Bromley Safeguarding Children Partnership

Child Safeguarding Practice Review

'Thomas'

"The risk of suicide is prevalent in neurodivergent populations, and we need to take action to address and minimise this risk… By increasing awareness and understanding of neurodivergent conditions, reducing stigma and discrimination, and providing accessible mental health support and resources, we can create a more supportive and inclusive society for all individuals, regardless of their neurodiversity."[1]

"Suicide is a leading cause of premature death among people with Autism spectrum conditions. The incidence of suicidality (i.e., suicidal ideation, suicide acts and attempts) among autistic youth is of particular concern. Autistic youth are six times more likely to attempt suicide and twice more likely to die by suicide – and at a significantly younger age – compared to their non-autistic peers. At least 1 in 6 autistic youth will also contemplate suicide during childhood, even as young as under 6 years old. Despite the seriousness of suicidality in autistic youth becoming increasingly clear, reasons *why* are unclear and under-researched. Efforts to distil knowledge from emerging suicide-autism research have largely focused on autistic adults or lifespan, with little focus specifically on autistic youth."[2]

October 2025

[1] Understanding neurodiversity and the risk of suicide | Papyrus (papyrus-uk.org)
[2] Suicidality in autistic youth: A systematic review and meta-analysis - ScienceDirect

The findings and recommendations in this report were agreed by the Bromley Safeguarding Children Partnership in February 2025. Publication was delayed to consider queries and comments from Thomas' Parents subsequent to them receiving the report. The report was amended or the Parents' additional information or views were added in an addendum. Where a comment refers to a specific paragraph this is signposted at the end of that paragraph and the paragraph number is noted in the Parents' comments in the Addendum. Agencies were then given the opportunity to consider Thomas' parents' comments. This has resulted in some further clarification from agency records. Further amendments have been made within the report in response to lessons from the Inquest which was held in September 2025. There is also a short addendum about the Inquest findings and the Coroner's Prevention of Future Deaths Report[3].

1. Thomas died in the late Autumn of 2023. He was 16 years old. He had been in receipt of services from a range of statutory and private services since primary school years because of his apparent neurodiversity. A formal diagnosis of Autism Spectrum Disorder (ASD) was not made until he was 14 years old. Over the Summer and Autumn of 2023, from age 16, there was increasing concern about his mental health and his increasingly acute levels of distress, despair and suicidality.[4] A number of services sought to respond to that concern and support Thomas and his family as his mental health deteriorated.

2. Following Thomas' death, there was concern that he had accessed at least one website supporting and promoting suicide. However, Police enquiries were not able to establish that a crime had been committed or that anyone within the UK was implicated in Thomas's tragic death.

3. Learning for this review has drawn on the parallel statutory **Child Death process**[5].

4. The review is based on contemporaneous records and independent management reviews of work by the agencies which sought to support Thomas and his family. Practitioners were also able to meet with the Independent author to share their own thinking and understanding of Thomas and the operation of local systems to contribute to the learning. The review has concentrated on the period 2022 – 2023 but has also considered the family's experiences and agency responses from Thomas' earlier childhood. Given Thomas' complex needs, the review was assisted by advice from an independent child and adolescent psychiatrist with experience in neurodiversity, depression and suicidality.

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[3] Reports to Prevent Future Deaths - Courts and Tribunals Judiciary Coroners have a duty to make reports to a person, organisation, local authority or government department or agency where the coroner believes that action should be taken to prevent future deaths.

[4] **Use of the pronouns he/him**. In the last few months Thomas questioned his gender but showed ambivalence about this and continued to use he/him pronouns to describe himself. This report refers to Thomas as he/him but acknowledges his deep feelings of distress and anxiety which it is understood contributed to the decline in his mental health and his suicidality.

[5] **Working Together to Safeguard Children 2023**; chapters 5 & 6 Working_together_to_safeguard_children_2023.pdf (publishing.service.gov.uk)

5. Thomas' parents, an aunt and his godparents met the Independent Reviewer separately to share their views. The parents contributed their own questions to the review's terms of reference. Later they were able to comment on findings. Their wish for agencies to learn from Thomas' death and the ways in which services responded to his autism and suicidality is noted. Their contribution to this review and other learning processes is invaluable. Their loss is enormous. Their views are summarised below.

6. The recent **Thematic Report** of the National Child Mortality Database into **deaths of children with a disability or autism**[6] provides important context to this Review. Of note: in the period covered by the thematic review more autistic boys died than autistic girls, a significant number of their deaths was by suicide or as a result of deliberate self-harm. As for the possible presence of contributory or modifiable factors in the deaths of autistic children, the thematic report notes: distressed behaviour, social isolation and problems with service provision. Learning identified from those child death reviews includes: the possible impact of waiting lists for referral and assessment of children with suspected autism; and poor co-ordination and communication between organisations involved in providing educational, healthcare and children's services – including where response or care was spread across different providers, including private providers. This may also include poor monitoring of prescribed medication.

Pen picture

7. Thomas' parents described him as "an incredibly bright, sensitive, funny and loving boy with the world at his feet" and said that he could have achieved anything he put his mind to. He was the eldest of three children born to a professional couple living in southeast London. The family is white British.

8. Professionals noted that Thomas was bright, very able and likeable. He was chatty and had a wide range of interests, often delving into subjects beyond his studies. He needed to control his environment and his frustration and social anxiety could lead to aggression to those around him. Yet he was also described as kind and empathetic to others, particularly as he matured and became more self-aware. He was able to maintain a very small loyal friendship group, which was important to him. He found comfort in the use of his computer and gaming and at times spent long periods online.

9. Thomas had a strong sense of shame after he was diagnosed with ASD. He did not want special consideration. He did not want to be seen as different. He showed traits of being hyper-focussed, impulsive, and easily distracted by ritualistic behaviours which comforted him. He was energetic and strong and at times this led him to being physical with other children, such as playfighting, which then became out of control and which others could

[6] Learning from deaths: Children with a learning disability and autistic children aged 4 - 17 years; National Child Mortality Database Programme; Thematic Report Data from April 2019 to March 2022 July 2024 NCMD-Learning-disability-and-autism-report_FINAL.pdf

find frightening or odd. He had a great deal of energy and in group situations his behaviour could dominate the setting. He found going to sleep difficult. His behaviour led to him being ostracised and bullied by peers. He was very self-conscious of his difference and about how others perceived him. This later led to him being reluctant to attend school. He was seen as resilient despite his experiences. It is believed that Thomas had learned to “mask” his behaviour to try and fit in but from early 2023 he seems to have found this more difficult.[7]

10. Thomas appeared to have obsessive compulsive tendencies with minimal insight into his ASD. He had not been formally assessed for ADD or ADHD at the time of his death although this process had just been agreed. Professionals who knew him have told this review that they did not think that he had ADD or ADHD.
    See Parents' comments about this in the Addendum.

11. It is understood that in the last few months Thomas used the chat rooms of specialised websites about gender dysphoria and also about suicide, appearing to seek the advice of strangers. He pretended to be an adult. This left him open to risk of exploitation and grooming; however, no evidence has been found that he was groomed or exploited.

12. His neurodiversity made him particularly vulnerable as he was not skilled at judging social relationships or the motivation of others; he was more likely to accept things at face value and then to develop fixed and rigid thinking about his ideas.

Thomas' development, assessments and responses to his needs and vulnerability - Timeline

This summary timeline of key assessments and interventions is drawn from information supplied to the review from the records of the agencies working with Thomas and his family.

13. At primary school, Thomas showed neurodiverse traits, had significant difficulties in managing relationships and demonstrated impulsivity, aggression and problems with diet. He had a **Sensory Processing Disorder**[8]. Parents arranged private Occupational Therapy over three years and school provided additional support. When older he showed self-loathing and suicidality. He was academically able. Aged ten Thomas was assessed to have difficulties with anxiety, social communication, and sensory processing, with behavioural difficulties, low self-confidence and low self-esteem. He had a period of therapy in 2017, age 10, and the local Mental Health and Wellbeing Service recommended that Thomas should be assessed for autism, but it was not progressed at the time for lack of information. Thomas was subsequently reviewed six-monthly by the Community Paediatric Service and in November 2019 (age 12) he was re-referred to the Complex Communication Diagnostic Service for an autism assessment.

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[7] Masking (autism.org.uk)

[8] Sensory Processing Disorder | Psychology Today United Kingdom *Undated summary notes, accessed for this review September 2024*

14. Parents have said that Thomas expressed suicidality from age 10 and that on one occasion he threatened to throw himself under a train.

15. Throughout secondary school Thomas continued to have difficulties and was provided with additional support.

16. **Age 11 – 12** A private psychiatrist diagnosed chronic reaction to stress and probable neurodevelopmental immaturity. Medication w*as* prescribed for sleep but Thomas did not always take it. Private psychological therapy was commenced. In Summer 2019 Thomas had suicidal thoughts. He was accepted for an autism assessment with a long waiting list for the two separate parts[9].

17. **Age 12 – 13** In Autumn 2019 the first part of the autism assessment showed scores exceeding the threshold for autism. The second part of the autism assessment was further delayed in 2020 by COVID. During COVID online therapy was not seen as appropriate.

18. **Age 13 – 14 October 2020** Mother contacted the CAMHS Crisis Helpline. Thomas was "out of control". He had hurt one of his brothers and punched his father. The family was not coping, had been waiting a long time for a diagnosis and was using private services to support Thomas. A referral was made to Children's Social Care but no record has been found that it was actioned by them.

19. **January 2021** Thomas met the diagnostic criteria for autism spectrum disorder, in the second assessment.

20. **Age 14 – 15 September 2021** Delayed Final Meeting confirmed the autism assessment. Thomas refused to accept the diagnosis up to his death. Parents had previously (in 2019) tried to get help from CAMHS and independent services and were now considering splitting the family up to safeguard the younger boys. The school agreed to use a **Common Assessment Framework CAF**[10] approach to support the family.

21. **January and February 2022** Thomas was struggling with attendance at school. He was unwilling to accept help for autism. The family arranged private tuition. One of Thomas' brothers reported that Thomas had assaulted him. A **Child and Family Assessment**[11] provided advice on about relationships between the brothers and was stepped back down to Common Assessment Framework support led by the school.

22. **February 2022** Thomas had suicidal thoughts; risk was assessed as low. Sleep medication was re-prescribed.

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[9] Criteria and tools used in an autism assessment

[10] **Common Assessment Framework** – now called Early Help Assessment in Bromley. Early Help Assessment (EHA)

[11] **Child and Family Assessment –** a multi-disciplinary assessment led by Children's Social Care to assess if a child and family need support. CP2. Referral and Assessment

23. **Age 15 – 16 July to October 2022** Family Support was provided by the Early Intervention Service. Mother benefitted from a separate autism parenting course but had to withdraw when her mother became seriously ill and later died.

24. **October and November 2022** Thomas was not sleeping; he had suicidal thoughts and was self-harming. He was anxious about exams and was struggling with relationships and the school environment.

25. **January 2023** Thomas refused to return to school. He had suicidal thoughts and anxiety. He was losing his capacity to **mask** his autism and did not want to be treated differently. It was agreed that he could attend for three days a week and would be provided with revision materials. He continued with private tuition and did not return to school.

26. **January 2023** The Family requested anti-depressants from the GP. Community Paediatrics advised the GP that Thomas should be referred to CAMHS for anti-depressant medication. He was restarted on *sleep* medication. Parents requested a referral to private psychiatry.

27. **February 2023** In early February the Parents also re-referred Thomas to the private psychologist. Later in February, Mother contacted the CAMHS duty service, which signposted her to the Mental Health and Wellbeing Service for triage for referral to the appropriate service. CAMHS also advised taking Thomas to A&E if necessary. Advice was given but no formal referral was made. Parents have advised this review that they decided to go to private services as they had been advised by a mental health professional that there would be a six-month waiting list for CAMHS services.

28. **March 2023** The private psychologist noted depressed mood, and low motivation, with tiredness. Thomas saw the autism diagnosis as negative saying that it was "used by peers against him". He denied any recent incidents of self-harm but had suicidal thoughts; he denied plans to act on them.

29. **March 2023** Thomas saw a private psychiatrist who was unable to provide medication in an online consultation. Mother re-contacted CAMHS about Thomas' depression, also querying whether he may have Attention Deficit Disorder. She was advised to consult the Community Paediatric Service about ADD and to seek a specialist CAMHS referral via the Mental Health and Wellbeing Service for anti-depressants to be considered. By the end of March Thomas was pulling out his hair and was finding it hard to get out of bed. The private psychologist gave Thomas strategies to manage stress related behaviour.

30. **April 2023** A new private psychiatrist prescribed anti-depressant medication. Thomas continued to see the private psychiatrist and private psychologist throughout the summer until the end of September.

31. **June 2023** Improvements were noted as exams had finished but Thomas remained scared of meeting peers. He was less sad and reported no suicidal thoughts. Mother was showing stress.

32. **Age 16 July and August 2023** Thomas first disclosed his feelings of gender dysphoria. He self-harmed and had suicidal thoughts often. The private psychiatrist assessed risk as mild to moderate. Thomas told the private psychologist that he was depressed and reported distress, confusion, and fear of not being accepted. He denied suicidal intent. The psychologist gave safety advice to remove blades. By late August, despite successful GCSE results, Thomas' mood had lowered. He reported self-harm by cutting in the groin area. The psychologist gave safety advice.

> **Late August 2023** *Information provided to the Inquest but not known to agencies working with Thomas or his family at the time, and not available to this review, showed that Thomas accessed a website chat forum in August which discusses mechanisms for suicide.*

33. **Throughout September 2023** the situation worsened. Thomas attempted to restart school but soon ceased. He was depressed, with low motivation. His mood was impacted by isolation and being overwhelmed about his sexual identity. He wanted "testosterone blockers" to "stop growing" and felt he was "running out of time". He became obsessive about removing body hair as a sign of masculinity and was showing increasing gender and body dysmorphia. He had thoughts of hanging himself but denied specific plans. Mother sought advice from Community Paediatric Services which advised her to seek an urgent referral to CAMHS, via the GP, or to take Thomas to A&E if the situation worsened.

34. The private psychologist and private psychiatrist referred Thomas to CAMHS via the GP as they were unable to maintain him safely in the community. Thomas was placed on the waiting list for the CAMHS Learning Disabilities and Neurological Disorders (LDND) Team.

35. **22nd September** Mother contacted the CAMHS Duty service. Mother reported that Thomas had increased suicidal ideation and had spoken of hanging himself but he also denied intent to carry this out. He was frequently seriously self-harming. Thomas was shaving excessively and was fixated about wanting to live as a woman. Parents were always supervising him but were desperate for help. CAMHS proposed a crisis mental health assessment at A&E but Thomas refused. It was agreed to undertake a risk assessment via video six days later. *See Parents' comments*

36. **25th – 27th September** Mother rang the CAMHS Crisis Line (a separate regional service) for advice on 25th. The service sought to give reassurance on the safety advice and told the local CAMHS about the call. On 26th and 27th the local CAMHS LDND service attempted to contact the parents on three occasions by phone and finally sent a letter with information about resources.

37. **28th September** The CAMHS Duty Team contacted Mother. Thomas was isolating himself and self-harming. Mother reported concern about a man (understood to be transgender) with whom Thomas was talking online and that this posed a possible risk of grooming. If parents sought to remove the phone or Wi-Fi Thomas self-harmed more as he saw this person as the only positive thing in his life. The risk management and a Safety Plan were discussed. The planned online assessment was due the next day.

38. **28th September** Thomas told the private psychologist that he had tried to hang himself on 27th September. He had felt worthless and had donated his savings to charity and sent a message to the online contact saying he was going to end his life. Thomas was refusing to take prescribed medication. The private psychologist informed Mother and recommended that someone was with Thomas at all times until the CAMHS assessment the next day.

39. **29th September** CAMHS conducted the planned online psychiatric assessment. Risk was assessed as high. On CAMHS advice Thomas later went with his parents to A&E for an in person psychiatric assessment. Parents understood that he would be admitted for a period of a few days. They were advised to pack a bag. *See Parents' comments*

40. At A&E Thomas said that he was not actively suicidal and that he was unwilling to remain in hospital voluntarily. It was assessed that there were no grounds to section him. He expressed dislike for the hospital environment because of his autism and agreed to work with his parents to keep himself safe at home. A **Safety Plan** was agreed and signed by Thomas and he returned home. Thomas' parents have commented to this review that Thomas had been ready to be admitted to hospital and wanted help to get better, he was in hopelessness and in their view was in no fit state to make decisions about himself. They feel that staff counselled him against admission as they believed a hospital environment would not be conducive for an autistic young person like Thomas because evidence was that neurodivergent young people do not do well as psychiatric inpatients.
    See Parents' comments

41. **October 2023** The CAMHS Adolescent Team accepted Thomas as a patient and the private arrangements ceased. He had low mood, was limiting his food intake, isolating himself and cutting. He was refusing his sleep medication and was understood to be refusing his anti-depressant medication because they made him feel numb. Thomas had suicidal thoughts due to his gender dysphoria and his only goal was to have hormone replacement therapy.

42. Children's Social Care initiated a Child and Family Assessment. It concluded at the start of November, without CAMHS input, that Thomas met the threshold of a Child In Need.[12]

[12] Section 17 Children Act 1989

43. **10 October** The CAMHS Care Plan included to commission an urgent **Care, Education and Treatment Review** meeting[13]. A Local Area Emergency Protocol process was to be considered if required[14]. Thomas was seen by a Consultant Psychiatrist. He denied active suicidal ideation but stated that he thought about ending his life daily. A trial of anti-depressant was agreed with a view to increasing the dose after 14 days.
See Parents' comments

44. **13 and 18 October** Small improvements were reported. An updated Care Plan included to consider return to school and to consider psychological support for gender dysphoria. On 13 October records note that Thomas said that he was taking his Sertraline without any side effects.

45. **25 October** The Psychiatrist noted in a telephone review that Thomas had regressed and had "stopped taking his medication". Mother was worried about Thomas' ongoing use of social media and (suicide) chat rooms, and Thomas' self-neglect; he was refusing to eat, not sleeping and staying in bed all day. The psychiatrist was to review Thomas in two weeks.

46. **30 October** Mother contacted CAMHS Duty urgently seeking advice, she thought Thomas may be planning suicide by hanging. The Care Coordinator rang back and advised to continue with the Safety Plan and to attend A&E, call an ambulance or seek advice from the Crisis Line, if necessary. The Care Coordinator also discussed Mother's concerns with and completed a referral to the Response Team[15]. The referral to the Response Team was later agreed. An urgent review was also arranged for the following day.

47. **31 October** After further telephone contacts, first thing, it was arranged that Thomas should be seen urgently by a duty psychiatrist and duty CAMHS worker. He did not want to engage with them and wanted to go home. He denied being suicidal or accessing suicide websites. He believed that the service did not care about him and that no-one could help him. The Referral to the Response Team was updated. Mother was exhausted. She was

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[13] NHS England » Care, Education and Treatment Reviews (CETRs) Their purpose is to ensure services better understand the needs of people with a learning disability and/or people who are autistic so that they can receive the right support; to prevent crisis and that additional support can be put in place quickly to prevent unnecessary hospital admission.

[14] **Local area emergency protocol** "In circumstances where an admission is unplanned, urgent or someone is in 'crisis' it is recognised that a C(E)TR may be, on a practical level, very difficult to set up due to short time scales, level of risk and the need for urgent action. The aim of the local area emergency October protocol (LAEP) is to provide the commissioner with a set of prompts and questions both to prevent people with a learning disability or autistic people from being admitted unnecessarily to a mental health hospital; and where there is a clearly supported clinical indication for admission to ensure that the intended outcomes and timescales are clear. It is also intended to help identify barriers to supporting a person to remain in the community and to make clear and constructive recommendations … "
Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf Appendix 8 page 92

[15] **CAMHS Response Team** - a regional commissioned service across Mental Health Trusts to provide up to two weeks' intense and additional, including, daily support for families to seek to manage a young person's risk. The overall clinical responsibility and case leadership rests with the commissioning CAMHS Service.

advised to always monitor him. Follow up appointments were agreed for 1 and 2 November. Thomas was asked to eat and drink more.

48. **1 November** The Care Coordinator and a CAMHS Social Worker visited in the afternoon after Thomas had refused to attend CAMHS that day. He was in bed, under a blanket, he stated that he had not eaten or drunk and had not taken his medication. Thomas described his distress as 'panic'. Goals were discussed with Thomas and it was agreed to see him the following day.

49. **2 November** The Care Coordinator visited and during that session an online meeting was held with the Response Team in which Thomas participated. As a result additional direct support to the family at home was commissioned. Thomas was seen to have engaged well with the Care Coordinator talking about music and countries he had visited. He was observed to eat several pieces of chocolate; he was bright and animated and smiling at times. It was agreed that the Response Team would begin visiting the following day and over the weekend with additional phone contact in between.

50. Parents were very worried that Thomas was not being honest about his level of intent and that this was compounded by his concrete thinking processes due to his autism. He was reported to have said that he did not believe that anyone could help him, including CAMHS.

51. **3 November** Thomas felt that he had met so many different practitioners and was disheartened that nothing was changing for him. Safety Advice was updated to include locking away all sharps, ligatures (including phone leads) and medications, locking all doors and windows and for an adult to be present in the home 24/7 and check in on Thomas regularly. The Response Team was to provide daily contact for two weeks to support Thomas to explore his internal world and to introduce strategies for him to manage the risks. The CAMHS Team was responsible for responsibility for clinical leadership, medication, and twice weekly therapy sessions.

52. **5 November** Thomas left the house without being noticed but returned safely.

53. **6 November** Thomas appeared slightly improved but there were fresh cuts to his arms despite attempts to remove all sharps. Father was sleeping in the next room to monitor Thomas. Thomas denied thoughts of self-harm; the Response Team Practitioner challenged this but Thomas refused to discuss it.

54. **7 November** The Response Team arranged an additional visit as the CAMHS Team practitioner was unavailable. Thomas refused to see anyone. Mother believed that Thomas was continuing to self-harm.

55. **8 November Child in Need Meeting** agreed to refer Thomas for support to return to Education. The Care, Training and Education Review was to be held on 15 November.

56. **8 November Correspondence between the teams, and Response Team and CAMHS Team Joint Visit** Thomas was spending most of the time in bed and had fresh cuts to his arms. Mother was given advice. Thomas was advised that hospital admission would have to be considered if he did not work with CAMHS or the Response Team as he could not just remain in his room not eating and having such a poor quality or life. Thomas did not want to go into hospital. He was struggling to be motivated to try the suggestions from practitioners. He agreed to restart sleep medication. CAMHS was concerned about Thomas' deterioration and that any apparent positive changes were brief and not being sustained. Thomas' suicidality was assessed to be moderate/high but difficult to assess because of his non-engagement. The risks of self-harm and neglect were high. CAMHS noted the need to extend the Response Team involvement due to instability and fluctuating risk.
    See Parents' comments

57. **9. 10, and 13 November** Some small improvements in mood and sleep were noted. CAMHS asked the Response Team to extend its involvement beyond the usual commissioned two weeks.

58. **15 November Care, Education and Treatment Review.** *This is a significant step and process in patient care, led independently by the Integrated Care Board to explore need and access to any specialist resources for patients who have autism*. The meeting was conducted online, in stages, Thomas and then Parents joined the first part of the meeting for their views to be heard and after the agencies involved discussed Thomas in the family's absence. The Meeting agreed several actions but most were not in place before Thomas died.

59. **16 November** Improvements were noted; however, Thomas had cut his thighs and arms.

60. Thomas spent the weekend away from London with his father visiting extended family.

61. **22 November** Response Team Visit in the absence of the CAMHS worker. This was the first time that Thomas had been seen for a few days. He was anxious and appeared to have resumed pulling his hair out. He said he was "depressed not suicidal" and was seen by the practitioner as being reluctant to accept changes to his medication. Mother was understood to be seeking an increase in anti-depressant and access to psychology services. The Response Team worker saw the visit as essentially positive. However, they noted that it was difficult to assess Thomas' suicidality. It was not thought that there was an immediate crisis. Intense parental supervision was to remain in place.
    See Parents' comments

62. **23 November** The Response Team Meeting noted a dramatic deterioration. The actions from the CETR had not yet progressed, the CAMHS Care Coordinator was away from work and the Response Team had been asked to provide additional support beyond the original agreement. The plan was to close the Response Team's work the following week. Risk of suicide was seen as moderate, risk of self-harm as moderate and of self-neglect as high. Thomas was isolated and depressed and the team was unclear of how much Thomas was accessing suicide websites. Thomas was reluctant to engage with practitioners.

63. **23 November** A CAMHS Team duty worker phoned Mother who was very anxious as Thomas had left the house at 4am but had come back when Father had heard him outside and phoned him. Mother was worried about Thomas' medication. It was agreed that the psychiatrist would call Mother on Monday 27 November and that a fuller review would be planned. The Response Team agreed to visit on Friday 24th but stressed the importance of the CAMHS team seeing Thomas in person.
Practice note *The information that Thomas had gone out at 4am is a significant indicator which should have been explored more fully and directly with him at the time by mental health services to understand his motivation and implications for risk. Despite all the care and close supervision by his parents Thomas was able to evade their monitoring. After Thomas' death, father was able to access Thomas' computer and discovered a conversation in a pro-suicide chat room where Thomas had said that on that morning he was on his way to take his life but got caught. Thomas also appeared to have accessed online maps.*

> ***At Inquest**: The Coroner noted that this was a missed opportunity to prevent Thomas' death and that had there been a structured risk assessment by clinicians on the first day that Thomas left the home Thomas would probably not have died when he did.*

64. **Friday 24 November Response Team Visit** Thomas would not initially get out of bed to see the practitioner. Mother and the practitioner spoke downstairs. Mother was worried and stressed. Parents had received no feedback from the CETR Meeting about the proposed actions; the practitioner agreed to chase this. The practitioner spoke with Thomas upstairs. He declined to get out of bed saying that he had no energy. Thomas going out during the night for a walk was mentioned in the conversation but the reason for this was not explored in detail. Thomas appeared alert and made good eye contact. He described his mood as low but said that he had not cut himself. They discussed the use of pronouns and Thomas said that he would accept whichever pronouns people chose to use for him and that he did not want the worker to advocate for him on this matter to others. He declined to go out for a walk but did finally come down for cake and then played a game of Uno with the worker and Mother. Thomas engaged in conversation and occasionally smiled or laughed during the game but overall was seen to be subdued. The worker noted no new risks and that the current safety advice should continue over the weekend but that the multi-agency plan should be reviewed the next week including plans for face-to-face contact (by the CAMHS Team).

65. **Sunday 26 November Response Team visit** Thomas had been awake most of the night. He refused to see the practitioner. Safety advice was reconfirmed. The Plan was to liaise with Social Care about the progress in identifying a mentor for Thomas and to plan the discharge from the Response Team. In a follow up email to CAMHS the Response worker described the family as "scared and lost". The Response Team was to make a final home visit on 29 November.

66. **Monday 27 November** The CAMHS psychiatrist briefly reviewed Thomas' situation by phone with Mother. The psychiatrist did not speak with Thomas. Thomas was refusing to leave the house but had been out for a walk around 4am because he could not sleep. The house was now locked at night and the keys were hidden. Mother felt that Thomas' mood was worse. He was refusing to take his sleep medication and was saying he would not

accept an increase in antidepressant. Mother was advised that the primary issue was probably the reversal of his sleep/wake cycle. Mother was advised to increase the dose of antidepressant. It was agreed to review Thomas again in a week. *See Parents' comments*

67. **28 November** Early in the morning Thomas took his life by stepping in front of a train.

Family's views (in addition to those in the Pen Picture above)

It was agreed with Thomas' parents that it would not be in the brothers' best interest to seek their views at this time. Family members have commented on the impact of Thomas' needs on his brothers.

68. Thomas' neurodiversity appeared evident from a young age but it took ten years to assess him for ASD. He found it hard to accept the diagnosis as a teenager, he hated to be seen as different. He wanted to be accepted and just like other children. A key question for the family is why it took so long to reach the diagnosis of ASD and whether he might have been helped to come to terms with his difference if assessed at a younger age.

69. The family questions whether Thomas' history of impulsive behaviour, difficulties with executive functioning and emotional dysregulation mean that these should have been considered as possible symptoms for ADHD / ADD and whether ADHD medication would have assisted him as he did not appear to respond to anti-depressant medication.

70. A critical moment for the family was the decision at the end of September 2023 and then in subsequent assessments, when he appeared to be getting worse, not to admit Thomas to hospital. Thomas' parents believed from a conversation with the Crisis Helpline that, given his despair, his serious self-harming and his active suicidality that he would be admitted to hospital via A&E. The private psychiatrist and psychologist had also suggested that in-patient treatment may be beneficial for Thomas. Not being admitted to hospital was a big cliff for him and his hopelessness worsened from that point. Thomas himself was prepared to go to hospital as he felt in such despair and he hoped that a few days in hospital would help him. Thomas had a great respect for people in authority. His parents believe that because of this Thomas was easily persuaded that it would be best for him to go home. After that his despair and suicidality became worse but he was reluctant to consider hospital as he had been persuaded that it would not be good for him. They believe this led to greater despair as there seemed to be no hope for him. *See Parents' comments*

71. Thomas was clear that he hated being labelled autistic and he would rather be considered transgender than autistic, despite the risk of being bullied and others' reactions. From August 2023 he experimented with a female identity through dressing and make up. Family believed that being "trans" was almost like a solution for Thomas – everything would be all right if only he could transition. He would not accept that there was a possible risk in puberty blockers and would not hear it.

72. Given Thomas' mental state, autism and sleep deprivation Thomas' parents questioned whether he could have given meaningful consent to any aspect of his treatment.

73. It was not clear to Thomas's parents where the clinical leadership of the multi-disciplinary response lay in the period after the Rapid Response Team became involved with daily visits and contacts.

74. **Safety Plans** Parents could not remember getting written safety plans beyond the handwritten one from A&E. They said that they had already been trying all the things suggested to them from their prior awareness of the risk of self-harm and suicide in another family. Father was not aware of the "monitor Thomas every 8 – 12 minutes" advice. They were clear that Thomas would not allow one of them to sleep in his room nor could they take the door off the hinges for the same reason. All the keys had been locked away and the doors were locked so they do not know how Thomas managed to open the window door from his bedroom on to the roof. *See Parents' comments*

75. From October 2023 Thomas' mother supervised Thomas taking his daily anti-depressant at 1pm each day without fail. The initial does of 25mg was increased after two weeks to 50mg. On 27 November the psychiatrist was said by Mother to have stated that the dose should have been 100mg by now. They have questioned how this was managed and whether Thomas should have been seen face-to-face more than once by a psychiatrist while under community care.

76. The parents have said that the regular assessments of the risk of Thomas' acting further or more seriously on his suicidal thoughts may have been impacted by his developed skills at **camouflaging** or **masking**[16] his true mental state. Thomas had learned to mask as part of his managing his autism and he was also bright enough to know how to say what people wanted to hear.
See Parents' comments

77. The family was repeatedly told that 'autistic children do badly' in psychiatric units and that Thomas' best interests were being served by him being treated in the community. They question whether there should be specialist resources for neurodiverse children in mental health crisis if not an adolescent psychiatric unit. They thought it was unhelpful when practitioners talked in front of Thomas about adolescent inpatient units being unhelpful for young people with autism.

78. The parents and perhaps Thomas were not fully clear of the purpose of the **Care, Education and Treatment Review**[17] in mid-November 2023 nor why it was held online rather than face-

[16] Camouflaging: Autistic people—particularly those with level 1 autism—often try to "camouflage" their autism, finding ways to mask their symptoms in order to fit in with other people. Camouflaging is mentally burdensome and is linked to higher rates of mental illness and suicidality. From: : 6 Reasons Autistic People Are at Greater Risk of Suicide | Psychology Today 2023
[17] NHS England » Care, Education and Treatment Reviews (CETRs) 2023

to-face. For the part of the meeting that they and separately Thomas joined they met on screen new people with whom they and Thomas were unfamiliar. They did not get feedback about the decisions at the end of the meeting and it was sometime, after mother chased them, before the decisions were made available in a confusing spreadsheet format.

79. They were worried about the Response Team withdrawing as nothing was yet in place to support them and they did not have the outcome of the CETR. Although they were told that if things got worse to go back to A&E. They said that they were unlikely to do so because of the previous experience and they believed that Thomas would not have agreed to go back to A&E as he had put so much hope into getting help there previously and would no longer trust A&E.

80. A key issue for the family was that Thomas found it hard to get to know and trust people or adjust to new routines. When he did trust someone he found it hard when the system required the work to be transferred to different teams and practitioners. He trusted the private practitioners as he came to know them over time. He found the number of different professionals involved in the crisis of October and November 2023 very difficult and did not want to engage with them, at times refusing to get out of bed to minimise their contact. *See Parents' comments*

81. Was there enough **consideration about the way that neurodiverse high functioning autistic young people think and are influenced?** The parents question whether all the services/practitioners considered Thomas' needs and their responses from his specific neurodiverse perspective. Thomas was easily influenced and when he took on an idea he did not see nuances and would not have been able to see though other people's intentions or question what was being said in a critical way. For Thomas things were black and white, all or nothing – which they believe are typical of neurodiverse children. (***See note on Cognitive inflexibility below***).[18] They believe that Thomas was heavily influenced by the websites he spent time on – a lot of time.

82. A challenge has been to know how much Thomas was influenced in the last months by his online activity and access to specialist sites. It was known before his death that he had accessed a suicide website and probably pro-transgender material. Thomas' father had tried to talk with him about the risk of such sites and the need for perspective but Thomas' autism affected his judgement and he would not hear rational discussion.

83. The family questions whether some of Thomas' impulsive behaviour, difficulties with executive functioning and emotional dysregulation may have been ADD or ADHD rather than autism, as there are similarities. They believe that Thomas may have found it easier to have

[18] **Cognitive inflexibility**: Cognitive flexibility is someone's ability to think about situations in different ways and adjust to evolving circumstances. Autistic people tend to experience a higher degree of inflexibility, which may make it harder for them to see alternatives to suicide as a means to ending the emotional pain or life challenges they may be experiencing. From: 6 Reasons Autistic People Are at Greater Risk of Suicide | Psychology Today 2023

an ADHD diagnosis and that ADHD medication would have assisted him as he did not appear to respond to anti-depressant medication.

84. Mother was very conscious of the utter hopelessness that Thomas was showing from September – he had lost hope - and any perceived improvements were minimal and temporary. Father was concerned about Thomas mental state but had hoped that with help Thomas would pull through. He did not think Thomas would take his life.

85. Thomas' father saw, postmortem, some of the chat on a pro-suicide site where others appear to have encouraged Thomas to try again to end his life. He had also asked for advice on how to overcome the "S.I." – *the survival instinct* - after he had ended a hanging attempt.

See also the Parents' additional comments in the Addendum

Findings/Learning /Practice Points and Recommendations

Assessing risk of self-harm and suicide in young people with autism

86. A key area of learning from this review is the complexity of assessing risk of self-harm or suicide in young people with autism. Factors will include:
    - the experience and skills of those undertaking the assessments,
    - whether the assessments are a one off – such as during Thomas' only visit to the A&E department
    - or undertaken over time by practitioners who know the young person well enough to be able to assess change in the young person, the young person's responses and their credibility – for example the private practitioners and the Response Team or CAMHS Adolescent Team staff who came to know Thomas over time.
    - whether the assessments are face to face or online, and
    - taking into consideration the ways in which neurodivergent young people think and formulate their ideas and manage their emotions in acute stress of depression.

87. The private practitioners noted increased risk from conversations with Thomas and his mother over the summer of 2023 and referred him via the GP in mid-September to local CAMHS services as they thought local NHS and multi-disciplinary services would be required to meet the increased level of risk/need. NHS risk assessments for self-harm and suicidality took place in hospital A&E and at home, including online, subsequently.

88. The 2022 NICE **Self-harm: assessment, management and preventing recurrence**[19] sought to clarify and change approaches to the assessment of self-harm and suicidality. It sets out best practice in the assessment of self-harm. A key issue is that it counsels against the use of standardised risk assessment tools and scales, including those which stratify risk

[19] Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE Updated 2024

into low, medium or high. Such categories were regularly used in notes about Thomas. The Mental Health Trust Serious Incident Report undertaken across the two key Trusts notes that such scales should no longer be used. The Royal College of Psychiatrists stated in 2023 that such scales were still often found in practice[20] and are potentially unhelpful as they risk giving a false positive. Best practice is a collaborative process with the young person and family to identify and summarise the specific risks and difficulties and understand why they are happening in order to inform a specific treatment/safety plan. This assessment should take into account historical factors and experiences, more recent problems, and existing strengths and resources and where necessary the young person's neurodiversity. A key challenge is to complete such a psycho-social assessment in a one-off interview such as in an A&E Department.

89. It is not clear to this review that local services fully took into account the professional views of the private psychiatrist and private psychologist who knew Thomas and his situation well and who were worried about him, when the clinical responsibility transferred in October 2023. It was noted that the private psychiatrists' views should be sought as a task on transfer to CAMHS but there is no evidence that this happened. Thomas and his parents had invested trust in these two private practitioners. A practice lesson is that a fuller transition of care could have been more beneficial for the new team/s of practitioners to get a clearer history of how Thomas was rapidly changing, what support he had had to date and how he had responded to that support and why those practitioners were recommending the urgent need of local NHS resources, including possible in-patient care. It appears that services "started again" rather than took into account the work of the private practitioners. It would have been useful to have involved them in an urgent Local Area Emergency Protocol process or the Care, Education and Training Review and in the Social Care Child and Family Assessment. *See Parents' comments*

90. A further challenge may be that Thomas was not always open about what he was thinking. At times he would tell professionals or his parents that he was not suicidal or that he was having suicidal thoughts but had no intention of acting on them and that he was rather more depressed or in panic. Yet he continued with intermittent self-harming and was known to be using a suicide website, although he denied this. It became known to practitioners that he had also made two attempts on his own life, which he had concealed at the time. It is not clear if when Thomas said that he had no intention that he was seeking to conceal his real intentions, itself a risk factor or if he wanted to manage his emotions but was not able to do so as further despair or panic overwhelmed him. There were also periods when he avoided the visits from mental health practitioners or would not open up to them. A skill in risk assessments for suicidality is when to take what the patient says at face value and when to challenge or doubt it. This is harder when the practitioner is meeting the patient for the first time.

[20] https://www.rcpsych.ac.uk/news-and-features/latest-news/detail/2023/09/10/inaccurate-suicide-risk-assessments-could-be-putting-lives-at-risk-says-rcpsych

91. A practice dynamic here is how practitioners can establish a therapeutic working relationship and trust with autistic young people. Thomas showed that he had the ability to form working relationships with some practitioners, for example, his private tutors, the first social worker, private psychologist and the private psychiatrist. Later as the crisis developed in October and November, he appears to have become overwhelmed with the number of different and changing practitioners he was seeing and complained about this. He was described as finding it easier to relate to practitioners who responded better to his autistic ways of thinking in concrete terms. Papyrus, an organisation which seeks to prevent suicide in young people has noted the need to have better understanding of neurodiversity in assessing the risk of suicide[21]. *See Parents' comments*

92. Thomas was seen to be able to understand and make decisions for himself. He contracted into the formal written Safety Plan at the hospital and agreed actions to keep himself safe but then was unable to carry them through as his emotional state deteriorated. Such inability to adhere to risk safety plans should form part of ongoing risk assessments. Practitioners (and parents) were fully open to the possibility that Thomas was often thinking about suicide and considering different methodologies and rightly discussed this with him. Clearly in assessing risk that a young person might harm themselves it is important to seek and hear their views but this also needs to be balanced by evidence from any patterns in their behaviour which suggest otherwise. In November 2023 when it had been thought that Thomas was improving but there was a surprising downturn and Thomas later left the house in the early hours there should have been a fuller assessment of why he had gone out. It is easy to say this in hindsight in the light of his death a few days later. His statement that he had wanted to go for a walk was accepted. If he had been questioned further about it by the professionals involved at the time there can be no guarantee that he would have been more open about what his thinking and intentions were. It is known that Thomas was bright and that he had learned throughout his life to mask/camouflage his thoughts and behaviours; this is a common trait in able people with autism spectrum disorder.
See Parents' comments

> *The Coroner noted that if there had been a structured re-assessment by clinicians in relation to the occasion when Thomas left the home in the early hours Thomas probably would not have died when he did, a few days later.*

93. There is also a question about Thomas' **mental capacity** at the time (September – November 2023) which is separate to his autistic frame of thinking. Did Thomas have mental capacity to make decisions for himself? is a question raised by his parents. Mental capacity is one of the factors to be considered in an assessment of potential self-harm or suicide. There are separate NICE **Guidelines for Decision-making and Mental Capacity**[22] to assist practitioners in assessing a person's ability to understand and make informed decisions. At the A&E Department at the end of September 2023 the assessing practitioner

[21] www.papyrus-uk.org/understanding-neurodiversity-and-the-risk-of-suicide/
[22] Overview | Decision-making and mental capacity | Guidance | NICE

had to make a judgement about Thomas' mental capacity and risk based in a one-off interaction and assessed him to have capacity. The legal assumption is that a patient has capacity unless there is evidence to the contrary. Where possible it is important to consider this over time and several discussions to assist the consistency of assessment and to test out whether the underlying distress or the autistic thinking is itself impacting on the capacity to make informed decisions. Advice to this review is that it is not uncommon for capacity to fluctuate depending on the stress and suicidality and where this is more intense or painful it is possible that the capacity becomes impaired in some way. *See Parents' comments*

94. **Recommendation 1** The Bromley ICB / Health and Wellbeing Board should undertake a review to ascertain how Partner agencies working with children and families in Bromley train and support practitioners across health, education and social care services to undertake assessments of self-harm, suicidality and mental capacity, including differences for young people and those who are neurodivergent. The purpose of the review is to inform whether additional local guidance or training is required. The review should be undertaken within three months.

95. **Should Thomas have been admitted to hospital?** There were differences in opinion between the private practitioners and the NHS practitioners, although there was no discussion between them about this. The private psychiatrist who had treated Thomas for several months came to believe by the end of the summer, with the private psychologist, that Thomas probably required hospitalisation and advised parents of the possibility of a private resource in the Netherlands if an inpatient resource was not available in UK via the NHS. The CAMHS Crisis Helpline advised parents to take Thomas to A&E; Mother and Thomas believed he was to be admitted. Thomas was said to be willing to go into hospital for a few days to help him get better, but he was not prepared to go to a private facility in the Netherlands.

96. In A&E, the duty Nurse Practitioner did not assess that Thomas required compulsory admission under the Mental Health Act. In the assessment Thomas stated that the main trigger for his suicidal and self-harming thoughts was his urgent need for medical treatment for his gender dysphoria. Given Thomas' expressed wish not to remain in the busy and noisy hospital environment and that Thomas said that he was not actively intending suicide at the time and agreed to cooperate with the safety plan and not self-harm it was assessed that it was better for Thomas to return home and be supported by community CAMHS services, although these were not yet in place. Thomas' parents have stated that they consider that Thomas was easily persuaded not to stay in hospital although he was offered a chance to stay in a cubicle in A&E under parental supervision, which they deemed to be unsuitable.

97. Evidence is that autistic people do not do well in psychiatric inpatient settings and can, in fact, fare worse. This is also the advice to this review and the view held in the 2021 White

Paper on reforming the Mental Health Act and responses to it [23] [24]. Hospital admission should only be used as a last resort and for the minimum period necessary. This is a systemic issue with an underlying intersectionality in that adolescent in-patient resources are in short supply and those that are available are not usually the most appropriate resource for young people with autism, unless reasonable adjustments can be made to meet their additional neurodivergent needs. *See Parents' comments*

98. **Recommendation 2** The Bromley ICB / and the Child and Adolescent Mental Health Trust should review the resources available to neurodivergent young people in mental health crisis, including possible in-patient treatment with special considerations to ensure that they are able to meet any specific needs arising from the young person's neurodiversity and its interplay the young person's mental ill health and how any responses may need to be adapted. Such a review should also look at possible local need based on census data about child and adolescent mental ill health and neurodiversity.

99. Hospital admission was kept in mind as a possibility for Thomas throughout the period of support at home during October and November 2023. He was seen at times to be gradually improving, even if slowly and erratically up to the Care, Educational and Treatment Review in mid-November. A CETR would only be convened where there was a possibility of hospital admission. *See Parents' comments*

100. The Treatment Plan and the safety planning appear therefore to have been based on a widely held view that hospital admission is contra-indicated for young people with autism and that the risk could be mitigated by careful vigilance and monitoring by family and mental health services working with Thomas, aided by medication to alleviate his mood and improve his sleep and to arrange psychological treatment, pending the fuller review of the **Care, Education and Training Review**. *See Parents' comments*

Safety Planning

101. This review has noted what appears to be different approaches to risk reduction assessments and safety planning and advice for Thomas and his parents. The term "safety plan" appears to have been used generically rather than specifically and has different meaning in different services. At times Thomas was involved in discussions about mitigating risk and managing his thoughts and feelings and at other times advice was given to his parents about actions that they should take to keep him safe. These activities appear to have been regarded as "safety planning" and there were references to "safety plans" and

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[23] *See the LGA Summary of recommendations from the White Paper and how they refer to learning disabled and neurodivergent people.* Reforming the Mental Health Act white paper 2021 | Local Government Association

[24] Reforming-Mental-Health-Act.pdf (nhsconfed.org)

"updating the safety plan" but they did not always follow the NICE guidance on **Self-harm: assessment, management and preventing recurrence**.[25]

102. The safety advice from both private and NHS practitioners put a heavy onus on Thomas' parents to closely monitor Thomas and followed patterns similar to those for other adolescents in crisis of self-harm or suicidality to remove sharps, ligatures and medication and later to closely monitor at short regular intervals and even sleep in Thomas' room. This raises questions about what it is reasonable and realistic to ask a family to do to keep their child safe from self-harm or suicide without providing additional resource such as (agency) staff, for example at night. *See Parents' comments*

103. It does not seem that any of the safety advice addressed Thomas' use of specialist and unregulated websites which were a potential cause of harm to him, yet the risk of him being exploited through such sites was noted. This is an area which may benefit from the development of practice guidance – *see below.*

104. The safety advice was very responsive to the day-to-day changes in risk, growing more complex over time and building on the written Safety Plan negotiated with and signed by Thomas and his father when he left the A&E at the end of September. It is not clear to this review that a written safety plan was regularly agreed with or signed by Thomas. The frequently amended "plans" were oral advice to one of the parents. It is not clear that the proposed actions were held in one central place of coordination as they were amended or added to by different practitioners from different services. Practitioner learning for this review has shown that not all practitioners were in agreement with the actions being proposed.

105. There are key practice issues here. Human rights, inclusion and mental capacity indicate that a patient should be involved in the treatment and safety planning however there is also a risk that by involving the young person in some of the detailed planning of monitoring to prevent self-harm or suicide that they may be alerted to the measures that are being taken to prevent them hurting themselves, for example frequency of observation. Safety actions also rely on the cooperation of the young person and for a parent to negotiate or impose control over a child. Thomas resented some of his mother's attempts to both care for and support him and at times control him for his own safety, which is also part of normal adolescent child/parent relationship but in the middle of a mental health crisis. Children at risk in their own homes are not covered by the Deprivation of Liberty Safeguards (DOLS)[26] under the Mental Capacity Act.

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[25] **Safety plan** A written, prioritised list of coping strategies and/or sources of support that the person who has self-harmed can use to help alleviate a crisis. Components can include recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods. The safety plan should be written with and agreed by the person who self-harms.

Overview | Self-harm: assessment, management and preventing recurrence | Guidance | NICE

[26] Deprivation of Liberty Safeguards (DoLS) at a glance - SCIE

106. A regular feature of all the safety advice was that if the situation worsened, in the absence of being able to speak with the CAMHS clinical lead, to ring the Duty team for CAMHS, or out of hours the tri-borough CAMHS Crisis Line or in acute crisis to take Thomas to A&E. Unfortunately Thomas and the family had lost confidence in the A&E.

107. **Recommendation 3** The Bromley ICB / Health and Wellbeing Board should commission practice guidance on risk assessments and safety planning/advice in relation to children and young people at risk of self-harm and suicidality for practitioners working across the health, education and social care sector. Such practice guidance should draw on evidence-based theory and practice and cover parent or carer's capacity to manage high risk safety plans, over extended periods, and include when additional resources may be needed for a young person or parents.

108. **Recommendation 4** When there is a high risk of self-harm or suicide by a child and parents or carers are to manage this with advice and support of mental health and or other services there should be an assessment of the parents' or carers' capacity to manage the required care, supervision and giving of medication as well as the impact of stress on them and the existence of, or need for, a support network to assist them. This should be included in the practice guidance above. A Carers' Assessment should also be offered – see below.

The Care, Education and Training Review and the need for a Local Area Emergency Protocol Review[27]

109. It was noted in early October that a **Local Area Emergency Protocol** (LAEP) may be required in advance of a CETR. It is not clear what would have triggered this emergency meeting in Thomas' case nor why one was not requested or convened. He was clearly in crisis and some practitioners considered that he required hospitalisation. This review has formed the opinion that a LAEP process should have been convened in the interim given that hospitalisation was considered in September and actively throughout October and November. The purpose of a LAEP meeting or an earlier CETR would have been to ensure that all the specialist resources to support Thomas and his family in crisis in the community, including with his neurodiversity, were being considered and coordinated.

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[27] [27] NHS England » Care, Education and Treatment Reviews (CETRs) Their purpose is to ensure services better understand the needs of people with a learning disability and/or people who are autistic so that they can receive the right support; to prevent crisis and that additional support can be put in place quickly to prevent unnecessary hospital admission.

[27] **Local area emergency protocol** "In circumstances where an admission is unplanned, urgent or someone is in 'crisis' it is recognised that a C(E)TR may be, on a practical level, very difficult to set up due to short time scales, level of risk and the need for urgent action. The aim of the local area emergency protocol (LAEP) is to provide the commissioner with a set of prompts and questions both to prevent people with a learning disability or autistic people from being admitted unnecessarily to a mental health hospital; and where there is a clearly supported clinical indication for admission to ensure that the intended outcomes and timescales are clear. It is also intended to help identify barriers to supporting a person to remain in the community and to make clear and constructive recommendations … " Dynamic-support-register-and-Care-Education-and-Treatment-Review-policy-and-guide.pdf Appendix 8 page 92

110. The CETR was not held until mid-November nearly seven weeks after Thomas' assessment in the A&E Department. It is an independent process chaired by a commissioner from the Integrated Care Board (ICB) with independent professional and user-experience representation on the Panel. It is governed by national guidance based on practice research to ensure that the needs of neurodiverse patients with a learning disability or autism who are at risk of hospitalisation (or continued hospitalisation) have their needs fully assessed and met. The guidance was revised in March 2023. At the time local guidance was being devised but the national guidance was used. The process is to quality assure and plan and may also possibly commission additional resources, bespoke, which are not available through the standard locally commissioned mental health services. An example may be paid carers within a family home to support a family in crisis in monitoring patients who are self-harming or suicidal. A CETR is itself predicated on research and evidence that it is better for a person with autism not to be in hospital unless as a last resort; and if so for as short a time as possible. This view, while evidence-based, is likely to influence thinking about any possible need for in-patient treatment.

111. The CETR "meeting" takes place in stages, hearing from the patient and their family/carers and then the practitioners involved in supporting the patient before agreeing plans. As such it is a key process which brings together the family and multi-disciplinary network to agree the future Treatment and Safety Plans. The review was requested on 10 October and a timescale of five weeks was set to bring together all the necessary information for the meeting for 15 November. However local guidance was that for young people CETR meetings should be held as soon as possible and within two weeks of being requested if all the information is available. An urgent review was not requested, despite Thomas's circumstances. The opinion of this review is that it should have been held earlier than seven weeks after Thomas was assessed in crisis in hospital in the absence of a LAEP process.

112. Coordination of the process straddles two services. The ICB manages the review and provides the independent panel, the clinical team responsible for the patient works with the patient and carers and wider network to prepare them for the meeting to ensure that the minimum sufficient network and all the relevant information is available.
See Parents' comments

113. Mother was concerned, ten days later, that she had still not had feedback from the meeting on what had been decided. Parents have stated that Thomas died unaware of the decisions and proposed actions.

114. The outcome report and decisions from CETR meetings are set out in a complex Excel spreadsheet over several different worksheets based on a national proforma. While this may be a useful national tool for risk-analysing, collating, and reporting data there is a question whether a neurodiverse patient and their carers would find it easy to use or understand.

115. Feedback to this review was that some of the practitioners who worked with Thomas who were present at the meeting did not fully understand its role and purpose.

116. There is a practice question about whether an online meeting is the best method for the neurodiverse patient and their carers. Thomas and his parents were not given another option.

117. The CETR (or LAEP) is clearly a very important systems process at a crucial time in a young neurodiverse patient's life and when it is convened as part of a process to look at alternatives to hospitalisation it is crucial that it is coordinated in a way that the young person and their parents/carers can fully participate. It is also important that the proposed actions from the meeting are discussed with the patient and carer as soon as possible after the meeting, if not on the same day, so that they can understand and comment on them. It is not clear to this review that Thomas ever received feedback from the meeting on the actions to be taken to help him. Good practice would be for the Chair of the Panel to provide such feedback and answer their questions pending the arrival of the formal papers within the ten-day timescale.

118. We cannot know if there would have been a different outcome if the meeting had been held sooner or conducted in a different way. *See Parents' comments*

119. **Recommendation 5** The Integrated Care Board has contributed to this review and has decided to undertake a review of the local operation of the Care Educational and Treatment Review process as it applies to young people. This review endorses that decision and recommends that as part of that review the ICB looks at a small number of recent examples of young people in hospital or at risk of hospitalisation where CETR or LAEP meetings were applicable/convened. In reviewing and concluding local guidelines the ICB should consider the decision-making process, the timelines of CETR or LAEP meetings and whether there is adequate guidance about urgency, how young patients and their parents or carers are prepared for the CETR meeting process, how non-mental health practitioners are prepared, whether an advocate may be required and finally how feedback, including oral, is given in a timely and easily understandable way. It may also be useful to consider a plain English leaflet or guidance note or some other form of communication suitable to the patient group (Learning Disabled or Autistic). The ICB should liaise with NHS England on any learning from its review which has implications for changes to national guidance.

Use of Emergency Departments for the assessment of autistic children and young people in crisis

120. Recent changes to the NHS Long term Plan and Guidance in relation to **Urgent and emergency mental health care for children and young people: national implementation**

guidance[28] have made improving the experience and outcomes of children and young people who present in a mental health crisis a national priority. In exploring the four pathways[29] for urgent assessment and brief intervention the guidance recognises the need to consider reasonable adjustments for disabled children and young people, including those with a learning disability and/or who are autistic or neurodivergent, recognising that this group may not be able to engage with the brief response or intervention themselves without adjustments.

121. This review has raised a question, as does the national guidance, about the suitability of an Emergency Department for autistic young people who require a crisis mental health assessment. As an autistic young person, Thomas found the environment of the Emergency Department very difficult and had to wait several hours for an assessment. His family question whether this experience played a part in his reluctance to consider inpatient admission to an adolescent unit. Since Thomas' death, two safer room spaces at the local Emergency Department have been identified for patients at risk (mostly mental health risk), which are ligature-light and also used and adapted as and when required for younger people are presenting with learning difficulties or autism. Any such patient who comes into the Department is escalated and reviewed for potential input and/or reasonable adjustments, as part of the triage process. An application has been submitted recently to secure additional funding for sensory kits to improve patient and family/carer experience. A Standard Operating Procedure will be written to go alongside this and the resource will sit with the vulnerabilities (incorporating Learning Disabilities) teams. The hospital team is also working with the volunteer services and potential future contribution and responses. The hospital has added reasonable adjustments to the agenda for the Emergency Department Safeguarding Business Meetings to further scope out and discuss projects in relation to their younger patients.

122. This review has been advised that the Mental Health Trust has been undertaking bespoke data analysis to better understand the attendance of young people with mental health needs at the local Emergency Department. This work provides a possible insight into potential "near misses" of self-harming or suicidal intention or behaviour which statistics based on actual suicides do not. There are challenges with the way that the original data is noted as some of it is within the descriptive clinical notes rather than categorised identifying and diagnostic data which is routinely collected and thus not easily accessible by routine computer record interrogation. The work is developmental and does not look at possible

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[28] NHS England » Urgent and emergency mental health care for children and young people: national implementation guidance

[29] 4 core functions of a comprehensive crisis offer for children and young people under 18:

1. Single point of access through NHS 111
2. Crisis biopsychosocial assessment in the emergency department and/or community settings.
3. (a) Brief response in the emergency department and/or community settings, with (b) children and young people being offered brief interventions in the home and/or community.
4. Intensive home treatment service for children and young people who might otherwise require inpatient care or intensive support that exceeds the normal capability of a generic children and young people's mental health community team in the home and/or community.

numbers of young people who are in crisis or suicidal but who do not attend the emergency department. It has, however, already been useful in identifying possible patterns of gender, locality or service at a local demographic level which can give indicators about where to focus preventative work. However, it does not yet seek to collate data about disability or neurodiversity. The work to date suggests that it will be of benefit to both providers and commissioners in recognising potential need and planning service provision in crisis mental health, with the caveat that it will not provide a complete picture of potential need.

123. **Recommendation 6** The ICB, the Public Health Service and the Mental Health Trust should continue to develop a more comprehensive annual data set, including neurodiversity as a category, to ensure as full an understanding as possible of levels of acute and potential need. This will provide information about possible need from neurodiverse young people and will thus enable the ICB and providers to explore what reasonable adjustments may be possible either within or as alternatives to attendance in crisis at Emergency Departments, in line with the revised national guidance. It will be useful to explore best practice in Emergency Department mental health assessments for neurodiverse young people in other areas of the UK.

Use of medication and its monitoring.

124. Thomas was prescribed medication at different times to support him both before and during the crisis of October and November 2023. A key early issue was his difficulty with sleeping, possibly related to his neurodiversity, for which he was prescribed *melatonin* several times from 2019. The first prescription was by a private psychiatrist who saw him three times before it was agreed that he would be assessed by CAMHS for autism. This raises key questions about how the use of medication was to be monitored. Technically it remained the responsibility of the prescribing psychiatrist, who ceased to be involved.

125. Community Paediatrics advised the GP to prescribe *melatonin* again in November 2020. Thomas did not take it, but this was not known until his mother requested it again in February 2021 saying that he was now prepared to try it. It was later reported to have been beneficial but the GP was not asked to prescribe again until February 2022 when Mother described Thomas as suicidal and not sleeping.

126. The monitoring of the use and efficacy of such medication in the community for young neurodivergent patients presents a challenge for community health care. Community Paediatrics were only able to monitor Thomas at most six monthly. A busy GP practice will rely on parents asking for a repeat prescription rather than proactively following up whether a medication is being used and is beneficial. A neurodivergent adolescent and their parents may need additional support to understand why medication is important and to develop strategies to help the (autistic) child to continue to take the medication.
See Parents' comments

127. In January 2023 Mother contacted the GP to ask for anti-depressants for Thomas as he had suicidal ideas, was anxious, had disrupted sleep and was refusing to go to school. He was no longer taking his *melatonin*. The GP referred Thomas to Community Paediatrics for antidepressants as GPs do not prescribe anti-depressants to children. Community Paediatrics advised that Thomas should be referred to CAMHS for medication. He was restarted on *melatonin*. *See Parents' comments*

128. From April 2023 the new private psychiatrist prescribed fluoxetine for Thomas' depression and quetiapine for his sleep and to calm him. The psychiatrist monitored his medication until transfer of clinical responsibility to CAMHS in October 2023. The psychiatrist kept the GP informed of Thomas' progress and the use and changes in medication. In July the fluoxetine was reduced and the quetiapine was increased and aripiprazole was introduced at a low dose to be trialled and increased over time if tolerated. Aripiprazole, although mainly an anti-psychotic drug can be used help stabilise mood. The psychiatrist noted that Thomas was reluctant to take the medication at times as his health deteriorated over the summer and into September. The medication was seen as a key intervention alongside the therapy being provided by the private psychologist.

129. From summer 2023 medication was a key part of the Treatment Plan to support Thomas to help him reduce his anxiety and the overwhelming feelings that he had. When Thomas transferred to the care of the local CAMHS Team in October his medication was changed to quetiapine and promethazine, a sedative. Mother has informed this review that a trial of sertraline, an anti-depressant, was also started and the dose was increased after 14 days. Thomas was reluctant to take the quetiapine because of what he believed to be side-effects. Different staff encouraged him to take the medications but there was no consistency and it came to be understood that he was not taking his medications which was a confusion as he was taking his daily sertraline under his mother's supervision and did so throughout the period. It was the night medication that he was at times not taking. The CETR, in mid-November, noted that an increase in sertraline may be beneficial subject to a review of the medications Thomas was taking, no timescale was set for that medicine review. At the end of November, the day before his death, Mother was advised in a telephone psychiatrist review to increase the sertraline, Mother believes that it was said that it should already have been increased. Thomas was not part of that review. The psychiatrist's records indicate that mother reported a refusal by Thomas to increase his dose of sertraline. Mother disputes this. It is the opinion of this review that an increase in the dose of sertraline should have been considered earlier. However, it is not possible to say if there would have been a different outcome if Thomas' antidepressant had been increased sooner.

130. **Therapy** There is evidence that Thomas responded well at different times in his life to therapy. In particular in the spring and summer of 2023 he is reported as using the private psychologist well and it appears that he had a trusting working relationship with her. As his health deteriorated and as he became more fixated on his gender dysphoria it seems that he was less able to benefit from therapy although he was still open with and confided in his private psychologist and private psychiatrist. However, his suicidality and self-harm and the

risk became too great for this to be managed outside a local multi-disciplinary framework with a possibility of in-patient care or more intensive community treatment.

131. Thomas did not establish such trusting therapeutic relationships after that and he had not been re-linked with a psychologist for therapy or as a preparation for possible referral to a Gender Identity Service before he died. His Care Coordinator from CAMHS and three different practitioners from the Response Team met with him over October and November but he was often withdrawn and reluctant to see them, sometimes refusing to get out of bed. But at times he would talk with them, play cards and occasionally went for a walk. They gave him advice and monitored the risk as carefully as they could given what Thomas told them and his actions but as noted above he did not tell them everything that he was thinking or doing or about other important influences on his thinking. They were also sensitive to his feelings about his gender dysphoria.

Responding to Thomas' gender distress

132. It is understood that Thomas was accessing information about gender from different sources online and he was also speaking with a transgender "friend" in the USA who was presumably giving him advice. Thomas told the practitioner in the A&E department that he had had such feelings since he was eleven but these had not been shared with family or the private psychiatrist or private psychologist before July 2023 when he was 16. Up to then he was perceived to have developed in a masculine way and he had briefly had a girlfriend.

133. Thomas' family have questioned whether there was an element of Thomas believing that it might be better to be transgender than autistic as if this was possibly more acceptable to him rather than a genuine developing experience of being transgender. He was occasionally experimenting with makeup and dressing as a woman and occasionally talked with professionals using female gender pronouns about himself. His family and professionals were concerned that he may be rushing into something because of his autistic way of thinking and seeing things in absolutes rather than in a nuanced way. They felt that he needed more time to understand his feelings and sexuality but Thomas became obsessed with seeking to stop his masculine body developing further and his main goal appears to have become medication to prevent that. *See Parents' comments*

134. Thomas occasionally discussed his feelings about being transgender with practitioners. Their responses appear to have been appropriate for what was understood in summer 2023 about Gender Identity assessments and treatment for under 18s. The context for children and young people was that the single Gender Identity Service provided nationally was insufficient and was to be re-developed into regional services. The Interim Cass Report[30] into gender dysphoria and services for children and young people had been published in February 2022. The final report was awaited. The interim report had questioned the use of hormone treatment without further research and through carefully controlled assessments

[30] Interim report – Cass Review

and conditions. This present review is not clear if what Thomas thought he was requesting was puberty blockers or hormone replacement therapy; he was likely to have been post puberty. Thomas would have had to be assessed carefully before he could be referred to the gender identity service and was advised of the need to consider the issues slowly but he was adamant that he wanted medication immediately and it seems that this had become his main priority when he was seen and assessed in A&E at the end of September. Thomas was not aware when he died that the CETR had recommended that with further discussion and preparation he should be considered for referral to the Gender Identity Service.

Coordination of the multi-disciplinary services that Thomas needed

135. **Autism assessments and waiting list delays** The delay in completing an assessment for possible autism was affected by a high level of demand and waiting lists with additional delays because of the pandemic. Experienced primary school staff considered Thomas to probably be autistic and were surprised when the referral for his assessment was not accepted. There is now a revised local process and proforma for schools to use when seeking an autism assessment for a child making it clear what information is required. There is currently still a high national referral rate and it is a systemic problem with high demand and insufficient resources.[31 & 32]

136. At the time the autism assessments were conducted in two parts by two different services, Community Paediatrics and Child and Adolescent Mental Health. Each service had its own waiting list, the CAMHS waiting list being longer and also greatly impacted by the pandemic. There was also a nine-month delay in bringing the two parts of the assessment together to give a final diagnosis when Thomas was 14 and which he was subsequently unwilling to accept. This appears to have led him to refuse support which was offered but which was specifically geared towards his autism.

137. Autism assessments of children are complex and require time and clinical expertise, even when other professionals, such as experienced teachers, believe that a child may be autistic. There may be delays in accessing appropriate help and resources for families until a formal diagnosis has been made, rather than a needs led approach. Recent research and recommendations[33] from the N8Research Partnership[34], a collaboration between Northern Universities, examines current policy and guidance and concludes: *"The evidence on current autism support across the UK paints a compelling and worrying picture: there is an urgent need for the UK to transform its support systems for autistic CYP and their families. We cannot keep doing more of the same (e.g., throw some additional resource at conducting a few more assessments in hospitals to reduce autism waiting list times – a*

[31] Children's Commissioner: **Waiting times for assessment and support for autism, ADHD and other neurodevelopmental conditions** 15 October 2024 https://www.childrenscommissioner.gov.uk/resource/waiting-times-for-assessment-and-support-for-autism-adhd-and-other-neurodevelopmental-conditions/

[32] Autism crisis sees thousands of children wait years for support, report finds

[33] CoTN_Autism_Report_1.pdf **A country that works for all children and young people. An evidence-based plan for addressing the autism assessment and support crisis**

[34] N8 Research Partnership

costly approach tried many times, in many places, with no lasting impact). We need a radical overhaul of our approach to supporting autistic CYP and – most critically – to trial new approaches that better connect health and education." And *"We must move towards a needs-led approach, rather than just relying on a diagnosis-led system. Early identification and support, rather than waiting for a diagnosis, will lead to better long-term outcomes and reduce costs. As this report argues, improved information-sharing between the health and education systems and a more coordinated approach to support, including early help in nurseries and schools before formal diagnosis, is essential."*
See Parents' comments

138. An autism diagnosis changes nothing, especially if it comes late. Multi-disciplinary work to support the child and family should already be in place across the partnership to support that child. This would involve proactive communication between schools, primary care, mental health, community paediatric services, and when necessary, Children's Social Care. This will enable schools, Special Education Needs, CAMHS, Early Help and other services to coordinate early help processes and provide support from the beginning of the identification of a need prior to an autism diagnosis. This review has received information from local practitioners which suggests that there is a belief that it is not possible to provide appropriate support prior to an autism diagnosis.

139. Innovative changes to autism assessment and support are being used in Portsmouth[35] and Cornwall[36]; and in Bradford, as noted in the N8 Report above. These new approaches show the value of evidence-based neurodiversity profiling which can identify and provide support before a formal clinical assessment as outlined by NICE.[37] The innovative work has also led to a reduction in the number of requests for autism assessments when other services are put in place.

140. **Recommendation 7** The SEND Governance Board and the Joint Commissioners for Children's Services in Bromley should review the research and approaches being used in other parts of the UK and consider how such evidence-led best practice may be beneficial in Bromley in commissioning services to support and assess children whose parents or professionals think may be autistic. Bromley Schools and the Children and Young People's Programme Board should be involved early in the process, with the Designated Clinical Officer playing a key role. A report on that review should be made within six months to the SEND Governance Board, the Joint Commissioning Forum and the Safeguarding Children Partnership.

141. The Integrated Care Board has commissioned improved arrangements for autism assessments for children in Bromley from the start of 2025 to be provided fully within the Community Paediatric Service, including appropriate staff who are trained in ADOS assessments. The new provision also permits a fast track for children where there is a clear presentation of Autistic Spectrum Disorder and additional more specialised assessments

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[35] **Rethinking child neurodiversity** January 2024 Rethinking child neurodiversity | BPS

[36] Parent Carers Cornwall The Neurodiversity Hub and the Neurodiversity Profiling Tool

[37] Overview | Autism spectrum disorder in under 19s: recognition, referral and diagnosis | Guidance | NICE

are thus not required. This will help meet future demand and reduce the risk of increased waiting times. Work is also being undertaken to provide clear information for parents about symptoms of autism (including masking or camouflaging as a presentation), how to prepare for an assessment and where to get age-appropriate support for older children. It is planned that other children will not experience the delays that Thomas experienced.

142. The Integrated Care Board, as lead commissioners for the revised clinical autism assessment service, will ensure overview, scrutiny and monitoring of the new assessment service. The progress of the revised pathway will also be monitored by the Special Educational Needs Governance Board through the Partnership Performance Dashboard which includes data about autism assessments requests, acceptances, completions with timescales and waiting lists. This will permit strategic monitoring of waiting lists to enable future planning against demand/need.

Single Agency and Multi-Agency Work

143. Up to the summer of 2023 Thomas' needs triggered different demands for services some of which required more than one service. Thomas's schools offered additional support for him and there was evidence of good liaison and coordination by the secondary school and the private psychologist when she was working with Thomas.

144. In October 2020 a referral was made to the Multi-Agency Safeguarding Hub by the CAMHS Crisis Line following Thomas hurting his brothers and hitting his father. Changes to the Children's Social Care computer records system (in 2021) have prevented exploration for this review as to whether consideration was given to offering to the family to undertake a Child and Family assessment, which would have been appropriate. It should be noted that this was in the second phase of the pandemic and many services were still challenged with adapting to COVID measures. *See Parents' comments*

145. The Autism Assessment Feedback meeting in September 2021 did not note the possible need for a Carers Assessment for Thomas' parents given the challenges they were facing and the stress expressed by parents in getting help with Thomas. It is unlikely that a Carers' Assessment would have been routinely recommended unless a child's needs and support were very complex. As Thomas was very able it is unlikely.

146. **Recommendation 8** The ICB and the Community Paediatric Service should amend guidance and practice to ensure that Autism Assessment Feeback Meetings routinely consider whether the family/carers need additional post-diagnostic support for themselves to assist them in meeting the needs of a child identified during the assessments.

147. The Secondary School agreed to lead a multi-disciplinary Common Assessment Framework[38] approach to ensure that Thomas and his family were supported. It was later noted that there should have been a Child and Family Assessment because of the impact

[38] Now called : Early Help Assessment [Early Help Assessment (EHA)]

on the brothers and parents. In January 2022 after another incident of harm to one of Thomas' brothers a Child and Family Assessment was undertaken and parents have described the useful and straightforward approach taken by the social worker to help Thomas and his brothers manage their interactions at home, with Thomas seeing the need to respect others' boundaries.

148. This was followed by a further period of Common Assessment Framework approach led by the school with the addition later of a focussed intervention by a Family Support Worker from the Early Intervention Service which was positive. Mother also attended some parenting sessions for parents of autistic children in the Autumn which she reported finding useful but which had to end prematurely when her own mother became unwell. It may have been useful if Mother had had access to these sooner in Thomas' life and did not have to wait until he was "diagnosed".

149. From January 2023 the main coordination of Thomas's care fell to the parents, mainly Mother, as Thomas' was more and more reluctant to attend school and was becoming more anxious. In February, Mother sought advice from the GP and from the CAMHS Crisis service she was advised to self-refer him to the Mental Health and Wellbeing Service for consideration of a referral to CAMHS but instead sought support from the private psychologist and a private psychiatrist. The family was under the impression that Thomas had been referred to CAMHS and was on a waiting list, which was not the case.
See Parents' comments

150. The school was being kept informed of what was happening and was seeking to support Thomas at a distance, but he was not attending as his mental health deteriorated. They enabled Thomas to take his exams. *See Parents' comments*

151. By summer 2023, Thomas' main care was from the family supported by the private psychologist and psychiatrist. It is the opinion of this review that the quality of that care was good. There was a recognition of his mental state and his need and increased monitoring for his safety. The psychiatrist and psychologist kept the GP informed of Thomas' situation and their treatment. However, Thomas' mental health and self-harm and suicidality worsened over the summer. The private practitioners made appropriate referrals via the GP for local coordinated NHS and partner resources to treat Thomas. The private psychiatrist was of the view that Thomas possibly required a period of in-patient services. The GP saw Thomas and assessed for suicidality and quickly and appropriately referred Thomas to the Mental Health and Wellbeing Service which immediately triaged and referred him on to CAMHS. That resulted in Thomas' name being added to the waiting list for the Learning Disability Team. This is a systemic concern as a crisis referral led to Thomas' name being placed on a waiting list for consideration rather than a crisis response. The private psychiatrist and psychologist remained involved and responsible until Thomas was accepted by CAMHS.

152. Thomas' health seriously deteriorated and Mother was advised by the CAMHS Crisis Line to take him to A&E for consideration for emergency hospital admission. This appears to have been a "start again" process triggered by the crisis rather than a process which built on

the work that the private psychiatrist and psychologist had been doing. It would have been good practice to have had a handover meeting or conversation to understand Thomas' patient journey and treatment to date.

153. **Practice learning:** When the clinical responsibility for a patient is transferring between treatment teams it is best practice for there to be a **handover process** which makes clear the history of symptoms and treatment to ensure understanding of the patterns and progress and to know how the patient has responded previously; including how any neurodivergent traits have been assessed to impact on the symptoms or treatment responses.

154. The A&E attendance at the end of September rightly triggered a further crisis referral into CAMHS which superseded the earlier referral via the GP and led to Thomas being re-assigned to the Adolescent Team. It also triggered a Strategy Meeting led by Social Care within the MASH. It would have been good practice to involve the school and CAMHS in the Strategy process and to have invited the private psychiatrist and psychologist to contribute, although it is not clear that the MASH was made aware of their involvement. The private psychiatrist was still involved at the time of the Strategy Meeting.

155. The two separate assessment processes led by Social Care and CAMHS then appear to have operated in parallel. Best practice would have been for there to have been clearer planning of assessment between them and for the CAMHS mental health and risk assessments to have been more fully integrated into the Child and Family Assessment. The Social Care Child and Family Assessment relied on parental information about Thomas' mental health and the CAMHS' response rather than on direct discussion with CAMHS. *See Parents' comments*

156. Neither process considered a Carers' Assessment[39] for the parents, or whether a Young Carers' Assessment may be required for Thomas' brothers. It was not until the Care Education and Training Review in mid-November 2023 that it was formally noted that a separate Carers Assessment should be offered/undertaken. Thomas' parents do not remember being consulted about this. The purpose of such an assessment would have been to look at the wider needs of the family and whether the parents/carers required any support in their own right to assist them in caring for Thomas or managing their own stress. The needs of the family as a whole were considered as part of a Child and Family Assessment and the assessment noted the stress that parents were under and the challenges that they were having in caring for Thomas and protecting him from self-harm in crisis and in supporting and shielding the brothers from the impact of that. The assessment recognised that further post assessment work based on Thomas and his siblings as **Children in Need** would also require looking at what emotional support his parents and brothers might require.

[39] Assessments and care plans for children in England A note by the Autistic Society on Carers Assessments

157. In learning for this review the Children's Social Care Service has noted that Child and Family Assessments should be more pro-active in identifying where neurodiversity needs or mental health needs are more complex such that parents may be eligible for a Carers Assessment over and above any needs already identified within the Child and Family Assessment and then initiating one if the parent would want this. A challenge will be where older children are autistic and able to self-manage, like Thomas, or in situations of acute mental ill health what resources, services or supports a Children's Services Department would be able to offer to parents in their own right.

158. Conversations with practitioners across the wider network for this review have shown a lack of awareness about Carers Assessments and Young Carers Assessments and how these are requested or co-ordinated. They are mainly used for the families of physically or learning-disabled children with high levels of need rather than neurodiverse children or children in mental health need and they are more usually associated with a child being registered disabled and Thomas was not.

159. **Recommendation 9** To achieve a pro-active offer of Carers Assessments to those families where this may be of benefit, it is recommended that:
i. Children's Social Care should issue guidance to its workforce about Carers Assessments in the context of conducting Child and Family assessments and;
ii. Children's Social Care, ICB and Adults Social Care should establish clear referral pathways for Carers Assessments. *See also the comments above at paragraphs 107 and 108 with regard to assessing parents and carers capacity to provide care in acute risk situations.*

Information sharing between services

160. Notwithstanding the lack of a handover process between private and NHS mental health services the review has shown good information sharing between the private practitioners and the GP. There was also good liaison between the private psychologist and Thomas' school over the different periods of her involvement.

161. From the inclusion of the Response Team in the crisis period there is evidence of good quality communication to the CAMHS clinical team through their daily reports about their contacts and work with Thomas and his parents. Communication from the CAMHS team to the Response Team is less evident and questions asked by the Response Team about planning were not answered by the CAMHS team in a timely way. Practitioners drew to the review's attention a systemic challenge as the two services were from different providers and did not share a common records database and thus had to rely on emails or phone calls. Had the Response Team practitioners had access to a core patient record they would have been able to see the work of the CAMHS team. The Response Service at the time was a regional resource hosted by different provider. It will be provided directly in-house by the Mental Health Trust from mid-March 2025, which should permit direct sharing of patient records.

Availability of key workers

162. An important systems context to be noted includes high levels of demand in mental health (and other) services and the need to daily prioritise work where there is risk. This is known to be a national , as well as local issue. It is noted for this review that some of the key workers became unavailable for periods in the crisis period as a result of health or for personal reasons. The CAMHS team and duty systems provided "cover" and Thomas was discussed in team meetings but there was over reliance on the Response Team to monitor and report back on the developing situation at home. A result is that some of the required actions did not progress as quickly as they should, for example the medication review and actions from the CETR. The review was advised that care has to be taken when considering substituting for absent key workers in face-to-face work with a young person in crisis. It is noted that Thomas felt that too many people were involved. However, providers and commissioners in planning service delivery must ensure that there are adequate cover arrangements in place, especially for high-risk work, to ensure that essential tasks, including referral on to other services for those inevitable times when key personnel are unexpectedly absent.

163. **Recommendation 10** The ICB and the Mental Health Trust should review the standards and guidance for ensuring that in situations where there is unexpected absence of key personnel appropriate arrangements are put in place to ensure progress of Patient Treatment Plans, including onward referral to required urgent treatment and resources.

Online harm and its impact on vulnerable young people

164. Thomas was known to have accessed at least one suicide website and to have spoken on more than one occasion with at least one transgender person online who became a significant influence, and who Thomas presumably met through a transgender website. It is assumed that Thomas also sought other information online as he had awareness of transgender treatments.

165. Unregulated chat rooms where the motivation of participants is not clear present a high risk of influence, grooming and or exploitation to vulnerable young people, such as Thomas. Neurodiverse, autistic thinking may also impact on this as a young person may not be able to assess the risk or hear advice about the risks; for example from parents or professionals. There is also a need for the professionals supporting vulnerable young people to be knowledgeable about the risks that sites may pose.

166. At the time of Thomas' death the Online Safety Act 2023[40] had just been passed but was not yet in place. One of the areas which the Act seeks to address is the protection of children from content that may be harmful such as sites, including membership chat

[40] Online Safety Act: explainer - GOV.UK (www.gov.uk)

rooms, which include material relating to self-harm or suicide, among other areas. The Act also introduced a new criminal offence for encouraging or assisting serious self-harm. In May 2024, OFCOM[41], which has responsibility for guiding and enforcing the act, issued a consultation on **protecting children from harms online**[42]. The final statutory guidance on the protection of children online is not due to be laid before parliament for approval until summer 2025. Although the Act has powers to prosecute sites which are based outside the United Kingdom there are questions about how non-UK-based websites or sites where the owners are hidden and which facilitate or promote suicide will be reached. There have been questions about whether the Act has gone far enough and what is achievable in this area.[43] *It should be noted that since this report was approved in February 2025 the relevant statutory guidance for the protection of children from online harm was agreed and came into force on 25 July 2025* [44].

167. It is important to seek to prevent such harm caused by such sites but a learning for this review is also the challenge of investigating any possible culpability following a suicide such as Thomas'. It has been reported to this review that it is difficult to obtain cooperation from a major international search engine and internet services provider in gaining access to Thomas' search history. It is understood that the provider will not agree to provide access to material without an order from a US court. The Coroner is now liaising with OFCOM about an order under section 101 of the Online Safety Act to gain access to Thomas' internet search history. If it can be achieved it will give a clearer picture of how Thomas was being influenced. This will contribute more fully to learning about how (vulnerable) young people are influenced by access to such materials. The work of organisations like the Molly Rose Foundation[45] is important here.

The Coroner issued a Prevention of Future Deaths report on this matter – see Addendum.

168. **Recommendation 11 to OFCOM and the Department for Culture, Media and Sport.** In agreeing the final statutory guidance on protecting children from harms online OFCOM and the DCMS should consider introducing statutory guidance or by seeking amendments to the Act to ensure that internet providers are under a duty to assist the police or coroners in the investigation of a possible serious crime or a death without having to resort to OFCOM to issue an order to do so.

169. **Recommendation 12** The Child Safeguarding Practice Review Panel[46] and the National Child Mortality Database[47] should consider commissioning national learning into the

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[41] What is Ofcom? - Ofcom
[42] Consultation: Protecting children from harms online - Ofcom
[43] 'Failure to act' on suicide website linked to 50 UK deaths - BBC News

[44] Online Safety Act - GOV.UK
[45] Home - Molly Rose Foundation
[46] Child Safeguarding Practice Review Panel - GOV.UK
[47] National Child Mortality Database (NCMD) | Bristol Medical School: Translational Health Sciences | University of Bristol

impact of online providers which facilitate suicide or serious harm to children including recommending the collection and collation of relevant data on the impact of such sites on mortality or significant harm in order to seek future prevention.

170. **Recommendation 13** The Bromley Safeguarding Children Partnership with the Public Health Service should consider what information, guidance and or training should be provided to support practitioners working across the children's sector in understanding the risks of sites which promote self-harm or suicide so that practitioners can develop practice skills in direct work to advise young people at risk.

Suicide and self-harm prevention

171. Work to understand and prevent self-harm and suicide in Bromley is led by the Public Health Service with advice from a multi-disciplinary Suicide Prevention Strategic Group comprising representatives from key agencies, including representatives from agencies which support people with autism. At the time of Thomas' death, the five year plan to 2024[48] was in place with actions to tackle the priorities identified. The Plan has a population wide focus. For young people a key target has been work in schools to support better mental health and reduce self-harm and suicidality.[49] A gap is possibly young people who are not in school. A revised Five Year Strategic Plan is currently being devised. It is noted that collation of data for the group has improved over the period to ensure more targeted planning but collection of some personal data to aid targeted planning remains a challenge.

172. The Bromley Strategic Plan drew from the national plan (from 2012). In September 2023 the national five year plan was updated and expanded.[50] It recognises a wider range of areas for action including, among others, the need for improved data, a focus on key groups identified as at higher risk (including children and young people, people who have self-harmed, people in contact with mental health services, and autistic people), problems of online harm and social media and the need to provide effective crisis support across sectors for those who reach crisis point.

173. The Bromley Public Health Service, applying national projections, has analysed that locally in 2024 approximately 10,100 children and young people aged 8-19 may have a mental disorder. Planning for support services and emergency responses will need to take this into account. A key local target is to reduce waiting times for access to Child and Adolescent Mental Health Services; this includes the revised pathway for autism assessments, discussed above.

174. **Recommendation 14** The Public Health Service and Suicide Prevention Strategic Group in drawing up the new Five Year Strategy for Prevention of Suicide should take into account the lessons from this review and should consider calling it a Strategy for Prevention

[48] bromley-suicide-prevention-plan-2019--24
[49] See the **Mental Health and Wellbeing Toolkit** published on the Bromley Education Matters Website Bromley Mental Health and Wellbeing Toolkit for Schools | Bromley Education Matters
[50] Suicide prevention strategy for England: 2023 to 2028 - GOV.UK

of Self-Harm and Suicide. The strategy should consider a clear section for children and young people given the increased numbers of children showing mental ill health post pandemic. In terms of data the strategy should look to include "near misses" such as attendances at A&E, as discussed above, and noting identifying data such as neurodiversity. There may be benefit in looking at production of local public health information about the risk of online harms and social media as influencers to self-harm and suicide.

Additional learning from the individual agency reviews which is relevant to the wider system

Schools

175. Thomas' primary and secondary school recognised his additional needs and neurodiversity and worked closely with him and his family to support him, offering additional resources ls as necessary. In reviewing its work in partnership with Thomas' family the Secondary School Academy Trust has noted the following learning which will also be relevant to other schools.

176. When a student with autism is having difficulty attending school the value of a home visit to support them and re-integration should be considered with the family. Schools may have to support staff with the skills and time-resources for home-visiting.

177. When a student is unwell with mental health difficulties or less visible illness schools should consider how to maintain links between the student and school community. This is a wider issue as schools implement whole school approaches to mental health and wellbeing.

178. Where families are not getting the support they require from external agencies, such as mental health services, schools should consider if and how to escalate this within and external to the school notwithstanding awareness of the perceived pressures on external mental health services and a possible belief that a referral may not have any impact.

179. The secondary school offered Thomas additional support with social skills when he was younger which helped him establish a small but important longer-term friendship group. Later he struggled to come to terms with his autism diagnosis and would not engage in the specialist support available within the school. The learning is: gaining the young person's view at each stage is crucial when planning intervention and support. Schools should consider how support may need to differ year on year according to the student's development and wishes.

180. When attendance drops dramatically (and has been consistently good prior) and is combined with serious mental health issues it is important to work with families to create a bespoke support plan. This may include short term setting work, online communication and home visits. It may be important to work with staff to help them see that such intervention is

not "condoning absence". The DfE Guidance on attendance and mental health[51] should be used.

181. Escalation should be considered when essential partner agencies do not attend or contribute information to the multi-disciplinary Common Assessment Framework[52] process.

182. When a student is noted to have additional needs at transfer from primary school it is important to consider the indicators and thresholds for Special Educational Needs funding and services and to consider whether the student meets the criteria for an Education and Health Care Plan. *See Parents' comments*

183. Schools must drive their vision and values to prevent ostracism and bullying and to promote inclusion so that neurodiverse students can thrive.

Children's Social Care

184. When a young person is in receipt of mental health services relevant professionals from those services should be invited to participate in strategy discussions and expected to contribute to multi-agency assessments.

185. In high-risk work, such as serious harm or suicidality, there should be escalation of such work to the relevant senior manager to ensure that both social workers and their line managers receive reflective supervision. This will support social workers to challenge the realism of safety planning led by partner agencies and strengthen their capacity to advocate the voice of the child. In addition, this escalation will mean the senior manager in Children's Social Care can ensure there is appropriate line of sight with senior colleagues across the key involved agencies managing the risk.

General Practitioners

186. For reports to Social Care, GPs should use the report proformas embedded in the GP recording system as these automatically pick up coded diagnoses and recent consultations making reports more comprehensive.

187. GPs should ensure that there is a tight "safety netting system" for vulnerable patients (e.g. those with suicidal thoughts) to make sure that any follow up appointment occurs.

188. GPs should understand how anxiety and suicidal risk are associated with ASD and should have a clear referral pathway for these patients. Support should be provided to these

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[51] Summary of responsibilities where a mental health issue is affecting attendance (publishing.service.gov.uk) March 2023 *This guidance was issued after Thomas had ceased to attend school.*
[52] In Bromley this is now the **Early Help Assessment** process.

patients whilst they are on a waiting list.

189. GPs should have knowledge of early intervention pathways for ASD with respect to diagnosis, mental health support and support for families.

190. Children with serious mental health concerns or suicidal thoughts should be included on the list of vulnerable children at GP Practice level, enabling these children to be kept under review through discussion at Multi-Disciplinary Meetings. GPs should escalate to secondary care if safeguarding does not seem to have been considered.

Conclusion

191. Learning from this one example will hopefully support other families and young people in mental health crisis with heightened suicidality. The questions raised and recommendations made give pointers to improvements in systems and practice. Key areas of concern are:

- understanding and supporting children and young people who are neurodiverse and provision of timely assessments and support,
- access to advice and support for young people and families where young people are experiencing gender dysphoria,
- timely provision of mental health services within a system facing high demand and prioritisation,
- understanding of the impact of a child’s acute mental ill health and suicidality for parents and families; and ensuring that there is time to listen to parents and ensure that they have full information on the decisions taken and their rationale,
- practical support to families in crisis seeking to keep suicidal children safe (including greater awareness of Carers Assessments),
- reasonable adjustments for emergency mental health assessments in A&E Departments or an alternative suitable for neurodivergent young people,
- consistency in safety planning and advice approaches, and
- awareness of the risk of online harms with regard to suicide and how to support young people with these.

Malcolm Ward
Independent Reviewer

October 2025

In February 2025 the Bromley Safeguarding Children Partnership accepted the 14 recommendations made within this review. An Action Plan was agreed to implement and monitor those recommendations.

Addendum : Parents' response to the review and additional information provided by the Mental Health Trust following the Parents' Comments

192. **Paragraph 10:** Parents have stated that in an assessment in 2014 Attention Deficit Disorder was noted as a possibility but was not followed up. Thomas' parents do not think that professionals gave sufficient attention to the possibility of this.

193. **Paragraph 35:** Parents have stated that they were advised by the practitioner to whom they spoke that it was not possible to prioritise an earlier risk assessment. This demonstrates for them the difficulty of getting help for autistic children in crisis.
The Mental Health Trust has provided additional information that it was understood that Thomas' reluctance to attend A&E on 22 September was that he feared the possibility of being sectioned. The online assessment on 29 September was to be undertaken by a colleague from the specialist CAMHS Neuro-Diversity Team.

194. **Paragraph 39-40:** Parents believe that Thomas had been ready to be admitted to hospital and wanted help to get better, he was in hopelessness and in their view was in no fit state to make decisions about himself. They feel that staff counselled him against admission as they (staff) believed a hospital environment would not be conducive for an autistic young person like Thomas because evidence was that neurodivergent young people do not do well as psychiatric inpatients. The parents have said that the possibility of staying in the A&E Department in a cubicle, under parental supervision, over the weekend was suggested but that was not viable for them. As there was no other alternative Thomas went home. Parents believe that this outcome contributed to Thomas feeling worse and unsupported.
The Mental Health Trust has told this review that CAMHS advised bringing clothes, food and entertainment in order to make A&E a more comfortable experience for Thomas.
Author comment: *It is clear that Thomas' Parents were under the impression that the A&E visit and bringing a bag was with the possibility of Thomas being admitted.*

195. **Paragraphs 41 and 43:** Parents state that Thomas was not refusing his anti-depressant medication (Sertraline) and took this medication every day until he died.
CAMHS records indicate that at the 29 September video assessment Thomas had stopped taking his anti-depressants as he did not find them helpful. The record for 10 October notes that Thomas had stopped taking Fluoxetine two months prior and had ceased Aripiprazole in the previous two weeks.

196. **Paragraph 56:** In the Parents' opinion Thomas did not want to go into hospital because he had been scared off by the staff.

197. **Paragraph 61:** Mother is very clear that Thomas did not say that he was reluctant to increase medication. Mother remembers having raised a concern about Thomas looking at

maps and she commented in this meeting on Thomas' low mood. She also remembers the meeting as being on 24th, not 22nd November. The practitioner was reported to have commented that Thomas' low mood might have related to tiredness following his recent trip out of London.

198. **Paragraph 66:** 27 November Mother disputes the detail of this telephone call. She has stated that she advised the psychiatrist that Thomas had been on and off antipsychotic medication and that this was making his mood fluctuate and that she was worried about him going into a psychosis because of lack of sleep. When the psychiatrist had queried the current dose of antidepressant and was told 50mg, Mother states he had been surprised and stated that it should already have been increased to 100mg. Mother confirmed to the psychiatrist that no-one had reviewed Thomas' medication since the end of October.
The Mental Health Trust record of this call notes that Thomas was said to be refusing Quetiapine at night. Melatonin was reported to be making Thomas groggy and lethargic. Mother was advised to give Thomas Sertraline earlier in the day as it may cause insomnia. A prescription was issued for 75mg of Sertraline and Mother was advised to give Thomas Promethazine in place of Quetiapine at night, when required. (This had been prescribed a few weeks' prior.)

199. **Paragraph 70:** Parents have stated that at the A&E visit, admission to hospital was not offered but the hospital suggested the possibility of a cubicle in A&E for Thomas under 24-hour parental supervision or returning home. They were told that there were no beds available. They have said that later they were told that neuro-divergent children do not do well in hospital.
The Mental Health Trust record of the A&E visit notes that the level of risk was explored and that Thomas was not assessed to be actively suicidal. He did not wish to stay in hospital as he did not like the hospital environment as it was too noisy and full of people and he did not want to sleep there and agreed to be monitored at home.

200. **Paragraph 74:** CCTV footage later showed that Thomas had walked along a wall. Parents have questioned subsequently if this was to avoid the noise of the gravel, which had awoken Thomas' father on the previous occasion.

201. **Paragraph 76:** Parents question whether there was sufficient understanding about the way that neurodiverse high functioning autistic young people think and are influenced. They have also noted that Thomas was asked about suicidal intention several times in front of his mother and query this practice and whether he should have been asked alone. *(Records show that there were also conversations about this with Thomas alone.)*

202. **Paragraph 80:** Parents have additionally commented on the involvement of three different social workers, three different doctors, a Care Coordinator, three different Response Team staff and different people in the CETR meeting. In a period of extreme crisis this complexity was overwhelming for Thomas and parents alike.

203. **Paragraph 89:** Parents and Thomas experienced NHS practitioners being openly critical of the work of the private practitioners and that criticism contributed to undermining Thomas' confidence in practitioners.

204. **Paragraph 91:** Thomas and his parents found the number of different practitioners difficult. They believe that Thomas would have benefitted more from support from a single individual or a smaller team as a vulnerable autistic person so that a trusting therapeutic relationship could develop.

205. **Paragraph 92:** For Parents, Thomas going for a walk at 4 am was a major red flag. His statement that he just wanted to go for a walk should not have been taken at face value. Given his mental state, lack of sleep, previous suicide attempts and irregular anti-psychotic medication Parents believe that he should have been seen by a psychiatrist and sectioned that day. A child in Thomas' condition requiring such regular supervision as parents checking on him every 15 minutes and not leaving him alone should not have been left in the sole care of parents.

206. **Paragraph 93:** Parents do not think that Thomas had mental capacity while he was under NHS care. He was taking his anti-psychotic medication irregularly, not sleeping, not eating, not self-caring, self-harming, visiting suicide websites and openly discussing his death in addition to at least two actual suicide attempts. They question that practitioners would have assessed that Thomas was able to make rational decisions.

207. **Paragraph 97:** The parents' view is that**:** Had Thomas been admitted to hospital he would have had 24-hour supervision, psychiatric input, including review of medication and help establishing a good sleep pattern in addition to counselling and psychotherapy. In the community he did not receive that level of care.

208. **Paragraph 99:** Parents have said that they were unaware that the possibility of admission was being kept in mind for Thomas.

209. **Paragraph 100:** Parents believe that not enough was done to support Thomas with his sleep, his medication was not kept under review, as planned, and Parents' concern about this was not acted on. In their view Thomas did not receive adequate basic medical care. He received no psychotherapy or exploration as to why he had ended up in the state he was in. He received no help for his gender dysphoria. From the family's perspective lots of meetings and discussions were taking place with nothing concrete or useful arising.
The Mental Health Trust records indicate that gender dysphoria was discussed with Thomas at the A&E assessment on 30 September with advice to Thomas and family to seek support form a local specialist agency for transgender young people. On 4 October Thomas was advised that before the possibility of hormone treatment could be considered he would need to be mentally stable, and that referral would also be in the context of his self-esteem, motivation, structure and routine. On 10 October the Consultant tried to explore and explain to Thomas how gender treatments are managed and that they must be considered in the context of psychological support, monitoring of mental health and any possible mental

illness; and that hormonal injections alone would not be possible. Thomas was encouraged to cooperate with CAMHS to build rapport to support his underlying low mood in order to help get him ready for possible referral to a specialist transgender service.

210. **Paragraph 102:** Parents have confirmed that the possibility of night carers was never discussed with them.

211. **Paragraph 112:** Parents have said that the purpose of the CETR was not explained to the family or that it was to ensure services were in place as alternatives to being admitted to hospital. They did not get to meet the Chairperson separately. They were surprised that Thomas and they went online in a Zoom meeting to see people that they had not previously met. They believe that this made it difficult for Thomas to speak about himself and his needs and, in their view, Thomas did not engage in the meeting.
The Mental Health records indicate that the CETR was explained to Thomas and his mother, with supporting information. A CETR document was completed with Thomas on 14 November to support Thomas presenting his views and that he was noted to be positive about this.

212. **Paragraph 118:** Parents have said that if the meeting had been convened earlier, it may have given Thomas more hope. It might also have given them an option to consider other sources of help if they had been aware of the decisions sooner.

213. **Paragraph 126:** Parents have responded to this point in the review by adding: Neurodivergent children need and deserve a key worker that supervises them and is involved in their care from diagnosis until the age of 25. By having a trusted relationship with a key worker or a small team of workers, a lot of confusion and missed opportunities could be prevented namely ensuring that medication is taken as prescribed and if patients are responding properly or not.

214. **Paragraph 127:** Parents have commented to say that this this demonstrates the lack of awareness for families as to who is responsible for what in health services and that this is not helpful to families, in crisis, seeking to access help.

215. **Paragraph 133:** Parents have subsequently questioned whether Thomas' transgenderism was an example of *Rapid Onset Gender Dysphoria*.[53] Throughout his life Thomas showed no signs of wanting to be female or displaying stereotypically female tendencies. Throughout his life he was rejected and ostracised by groups of boys and in his last months perceived himself as a 'low status' male. The family believes Thomas 'self-radicalised' into wanting to be female as a means of trying to find acceptance.

[53] This review notes the Parents's additional views but is unable to comment on them as this was not considered by practitioners at the time. It is also noted that there is not clinical consensus about Rapid Onset Gender Dysphoria.

216. **Paragraph 137:** The experience of trying to obtain an autism diagnosis was exhausting and draining. Parents state that no meaningful support was offered after diagnosis. From start to finish the process took 10 years. They felt that they were being fobbed off and had to be persistent to get a diagnosis and believe that the unacceptable delay cost Thomas the opportunity to accept his diagnosis. The Family now feels that it would have been better to have not had the diagnosis at all.

217. **Paragraph 144:** Parents have said that the social worker who attended to this incident and visited the home was fantastic. They suggest that regular check-ins to help pre-empt crises rather than just crisis management would be beneficial and that if an autistic teen finds a person of trust, then this relationship should be supported and developed and not handed on to yet another new person. *This review was unable to see any records from this incident in 2020 or to confirm that a social worker did visit and therefore considers it possible that this positive experience described by the Family relates to the Early Intervention and Family Service response in 2022 (stepped down from social care) or the Social Care visit following Thomas' attendance at A&E in 2023.*

218. **Paragraph 149:** Parents have added that in order to access the private services via health insurance they were required to seek a referral to NHS services. On so doing the Family was told that it would be months before Thomas would be seen by the NHS as at that stage his self-harm involved 'merely' pulling his hair out. They believe that given the vulnerabilities to poor mental health, self-harm and suicide in the autistic population those with an autism diagnosis should expect a fast-track into mental health services to prevent the escalation that Thomas endured. The national adolescent mental health crisis and lack of available psychiatrists resulted in it taking three further months to find a private psychiatrist.

219. **Paragraph 150:** Parents have stated that Thomas was well supported when he was in attendance at secondary school but received no support from the school when he ceased attending in 2023. The school refused to provide remote learning materials or support. Parents believe that Thomas falling further behind in his studies was a massive contributor to his distress. Parents believe that even if there are not resources for home visits, schools could do more to facilitate home learning, such as online and that decisions should be made on a case-by-case basis. Thomas completed six GCSE's obtaining high grades only through the funding of private tutoring.

220. **Paragraph 155:** Parents have said that it would be better to have had a single point of contact. *This would not have been possible given the parallel assessments by two separate agencies. This can add to confusion or stress for patients and parents and increases the number of professionals involved.*

221. **Paragraph 182:** Parents have noted that Thomas' transition to secondary school was well supported by the schools and parents working well together with the aid of specialist advice about school selection, which the parents paid for. Despite this Thomas found the

transition to secondary school challenging, at the time he had neither a diagnosis nor an EHCP[54].

In addition to the responses to specific paragraphs above Thomas' Parents have asked for these additional points to be noted.

222. " A poorly understood aspect of Autism is Pathological Demand Avoidance[55] (analogous to Oppositional Defiance Disorder in ADHD). Neurodivergent children are often in a state of flight or fight and these pathological reactions to everyday situations are poorly understood and poorly managed in equal measure. Thomas' school works well for children who have accepted and embraced their diagnosis but there was no provision for children like Thomas who had not. Thomas was denied the opportunity to accept his autism without an earlier diagnosis and was then failed by the school system for his refusal to accept a diagnosis at age 14. He fell between the two stools. He was also failed by society in having been bullied and ostracised for being autistic his whole school life leading to his fear of being diagnosed / being autistic."

223. "The Family contend that Thomas did not receive adequate basic health care as evidenced by the confusion over his medications and the fact he was not sleeping. Despite all the agencies involved Thomas' care essentially involved him being confined to his bedroom and waiting for the medication to work. Other developed nations offer residential care with group therapy, one-to-one therapy and weekly reviews with a psychiatrist for teens in crisis. He was seen only once face-to-face with the NHS psychiatrist, with the subsequent reviews conducted on the phone with Thomas' mother and not talking to Thomas directly. The family will not accept that this is adequate medical care."

224. "The report details multiple incidents of poor communication, delay, confusion over policy and procedures, inadequate medical care and lack of protective action taken despite Thomas having multiple known suicide risk factors. The family are extremely disappointed in the finding that Thomas' death may not have been prevented if different actions had been taken. Thomas had fantastic care in the private sector and has been denied his future by a lack of provision and care under the NHS."

225. "The Family contend that Thomas' level of crisis was not taken into consideration because of his autism. They feel he should have been sectioned, observed by a psychiatrist over a period of several days and given medication to establish a better sleep pattern i.e. basic medical care. The family will forever contend that Thomas was in a period of crisis and with adequate support he would have recovered and developed into a happy functioning adult. The report must note that the family feel utterly failed by NHS services throughout Thomas'

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[54] Education and Health Care Plan About education, health and care (EHC) plans - Education, health and care (EHC) plans

[55] Demand avoidance *The National Autistic Society (UK) in this article on Demand Avoidance discusses Pathological Demand Avoidance.*

life. At every stage we asked for help whether that was in Thomas' early years, around the time of diagnosis of ASD and in the period of mental health crisis in his last year, nothing of any therapeutic value was forthcoming."

226. "This report fails to convey the level of desperation we experienced as a family and ultimately how the state failed in every aspect to provide a solution. The starting point of this report should be "What did we get wrong?" and "What could we have done better?" Despite all the policies and procedures and interventions that are outlined in this report they ultimately failed to prevent our son's needless death."

227. Addendum : Findings from the Inquest into Thomas' death (September 2025)

228. The Inquest concluded that Thomas' death was suicide as a result of a severe clinical deterioration in his mental state over the previous months. He had been under the care of crisis mental health services. There was a missed opportunity to prevent Thomas' death when five days previously he had left the house but that incident was not subject to a structured risk assessment by clinicians; had it been so then Thomas would probably not have died when he did. Thomas' actions were contributed to by his exposure to a website forum in which individuals exchange information about methods of suicide.

229. The Coroner issued a **Prevention of Future Deaths** report[56] to Google UK and Ireland requiring them to take action and respond setting out their actions or proposed actions and timescales in terms of preventing future deaths; or their reasons for not taking any action.

230. The Coroner set out reasons for this decision based on the analysis of Thomas' internet use. The British Transport Police were only able to view the chat and data that Thomas had accessed by the good fortune of Thomas' parents finding / suggesting passwords. This then enabled a judgement into the probable impact on Thomas of his use of the suicide website.

231. The reasons given by the Coroner for requiring a Prevention of Future Deaths report included:

- Thomas' access to the named website reinforced his decision to end his life;

- the material on the (named) website was easily accessible online to Thomas and as such presents a risk of future deaths to people in mental health crisis, including children; and

- Google did not respond to a request from OFCOM as part of the Coronial Investigation for Thomas' Inquest. The Coroner's understanding was that Google LLC's reason for not complying was that it is not within the jurisdiction of England and Wales but it is within the United States jurisdiction which prohibits compliance with such requests from England and

[56] Reports to Prevent Future Deaths - Courts and Tribunals Judiciary

Wales Coroners. Such a position may frustrate any future coronial investigation in similar cases and thus in itself gives rise to risk of future deaths by preventing coronial investigations from cumulatively mitigating risk from such deaths.

232. Google UK and Ireland was placed under a duty to respond by early December 2025.

October 2025