



**Adolygiad Diogelu Unedig Sengl**  
**Single Unified Safeguarding Review**

<p><b>Name of Safeguarding Board:</b></p> <p>Cwm Taf Morgannwg</p>
<p><b>SUSR Unique Reference Number:</b></p> <p><b>SUSR-2024-01/CTM CHILD G</b></p>
<p><b>Pseudonym 1:</b></p> <p>Child 1 Violet Rose</p>
<p><b>Date of incident which led to the Review:</b></p> <p><b>Month: 02</b> <b>Year: 2024</b></p>
<p><b>Date of death</b></p> <p><b>Month: 02</b> <b>Year: 2024</b></p>
<p><b>Review's start date (commissioned): 17/02/2025</b></p> <p><b>Review completion date (approved and signed off): 09/04/2026</b></p> <p><b>Publication date: 08/06/2026</b></p>

**Outline of circumstances resulting in the Review:**

A Single Unified Safeguarding Review (SUSR) was commissioned by Cwm Taf Morgannwg Safeguarding Board on the recommendation of its Joint Case Review Group in accordance with Welsh Government's Statutory Guidance.<sup>1</sup> The criteria for this Review are met under:

4.4 Child Practice Concise Review: in this case, the child, Violet Rose, died. The Joint Review Group identified a 'number of potential missed opportunities, [and] ...multi-agency learning around previous suicide attempts and the issues around bullying' as its rationale for commissioning a Review.

<sup>1</sup> <https://www.gov.wales/sites/default/files/publications/2024-12/single-unified-safeguarding-review-susr-statutory-guidance.pdf>.

The key SUSR criterion of the likelihood of multiagency learning was met 4.2.

Violet Rose is a pseudonym chosen by her mother and stepfather, as this was a name she loved.

The following agencies provided panel members for the Review and completed a timeline and analysis of their involvement:

- Local Authority Children's Services
- Education
- Child & Adolescent Mental Health Service (CAMHS), Hospital Accident & Emergency Department, Primary Care
- Police
- Housing Association
- Early Help Third Sector Agency.

Additional information was sought from the Welsh Ambulance Service regarding its involvement. The Reviewers relied on panel members to seek answers to specific questions or apparent gaps in the chronologies produced. All agencies that produced a chronology also produced summary reports of their involvement prior to the agreed Review timeframe of 2 years from 08.02.22 to 06.02.2024. This timeframe was agreed because of the number of significant incidents in these two years that the Panel felt contributed to a much richer picture of Violet Rose's struggles.

The Reviewers were able to view specific documents, such as the PRUDIC (Procedure for Unexpected Deaths in Children) minutes, Violet Rose's WARRN (Welsh Applied Risk Research Network) risk assessment and Safety Plan, letters produced by the CAMHS Consultant Psychiatrist and her Year 11 School progress tracker.

The Reviewers undertook a literature search on the links between an Autistic Spectrum Disorder (ASD) diagnosis and suicide attempts or completion and researched the differences in presentation between boys and girls with ASD. A request for a search of the Welsh Safeguarding Repository was also made with search criteria of CAMHS/ASD/Education/self-harm/suicide/poor inter-agency communication with a key question of 'What do past Child Practice Reviews tell us about cases where a young person has ASD and completes suicide?'. Whilst there were 6 Reviews that resulted from the keyword search, only one (CYSUR 7/2018<sup>2</sup>) from 2021 had any direct relevance to this Review. This Review concerned a 14-year-old boy who also completed suicide: he too had experienced bullying and was neurodivergent. Some of the learning identified resonates with the themes from Violet Rose's Review, specifically Learning Points 3,4 and 7 below:

Learning 3: All agencies will need to be compliant with the implementation of the new Additional Learning Needs (ALN) Code for Wales, December 2018 and the Additional Learning Needs and Educational Tribunal (Wales) Act 2018, (the ACT). In order to strengthen (using a person-centred approach), the voice and inclusion of children, young people and their families in their Individual Development Plan (IDP), evidence will be required to demonstrate that their participation in decision making has been encouraged, and the views, wishes and feelings of both the child/young person and their parents/carers have seriously been considered in all meetings/reviews.

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<sup>2</sup> [cysur-7-2018-final-report.pdf](#)

Learning 4: All schools and Local Authorities need to ensure that their practice, training and policy guidance on bullying, is compliant and acknowledges the added vulnerabilities of children, who may have additional learning needs, emotional mental health and well-being issues, have experienced ACEs, or have disabilities. They need to be compliant with Welsh Government Guidance, Keeping Learners Safe 270/202165 and Rights, Respect, Equality: Statutory guidance for governing bodies of maintained schools.

Learning 7: All schools need to consider how they ensure communication with parents is timely, proportionate and effective, in addressing any concerns that parents may have in respect of their child's wellbeing, and where possible an outcome is achieved and recorded.

An Inquest was opened, the hearing for which took place in March 2025. The Coroner recorded a conclusion of suicide.

The Panel met on 7 occasions and a well-attended Learning Event for professionals was held on 09.09.2025. Staff from both Violet Rose's secondary schools, Primary Care, CAMHS, Police, Children's Services, Housing and the 3<sup>rd</sup> sector attended. The Reviewers met with the CAMHS Consultant Psychiatrist separately as they were not able to attend the Learning Event because of illness and also with the then Assistant Head of Year 7, who had a good relationship with Violet Rose at her first secondary school.

Violet Rose lived in a large town within the Cwm Taf Morgannwg Safeguarding Board area. Her ethnicity was white Welsh and she was in Year 11 at secondary school at the time of her death, approaching her GCSEs that summer.

Sadly, Violet Rose completed suicide by ligature on 06.02.2024 at home overnight and was found by her mother and stepfather early the next morning. Both her mother and stepfather felt that there was no indication that her mood was low or that she was feeling suicidal when she went to bed that night. Her home, which is a housing association property on a large estate, was shared with her mother, stepfather and younger half-brother. Violet Rose had an older sister who had recently secured her own property for herself and her young son. Prior to this, she lived with her baby in the family home and had a close relationship with Violet Rose. Violet Rose's parents had separated when she was four and her stepfather had been in her life since she was five. The relationship with her stepfather was reported by both parents to have been close as evidenced by her decision to change her surname to his. There was relatively little contact with her biological father, which was reported to be a source of sadness for Violet Rose. She also had another half-brother who lived with her biological father and his partner. Violet Rose was a twin but, sadly, her twin died in utero. She knew about her twin from a young age.

Violet Rose's family describe her as 'unique': she was a talented artist and photographer. With a strong interest in Korean culture, she independently learnt Korean and was a virtual member of a Korean pop band as a vocalist. Other interests captivated her, such as Japanese anime and she was also a keen skateboarder. Violet Rose had plans to attend military preparation college she had an interview scheduled later on in the week that she died. Violet Rose had a few good friends, although she also experienced bullying from her peers. She moved to a different school because of this from Year 10 and her life appeared to improve. Her mother told the Reviewers that her half-brother also experienced bullying, often racist in nature in relation to his African heritage on his father's side of the family and there was a significant incident only days before Violet Rose died where her half-brother was attacked outside the local Tesco's and Violet Rose rang her great uncle to help him (this was conveyed by Violet Rose's great uncle: police had no record of her involvement in the incident and she was not believed by police to have been present by the time they arrived at the scene).

Violet Rose's mother told the Reviewers that she had always felt that Violet Rose had features of ASD but that she could not obtain an assessment despite requesting one on many occasions. Violet Rose also had long-standing morbid thoughts that dated back to her early childhood when she would express the feeling that she should not be alive and that she should have died rather than her twin. Low mood was often a feature in the period examined by the timeline: in addition, she demonstrated increased anxiety. Violet Rose also had a history of self-harming behaviours and had made previous reported suicide attempts. Violet Rose struggled to speak with strangers to the extent that she was described as selectively mute as was the case in some CAMHS appointments. It took time and persistence to build trust and rapport that enabled Violet Rose to speak and she had a particularly good relationship with a specific staff member at her first secondary school. Violet Rose was also finally diagnosed with ASD a few weeks before she died, although the letter confirming her diagnosis did not arrive until after her death.

### **Equality and Diversity:**

The protected characteristics relevant for Violet Rose are age, sex and disability. At the time of her death, Violet Rose was a 15-year-old secondary schoolgirl who had an undiagnosed (until a few weeks before she died) neurodevelopmental (ND) disorder and mental health issues that amounted to a disability under the Equality Act 2010. In addition to her Autistic Spectrum Disorder (ASD), anxiety and low mood, she also had to cope with all of the challenges that the transition to secondary education and puberty bring to young people.

Her presenting autistic traits resulted in professionals often experiencing challenges when trying to engage with her. This may have affected how successful agencies were in supporting Violet Rose. This difficulty with talking to strangers proved to be a significant barrier to access to appropriate services for Violet Rose as evidenced in several CAMHS appointments and some contacts with education. The referral for an ND assessment was significantly delayed as it appears there was a lack of recognition in her early education setting, despite her mother raising concerns. It is known that autism can be more difficult to identify in girls who might be more able than boys to mask or camouflage their autism in social situations or who present in different ways from boys (Halsall, Clarke & Crane, 2021<sup>3</sup>). A recent Swedish study has found that the ratio of male to female diagnosis pre-puberty was as high as 4:1 and that this ratio decreases as children grow so that, by the age of 20, the ratio is almost equal (Fife et al, 2026<sup>4</sup>).

These may have been factors in the decision-making of Violet Rose's primary school not to refer her for assessment. Once a decision was made to refer Violet Rose for an ND assessment, this was further delayed by the observations that school needed to make prior to any medical assessment. Once on the waiting list it took a further fifteen months for an assessment to be completed.

### **Involvement of family and principal individuals:**

<sup>3</sup> ["Camouflaging" by adolescent autistic girls who attend both mainstream and specialist resource classes: Perspectives of girls, their mothers and their educators](#)

<sup>4</sup> [Time trends in the male to female ratio for autism incidence: population based, prospectively collected, birth cohort study | The BMJ](#)

The Reviewers wrote to Violet Rose's mother and stepfather and her biological father on 3 occasions, the first time after the initial Panel meeting. The SUSR Information Leaflet was enclosed with the letters, along with contact details. Following a response from Violet Rose's mother, the reviewers met with Violet Rose's mother and stepfather (who she called Dad) together at their home and then with her adult sister and maternal great-uncle separately at their homes. Violet Rose's biological father did not respond to letters, although there were several attempts to make contact during the Review. He did make contact at the end of the process to inform the Panel that he did not wish to meet to discuss the Report outcomes.

Violet Rose's mother also took the opportunity to meet with the Panel. This provided the mechanism to allow her to emphasise how important it was to the family that professionals should listen better to concerns raised by parents.

The Panel had robust discussion about approaching Violet Rose's friends and half-brothers, but it was agreed (and her parents were also in support of this decision) that this might add to these young people's suffering to involve them. Violet Rose's young half-brother, with whom she lived, continues to struggle, as does her best friend who was with her in the evening before she died.

#### **Family History and/or Contextual Information:**

The agreed timeline for the Review was 2 years prior to Violet Rose's death, that is from February 2022 until February 2024. Summary reports of agency involvement prior to this time were received from Police, Children's Services, Education Services and the Health Board. In 2011, 2012 and 2013, there are police reports of disturbances at the home with the children present. Violet Rose's mother was clearly under stress for a protracted period of time. In March and April 2014, there were 3 police reports of Violet Rose being found alone in the neighbourhood. These incidents were all discussed in a Child Protection strategy discussion in May 2014, where it was agreed that the threshold for Section 47 enquiries was met with the outcome that Violet Rose and her half-brother's names were entered on the Child Protection Register under the category of Emotional Abuse and Neglect. Their names were removed in February 2015 and their cases were closed in July 2015. Violet Rose's mother feels that the children's names were placed on the Register because of Violet Rose's behaviours that she knew were stemming from undiagnosed autism, but no professionals agreed with her. Children's Services also reported a period of involvement in 2012 for 5 months, following referrals from Violet Rose's school. In Children's Services' analysis, it is noted that, whilst there were clearly difficulties at home at times, there were also long periods of time where Children's Services had no involvement with the family.

Violet Rose's mother described behaviours that she felt indicated autistic traits from a very young age. There were difficulties at nursery with Violet Rose's behaviour and she was excluded several times. She also said that she asked various professionals many times for her daughter to be assessed for autism but reported that this did not happen. She did note that Violet Rose's primary school were supportive, and she thrived there, but the school did not feel that Violet Rose showed signs of ASD: consequently, no referral for assessment was made.

The summary report from Education notes that the first incident of self-harm in her secondary school records was in January 2020, immediately prior to the first Covid

lockdown. This was Violet Rose's first year at her secondary school. She continued to attend school during the Covid pandemic, although her experience would have been very different from normal schooling. In January 2021, there is a school record of a meeting with Violet Rose's mother after she had taken her to the GP. Violet Rose had cut her arms and had told her mother that she had tried to hang herself. The GP had made an urgent referral to CAMHS (although neither the GP Practice nor CAMHS has any record of this referral and the GP practice has no record of the appointment), no further action was taken by the school. There was an incident of assault on Violet Rose in May 2021 that took place on her way home. Violet Rose named the perpetrator in school and he was spoken with. School do not appear to have spoken with Violet Rose's mother on this occasion or reported the matter to the police.

In September 2021, Violet Rose was subjected to another significant incident of bullying and assault by 2 other girls, one of whom attended her school. The incident took place at a local park often frequented by groups of young people, both incidents included fellow pupils. Violet Rose was taken to the local A&E Department by her mother for treatment of facial injuries and school made a Safeguarding referral to Children's Services following discussion with Violet Rose and her mother. The incident was reported to police by Violet Rose's mother, but no prosecution took place. A complaint by Violet Rose's mother after her death found that there were clear failures of the duty to investigate the report effectively or make the requisite Safeguarding consideration for the children involved.

#### **Agency Timeline:**

There are ninety-one entries on the combined agency timeline for the 2-year period from February 2022 to February 2024. A number of the entries relate to Violet Rose's low mood, self-harm and suicidal thoughts. The entry on 08.02.2022 relates to Violet Rose's class teacher noticing her scratching her arm with a broken pen clip in class and old scratch marks on her arm. Her mother was contacted and informed the school that she had taken Violet Rose to the GP and a CAMHS referral was being made. It is of note that neither the GP practice nor CAMHS have any record of a referral being made, although the GP record notes the need for a CAMHS referral.

On 16th March 2022, Violet Rose's mother contacted NHS Wales 111 as Violet Rose had been suffering from heightened anxiety and ongoing suicidal thoughts. Her mother also reported an episode of self-harm the previous day, but Violet Rose would not confirm what she had done. NHS Wales 111 tried to access an ambulance for Violet Rose, but because of the delay in an ambulance being able to attend, her mother took Violet Rose to hospital herself. However, they did not stay in A&E to be seen and, instead, went home and then Violet Rose's mother sought help from the GP the following morning. This resulted in a crisis assessment by CAMHS later that day: it was apparent in the timeline that school had additional information that was not available to CAMHS. This information was via a school friend who provided more detail from Violet Rose that this episode of self-harm related to taking tablets and ligature use.

An initial appointment was made with CAMHS who were aware of the information from the previous night, following this appointment the CAMHS Crisis Team then remained involved until June 2022. This was unusual as the Crisis Team would normally only see a young person for a brief period. If further intervention was needed, the team would request a medical review and then the wider CAMHS service would become involved if needed. However, it was noted in the Learning Event that at this point the wider CAMHS

were experiencing exceptional demand and the team felt it was important to offer a level of support for Violet Rose, until she received a medical review. The CAMHS Crisis Team ended their involvement because Violet Rose was going to be seen by a CAMHS Consultant Psychiatrist. In total, Violet Rose had eight clinic-based appointments with CAMHS – six with the CAMHS Crisis Team on 17.03.22, 24.03.22, 31.03.22, 19.04.22, 05.05.22 and 20.05.22 and two with the Consultant Psychiatrist on 20.06.22 and 06.07.22.

CAMHS records note ongoing difficulties with communication between health practitioners and Violet Rose. On 17.03.2022, she refused to speak with the CAMHS practitioner and was aggressive with her mother when she tried to remove her headphones. On 24.03.22, Violet Rose again declined to speak during the appointment but did agree to interact with the CAMHS nurse via unsent text messages on her phone. On 25.03.2022, CAMHS referred Violet Rose to Children's Services for Early Help (this is a preventative service provided by a range of statutory and third sector agencies to support struggling families). Violet Rose's mother was noted to be supportive and working well with CAMHS to help Violet Rose. A conversation by text was Violet Rose's preferred method of communication once again. On 19.04.2022, Violet Rose agreed for her mother to speak on her behalf. The appointments on 05.05.2022 and 20.05.2022 were equally problematic, although Violet Rose did speak a little on 20.05.2022, albeit with a facemask on that she refused to remove and her head lowered throughout. On both of these appointments, Violet Rose was accompanied by her mother and 1 and then 2 young males who she reported Violet Rose as having confided in (there does not appear to have been any further exploration by the CAMHS practitioners about who these individuals were). On 20.05.2022, Violet Rose's mother reported overall improvement although superficial self-harm continued and she had been grounded for alcohol use.

Despite CAMHS involvement, school records from 01.04.2022 until 08.04.22 note that Violet Rose's mood was extremely low; she was expressing suicidal thoughts, had cut her arms again and was barely speaking. On the 06.04.22, Violet Rose's mother was asked to collect her from school: when she arrived, she said she felt the school could support Violet Rose better and that the school were doing nothing about the bullying that has been reported to them. It is clear from school records that her mother was frustrated about what she viewed as the school's inaction about this bullying: it appears that there were no further enquiries into previous reports by her mother and the response was that Violet Rose's friend was spoken with. It does not appear that Violet Rose was spoken with and is unclear why this was not explored directly with her.

On 08.04.22, the school contacted the Multi-Agency Safeguarding Hub (MASH) to seek advice because of Violet Rose's low mood, self-harm and her report that she had all of her clothes with her in a bag and was staying with her older sister's friend. The school were not able to reach her mother, but MASH staff did reportedly speak with her and recorded that there were no safeguarding concerns. It is not recorded why Violet Rose was carrying all of her clothes with her or why she was choosing to stay at her older sister's friend's house. However, it was recorded by the school that Violet Rose was promised £30 to cleaning the friend's house. There is no record of the conversation between the MASH staff and Violet Rose's mother on the Children's Services timeline nor any direct feedback to the school.

There was a delay (19 working days) between the referral being made to the Early Help Service on 31.03.22 and being received by the third sector agency on 25.04.22 because it was not processed in a timely way by Early Help. The referral was then placed on a waiting list which was six weeks at that time. Violet Rose's mother was not contacted by the agency until 15.06.22: at that point, she declined parenting support and said that Violet Rose needed direct emotional support from a professional. It is unclear from the timeline if this response was ever unpicked within the Early Help services or what other services could have been provided. The referral was closed and the agency state that the referrer was notified of the outcome.

Violet Rose's grandfather passed away in April 2022 and she spent some time when back in school after the Easter holidays talking freely in well-being sessions. Her mother had suggested she contact Samaritans in the holidays so she could have someone to talk to about her feelings.

On 28.04.22, the school requested ND observation from the Communication and Relationships Team.

There was a significant incident on 20.05.22 when Violet Rose and her friend left the school site without permission and headed to some local fields. They were intimidated and assaulted by some pupils from another school. It is unclear why School did not report this incident to the police. Violet Rose and her friend left the school premises without permission again on 23.05.22 and were escorted back to school. On 25.05.22, Violet Rose admitted to leaving school in order to smoke and showed the staff member recent self-harm injuries that she did not disclose to CAMHS or her mother.

Violet Rose was seen by the Communication and Relationships Team Leader for an initial meeting on 25.05.22 and it was agreed that the ND observation pathway would proceed. Pertinent information noted was how Violet Rose's communication difficulties were impacting on her social experiences. In addition, she was noted to have repetitive behaviours and was inflexible where experiencing social injustice.

A further assault occurred on 27.05.22 when Violet Rose was walking from her friend's house to her great uncle's home. Violet Rose sustained facial injuries. School advised her mother to report the attack to the police, but her mother said there was no point as there were no charges brought last time this happened: it is unclear why school did not report this to the police, given that her mother declined to do so.

On 02.06.22, Violet Rose was reported to police by her mother as missing, having not returned home at the agreed time. She was found but would not speak to police. Her mother said she thought she might be under the influence of drugs or alcohol, but police do not note any obvious intoxication. Police shared information about this incident with Children's Services, who contacted Violet Rose's mother. She declined any support because Violet Rose was being supported by the school and CAMHS. There was no record of any discussion by Children's Services with school or CAMHS or Violet Rose herself.

On 09.06.22, Violet Rose was discharged from CAMHS Crisis Team following a call to her mother where she said that Violet Rose was presenting more with 'teenage behaviour than mental health'. Violet Rose remained in the waiting list to see the Consultant Psychiatrist for a medical review.

On 14.06.22, Violet Rose's mother applied for her to transfer to a different secondary school citing concerns in relation to bullying and her reportedly feeling unsafe in her current school. On 15.06.22, Violet Rose told her Year Leader that she had smoked cannabis and got drunk with her friends. She also said that she and her mother were arguing, and she wanted to live with her father. On 15th June (the same day that Violet Rose's mother was finally contacted by the Early Help Third Sector Agency), Children's Services contacted her: she declined the Care and Support assessment that was offered.

On 16.06.22, Violet Rose told a school staff member that she had self-harmed and wanted to kill herself. School contacted mum to share this information and asked her to collect Violet Rose. School asked mum to contact CAMHS crisis. The school sought advice from MASH and a referral was submitted, although the referral is not recorded on Children's Services' chronology.

An appointment with was undertaken with the CAMHS Consultant Psychiatrist on 20.06.22. This appointment was relatively successful as Violet Rose managed to speak quite fluently with the doctor, who arranged a further appointment on 06.07.22. However, at the next appointment, Violet Rose was less communicative and said she did not want to see the doctor again. She was then discharged with a plan to continue to access 1:1 support at school and from 'Early Help' and consider whether she would see a school counsellor. The psychiatrist acknowledges that Violet Rose might re-present in crisis as she had such difficulty managing overwhelming and complex emotions. It is unclear what if any support or strategies were offered to Violet Rose and the wider family

Violet Rose's attendance in the last few weeks of the school summer term deteriorated and in September 2022, she started the new school year at her new school. On her second day, Violet Rose presented at the school Wellbeing Hub as she became overwhelmed in class. It appeared that the new school did not have any information from her previous school about her needs. Once it became apparent that Violet Rose required additional support they made contact with the previous school. The school note through September, October, November and December incidents where Violet Rose was distressed and utilised 'Lead Worker' wellbeing support.

A referral for ND diagnostic assessment was finally made on 04.10.2022.

In January 2023, Violet Rose told school staff that she had smoked cannabis again and was extremely withdrawn. She was again referred to the MASH because of the school's concerns for her mental health. Violet Rose and her mother again declined support from Children's Services. On 13.02.23, school prepared a 'Pastoral Support Plan' for Violet Rose, following a meeting with her and her mother. This was the first time that the new school learned of Violet Rose's suicide attempts and the history of bullying. Her mother also shared that she feared Violet Rose might take her own life, just as her cousin had some years earlier. There is no reference to any further discussion about the impact of this loss on Violet Rose.

There was a further significant incident on 03.03.23 where police were called to Violet Rose's great uncle's home because a young person, accompanied by her friends, was banging on his door wanting Violet Rose. They had travelled from their community in order to harass and intimidate Violet Rose: she also had a series of abusive texts from

them. The outcome of the report to the police was that 'words of advice' would be given to the perpetrators.

A Review meeting was held at school on 24.04.23 with Violet Rose's mother who was happy with the progress she was making at this school. However, in May, school note that Violet Rose continued to self-harm and spoke with her mother in relation to this. Following this there is a period where there are no incidents recorded on the timeline, but on 01.12.23, Violet Rose shared with a school staff member that she was upset because her father did not want to see her. School again contacted her mother, to share this information. On 11.01.2024, Violet Rose had her assessment with the ND team. The conclusion of this appointment was that Violet Rose would meet the criteria for an ASD diagnosis. Regrettably, she did not receive a letter confirming this until after her death.

There were two further incidents recorded by the school on 25.01.24 and 02.02.24, Violet Rose's mood was low at school and this was reported to staff by a fellow student. Violet Rose refused support and refused referral to the school counsellor. On 02.02.24, Violet Rose told staff that her brother had been attacked on his way home from school and, when other students asked Violet Rose what had happened, they told her to 'slit her wrists'. When the other students, including witnesses named by Violet Rose, were interviewed, they all denied that this was said to her. Her mother was contacted and collected her from school at lunchtime.

Several days later, Violet Rose was found deceased in her bedroom by her mother and stepfather. She left a suicide note that was dated a month earlier.

### **Practice and Organisational Learning:**

The identification of the practice and organisational learning has been drawn from the following key elements of the Review:

- The multi-agency merged timeline
- Discussions within Panel meetings
- Meetings with Family members
- The Learning Event held for professionals.
- Consultations with individual professionals
- Literature Review.
- 2 relevant previous Child Practice Reviews.

#### **1. Autistic Spectrum Disorder diagnosis**

It is clear from the reviewing the timelines and from discussions with Violet Rose's family that the process for obtaining an autism assessment was challenging. There are recorded concerns raised her mother as early as 2016, although she states that she had been reporting her belief that Violet Rose had autism much earlier in her life. The Welsh Government's Autism strategies<sup>5</sup> have emphasised the importance of listening to parents and yet, in Violet Rose's case, her mother's concerns were not acted on. The process for referral for diagnostic assessment changed in 2017 resulting in only schools being able to make referrals (following a period of observational assessment) to the ND Service, which

<sup>5</sup> [refreshed-autistic-spectrum-disorder-strategic-action-plan.pdf](#)

operated separately from CAMHS. This change created a further barrier to obtaining referral for an assessment.

Whilst a diagnosis does not always require follow-up support, this can be offered within the region if required. There is no doubt that a confirmed diagnosis does impact positively on the level of support that families can access and school might also feel better supported to make specific reasonable adjustments to ensure that young people are able to reach their full potential. In the same way, diagnosis can provide the gateway for family education and support. It would appear from available information that, despite being raised by Violet's mother and a consultant paediatrician also suggesting the need for diagnostic referral in 2016, no referral was made whilst Violet Rose was at primary school. In fact, no referral was made until October 2022, although the request for ND observation was made by the school to the Communication and Relationships Team in April 2022. Violet Rose was being seen by CAMHS from March to July 2022 and both the CAMHS nurses she saw and the Consultant Psychiatrist informed the Reviewers that they thought she had ASD, but, at that time, these professionals were unable to refer to the ND Service themselves. During this period, only schools were able to refer pupils for assessment by the ND service.

There are several reasons why children fail to be recognised as requiring an ASD assessment: this includes evidence to suggest that girls are often not identified. This is because autism in girls can look very different from the stereotype of autistic behaviour. Girls may present with 'quieter' type symptoms which can often be misinterpreted, such as focused behaviour like obsessional following of favourite bands. Girls also present less often with speech and language difficulties and often learn socially acceptable behaviours more easily than boys – this phenomenon of 'masking' or 'camouflaging' is now widely recognised.

The timeline covers the periods just after the COVID pandemic and would have marked the reintroduction of all children and young people back into education following a substantial period of reduced contact. This may have been significant as far as the secondary school's recognition of Violet Rose's ASD traits is concerned, as schools were not functioning as usual during the pandemic, but this does not explain the lack of referral when she was at primary school.

### **Good Practice**

Notwithstanding the lack of a diagnosis, both schools ensured that Violet Rose had appropriate support to assist her with coping with the school environment. This included 'time out' in the Wellbeing Hub, quiet spaces and the use of headphones. They were responsive to Violet Rose's needs and it is noticeable that she was more settled after her move to her second school in Year 10.

The Reviewers have been assured that the procedure for referral have changed since Violet Rose's death, so that paediatricians and CAMHS psychiatrists can also refer to the ND service for diagnostic assessment. In Cwm Taf Morgannwg, Joint CAMHS/ND service clinics have also been established to expedite assessment for children who are struggling with poor mental health needs and suspected ND. These clinics aim to promote joint working and seamless care.

## 2. Self-Harm and Suicide Attempts

There is now a strong evidence base that links increased risk of suicidal and non-suicidal self-harm with young people who are neurodivergent.<sup>6</sup> Self-harm can be a coping strategy but may also include suicidal intent: wider awareness of both the increased risk for autistic young people and the different forms of self-harm needs further awareness-raising among professionals from all agencies. Risk assessment tools and risk management plans that are used to support young people need to consider this particularly when young people present with self-harming behaviours.

Where young people have demonstrated high risk self-harming behaviours including previous ligature use, combined with a potential diagnosis of ASD, the risk of completed suicide is intensified. Research suggests that these young people are at greater risk of continuing this type of behaviour. Professionals who are dealing with this concern need to be aware of the heightened risks.

A CAMHS crisis referral was made by the GP following Violet Rose's attempt to ligature in March 2022. The CAMHS crisis team had kept Violet Rose's open to their services longer than they usually would to provide support to Violet Rose while waiting for the medical review from March 2022 until June 2022. The Reviewers were subsequently informed by the Consultant Psychiatrist that CAMHS was under significant pressure at the time because of increased demand post-Covid and waiting times to see a consultant were extended. The Reviewers were also told that, due to service realignment, young people who require a medical review within two weeks are seen now within that timescale. There is additional provision of a Community Support Team, who would have been able to see Violet Rose at home. Whilst Violet Rose was seen in clinic face to face, she also had support in the school environment. The reviewers feel that the current provision of home visiting could have been beneficial for Violet Rose.

A WARRN (Welsh Applied Risk Research Network) risk assessment was completed by the CAMHS Crisis Team, but it was clear from the Learning Event that this was not shared either within or between agencies. Following the medical review in June 2022, a further appointment was offered by the consultant psychiatrist which resulted in Violet Rose being discharged from CAMHS with a plan that she should engage with the school counselling service, continue with 1:1 support at school and receive 'Early Help' (in fact, by the time that Violet Rose had her second appointment with the psychiatrist, her mother had declined Early Help when she was contacted).

Her psychiatric assessment determined that Violet Rose did not have a diagnosable mental illness but that her anxiety and low mood symptoms were consistent with 'emotional dysregulation and an undiagnosed autistic complex'. It appears that Violet Rose continued to use coping strategies including smoking cannabis, drinking alcohol and self-harm and she continued to struggle with low mood, but, in essence, from a health perspective, Violet Rose had no further specialist intervention and she was directed back to universal services to manage any new risks or crises.

### Good Practice

<sup>6</sup> [Updated Systematic Review of Suicide in Autism: 2018–2024 | Current Developmental Disorders Reports](#)

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.

The SBAR (Situation, Background, Assessment, Recommendation) document that is utilised by the CAMHS Crisis Team has been updated since Violet Rose's death to include neurodivergence as a specific risk factor when young people present with self-harming behaviour.

Both of Violet Rose's schools ensured that she had support with her mental health and demonstrated persistence in ensuring support using the Wellbeing Hub. Violet Rose often spent time there with staff that she had a good relationship with. The school communicated well with Violet Rose's mother although she felt school wanted her to remove Violet Rose when her mood was low rather than support her to stay in school. When Violet Rose moved to her second school, once that school understood her difficulties, she had a structured Pastoral Support Plan that included appointment of a Lead Worker.

### **3. Communication**

There were a number of agencies involved with Violet Rose within the timeline period, but there was little or no communication between them. When Violet Rose moved schools in September 2022, little information about Violet Rose's needs was shared with the new school either by the first school or by the Local Authority Education Department Pupil Admission Unit.

The GP did not have the first appointment or the Consultant's first appointment or discharge letter from CAMHS and would have been unaware of the plan to discharge from CAMHS. There was no process in place at the time for any risk assessments completed by CAMHS to be shared with primary care or with schools. Violet Rose's episodes of dysregulation within school were being managed by the school. This expert oversight could have informed and supported the pastoral care planning for her school.

The school did not liaise with CAMHS when there were incidents with Violet Rose despite knowing that CAMHS were actively involved with her. Referrals were made to the Early Help service by both CAMHS and the school, but neither were aware that Violet Rose's mother declined any service when it was offered.

Police Public Protection Notices (information-sharing documents) are always shared with Children's Services; however, they are not typically shared with Education or CAMHS (for over 5s) and Children's Services do not share them with any other agencies as it is not their information to share.

There was also one reported incident in March where an incident occurred at a family member's home. This resulted in a police occurrence and is detailed as bullying in nature and involved unpleasant text messages. This incident does not appear to have been shared with any agencies.

It is clear from the available information that Violet Rose's mother was often used as the conduit for information to reach different agencies, such as between CAMHS and school and between police and school. Whilst Violet Rose's mother did this diligently, the potential for misinformation was clear and the opportunity for joint working to support

Violet Rose was missed. Whilst family involvement is crucial to care planning, they should not have to undertake this role. Professionals who attended the Learning Event explained to the Reviewers that systemic barriers that exist which make communication between (and, sometimes, within) agencies difficult and there need to be better processes in place between agencies to support effective communication and joint working.

#### **Good Practice**

Violet Rose's second school worked hard to gather background information about Violet Rose from her first school and contacted her mother to obtain further history from her. When information from the first school was not immediately forthcoming, a new school staff member arranged to meet with the Additional Learning Needs Co-ordinator (ALNCO) lead from the previous school in order to obtain the information the new school needed in order to support Violet Rose effectively.

The Reviewers were told at the Learning Event that a Consultation Line for professionals has been established that can offer support to any professional pre-referral to Children's Services.

#### **4. Referrals**

There were several referrals made to the Early Help service and a referral to MASH in relation to Violet Rose's low mood, suicidal ideation and use of substances. It is clear from available information that where support from Children's Services was offered, Violet Rose's mother did not see the value in such support. There appears to be an absence of triangulation of risk where there were increasing concerns. It is not clear from available information if other professionals involved with Violet Rose were contacted by Children's Services, or if a phone call was simply made to her mother. It does not appear that any attempt was made to obtain Violet Rose's voice. There is also no evidence that demonstrates that the referrer, be that school or CAMHS, was contacted to inform them that service had been declined by Violet Rose's mother or that either service followed up their referrals to discover whether the offer of help had been accepted.

There was one occasion in January 2022 when Violet Rose's mother believed that the GP had referred Violet Rose to CAMHS, but receipt of a referral was not recorded by CAMHS and there is no evidence from the practice that a referral was made. When a referral for ND assessment was finally made in October 2022, Violet Rose was not seen until January 2024, which is a waiting time of fifteen months. Violet Rose was placed on the ND pathway in April 2022 and yet it took a further 5 months for the referral for diagnostic assessment to be made. She had to wait nearly three months from March until June 2022 to see a CAMHS Consultant after the CAMHS Crisis Team made an urgent referral for psychiatric review. Similarly, when the CAMHS Crisis Team made a referral for Early Help at the end of March 2022, Violet Rose's mother was not contacted by the Early Help Third Sector agency until June 2022 and she then declined any support.

#### **5. Bullying**

Violet Rose experienced intermittent bullying during her secondary school years. Some of this bullying appears to have occurred outside of the school environment but involved pupils from both her school and from pupils from other schools. Some incidents were reported by Violet Rose's mother to school and police and some were not. However, Violet Rose's mother told Reviewers that she had reported bullying on many occasions to

her first school and yet the school appeared to have no records of bullying reports by her mother from February 2022 to July 2023. In her application for Violet Rose's transfer to another school, her mother cites that Violet Rose was 'currently being bullied... and suffers with her mental health due to being attacked and bullying, my child does not feel safe in school'.

There is a discrepancy between Violet Rose's mother's account and the school records which has not been resolved. The school records do have 3 incidents recorded within the timeline:

- 06.04.22: School recorded Violet Rose's mother collecting her from school after school contacted her to collect Violet Rose because she was feeling 'really low and wanted to take her own life again'. Violet Rose's mother is recorded as stating that 'multiple teachers have been told' that Violet Rose was being bullied 'and nothing has been done about it'. After Violet Rose left with her mother, staff spoke with her friend, who said she had not mentioned that she was being bullied. There is no record of staff speaking with Violet Rose when she returned to school or of any further enquiries being made.
- 20.05.22: Violet Rose and her friend returned to school having left the site without permission and said they had been confronted by pupils from another school, vapes were forced into their mouths and they were chased. The incident was logged on the school's Safeguarding record. There is no record on this occasion of Violet Rose's mother being contacted or the incident being reported to police.
- 27.05.22: Violet Rose reported to school staff that she had been 'beaten up' by 3 boys when walking from her friend's house to her uncle's the previous evening. Violet Rose had visible bruising under her eye. School contacted her mother and advised that she report the incident to the police but did not report to police themselves, even when Violet Rose's mother said there was no point because no-one was charged when she did report to police in 2021.

Both schools have anti-bullying policies that are in line with Welsh Government statutory Guidance.<sup>7</sup> However, in her first school, there is no record of any incidents that were viewed by the school as bullying as the school felt there was no evidence of this. Neither policy covers incidents that occur outside of school or any provisions for communication between schools where pupils from other schools are involved. There is no mention in either document about when it is appropriate to report to police or, at the very least, seek advice from the school's Police Liaison Officer (now Youth Engagement Officers). The Police's recent 'School Beat Protocol' (April 2025) document is helpful in supporting school and police in dealing with potentially criminal incidents involving pupils.

On 02.06.22, Violet Rose was reported as missing to police. She was found by her mother and taken home. Police visited her at home as per their operating procedure, but Violet Rose would not speak to them. Violet Rose's mother had mentioned to police when she reported her as missing that Violet Rose had been assaulted the previous week, but more detail about this incident was not sought by the attending officers. Indeed, officers may not have been aware of the information shared with the Public Service Centre when Violet Rose's mother reported her as missing.

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<sup>7</sup> [rights-respect-equality-statutory-guidance-for-governing-bodies-of-maintained-schools.pdf](#)

There was a further incident reported to police on 03.03.23 when girls from Violet Rose's first school travelled to her uncle's house and were banging on his front door to harass and intimidate Violet Rose. There were also a number of malicious communications via social media which were provided to police. In addition, Police were told that these girls had bullied Violet Rose at her first school. There was no record of the school being contacted to determine whether they had any record of bullying in school and, whilst Violet Rose and her mother agreed for the ringleader to be 'given words of advice', there is no record that this was done. A Public Protection Notice was not created following this incident which prevented any consideration by Children's Services as to whether further Safeguarding actions might be needed.

There had, of course, also been a significant incident of assault outside of the timeline in September 21 when Violet Rose had been assaulted in the local playing fields by 2 girls who attended the same school. The management of this incident was reviewed as part of the investigation conducted after Violet Rose's death when her mother made a complaint to police. The outcome was that there 'were clear failures of duty to effectively investigate this matter or make the requisite safeguarding considerations for the children involved'.

### **Learning Point: Autism and Education**

- **Recommendation 1**

**Primary and secondary schools must review their process for early identification of those pupils who may present with autistic traits. The process must emphasise the need to respect parents' views and to work in partnership with them to ensure that the child's needs are recognised and met. Where there is a disagreement between a parent and school about whether a child is displaying neurodivergent traits, schools must inform the parent of their right to challenge the school and of support available to them.<sup>8</sup> The Local Authority Education department must provide assurance to the Safeguarding Board that this has been undertaken within the timeframe specified in the Action Plan.**

From the information available to the reviewers, it was apparent that many of Violet Rose's ND characteristics were present in her early years, and parental requests for an autism assessment seem to have been disregarded. Teachers' understanding of autism is critical to autistic pupils feeling supported in the classroom. Many autistic children and young people will 'mask' and may appear comfortable in school but may then experience burnout and express their discomfort in school when they are back home. Therefore, professionals need to be alert to parents' descriptions of different behaviours in the home environment, which may not be attributable to parenting styles.

All teachers and school staff in primary and secondary education need training to understand autism and the specific support needs of the children in their school. Without this whole school understanding, autistic students simply will not receive the support they need and this is likely to impact negatively on their potential and attendance. Settings that lack an understanding of autism often treat 'disruptive' behaviour by autistic students in the same way they'd treat it from non-autistic students. However, this behaviour is often

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<sup>8</sup> [A guide for parents about rights under the additional learning needs \(ALN\) system \[HTML\] | GOV.WALES Home - Snap Cymru](#)

an indicator that an autistic child's need for support at school is not being met and that the child is overwhelmed.

### **Learning Point: Autism and Mental Health**

- **Recommendation 2**

**The Local Health Board must work with Welsh Government to ensure that the Neurodevelopment (ND) Improvement Plan continues to strengthen service capacity. The Health Board must take appropriate action, including escalation where needed, to make sure there are sufficient resources to meet the needs of children and young people who require neurodevelopmental assessments. There must be:**

- **Ongoing evaluation of demand and capacity within the Neurodevelopment (ND) Pathway to identify gaps, delays, and bottlenecks across the Local Health Board.**
- **Ongoing collaboration between CAMHS and the ND service to reduce duplication, streamline processes, and speed up access to assessments.**
- **Further development of the joint CAMHS–ND clinic to fully embed a coordinated, wrap around model of support for children, young people, and their families.**

**CAMHS must provide update reports to the Regional Safeguarding Board via its Children's Quality Assurance and Performance Sub-Group to monitor progress of these actions.**

Whilst the National Improvement Programme focuses on reducing waiting times for diagnostic assessments, it remains essential that the ND service continues to strengthen collaborative working with education and social care, ensuring that needs-led services not reliant on a diagnosis are accessible to families in need of support. Reviewers were informed by the Local Health Board Panel Member, the Clinical Director for CAMHS and the Operational Lead for the Paediatric Neurodiversity Assessment Service that the ND assessment pathway has changed since Violet Rose's death and that it is now possible for CAMHS to refer directly to the ND Service, although information from the school setting would still be required to inform and support the assessment process. The jointly developed CAMHS–ND clinic will now benefit young people identified as high risk, such as those with multiple contacts with CAMHS, and would support a fast-track approach.

- **Recommendation 3**

**The Local Health Board CAMHS, together with the Local Authority Education Department and Children's Services, must review the effectiveness of current arrangements in place to support young people who are awaiting neurodevelopmental assessment and who also present with poor mental health. The Review must:**

- **Evaluate the adequacy and accessibility of interim support provided to families while formal ND assessment is pending.**

- Ensure that multi-agency collaboration is effective in meeting the young person's needs during the waiting period.
- Safety plans should reflect needs associated with likely ND and address safety taking into account these additional vulnerabilities.<sup>9</sup>
- Ensure that families and relevant professionals are provided with information and resources to help them support their child's mental health while waiting for assessment.

**CAMHS and the Local Authority Education Department must provide update reports to the Safeguarding Board to monitor progress of these actions.**

Violet Rose did not receive any service from CAMHS after June 2022 but continued to experience distressing anxiety and low mood, alongside ongoing self-harm. The only agency aware of the continuing emotional distress was the school, as no further referrals were made to CAMHS and she was not seen by GP services. The Reviewers have been told that there is now a CAMHS school in reach service called SHINE (Schools Inreach Emotional Wellbeing Service), which works with schools to embed a 'whole-school approach' to emotional and mental health. The service offers support to teachers and parents and individual and group interventions for pupils. This service is in line with Welsh Government policy.<sup>10</sup>

- **Recommendation 4**

**In order to improve timely referrals and ensure appropriate support, the Regional Safeguarding Board must, as part of its multi-agency annual training plan, provide training on the prevalence of autism, the risks autistic young people may face, and how autism can impact their mental health. Schools and Local Authority Education Departments should review and strengthen their training for teachers on recognising and supporting children on the autistic spectrum. Evidence of compliance with this recommendation must be submitted to the Safeguarding Board via its Training and Learning sub-group.**

Although Violet Rose presented in school with clear ASD indicators, she also sought support for her mental health. There are 10 entries on the timeline of significant incidents in school relating to her mental health between February and April 2022. It was at the end of April that a request from school to the Communication and Relationships Team for ND observation was made. This was her 3<sup>rd</sup> year at secondary school, albeit her first and second years had been overshadowed by the Covid pandemic. It does not appear from the timeline that any link was made between her likely ASD and her mental health issues.

**Learning point: Communication**

- **Recommendation 5**

**Statutory agencies must not rely solely on parents or carers to share information between services. Parents must be kept informed appropriately but not placed in position of mediating professional communication:**

<sup>9</sup> [Autism Adapted Safety Plans | Neurodevelopment and Disability | Newcastle University](#)

<sup>10</sup> <https://www.gov.wales/sites/default/files/publications/2021-03/framework-on-embedding-a-whole-school-approach-to-emotional-and-mental-well-being.pdf>

- **CAMHS and schools must ensure that communication and liaison responsibilities between professionals and agencies are clearly set out in local policies and procedures**
- **Schools, CAMHS and Children's Services must establish direct communication pathways to coordinate interventions, reduce duplication, and ensure that support is consistent, informed and child centred.**
- **Schools, CAMHS and Children's Services must review their processes in relation to the sharing of information to ensure timely and effective sharing of information that supports the safeguarding of all children at risk.**

There needs to be more effective communication within and between agencies to ensure that relevant information is shared and opportunities for agencies to work together are maximised. Parents should not be relied upon by professionals to share information about their interventions but should communicate directly with one another.

The Reviewers have been informed that CAMHS now share relevant information with school when consent is given, so while it appears that one service has moved forward, further development is required By Education and Children's Services to ensure consistency.

- **Recommendation 6**

**The Safeguarding Board must be assured that effective procedures are in place to support the transfer of children and young people with additional needs between educational settings. The Local Authority Education Department must:**

- **Review current transfer processes, identify strengths or gaps and ensure that gaps are remedied**
- **Ensure that schools enrol pupils as soon as they are instructed to do so by the Education Authority.**
- **Ensure that planning for school transfer is undertaken and joint transfer meetings with clear support plans are promoted.**

**The Local Authority Education Department must provide evidence of compliance with this recommendation to the Regional Safeguarding Board.**

The Reviewers have been informed that since this incident, the transfer process has been strengthened to improve communication and transfer of documentation. However, this is anecdotal based on comments by one school at the Learning Event.

- **Recommendation 7**

**Children's Services must provide assurance to the Safeguarding Board that referral processes to Early Help and the Multi-Agency Safeguarding Hub (MASH) are clear, consistent, and include arrangements for giving timely feedback to the original referrer on the outcome of each referral. All professional discussions and consultations must be recorded by MASH staff. Children's Services must provide evidence to the Regional Safeguarding Board confirming that they are meeting this requirement.**

Several referrals were made to the Early Help service and to the MASH. Violet Rose's mother declined services on each occasion. There is no reference in the timeline to the referring agency being made aware of the outcome of their referral. There is also no evidence that Violet Rose was asked whether she wanted any support.

- **Recommendation 8**

**CAMHS should complete an audit of their communication processes to ensure that information and letters are being shared appropriately. CAMHS must provide evidence to the Regional Safeguarding Board confirming that they are meeting this requirement. CAMHS must provide evidence to the Regional Safeguarding Board confirming that they are meeting this requirement.**

It became apparent at the Learning Event that the GP had never received the two letters that the CAMHS Consultant had written to the practice with the outcome of their assessment and the plan to discharge Violet Rose from CAMHS. The Reviewers were told by the current CAMHS Clinical Director that there were issues with administration capacity within CAMHS at the time and these have now been resolved.

**Learning Point: The Voice of the Child**

- **Recommendation 9**

**Childrens Services and Schools must review their processes and be assured that they are capturing the voice of the child in relation to referrals for Early Help, Care and Support assessment and when there are Safeguarding concerns. Children's Services and the Education Department must provide the Safeguarding Board with evidence of improvement within the timeframe agreed in the Action Plan.**

All agencies must ensure that their processes include speaking directly with the child or young person. There were occasions when Violet Rose was not spoken to by the school (in relation to her mother's reports of persistent bullying), the Early Help Service or the MASH about a specific issue, incident or referral and her mother was relied upon to advise of Violet Rose's views and wishes. It is especially important that, when parents are contacted and services are declined, that every attempt is made to capture the voice of the child and not rely exclusively on the parent to speak for the child.

**Learning Point: Bullying**

- **Recommendation 10**

**All schools must review their Anti-Bullying policies to ensure that staff have guidance on what action they should take if there are incidents reported to them of bullying off-site or involving pupils from other schools. Policies must include guidance on when to report directly to Police and when to report to the Local Authority under the Wales Safeguarding Procedures.<sup>11</sup> The Local Authority Education Department must provide evidence to the Regional Safeguarding Board when this action has been completed.**

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<sup>11</sup> [Safeguarding Wales](#)

It was apparent to the Reviewers that Violet Rose experienced bullying, although this was likely to have been largely outside of the school day and on-line. There is little guidance available to staff currently about how they should manage these situations.

- **Recommendation 11**

**In order to ensure that responses to allegations of bullying, assault, harassment or malicious communications by young people against their peers, whether incidents occur within or outside of the school premises, are robust and that appropriate action is undertaken, multi-agency collaboration is essential. Welsh Government should lead a Review of the 'Wales Police Schools Programme: School Crime Beat Protocol' policy that includes key partners (Police, Schools, Youth Justice, Local Authority Education and Children's Services) to support a clear, staged and coordinated approach. The policy must also align with partner agencies' systems so that professionals have timely access to accurate, shared information, enabling informed decision-making and early intervention.**

**Schools in particular must provide guidance to their staff on the need to complete and maintain chronologies that capture both the number and nature of incidents over time (longitudinally) and review the chronology when dealing with every individual incident. Incidents must not be seen in isolation. The Local Authority Education Department must provide evidence to the Regional Safeguarding Board when this action has been completed.**

There are references in the timeline to Violet Rose's mother alleging persistent bullying. The Reviewers felt that these allegations were not fully explored by the school either with her mother or with Violet Rose. On one occasion, a staff member asked Violet Rose's friend whether she was being bullied and the friend said she was not. That appeared to be the end of the matter. There is no record of Violet Rose being spoken with.

#### **Dissemination**

List of recipients who will receive copies of the Review Report (in line with [SUSR Statutory Guidance](#) and due to the recommendations of this Report):

Please include the recipient, reason for sharing and the date circulated:

Click or tap here to enter text.

#### **SUSR process**

To include here in brief:

- The process followed by the Board and the services represented on the Review Panel
- A Learning Event was held and the services that attended
- Family members had been informed, their views sought and represented throughout the learning event and feedback had been provided to them where appropriate. Where this was not appropriate, an explanation should have been provided.

Click or tap here to enter text.

**Final confidence check**

This Report has been checked to ensure that the SUSR process has been followed correctly and the Report completed as set out in the statutory guidance.

I can confirm that this Report section is at a standard ready for publication

**Does this Report include aspects which meet the following requirements of completing a Domestic Homicide Review?**

*The death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by—*

- a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or*
- b) a member of the same household as himself*

If yes, upon completion and ratification by the Safeguarding Board Chair, in consultation with the Community Safety Partnership Chair, the SUSR Report needs to be forwarded to the Home Office Quality Assurance Panel.

**For Welsh Government use only**

<b>Date information received:</b>	Click or tap to enter a date.
<b>Date acknowledgment email sent to Board Chair:</b>	Click or tap to enter a date.
<b>Date circulated to relevant Policy Leads:</b>	Click or tap to enter a date.
<b>Date presented to the SUSR Internal Tasking and Co-ordination Meeting:</b>	Click or tap to enter a date.

## Statements of Independence

### Statement of Independence by Reviewer(s):

Please read and sign the following statement. Consider section 6.32 on independence in the [SUSR Statutory Guidance](#) before completing.

**Reviewer 1: Jackie Neale**

**Reviewer 2: Nicola Jones**

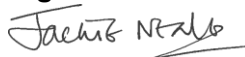
### Statement of independence from the case

*Final check statement of qualification*

I make the following statement that prior to my involvement with this learning review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the 7 Nolan Principles and will apply accordingly.

#### Signature:



**Name: Jackie Neale**

**Date: 09/04/2026**

#### Signature:



**Name: Nicola Jones**

**Date: 09/04/2026**

### Statement of Independence by Chair of the Review Panel:

Please read the following statement and sign below. Consider Section 6.18: [SUSR Statutory Guidance](#) before completing:

*Final check statement of qualification*

I make the following statement that prior to my involvement with this learning review:

- I have not been directly involved in the case or any management or oversight of the case.
- I have the appropriate recognised qualifications, knowledge and experience and training to undertake the review. Therefore, I have met the criteria of an Approved Chair/Reviewer.
- The review was conducted appropriately and was rigorous in its analysis and evaluation of the issues as set out in the Terms of Reference. I recognise that the purpose of this is to identify learning from the case, not to attribute blame to practitioners or agencies.
- I have read and understood the 7 Nolan Principles and will apply accordingly.

**Signature:**



**Name: Robert Wigmore**

**Date: 09/04/2026**

## Review Panel Members

Number of times the Panel met: 10

Role and job title	Agency	Confirm Independence
Statutory Review Manager	South Wales Police	<input checked="" type="checkbox"/>
Group Manager IAA & Safeguarding	Children Services	<input checked="" type="checkbox"/>
Safeguarding Lead	Wales & West Housing	<input checked="" type="checkbox"/>
Patient Care and Safety	Cwm Taf Morgannwg University Health Board	<input checked="" type="checkbox"/>
Education and Engagement Manager	Local Authority	<input checked="" type="checkbox"/>
	Action for Children	<input checked="" type="checkbox"/>

## Terms of Reference

### Core tasks

- Determine whether decisions and actions in the case comply with the policy and procedures of named services and Board.
- Examine inter-agency working and service provision for the individual and family.
- Determine the extent to which decisions and actions were outcome focused.
- Seek contributions to the review from appropriate family members and keep them informed of key aspects of progress.
- Take account of any parallel investigations, reviews or proceedings related to the case.
- Hold a learning event for practitioners and identify required resources to establish what lessons are to be learned from the incident.
- Identify clearly what the lessons are, both within and between agencies, how and within what timescales they will be acted on and what is expected to change as a result;
  - Apply these lessons to service responses including changes to the policies and procedures as appropriate;
  - Prevent domestic homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working;
  - Contribute to a better understanding of the nature of domestic violence and abuse;
  - Highlight good practice.

### **In addition to the review process, to have regard to the following:**

- Whether previous relevant information or history about the individual at risk and/or family members was known and considered in professionals' assessment, planning, and decision-making in respect of the adult at risk, the family, and their circumstances. How that knowledge contributed to the outcome for the individual at risk.
- Whether the actions identified to safeguard the individual at risk were robust, and appropriate for that person and their circumstances.
- Whether the actions were implemented effectively, monitored, and reviewed and whether all agencies contributed appropriately to the development and delivery of the multi-agency actions.
- The aspects of the actions that worked well and those that did not work well and why. The degree to which agencies challenged each other regarding the effectiveness of the actions, including progress against agreed outcomes for the individual at risk. Whether the protocol for professional disagreement was invoked.
- Whether the respective statutory duties of agencies working with the individual at risk and family were fulfilled.
- Whether there were obstacles or difficulties in this case that prevented agencies from fulfilling their duties (this should include consideration of both organisational issues and other contextual issues).

## Specific tasks of the Review Panel

- Identify and commission a reviewer/s to work with the Review Panel in accordance with guidance.
- Agree the time frame.
- Identify agencies, relevant services, and professionals to contribute to the review, produce a timeline and an initial case summary and identify any immediate action already taken.
- Produce a merged timeline, initial analysis, and hypotheses.
- Plan with the reviewer/s a learning event/s for practitioners, to include identifying attendees and arrangements for preparing and supporting them pre and post event, and arrangements for feedback.
- Plan with the reviewer/s contact arrangements with the individual and family members prior to the event.
- Receive and consider the draft SUSR report to ensure that the Terms of Reference have been met, the initial hypotheses addressed, and any additional learning is identified and included in the final report.
- Agree conclusions from the review and an outline action plan and make arrangements for presentation to the Board for consideration and agreement.
- Plan arrangements to give feedback to family members and share the contents of the report following the conclusion of the review and before publication.

## Tasks of the Safeguarding Board

- Consider and agree any Board learning points to be incorporated into the final report or the action plan.
- Ensure the Review Panel completes the report and action plan.
- Board sends to relevant agencies for final comment before sign-off and prior to publication submits the final report and action plan to Welsh Government (and in cases of Domestic Homicide, the Home Office).
- Confirm arrangements for the management of the multi-agency action plan by the Review Sub-Group, including how anticipated service improvements will be identified, monitored, and reviewed.
- Plan publication on Board website and SUSR Co-ordination Hub website.
- Agree dissemination to agencies, relevant services, and professionals.
- The Chair of the Board will be responsible for overseeing all public comment and responses to media interest concerning the review until the process is completed.