

## Single Unified Safeguarding Review: Violet Rose

### 1) Background

An SUSR was commissioned following the death of Violet Rose (pseudonym), a 15-year-old girl who completed suicide in February 2024. Multiple agencies had some involvement: Education, CAMHS, primary care, police, Children's Services, housing, and third-sector services. The review highlighted several missed opportunities across key areas, including suicide risk assessment, recognition of neurodevelopmental needs, responses to bullying, and the effectiveness of inter-agency communication. A detailed merged timeline, family involvement, learning event, and wider literature review formed the basis of the analysis.

### 7) Recommendations

4. Better training for all professionals in contact with children and young people with co-occurring ND and mental health difficulties
  5. Developing clear information-sharing pathways between Schools, CAMHS and Children's Services
  6. Strengthening school transfer processes,
  7. Improving recording and feedback in Children's Services MASH and CAMHS
  8. Capturing of the child's voice in relation to Early Help assessment and when there are Safeguarding concerns
  9. Revising anti-bullying policies to include guidance on off-site incidents and the duty to report.
  10. The use of chronologies when allegations of bullying are made
- Agencies are required to evidence training, process changes, and improved collaboration.

### 2) Context

Violet Rose had a complex developmental and emotional history, including long-standing low mood, anxiety, selective mutism, and self-harm behaviours. Her mother had repeatedly raised concerns about autism from an early age. Despite this, Violet Rose was not referred for neurodevelopmental assessment until late 2022, receiving an ASD diagnosis only weeks before her death. She was described as artistic, intelligent, and deeply connected to Korean culture, but also emotionally vulnerable, socially anxious, and struggling with identity and trauma linked to early childhood experiences. Violet Rose also experienced bullying and targeted physical attacks several times during her secondary schooling.



### 6) Recommendations

Ten recommendations were made, focusing on:

1. The need for early identification of ASD in schools and to work with parents
2. Improving ND referral and assessment pathways and increased service capacity
3. Access to support for young people awaiting ND assessment who have mental health needs

### 3) Key Learning Points

A significant theme was the delay and barriers to securing an autism assessment. There was an absence of communication between CAMHS and school and CAMHS discharge letters did not reach the GP. Violet Rose's ongoing poor mental health in school did not lead to further referrals to CAMHS. Her mother's reports of bullying were not properly managed by school and incidents of harassment, assault and threatening behaviour were not linked by police. The review highlights that neurodivergent young people face elevated suicide risk, especially when combined with previous ligature use and unmet emotional needs.

### 4) Key Learning Points

Bullying occurred inside and outside school, but school records were inconsistent with parental reports. Several incidents were not reported to police, not followed up, or were inadequately investigated. Inter-agency communication was notably weak. Violet Rose's voice was absent from Early Help and Children's Services assessments, with professionals relying heavily on her mother's accounts.

### 5) Good Practice

Violet Rose's schools ensured that she had support to assist her with coping with the school environment. Violet Rose's second school worked hard to gather background information from her first school. The CAMHS Crisis Team demonstrated flexible practice in attempting to support any gaps in care and went beyond their remit to continue to support Violet Rose until she had her medical review.