontinue our sessions for now as I think currently, I can manage without them. I'll let you know if I'm struggling in the future if you would like".

3.36 This message was sent two weeks after the therapist had a telephone conversation with Father who explained that Robert's grandfather had died and that Robert was "fragile".

3.37 Following this text message, the therapist sent an e-mail to Robert's parents to inform them that due to Robert's request he would be discharged from the service and that they could re-refer if support was needed in the future. There was no further follow up with Robert or his parents and his case was closed to the mental health and emotional wellbeing service.

3.38 The GP and Robert's school were not aware of the case closure.

Evaluation of Practice

This was a crucial period when there were opportunities to look below the surface, evaluate risk and make sure that services were proactive in providing the right help to Robert. His parents have noted that when Robert had previously asked for help in 2022 he was open about what he was experiencing. By 2024 he was much less forthcoming and they now see this as part of a wider pattern of emotional withdrawal and isolation.

In 2024 a picture was building of an intelligent, outwardly sociable young person who had profound insecurities about his appearance resulting in suicidal ideation. Anxiety linked to acne scarring in 2022 was now compounded by a focus on his body shape and diet, and his parents have described his gym use as excessive. It is clear from discussions with his school that he always strove for excellence and focused on being the best in all pursuits. This would have been important information in any assessment of the root causes of his anxiety and taken together might have prompted more consideration of the possibility of body dysmorphia or neurodivergence.

The SPA/iSPA assessment within the local mental health and wellbeing service is designed to be further triage rather than a full biopsychosocial assessment but discussion for this review with practitioners suggests that there was (and is) a lack of clarity as to whether this was a point of triage or a point at which a full assessment should take place. The assessor did not gather a full social history or a detailed account of all the parent's concerns about the change in his behaviour. There was also no expectation of liaison with Robert's school or his GP to provide a wider context for the assessment. As a consequence, the evaluation of risk did not take account of the totality of the factors relevant to arriving at a plan which would focus on reducing risk of harm and promoting Robert's wellbeing. Had a fuller assessment been completed consideration could have been given to a referral to CAMHS. Robert's parents were seen at the start of the first session but thereafter they felt increasingly isolated and believe that they could have contributed positively to the ongoing assessment of Robert's needs and risk of suicide.

Subsequent discussions in supervision after allocation did identify risks but approaches to intervention were then passive rather than proactive. There was no consideration as to whether a safeguarding alert should be raised following an assessment of moderate risk, and the expectation of the supervisor that risk needed to be checked every session was not followed up. When there was a request for sessions to be paused, the default position that the case would be closed if there was no contact by an agreed date does not demonstrate sufficient focus on what this might mean for a young person's mental health in the context of previous suicidal ideation and anxiety.

The patient led nature of the sessions meant that the practitioner did not proactively attempt to explore those aspects of Robert's life that were impacting his mental health even if they were sensitive to discuss.

Case closure following a text from Robert should not have happened without follow up with the young person and their parents. This is especially important given the last call from Father had described him as fragile following the death of his grandfather. This important information had not prompted an increase in contact and when Robert self-discharged, supervision and managerial oversight did not identify the importance of follow up.

The overall impression from the case files of the mental health and emotional wellbeing service is that it was a service under pressure leading to process driven responses rather than a full and holistic evaluation of the circumstances of the individual child.

Contact with orthodontic services.

3.39 Robert had started orthodontic treatment in early 2023. The need for treatment had been confirmed by the orthodontist and braces fitted by an orthodontic therapist[9]. He also needed tooth extractions. There were several emergency appointments as Robert was a worried about aspects of the treatment, but these were not considered to be beyond the norm. Both the orthodontist and the therapists are used to managing patient anxiety, liaising with CAMHS and the registration form asks whether the patient has been diagnosed with any mental health disorder. None was identified for Robert.

3.40 Robert had his braces removed in November 2024. Although the results from a clinical perspective were good, the orthodontist recalls that Robert did not seem pleased. As is usual practice, retainers were fitted at this stage, and a second additional set was paid for. When retainers are made a 3D model is used and this was given to Robert without

[9] Orthodontic therapists are trained dental nurses who have additional training to provide assistance to qualified orthodontists. Their role can involve direct treatment, and they routinely see patients. without the orthodontist present

charge. Two days later Robert revisited the surgery as a retainer had cracked and this was replaced without charge.

3.41 On 27th February 2025 he saw his usual orthodontic therapist who noted all was going well and that Robert would like to be a dentist. However, on 8th March Robert attended the Emergency Department with facial pain and a worry that he could not smile.

3.42 On 19th March 2025, Robert's mother called the orthodontist practice and said that Robert was anxious that a tooth had moved. He had become more and more anxious as he looked at the 3D plastic model of the retainer that had been given to him. Because of the urgent nature of the contact, Robert was seen on 26th March 2025 with his father by an orthodontic therapist he had not met before because his usual therapist was not available at short notice. Robert reported that his upper lip was getting stuck, but from the therapist's perspective, everything looked good and he should now be wearing the retainer only at night. He was asked to make an appointment with the orthodontist for the next week. On leaving the surgery an appointment was then made for June 2025.

Evaluation of Practice

With hindsight, Robert's anxiety about the orthodontic treatment and its impact on his smile can be understood within the context of other anxieties linked to his physical appearance. Although the orthodontic team is used to managing anxiety and liaising with CAMHS when required, the significance of Robert's concerns about treatment was not understood for a number of reasons:

1. Although information gathered at the point of referral asks whether the child has a mental health disorder this is a very specific question which was answered as "no". This was the technically correct answer. A more general question about anxiety of whether the child has ever been referred to mental health services might be more useful.
2. NHS orthodontic services seem to operate in isolation from other health provision. GPs are not routinely informed that a child is undergoing treatment, and the orthodontist was not aware that Robert had visited A&E with dental pain and concerns about his smile.
3. The orthodontic practice is clear where they should go with any obvious safeguarding concerns but are less clear where issues relate to emotional wellbeing. A pathway which clarifies expectations where this is the case would be a positive step forward.

The practice has reflected as to how they can improve practice and would benefit from further discussions with safeguarding partners as to the best way to integrate with the safeguarding system as a whole.

Robert's death

3.43 The day before the visit to the orthodontist Robert had been on a University and Colleges Admissions Service (UCAS) visit at the Excel Centre with his friends, and his school believed that he was enjoying talking to all the universities.

3.44 On 27th March 2025 Robert died by suicide.

3.45 A review of Robert's online searches carried out by City of London Police and passed to this review shows no evidence of bullying, coercion or visiting suicide forums, but it does show that in the weeks leading up to his death he had extensively searched the internet about facial appearance. He also researched multiple methods that he might use to end his life. His search history on the day of his death shows meticulous planning including high rise venues and ultimately how young people could make reservations for a particular high-rise restaurant and the expected dress code.

3.46 On the morning of his death Robert had seen his father and had been discussing going to the gym at the weekend. Robert made the booking for the restaurant online at 12.15 on the day of his death and paid a £20 deposit. He sent a selfie of himself on a bus to his father at 13.50 and at 14.02 he sent a text message to a friend who lives in Ireland which raised immediate concerns about his possible intention to end his life. At 14.07 there were multiple 999 calls made concerning a male who had fallen from a tower in the City of London.

3.47 There was nothing within Robert's search history to indicate that he had actively searched for easily accessible high-rise venues but there is information available online that the restaurant in the tower had been issued with a Prevention of Future Deaths report by the coroner as a result of a previous suicide in 2022. The extent to which the required changes had been made by the restaurant is beyond the scope of this review and the review has not received any evidence that this influenced Robert's decisions on the day of his death.

4 LEARNING FOR THE SAFEGUARDING SYSTEM

Information Transfer

4.1 The importance of information sharing is well documented, yet this remains a recurring theme within safeguarding reviews. The reasons for ineffective information flow vary and include; inadequate processes and procedures, myths about the legal basis for sharing information, lack of recognition about the significance of information and a system which does not support reflection, critical analysis and the curiosity needed to ask the right questions.

4.2 For Robert and his family, problems in the way in which information was transferred and shared was a theme throughout this review. The indications are that one important underlying cause was not an unwillingness to share, but systems and processes that did not actively promote information sharing and often were set up in such a way that it was very likely that information would become diluted or lost. This

was particularly obvious when Robert was first referred with concerns about his mental health in 2022. This is explored in more detail in Finding One of this report.

4.3 The point of crisis when a family first ask for help is a crucial time when there is a need for an accurate assessment of risk and there is the opportunity to respond in a way which supports ongoing engagement with the child and family. Effective information transfer at this stage will be vital to prevent the stress of children and their families having to repeat information and reduce the likelihood that assumptions will be made that information has been transferred when it has not.

4.4 Our current system relies heavily on practitioners at all stages recognising what information needs to be shared and for those in receipt of information asking the right additional questions. Some practitioners will be working in emergency contexts where there are time pressures and competing demands as well as the need for a wide knowledge base which may not fit every circumstance. In these situations, clear protocols are vital and Finding One outlines the gaps in information transfer from NHS111 through to the CAMHS Liaison & Crisis Team who were unaware of the gaps and assumed they had all the information in front of them. This resulted in inadequate exploration of the suicide notes and their content.

4.5 Beyond an immediate crisis situation, the needs of children and young people will be best served where it is possible to bring together information from across the multi-agency network. Where there are no safeguarding concerns, information sharing will take place with consent. Consent is sometimes mistakenly used as a reason not to share where there concerns about the safety of a child but in this case, there was no indication that worries about the legal basis for sharing information was considered an issue. Instead, the issue seems to be the lack of an information sharing mindset which was most evident within the mental health and emotional wellbeing service where there was no liaison with the GP or Robert's school. This is explored further in Finding Two in relation to the quality of assessments.

Suicide and young people.

4.6 The context for the learning from this review is the knowledge that suicide is one of the leading causes of death in children and young people and young men are more likely to take their life than young women. For example, data by the Office for National Statistics (ONS), analysed by Young Minds and reported by Disability Rights UK[10], showed that among young people aged 15-19 in England suicide rates rose by 35 per cent from 2020 to 2021. ONS data for 2025[11] confirmed that suicide rates are higher for males and also identified that they are highest in households where the household reference person holds a degree level qualification. Males with special educational

[10] https://www.disabilityrightsuk.org/news/suicide-rates-record-high-amongst-15-19-year-olds

[11] https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/mentalhealth/articles/riskfactorsforsuicideinchildrenandyoungpeopleinengland/2025-02-27

needs (SEN) also had higher rates. Within this context, children and young people are a priority group for support in the national suicide prevention strategy.

4.7 The learning from this review therefore needs to be used to inform development of local and national strategies since the issues will extend beyond the experience of one child and their family. Although the focus of this review must be Robert who was loved and respected by so many people, his parents have expressed the hope that any learning will be used to prevent another young person's death by suicide.

4.8 Whilst Robert outwardly presented as confident and sociable he effectively masked deep underlying distress. Some professionals such as school staff had no idea after 2022 that he was experiencing any anxiety, and other professionals who knew him did not effectively distinguish between suicidal thoughts and the risk that he would follow these through and die by suicide. This is not easy. A study by the Bristol Suicide and Self-Harm Research group[12] aimed to identify factors that differentiate individuals with suicidal thoughts from those who have made a suicide attempt and to identify factors that predict a future suicide attempt among those who have experienced suicidal thoughts. Factors identified such as substance misuse do not obviously fit the profile of Robert. There is some evidence elsewhere of the wide range of antecedents and the impact of cumulative stressors in increasing risk including bereavement. This Manchester report noted:[13]

The wide range of antecedents that we have found highlights the shared role in suicide prevention among front-line services and agencies, including mental health, social care, youth justice, and education. However, our findings show that a majority of young people who die have not had recent contact with front-line services; when they have, suicide risk has not usually been recognised. Staff in these services need the skills to assess suicide risk as well as the multi-agency collaboration that we have found in too few cases.

4.9 This is an important message when we consider the findings from this review.

The importance of high-quality biopsychosocial assessments where a young person is presenting with suicidal ideation.

4.10 It is now apparent that there was no robust biopsychosocial assessment of Robert. Good practice in assessing risk of adolescent suicide[14] should include consideration of

[12] https://bristolsash.bristol.ac.uk/what-distinguishes-adolescents-with-suicidal-thoughts-from-those-who-have-attempted suicide/#:~:text=We%20also%20looked%20for%20factors,cognitive%2C%20and%20mental%20health%20factors.

[13] Suicide by children and young people. National Confidential Inquiry into Suicide and Homicide by People with Mental Illness (NCISH). Manchester: University of Manchester, 2017. https://documents.manchester.ac.uk/display.aspx?DocID=37566

[14] See for example https://pmc.ncbi.nlm.nih.gov/articles/PMC11036461/#:~:text=Psychological%2C%20social%2C%20family%2C%20individual%2C%20and,direct%2C%20indirect%2C%20or%20combined%20pathways.

all relevant information including an analysis of the impact of psychological factors, social and environmental factors and family and individual factors. No one assessment resulted in an analysis of all the relevant factors including consideration of whether Robert could be neurodivergent and/or experiencing body dysmorphia. Consequently, the cumulative risk factors[15] that other reviews have identified as important when understanding child suicide were not identified.

4.11 There was confusion within the system at that time as to which service would be completing a full assessment. The CAMHS Liaison & Crisis Team do not carry out full mental health assessments but focus on immediate presenting factors and risk. It was expected that a full assessment would be carried out within the local mental health and emotional wellbeing service.

4.12 The review was told by practitioners in the local mental health and emotional wellbeing service that in 2022 they had assumed that an "expert" assessment had been completed within the CAMHS service and that Robert had been deemed to be "low risk". The completion of a full "expert" assessment was a wrong assumption and seems to have influenced the decision within the mental health and emotional wellbeing service that Robert should be offered help within the "Getting Advice" team. A decision that was made prior to any further assessment being carried out.

4.13 Current NICE guidance specifies that risk should not be categorised as high, medium or low[16] in order to either predict risk of suicide or determine threshold for services. This guidance was issued four months after the assessment by the CAMHS Liaison & Crisis Team in 2022. Another recent review within Bromley[17] noted that this as still common practice and the importance of moving away from risk categorisation is demonstrated in work with Robert. After the referral to SPA by the CAMHS Liaison & Crisis Team, categorisation at the point of crisis was not then reviewed adequately. A subsequent assessment at this stage should have led to a risk formulation which the NICE guidance describes as:

A risk formulation is a collaborative process between the person who has self-harmed and a mental health professional that aims to summarise the person's current risks and difficulties and understand why they are happening in order to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

4.14 In 2024 there were also problems and lack of clarity with the assessment process. This review has been informed that the expectation was (and is) that SPA/iSPA *triage* rather than carry out a full assessment. The document labelled "iSPA assessment" was the only assessment that was carried out after referral and was neither triage nor a full assessment. As an assessment it lacked depth and again resulted in a categorisation of

[15] https://learning.nspcc.org.uk/research-resources/learning-from-case-reviews/suicide

[16] Recommendations | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

[17] https://media.inzu.net/cms/f0e9b37b8c44e338f64ae38c6d41e267/articles/644/Thomas_CSPR_report_published.pdf

moderate risk. A crucial issue was the narrow focus of the assessment which did not include adequate consideration of history, social circumstances, the increasing concerns of the parents and what had changed since the previous referral in 2022. Generally, parents felt excluded after one initial consultation, and there needs to be further consideration as to how to work effectively with the whole family whilst giving the child their own voice. The assessment also did not involve any consideration of liaison with Robert's school or GP and there was also an opportunity to reflect on the impact of orthodontic treatment on Robert given that his smile was such an important aspect of his identity.

4.15 Roberts's school was within a neighbouring Borough and although this may have had some bearing on the effectiveness of liaison and coordination, the evidence points to an absence of routine liaison with schools as part of the assessment process within the mental health and emotional wellbeing service at that time.

4.16 When considering the involvement of other agencies, it is also of relevance, whether suicidal ideation should be considered a safeguarding issue requiring coordinated early help. The findings of this review are unequivocal in establishing the importance of such an approach where schools, health and mental health services work together to assess risk and provide the right help at the right time.

4.17 Within Bromley, practice has now changed with iSPA being a joint service with CAMHS. This is however a triage service and it is the view of this review panel that another triage should not be necessary when a child has expressed suicidal ideation and has had a seven day follow up by the CAMHS Liaison and Crisis Service. A holistic biopsychosocial assessment should be the next step. NICE guidance for assessment where young people self-harm[18] is relevant here and sets out expectations that a biopsychosocial assessment should be carried out by a mental health professional experienced in assessing children and young people who self-harm. Future development of assessment practice will need to take account of good practice guidelines and ensure a full in-depth multi professional analysis of risk. This is discussed further in Finding Two.

Looking below the surface – masking behaviours and body dysmorphia

4.18 Looking below the surface is inextricably linked with the quality of assessments as described above. There are two connected issues which could have been considered more fully: neurodivergence including masking behaviours and the possibility of body dysmorphia.

4.19 The accounts from both Robert and his parents described a young person who was showing behaviours that should have warranted consideration of possible autism and/ or body dysmorphia. It is not for this review to diagnose retrospectively, but the descriptions of intense focus on certain activities (such as food choices/gym

[18] https://www.nice.org.uk/guidance/ng225

activities/excellence in sport), alongside the social anxieties he spoke about in therapy, should have prompted more professional curiosity and analysis.

4.20 Although on the surface Robert presented as sociable and confident, masking behaviours are a well-known feature of autism and have been described as one of the main barriers to diagnosis. Masking is the conscious or unconscious suppression of autistic traits to blend in and can result in severe exhaustion and anxiety even though the person appears fine in public. It is not possible to say with any certainty that this applies to Robert but there was nothing within the records to suggest that this possibility was properly considered and the potential for specialist assessments explored.

4.21 This is highly relevant within the context of a young person who died by suicide as autistic children are 28 times more likely to attempt suicide and one study showed that 15% of autistic children had suicidal thoughts compared to 0.5% of typically developing children [19]. Autistic adults are nine times more likely to die by suicide and 66% of the autistic population have seriously considered suicide[20]. There was sufficient information available about Robert and his family to warrant further discussion as to the potential for neurodivergence/body dysmorphia and the implications for an assessment of risk.

4.22 Body dysmorphic disorder (BDD) is a psychiatric condition marked by a preoccupation with perceived appearance flaws that are minor or undetectable to others. People with body dysmorphic disorder typically engage in repetitive behaviours (e.g. mirror checking and reassurance seeking) and/or mental acts (e.g. social comparison) in response to their appearance concerns. Evidence also suggests that body dysmorphia and autism often coexist[21]. Extreme concerns about his appearance are a theme for Robert from 2022 onwards, starting with worries about acne scarring though to concerns about the impact on orthodontic treatment on his smile in the days before he died. The need for the family to remove mirrors from the house so as not to cause Robert distress should also have led to further discussion. His internet searches accessed by the police after his death confirm anxiety about medical conditions such as Cushing's Disease[22] and facial conditions, but by this stage he was no longer in touch with mental health services.

Safe discharge from adolescent mental health services

[19] Cusack, J et al (2016) *Personal Tragedies, Public Crisis.* Autistica https://www.autistica.org.uk/downloads/files/Personal-tragedies-public-crisis-ONLINE.pdf#asset:1499

[20] https://www.rcpsych.ac.uk/docs/default-source/improving-care/nccmh/suicide-prevention/workshops-(wave-4)/wave-4-workshop-2/suicide-and-autism---slides.pdf?sfvrsn=bf3e0113_2

[21] Janus J, Meyer D, Byrne E, Court KHÀ, Castle DJ, Rossell SL. Body dysmorphic symptoms in autism and attention-deficit hyperactivity disorder: A comorbidity study. Aust N Z J Psychiatry. 2026 Feb 12:48674261418840. doi: 10.1177/00048674261418840. Epub ahead of print. PMID: 41684190.

[22] Hormone overproduction in Cushing's Disease can lead to distinct physical changes including a rounded face.

4.23 The second referral to the mental health and emotional wellbeing service had been an opportunity to work with Robert, understand in more depth any vulnerabilities, facilitate positive change, evaluate progress and consider whether his wellbeing had improved. The treatment programme became fragmented due to the family's request for a break due to exams and a holiday. The mental health and emotional wellbeing service did follow up with the family to arrange resumption of therapy but there could possibly have been a clearer message that sessions were important if Robert's emotional wellbeing was to improve. This was significant at the point Robert self-discharged from therapy via a text message. Given the original concerns and the knowledge that he was currently "fragile" following the death of a grandparent it was not acceptable to accept his self-discharge without any further conversation with Robert or his parents.

4.24 Whilst a 16–18-year-old adolescent does have to consent to treatment and has the right to discharge themselves from a mental health and wellbeing service, this does not mean that a more proactive approach should not be taken to encourage them to engage with the treatment offered. Accepting self-discharge via text was not in line with policy at the time and further work has now been done to make this clear in latest revisions to its guidance. Guidelines need to be established within the local mental health and wellbeing service to make it clear that there must always be review by senior clinicians and follow up and risk assessment following self-discharge before a course of therapy is complete.

5 FINDINGS AND RECOMMENDATIONS

5.1 It would not have been possible to predict that Robert would die by suicide when he did. Outwardly he presented as a sociable, young person who loved his family, was achieving well at school and planning his future. What this review does find is that in the three years before his death there had been opportunities to better understand the depth of his distress and explore the issues that were driving his anxiety and suicidal ideation. The way that services were organised from first point of contact with NHS111 did not facilitate an accurate assessment of Robert's needs or ensure that he received the right help at the right time.

5.2 The underlying issue is the focus on repeated triage rather the completion of a timely holistic biopsychosocial assessment which could determine with a greater degree of accuracy the level of risk and what intervention was required. In 2022 Robert and/or his parents had four triage discussions in one day and one further brief assessment focused on the presenting issue and immediate risks. The referral to the local mental health and wellbeing service resulted in another triage two months later. By the time Robert withdrew from services three months after the first triage, there had still not been a holistic biopsychosocial assessment including information from all relevant professionals. It is not acceptable that Robert and his family were required to jump through repeated hoops, during that process crucial information was lost or diluted and no assessment was completed. In 2024, again there was triage via an iSPA/SPA

assessment over the telephone but no holistic assessment which considered information from all relevant agencies competed before therapy commenced.

Finding One

Information flow through the system was ineffective from the time that Robert first asked for help, with therapeutic help being disconnected from other aspects of the safeguarding system – preventing a holistic approach to his care.

5.3 In the absence of a single patient record within the NHS, the system depends upon the right information being shared between professionals as the patient passes through the system. For Robert the system failed from the first point of contact when there were several gateways to pass through before he was assessed by the CAMHS Liaison & Crisis Team. This resulted in information becoming diluted and lost. The process is set out in detail below.

1. Robert's mother called NHS111 after discovering a torn-up suicide note which contained specific details such as Robert's PIN numbers. He had also prepared a typed note which he gave to Father. This initial call was taken by HUC (Hertfordshire Urgent Care) who provide a triage service to support the local Bromley NHS111 service (provided by London Ambulance Service). This call was brief as Robert and his father were out and the triage service arranged for a callback by a clinician from London Ambulance Service (NHS111).

2. After another brief triage by London Ambulance Service, the call back from the clinician was initially a call with the parents and Robert over a speaker phone which later transitioned to a video call. Robert and Father talked about the suicide note, low mood and acne. An assessment document was completed which concluded that the diagnosis was mental health problems – suicidal thoughts, acne scarring and altered body image. The presence of a suicide note was recorded within the assessment, although there is no mention in the written assessment of Robert accessing harmful website content. This had been discussed during the call[23] and Father was advised to look at parental controls on devices used by Robert to protect him from viewing this content. Information was sent by NHS111 to the Urgent Care Centre and an appointment was given to the family for an arrival time within one hour. Father was advised to tell the hospital on arrival about the suicidal behaviour. The GP was sent a copy of the full NHS 111 assessment with a request for an urgent mental health assessment, and the parents were to discuss referral to a dermatologist.

3. After being triaged within the Urgent Care Centre Robert was "streamed" to the Emergency Department. The process at this point is for the patient to be walked through to the Emergency Department (ED) and the Urgent Care practitioner prints off a copy of their notes to handover. It was not usual practice to print off the entire

[23] The review has received this information from an analysis of the audio transcript of the call by the NHS111 safeguarding specialist.

patient record including the NHS111 record and the advice from NHS111 to tell the hospital about suicidal thoughts is therefore highly relevant. However, the system should not rely on patients who are likely to be in a distressed state to recall the detail of all important information, and it is also the responsibility of the clinicians to ask the right questions at this stage.

4. The Emergency Department then typically sends a brief referral to the CAMHS Liaison and Crisis Team. Once again, the patient will need to give a full account to the CAMHS practitioner. It is important to note that the London Ambulance Service are currently developing a process whereby NHS111 records will be uploaded to the London Care Record and Emergency departments will automatically have access to their record.

5.4 It was within this context that the significant details contained within Robert's suicide notes became lost and the practitioner from the CAMHS Liaison and Crisis Team who saw Robert for a face-to-face assessment does not recall any discussion about the notes. It seems that it is not routine practice to enquire about the existence and/content of notes when a young person presents with suicidal ideation and in this case the focus remained on Robert's concerns about facial scarring due to acne rather than a wider perspective on potential causes of anxiety. This information about the notes also became lost within the ongoing referral to the local mental health and emotional wellbeing service. Information that was passed to them confirmed that suicidal ideation was within the context of *having spots on his cheeks that has affected his self-confidence and self-esteem, mental state and behaviour.* This did not convey the full picture, including his parents concern that his distress was deep rooted and wider than a worry about acne scarring.

5.5 Before the GP took any action as a result of the NHS111 request for an urgent mental health assessment, the GP was notified by ED of their referral to the CAMHS Liaison & Crisis Team. The GP was then later informed by the CAMHS Crisis and Liaison Team that Robert had been discharged. The absence of a flag in the GP records indicating suicidal ideation meant that any subsequent consultations such as the visit to the GP hub in 2024 could not be understood within that context. This was compounded by lack of communication with the GP from the mental health and emotional wellbeing service, who also did not contact Robert's school when he was referred in 2024. When Robert registered with a new GP previous mental health consultations were not obvious, and the national GP registration form does not ask for specific information about referrals to mental health services to be included.

5.6 NHS orthodontic services were also operating in isolation from the rest of the system with the result that they were unable to understand Robert's anxiety about the results of the treatment as linked to more generalised anxiety about his appearance.

5.7 This finding does not dismiss the importance of patient choice, confidentiality and boundaries that may impact on information sharing. What is striking is that there is nothing in the records to suggest that this was an impediment to a multi professional

approach nor that Robert or his family were reluctant for information to be shared. Robert's school was in a different Borough but the evidence from this review does not point to this being a strong factor influencing their isolation from the system as a whole. The issue seems to be rooted in a combination of systems and processes within health systems alongside lack of effective challenge and clinical oversight within child mental health services.

5.8 The impact of lack of information sharing across the system is explored further in Finding Two below.

Recommendation One

The Integrated Care Board (ICB) should:

- Work with GPs to ensure that patient records clearly flag/code when a patient has been in contact with mental health services.
- Ask the Department for Health and Social Care to work with the relevant agency to review the national GP registration form and include information about previous contact with mental health services.
- Review the contract for Urgent Care services so that that a process is in place to ensure the Emergency Department has access to the full patient record and passes all information to CAMHS Liaison & Crisis Team.

Recommendation Two

The Safeguarding Children Partnership should work with the relevant regulatory body for orthodontists to:

- Review best practice in relation to registration forms to ensure that they move beyond asking whether the patient has a mental health diagnosis to adequately capture any current/recent mental health or emotional wellbeing needs and if any current support/services are required.
- Ensure that pathways for referral are clear where an orthodontist has any worries about the emotional health and wellbeing of a young person.

Recommendation Three

The Safeguarding Children Partnership should work with all agencies to promote a "think school" approach. Specifically:

- Child mental health services should always work with the child and parents to encourage information sharing and full participation of the child's school in all assessments and plans.
- Schools should always follow up with parents following any mental health referral to ensure that the child is receiving the appropriate help and support.

Finding Two

Practice across all organisations delivering children's mental health services was not rooted in a whole system multi-professional approach and did not include a robust biopsychosocial assessment which involved Robert's school, GP and any other relevant professionals. As a result, there was only a partial understanding of Robert's needs, risk of harm and the best way to provide help.

5.9 This finding relates to systems, processes and the culture and expectations set by senior leaders within child mental health services as to what good practice looks like.

5.10 The overarching picture is of fragmented services with practitioners operating in silos, often unaware of the involvement of others. Robert's school for example were totally unaware of the outcome of the 2022 referral to children's mental health services and had no knowledge at all of their involvement in 2024. Robert's school had been very proactive in providing support in 2022 and had the potential to be an important part of any plan to help Robert but were not able to do so as they had no knowledge of ongoing concerns. The orthodontist operated in isolation from the whole system and there was no liaison with the GP by the mental health and emotional wellbeing service.

5.11 One key question for this review is whether the assessment of risk and decision to allocate Robert to an early intervention mental health and emotional wellbeing service (previously known as a Tier 2 service) for psychological therapy, rather than refer to CAMHS community services, was the right decision in 2022. It is possible to describe why the decision was made based on the information available at the time, but it is now clear that (as discussed in Finding One) important information had not filtered down from NHS111 through the Emergency Department to the CAMHS Liaison & Crisis Team. This combined with practice which was insufficiently curious about the detail of the original parental concerns that had prompted the call to NHS111 resulted in the final decision.

5.12 The problems with the information sharing system are therefore only one aspect of practice. Practitioners also have a responsibility to ask the right questions and for there to be effective clinical oversight to ensure that this happens. Although information about the content of the suicide notes had not reached the CAMHS Liaison & Crisis Team via transfer of records, it would not be unreasonable to expect that questions about the presence of notes, and the extent of planning for suicide would be routine practice where a young person presents with suicidal ideation. This did not happen and consequently the decision was not made. Expectations should be clarified within practice guidance.

5.13 The threshold decision should not have been influenced by assumptions around wait times. The review was told by practitioners that since the need was for psychological therapy which could be delivered by the early intervention mental health and emotional wellbeing service, a referral to that service was thought to be best as their waiting times were less than community CAMHS. In fact, we now know that Robert did not engage with the service as it took four months for an appointment to be offered. The review was told by practitioners that the system has now changed and the CAMHS Liaison and Crisis Team no longer influence which treatment pathway would be best for the child. Additional information received from the mental health trust is that this was never agreed practice and all decisions were made by the SPA, (now iSPA) and the iSPA triage therefore determines next steps. It is of concern that there was apparent lack of clarity from practitioners as what expected practice was at the time. Lack of clarity has also been identified in descriptions by practitioners in the mental health and emotional wellbeing service about the interface been iSPA triage and assessments,

highlighting the challenge of embedding organisations procedures and expectations into day-to-day practice.

5.14 The new integrated single point of access service has addressed issues insofar as every referral is now jointly reviewed and triaged by Bromley CAMHS and the local mental health and emotional wellbeing service, providing additional clinical governance to decision making processes.

5.15 This notwithstanding, the iSPA remains another point of triage and it is the strong view of the review panel that where a young person presents with suicidal ideation and has been seen by the CAMHS Liaison and Crisis Team they should move directly to a holistic biopsychosocial assessment. This holistic assessment should collaborate with the child and their family and:

- Be thorough and includes consideration of a full medical and social history, family culture, context and current circumstances.
- Include detail of all current concerns expressed by the young person and the family.
- With appropriate permissions include contact with all relevant agencies and professionals including the child's school and GP.
- Arrive at a formulation which summarises the young person's current risks and difficulties and why they are happening in order to inform a treatment plan. This should take into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

5.16 Through this process and beyond it is important to consider how to best work with parents and carers, both to share information and work together in the best interest of the child and to meet their own specific needs. Robert's parents had vital information to share and it is concerning that they have described feeling excluded and that their perspective was not valued. Receiving information about parenting courses felt inappropriate for them but they would have valued a concise leaflet to help them respond to suicidal ideation. How to respond flexibly to parents and work together with them needs further consideration.

Recommendation Four

The CAMHS Liaison & Crisis Team should continue to work with their staff to ensure that curiosity rather than assumptions drive practice. Parents and children should be encouraged to give a full account of worries and concerns (even if they have been given to others previously) and where there are reports of suicidal ideation the presence and detail of any suicide notes must be explored.

Recommendation Five

CAMHS and the local mental health and wellbeing service should review the journey through the system for young people presenting with suicidal ideation to ensure that a holistic biopsychosocial assessment is completed at the earliest opportunity and that relevant staff have the necessary knowledge and skills and practice guidance to carry out high quality assessments which:

- Are thorough and include consideration of a full medical and social history, family culture, context and current circumstances.
- Include detail of all current concerns expressed by the young person and the family.
- With appropriate permissions include contact with all relevant agencies and professionals including the child's school and GP.
- Arrive at a formulation which summarises the young person's current risks and difficulties and why they are happening in order to inform a treatment plan. This should take into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

Recommendation Six

Parental input and needs should always be considered on a case-by-case basis where young people are at risk of suicide. All mental health services should give due consideration to the adequacy of information available to parents where their child is expressing suicidal ideation.

Finding Three

The possibility that Robert's anxieties were linked to neurodivergence and/or body dysmorphia was not explored by practitioners assessing his needs or providing therapy.

5.17 This finding highlights a potential knowledge and skills gap across the workforce as well as the role of supervision in challenging practitioners to explore all relevant factors that might be affecting a young person's wellbeing.

5.18 The absence of reflection and challenge which prompted further consideration of these possibilities indicates that knowledge needs to be improved across the whole system including supervisors and managers who are reviewing or auditing practice.

5.19 A recent Local Child Safeguarding Practice Review in Bromley has noted some of the gaps in the provision of timely autism assessments and made recommendations as to how this should be improved. The issue for Robert was somewhat different as there was no suggestion that autism and/or body dysmorphia was considered and an assessment requested. However, the development of autism practice more generally can only be helpful in improving awareness.

Recommendation Seven

The Safeguarding Children Partnership should bring the findings of this review to the attention of Bromley All Age Autism Partnership, Bromley Healthcare Community Paediatrics and London Borough of Bromley Education Department. These partners should develop resources for frontline workers across the children's workforce to identify neurodivergent traits and know where to access support for children and young people.

Recommendation Eight

CAMHS and the mental health and emotional wellbeing service to ensure practitioners assessing children and young people and/or providing counselling/therapy have training on identifying body dysmorphia and understand treatments/best therapeutic interventions.

Finding Four

Approaches to ensuring that Robert was able to engage with therapy were process driven and insufficiently proactive. When Robert did not wish to engage with services in 2022, and later in 2024 discharged himself via text there was insufficient review by senior clinicians, feedback to other agencies and consideration as to the impact on his wellbeing.

5.20 This finding relates to systems and processes in place at the point of non-engagement/discharge. The context of increased demand on services is also relevant with a focus on reducing waiting times and managing workloads. Improvement needs to be driven by a leadership culture which embeds challenge and review at all stages of a young person's journey through the system.

5.21 Once a young person has been assessed as requiring a service, especially when there is any risk of harm, non-engagement or withdrawal from the service should prompt curiosity and a proactive approach. This approach should:

- Consider how the service has communicated with the young person and their family. Is this their preferred means of communication? Have all alternative approaches been tried?
- Consideration of whether messages encourage the young person and family to engage. They should avoid default positions such as *if we don't hear from you by x we will close the case* which might be interpreted as engagement with therapy is not important.
- Self-discharge should always involve follow up with the young person and their family and oversight by a senior clinician.
- All non-engagement or self-discharge episodes should be notified to other relevant professionals/agencies.

Recommendation Nine

Agencies who work with children and families on a consent basis, should amend their Practice Guidance/Operating Procedures to address the issue of non-engagement or withdrawal of a service, to include:

- Consideration of how the service has communicated with the young person and their family. Is this their preferred means of communication? Have all alternative approaches been tried?

- Consideration of whether messages encourage the young person and family to engage. They should avoid default positions such as *if we don't hear from you by x we will close the case* which might be interpreted as engagement with therapy is not important.
- Self-discharge should always involve follow up with the young person and their family and oversight by a senior clinician.
- All non-engagement or self-discharge episodes should be notified to other relevant professionals/agencies.

Recommendation Ten

Children and Young People with residual risks should not be able to discharge themselves by text without a follow-up discussion with parents and a management overview. The reason for the wish to self-discharge should always be explored and if the child wishes to cease contact their school and GP should always be informed.

Finding Five

The gaps in the quality of practice within the mental health and emotional wellbeing service were not challenged by managers within the service or by external scrutiny.

5.22 Robert's parents have understandably asked who has responsibility for ensuring practice quality within the mental health and emotional wellbeing service.

5.23 Internal systems for ensuring quality necessarily sit with supervisors and managers and when Robert was referred in 2022 and 2024, the review has found that there was insufficient oversight and challenge.

5.24 In 2021 the contract for the service had changed with a move to a more "light touch" approach with an agreement that generally their offer to a young person would be four to six sessions only. The focus in 2022 has been described as managing waiting times which did have an impact on the oversight of practice. By 2024 the focus was on implementing the new iSPA service jointly with CAMHS. It has been acknowledged within the local mental health and emotional wellbeing service, that there needs to be improved oversight on day-to-day practice quality and case file audits as part of a quality assurance practice are now in place. A new clinical director is now in post to oversee the quality of practice.

5.25 As a charity, the mental health and emotional wellbeing service is not subject to the scrutiny of Ofsted or CQC. Commissioned jointly by the local Integrated Commissioning Board (NHS health commissioning body) and the local authority and is subject to quarterly contract monitoring arrangements. These meetings review service activity, access, waiting times, caseloads, outcomes measures and service-user feedback. These include requirements for the provider to maintain an initial assessment process within its standard operating procedures, operate safeguarding policies and protocols supported by a designated safeguarding lead, have arrangements in place for transition planning and support, and manage both planned

and unplanned exits from the service. Providers are also required to comply with applicable service standards and relevant NICE guidance.

5.26 The iSPA service operates under a memorandum of understanding with quarterly contract monitoring meetings in place to review the mental health and emotional wellbeing service and monthly meetings to review iSPA. Following triage by iSPA, the threshold for each service is clear with children who have a severe and enduring mental health condition referred on to CAMHS and those with a mild to moderate condition referred to the mental health and emotional wellbeing service.

5.27 These developments have mainly occurred after Robert was involved with child mental health services. This will be no consolation to his family who rightly expected that there was sufficient scrutiny and oversight to ensure an effective service.

Recommendation Eleven

The local authority and the ICB should review whether the contract for the mental health and emotional wellbeing service is sufficiently supported by provider governance, quality assurance and reporting mechanisms to ensure adequate monitoring of:

- the quality of assessment practice – what a good biopsychosocial assessment looks like
- clinical oversight of practice and threshold decisions
- responses to self-discharge by children and young people
- what should happen at the point of discharge, including who should be informed.

Recommendation Twelve

Contract monitoring for the mental health and emotional wellbeing service should be enhanced to ensure there is an adequate focus on the quality of service provision through audits of practice quality, peer reviews including on-site visits and independent discussions with children and families using the service.

6 SUMMARY OF RECOMMENDATIONS

Recommendation One

The Integrated Care Board (ICB) should:

- Work with GPs to ensure that patient records clearly flag/code when a patient has been in contact with mental health services.
- Ask the Department for Health and Social Care to work with the relevant agency to review the national GP registration form and include information about previous contact with mental health services.
- Review the contract for Urgent Care services so that that a process is in place to ensure the Emergency Department has access to the full patient record and passes all information to CAMHS Liaison & Crisis Team.

Recommendation Two

The Safeguarding Children Partnership should work with the relevant regulatory body for orthodontists to:

- Review best practice in relation to registration forms to ensure that they move beyond asking whether the patient has a mental health diagnosis to adequately capture any current/recent mental health or emotional wellbeing needs and if any current support/services are required.
- Ensure that pathways for referral are clear where an orthodontist has any worries about the emotional health and wellbeing of a young person.

Recommendation Three

The Safeguarding Children Partnership should work with all agencies to promote a "think school" approach. Specifically:

- Child mental health services should always work with the child and parents to encourage information sharing and full participation of the child's school in all assessments and plans.
- Schools should always follow up with parents following any mental health referral to ensure that the child is receiving the appropriate help and support.

Recommendation Four

CAMHS Liaison & Crisis Team should ensure that curiosity rather than assumptions drive practice. Parents and children should be encouraged to give a full account of worries and concerns (even if they have been given to others previously) and where there are reports of suicidal ideation the presence and detail of any suicide notes must be explored.

Recommendation Five

CAMHS and the local mental health and wellbeing service should review the journey through the system for young people presenting with suicidal ideation to ensure that a holistic biopsychosocial assessment is completed at the earliest opportunity and that

relevant staff have the necessary knowledge and skills and practice guidance to carry out high quality assessments which:

- Are thorough and include consideration of a full history, family culture, context and current circumstances.
- Include detail of all current concerns expressed by the young person and the family.
- With appropriate permissions include contact with all relevant agencies and professionals including the child's school and GP.
- Arrive at a formulation which summarises the young person's current risks and difficulties and why they are happening in order to inform a treatment plan. This should take into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

Recommendation Six

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- responses to self-discharge by children and young people
- what should happen at the point of discharge, including who should be informed.

Recommendation Twelve

Contract monitoring for the mental health and emotional wellbeing service must move beyond a qualitative approach to one which interrogates the quality of service provision, through audits of practice quality, peer reviews including on-site visits and independent discussions with children and families using the service.