MAPF Independent Review Report

Ysgol Dyffryn Aman

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Report Author:	Gladys Rhodes White OBE, Independent Reviewer
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CYSUR 2 2024 MAPF REPORT

1. MAPF process

In line with the relevant guidance as referenced in the Social Services and Well-being (Wales) Act 2014, a Learning Event has been held as part of a Multi-Agency Professional Forum (MAPF). Single Unified Safeguarding Reviews (SUSRs) and MAPFs are articulated under Part 7 of the Social Services and Well-being (Wales) Act 2014, specifically in the Single Unified Safeguarding Review Statutory Guidance published in October 2024.

As per the agreed regional process, ratified by the Mid and West Wales Safeguarding Board (MAWWSB), a referral was submitted to the Case Review Subgroup on 25th September 2024, the outcome of which was an agreement to undertake a MAPF.

This case did not meet the threshold for an SUSR, as child A is the alleged perpetrator in this case rather than a victim. It was also noted that the victims of the incident were not suspected of being at risk of abuse or neglect. It was agreed however that there is potential learning from this case and that it would be beneficial for the case to be considered in a Multi-Agency Professional Forum. The sub-group unanimously agreed to recommend a MAPF, which was agreed by the Chair of CYSUR, the Mid and West Wales Safeguarding Children's Board.

This MAPF has been undertaken as a direct result of that recommendation; it will focus entirely on identifying any lessons learned and using these to formulate recommendations and actions.

Due to the high level of public interest and because of the seriousness of the incident, it was agreed by the panel that the involvement of an independent reviewer would bring a helpful critical and independent dimension to the review. The independent reviewer is the author of this report and has worked closely with the panel and facilitated a learning event for managers and practitioners.

2. Background and summary of agency involvement

This review considered a young person who at the time of the critical incident, was aged thirteen and lived at home with her father, father's partner and her brother. She has contact with her birth mother. Child A was a pupil at school A, where the critical incident took place.

On the 24th April 2024, child A was on the school premises in the playground when she got into a disagreement with a staff member that led to her stabbing two teachers and a fellow pupil with a bladed object that she had taken into school with her. A third teacher became involved and after the attack on the pupil managed to restrain child A, preventing any further harm. The school followed emergency lockdown procedures, the emergency services were alerted, and child A was arrested.

This review has taken place following the conclusion of a criminal trial, where child A was found guilty on three counts of attempted murder. On the 28th April 2025, child A was sentenced to 15 years imprisonment for the three counts of attempted murder. She is currently detained in a secure unit.

3. Timeline

The MAPF and discussions were focussed on the period 24th April 2022 – 24th April 2024. This is the two-year period prior to the incident taking place. This timescale was agreed to capture any key issues for learning across the relevant agencies. As in many cases, there is a

substantial amount of information that sits outside of the timeline that is relevant in understanding child A, her history and engagement with services. This contextual information has been sought prior to, and as part of the learning event, to help inform understanding and analysis.

The timeline submitted by all agencies was discussed in detail during the learning event. Professionals had the opportunity to share further information and ask questions of each other, as well as debate and seek clarification on any relevant points of interest.

Prior to the timeline, in November 2021, a multi-agency referral form was submitted by child A's school at the time, highlighting concerns that child A is reported to have a BB gun in her school bag. A referral is also made to the Early Intervention Team, with child A's father's consent, as he shares that child A finds it difficult to engage in her learning through the Welsh language. The father also notes that she is awaiting an ASD assessment.

In September 2022, child A joins a new school (school A). Some issues in relation to incorrect uniform are recorded within the first term, and in 2023, the school's Attendance and Punctuality officer visits child A's father at home to discuss issues being experienced. In May 2023, child A is noted to have threatened to use a knife on another pupil, and agreement is reached with her father to conduct bag checks. War memorabilia was found in child A's bag.

In September 2023, a search of child A's bag following a behavioural incident within the school toilets led to the discovery of a knife. Child A stated that she carried the knife for her own protection due to an incident that had occurred on the school bus. The Police are contacted, and a strategy meeting convened. It is agreed that a temporary exclusion of four days will be put in place, and the Youth Justice Team will be contacted for advice, which was then duly given.

Father consented to a referral to EVOLVE, which is a project that provides help and support to young people experiencing poor mental health and agrees to her receiving help and support in school. Father agrees to check child A's bag daily prior to school, with the school also undertaking periodic checks. Counselling support was offered but refused, and it is agreed that Education will follow up and action a referral in relation to autism spectrum disorder (ASD).

In November 2023, child A is visited at school for an Assessment for Care and Support because father does not consent to a home visit, and it is felt that the school are better placed to provide support to her. It is noted at this point that a move in class appears to have resulted in child A being more settled, and the school agree to provide wellbeing support. The Care and Support Assessment is closed at the end of 2023, having considered the incident that child A had experienced, her own wishes and feelings, and earlier ACEs she was noted to have experienced.

No concerns are noted within the school or by any other agency until the incident which occurred at school A in April 2024.

4. Views of the family

A key principle of the MAPF guidance is to be transparent and to provide opportunities for the family to contribute to the process. This means that, wherever possible, we engage with the family and take account of their wishes and views. In this instance only the father of child A was available and willing to be interviewed. Several opportunities were provided to child A to

engage in the MAPF process; however, child A did not wish to take part. The information gained from child A's father was shared and explored in the discussions at the learning event and is reflected below.

The contents of this report will be shared with the family and because of the high level of public interest, will be published. The Panel are grateful for the input from child A's father, recognising the difficulty for the family in dealing with the trauma and aftermath of the incident and having to revisit it for the purposes of the review.

The Independent Reviewer extended an invitation to meet with child A's father to enable him to contribute to the review. Unfortunately, attempts to contact child A's mother to invite her to engage in the review were not successful. The reviewer met with child A's father and his partner to consider what happened, hear from him his perspective on the incident and to explore what, if anything, might have prevented child A from committing these offences. It was also an opportunity to learn more about child A and her background and to explore the family's experience of services.

Family Perspectives and Reflections – Child A's Father

- Child A's father felt that services had let child A and the family down. He described occasions when he tried to get help for child A in dealing with her emotional and behavioural issues and felt none of the services understood child A and her needs.
- Child A's father described concerns he had held in relation to child A experiencing bullying and around potential neurodiversity and felt that these concerns were not addressed by services. He described child A as having signs of Autism in her behaviours, for example, her low moods, her tics, tip toeing, cracking fingers, self-harming and escapism through 'made up stories', such as being able to speak German and Russian. Child A was referred by the GP to CAMHS, but father says there was no follow up help as a result of that referral. This was at the time when COVID restrictions were in place.
- Father feels it is only since her conviction that she has started to receive help.
- Child A's father talked about child A's early life experiences and some of the trauma she experienced due to his difficult separation from child A's birth mother, and negative experiences child A and her brother were exposed to then and subsequently, including violence towards him from a subsequent partner. He recognised that child A had suffered because of his relationship choices and the deterioration of these.
- Child A's father felt that he had maintained relative consistency in undertaking bag checks as part of the agreed plan following child A's temporary exclusion, but regrets that he had not been able to check her bag on the day of the incident, as she had left home early that morning. He felt agencies "*didn't listen to me or my child* when *we needed help*."
- Child A's father hopes the review can recognise the missed opportunities to help child A and that things improve because of this review.
- Father described child A as '*a bright clever girl, who is witty, a "show off", someone who likes to draw and write and is always ready to 'stick up for her friends and family'. She will 'say it how it is' and is often misunderstood – not everyone gets her humour."* Father felt it was wrong that she was judged in Court as not showing remorse as he

said when he first saw her after the incident, she apologised to him and was extremely distressed about what had happened.

5. Views of the Victims

The Independent Reviewer met with the two adult victims and the teacher who intervened to restrain child A. The Panel members are hugely grateful for the courage shown by all three teachers, who shared their experiences in an open and honest manner, and offered reflections on learning, despite the trauma they are still trying to come to terms with.

Child A is described as *"quirky, rebellious about her uniform, and having difficulty making friends"*.

Child A was seen as a capable learner and whilst not subject to an individual learning plan, she was on a list of pupils known to the Additional Learning Needs Co-ordinator (ALNCo). She was in the process of reviewing all the 109 children on the list to update their plans in line with the new legislation and guidance. Child A was not a priority as she had an orange marker for social needs, meaning she may have had previous emotional/behaviour concerns but was not one of the pupils requiring urgent consideration. Her priority was to review those children who required an individual learning plan.'

None of those interviewed felt they knew very much about child A and her history. Education records show in her primary and previous secondary school she was assessed as needing help, at a lower level, of 'school action/school action plus' meaning she would be eligible for support. This was in relation to her emotional and behavioural needs.[1]

On the day of the incident a small group of pupils were aware that child A had brought a knife into school but had not alerted any of the staff. Child A had been missing from a lesson and the Code 9 procedure to track missing pupils was activated. She was not found but did appear in lessons later.

Child A was challenged about her presence in the old lower school building, which is an area that some pupils were given permission to stay in during breaks if agreed by their Head of Year. Child A did not have permission to be there and was asked to leave on more than one occasion by teacher 1. Child A was adamant on the day that the incident occurred that she should be able to stay in the Hall with the others and challenged teacher 1 about this. She was also challenged about wearing the wrong uniform that day. It was soon after these challenges that the critical incident occurred, with child A attacking teacher 1 first.

This review is not intended to investigate the details of the assaults and subsequent actions as these have been explored in detail in the two criminal trials (a retrial had to be undertaken) and in other agency investigations.

The views of the teachers regarding learning points, as well as questions they felt the MAPF should explore, are included below.

[1] Statutory guidance on the Additional Learning Needs and Education Tribunal Act. The Additional Learning Needs Code for Wales 2021. It should be noted that support for children with additional needs are assessed and supported differently now because of new legislation and guidance. The special educational needs (SEN) system is being replaced by the additional learning needs (ALN) system. This is happening over four school years, between September 2021 and August 2025.

Victims' Perspective and Reflections

- It seemed that being allowed to be in the hall was very important to child A – could she have been allowed to stay in the Hall with the others? Would that have made her feel safer and have helped with any social/friendship challenges she may have been experiencing?
- Other pupils knew child A had a weapon, but no one reported it – do pupils need to better understand the consequences of carrying weapons?
- Information needs to follow a pupil when they transfer schools, so that any issues, concerns or risks are understood by the new school.
- When asking parents to check their child's bags it is important that other measures are considered, so that sole responsibility is not left with the parents – child A left home before her father was up on the day of the incident.
- There is a need for pupils with additional needs or vulnerabilities to be flagged with all relevant staff.
- It did not appear that child A had established any trusting relationships with school staff who she felt able to go to for support.
- Bullying was an ongoing issue for child A, mainly noted as happening on the school bus.
- Providing adequate support for the growing numbers of vulnerable pupils is a challenge for schools with competing resource priorities.
- A PREVENT referral was considered for child A but was not pursued.
- There was a lack of information sharing in relation to child A's emotional health and behavioural needs in previous educational settings.
- Following the previous concerns when child A had brought a knife to school, was there a suitable risk assessment/plan in place, and was this information shared with necessary and relevant persons?
- All staff in schools need to be up to date with agreed restraint and de-escalation policies/actions.
- The extent of child A's Adverse Childhood Experiences (ACEs) and how they might influence her behaviour were not known to the school.
- Was there an effective relationship between home and school in communicating about child A's behaviours and understanding what needed to happen in relation to incomplete assessments from previous referrals?

6. Independent reviewer's overview

Within this review, it is important not just to focus on child A as a perpetrator of a knife crime. This has been dealt with through the criminal justice system. The learning from this incident needs to focus on child A and her 'lived experience' leading up to and much earlier than the day of the critical incident. This does not minimise the impact of her crime and the trauma for those affected by her actions, but hopefully helps to extract any relevant insight and learning, around how we help young people who may have a predisposition to violence.

Child A had a troubled childhood with fractured parental relationships, exposure to domestic abuse and a lack of a consistent, secure and stable maternal figure in her life. The Police have on record several domestic incidents involving child A's parents. Those incidents occurred between 2011 and 2019. It is likely that child A was affected by several Adverse Childhood Experiences (ACEs), which we know can have a long-term detrimental impact on a young person's emotional, social and behavioural development.[2]

"Research has shown that adverse childhood experiences (ACEs) – such as experiencing child abuse, domestic violence, and parental substance misuse – are associated with later involvement in violence. However, positive life experiences (PCEs) – such as connectedness to family, peers, school, and community – are associated with decreased risk".

There is no way of knowing whether the impact of child A's ACEs and any links to future violence could have been mitigated by a more stable family life, more consistent positive school experiences and/or better peer relationships, but this is an area that might be of further research and interest to those working with children affected by ACEs when early indications of violence are seen.

The commitment across Wales to use trauma informed practice is a positive step in addressing the significant emotional difficulties facing pupils whose educational outcomes may be compromised due to their vulnerable state.[3] A study by Public Health Wales and Bangor University, published in the journal BMC Public Health, has found that "*adverse childhood experiences (ACEs) and negative school experiences increase the risk of poorer mental health and wellbeing into adulthood. The findings underscore the need for trauma-informed approaches in schools to support children experiencing adversity at home."*

The study also states that *"children have a right to education, and a right to be safe. This research finds that those who experienced more ACEs at home were also more likely to experience bullying and traumatic experiences at school, and that more positive school experiences can help mitigate the impact of ACEs. The study signals that it is vital we maintain focus on developing a trauma- and ACE-informed education system in Wales."*

It may be worth noting that child A is one of many young people whose education and social development were affected by the COVID pandemic. There is research to suggest that he

[2] Adverse Childhood Experiences (ACEs), Research organisation - Centre for Longitudinal Studies (2023)

[3] Impact of Childhood Adversity and School Experiences on Adult Health. **Published:** 3 March 2025
A new study by Public Health Wales and Bangor University, published in the journal BMC Public Health

impact for pupils may have a lasting effect. The Welsh Government report published in March 2021 references the response to these concerns.[4]

"While we recognise that children and young people have thankfully been less susceptible to COVID-19 than adults, there is little doubt that the wider effects of the pandemic—and the measures taken to manage it—have impacted their lives and their rights significantly".

Whilst child A's father suggests that child A presented as a happy child in her initial primary years, there is evidence that her emotional state deteriorated as she progressed through primary school, and she experienced even greater challenges in her secondary school days. Her transition into adolescence is likely to have added to her pre-existing fragile emotional state. It is difficult to know the extent of child A's challenges in relation to her emotional health and whether this may have been impacted by any neurodiversity, as an assessment or specific diagnosis for neurodiversity was not carried out. In April 2022, a copy of a letter in child A's GP records from a CAMHS Choice assessment noted that child A was not presenting with a moderate to severe mental health illness such as psychosis, however there appeared to be some traits that might fit with a possible diagnosis of ASD.

Child A is described by education staff as capable and bright academically with no additional learning needs support required. However, there is a pattern of behavioural, compliance and emotional issues presenting from primary school onwards. She struggled in her first secondary school, which was a Welsh speaking school. Child A was adamant for some time that she did not wish to speak Welsh and eventually moved to a school where this was not required. She appears to have been happier in her second school although it was not without challenges.

Child A is seen as 'quirky' and 'not quite fitting in', having unusual interests in war memorabilia, Hitler, a fascination with weapons and purporting to speak German and Russian. She was an Army cadet, which father said she loved, and this may have fed her fascination with things related to the war, weapons and conflict. Her father describes her as loving to read, research things and having a fertile imagination, creating fantasies. This was evident in the reports of her presentation in school. Following the first knife possession incident there were discussions regarding whether a referral to PREVENT should be made, due to concerns that child A may have the potential to be radicalised. There is no evidence to suggest a referral was made. In later discussions, when concerns continued to be raised, it was suggested that child A would benefit from targeted youth work and help from the school counsellor.

Whilst child A may not have met the criteria for PREVENT, this triggered an action for an Early Help assessment to be offered to holistically understand child A's needs. This referral was made, and the team contacted the father, who declined the assessment. Had this assessment occurred, this may have been a pathway through which agencies could consider alternative help, or for monitoring and support to be provided.

On 13th October 2023, during a CAMHS School in Reach consultation, the school described her as showing distinctive behaviours that made her stand out from peers developmentally, and that a knife had been found in her school bag recently, leading to Police involvement. We know from research that the early onset of serious violence is an indicator of significantly

[4] Welsh Parliament Children, Young People and Education Committee The impact of COVID-19 on children and young people Final report 24 March 2021

increased risk of future violence to others. This would also potentially be true of her interest in weapons.

Historical behaviours in relation to risk of harm to others were discussed within the initial CAMHS assessment in February 2022, before the timeline for this report, with no further action taken in relation to this risk. The clinician explains this as being due to the service user's young age and the fact that her father knew about the incidents. This assumption could have led to a missed opportunity to gather further risk information which would, in turn, have informed a more comprehensive assessment and formulation of risk of harm to others. Further questions could have explored, in a developmentally appropriate way, the service user's thoughts and feelings, as well as her current thoughts or behaviours of violence to others or possession of weapons that might have informed a current understanding of her risk. There would also have been an opportunity to explore her father's observations in relation to any additional risk behaviours. The risk assessment would also have benefited from additional contact with the service user's previous primary school, and/or current secondary school Safeguarding Lead, to corroborate the information and any steps taken to manage the issues. An evidence-based response is key to understanding and addressing this issue effectively. Recent insights from the Youth Justice Board (YJB) [5] and other experts show that "*the reasons children carry knives are often linked to societal factors like poverty, marginalisation, fear, and trauma. Children's lived experiences, including Adverse Childhood Experiences (ACEs), criminal exploitation, and victimisation, must be taken seriously when crafting solutions."*

Swansea University's research project, part of their Voices from Research programme, is one of many efforts aimed at better understanding why children carry knives. "*By directly engaging with children, we can ensure that our response is both compassionate and informed by children."*

Examining Current Interventions

- *Equally important is examining current interventions. Evidence suggests that some popular strategies have shown limited success. Knife surrender schemes, education programmes, and media campaigns often have weak or unclear outcomes. For example, some studies suggest that media campaigns might increase fear and the likelihood of children carrying knives. Similarly, stop-and-search practices do not effectively prevent knife crime and may disproportionately affect Black children. Moreover, mandatory minimum sentencing has been shown to harm children, often increasing stigma and reoffending rates.*

Successful Strategies

- *On the other hand, strategies focused on diversion and early intervention have proven more effective. Programmes like Pre-Court Diversion have led to a 13% reduction in reoffending, and Wales has a strong track record in implementing diversion programmes. The Welsh Government Youth Justice Blueprint emphasises the importance of these approaches.*

[5] Knife Crime – an evidence based approach Tackling 'Child Knife Crime' in Wales: We Need an Evidence-Based Response, Mar 26, 2025 , Dr Rhian Croke, Children's Rights Strategic Litigation and Policy Advocacy Lead, Children's Legal Centre Wales

- *Tailored assessments that consider broader issues such as education, housing, and mental health are also crucial for addressing the underlying needs of children involved in knife crime. Youth Justice Services, working in collaboration with other services across Wales, are well-positioned to offer an approach that allows for more effective, individualised support and reduces the likelihood of long-term harm".*

Following the CAMHS assessment in early 2022, child A's father was sent an Autism Screening Questionnaire (ASQ), which he completed and returned. The results of these, along with observations from the CAMHS assessment, suggested the need for further investigation for an Autism diagnosis. The strategy meeting minutes from October 2023 recorded that school were going to follow up a potential referral for ASD assessment, but there is no evidence this was progressed.

It appears there was some confusion over whether child A was on a waiting list for an ASD assessment, and it is understood that the wait time to be assessed once on the list is several years. Father was aware that if there was a change in presentation regarding mental health to seek a rereferral.

There is a pattern throughout the review of agency records of child A and her father receiving some offers of help and support that were declined or not followed up.

Children's services records disclose a consistent level of multi-agency involvement within child A's family environment, including several lower-level domestic incident reports. Although there are several entries detailed, they occur over a period of nearly ten years and as a result are not viewed as 'prolific' in their frequency.

Children's services records show evidence of involving child A and her father in assessments and discussions on how to secure appropriate help and support. It can be seen however that there were challenges in terms of engagement; as the criteria for statutory intervention was not felt to be met, preventative/early help support, and interventions were offered to the family. However, engagement with early help services was not always followed through by father or child A. There may have been several factors influencing this that have not been fully explored as part of this review.

Child A's father's lack of engagement with the offer of an early help assessment should have been communicated back to the Central Referral Team (CRT) for a further analysis of the information available; at this point, a different level of intervention might have been considered given child A's family situation and the issues known at the time.

Child A was clearly seen as a victim (and treated as such by the Police) when she made the allegation in relation to an incident having occurred on the school bus. This was the correct approach, however, at this point, it appears that the wider levels of concern around bullying and child A's carrying of weapons were not fully understood or assessed in terms of risk that child A herself may pose to others.

Throughout agencies' involvement with the family, it appears that child A's birth mother, who has Parental Responsibility, and who child A was having contact with, was not contacted or asked to contribute to assessments or plans, therefore her contributions were not captured. Given that child A was still having contact with her mother, it would have been helpful to have gained her input into gaining an understanding of child A and her behaviours.

In conclusion, it is fair to say that child A had experienced several challenges which agencies had some awareness of at different times and in different ways. Each agency had their own pieces of the jigsaw; in collating all the pieces of the jigsaw, there is a much clearer picture of the extent of concerns around child A's state of mind and her associated behaviours.

It is important to note that no information held by agencies identified a clear ability to foresee the shocking and unexpected events which occurred in April 2024.

It is possible, however, that child A could have benefitted from more targeted help if all the information had been fully shared and assessed. On occasions, there is evidence of a lack of 'professional curiosity' around child A's presentation, her history and how it may have been affecting her as an adolescent. The lack of engagement of child A and father, on occasions, was a barrier to this understanding. The absence of a trusted adult amongst agencies meant no one really gained child A's trust and understood her behaviours and what they might mean.

There is evidence of good practice that the review has captured and a willingness of those involved to reflect and share in an open and transparent manner. Many lessons learned have already been implemented because of agencies and schools proactively responding to the critical incident. It is refreshing to observe the multi-agency commitment to working in a restorative and trauma informed manner and the extent to which this approach has been adopted across the agencies.

It is impossible to determine whether, with the right help and support, child A could have been prevented from taking the actions she did, and therefore it is of more importance to focus on ensuring the learning from this review is captured and acted on. There appears to be a huge commitment from the agencies involved to do so.

7. The Learning Event

The following agencies were represented at the Learning Event, all of whom had some involvement with the family.

Agencies represented:

- Carmarthenshire Children's Services
- Carmarthenshire Education Services (including representation from relevant schools)
- Hywel Dda University Health Board (Primary Care and School Nursing)
- Dyfed-Powys Police
- Carmarthenshire Youth Justice Team

The Learning Event was introduced by the Chair of the Panel and facilitated by the Independent Reviewer.

As mentioned above, the Learning Event considered the timeline of contacts and events for the period 24th April 2022 to the 24th April 2024.

Professionals were asked to consider the following questions (the responses are addressed in the next section):

- What went well - areas of good practice?
- What do you feel did not go well?

- What do we do differently – what have we learned?
- What actions do we need to take to ensure any learning changes what we do in the future?

The attendees were given an opportunity to consider the timeline, the literature review, potential themes and the input from child A's father and the victims. There were structured group sessions to allow detailed multi-agency discussions in response to the questions posed. All responses were captured and have been used to inform the learning points below and the recommendations. These are a collation of the main points shared at the event.

8. Practice and Organisational Learning

8.1 What went well and were there areas of good practice?

Communication, information sharing and record keeping

Referrals were made in relation to concerns and strategy meetings were appropriately convened. Whilst this is positive, the outcome of the referrals and strategy meetings could have led to better actions and outcomes (as seen below).

It is good practice that when school staff failed to speak to child A's parent, they followed this up with a home visit.

School records appear to have been comprehensive and up to date.

Child A's attendance at school was good, and she was able to access the curriculum and perform well academically in many areas.

The critical incident

On the day of the incident, the school 'lockdown' was very well implemented. The process and policy were up to date and comprehensive. There was good liaison between the Central Referral Team (CRT) and school. Following the incident, the school was clear and exhibited good leadership in supporting staff and pupils and in responding to the post-incident learning. There was evidence of Youth Justice, Children's Services and Education maintaining effective multi-agency working.

The school had recently invested in training for staff on Team Teach (an approved method of restraint) and in ensuring the lockdown procedures were up to date and understood.

The emergency services responded with a quick and excellent collaborative response and those requiring medical attention were attended to swiftly.

8.2 What do you feel did not go well?

Transition arrangements

When child A changed from primary to secondary school, and in transferring mid-year from one secondary school to another, it may have helped if all child A's relevant history had followed her and that those receiving that history could understand its implications.

Communication and information sharing

We can see from agency records that different professionals (along with father and child A) held information that, if shared more effectively, and in a timely manner, could have provided a more comprehensive overview of child A, her history, her vulnerabilities, her strengths and her needs.

Assessments and follow up actions

Child A is reported to have previously taken weapons into school (once in a previous school; and once in school A). Both incidents predated the critical incident, and the incident at school A, which falls within the timeline period, was logged with the Police and followed up. The safeguarding/risk issues needed to be assessed and addressed by multi-agency professionals. This was done in a strategy meeting, where it was agreed that further advice was required from the Youth Justice Service (this was sought and was duly given). Furthermore, consideration would be given to a referral to PREVENT.

There were key points when child A's needs could have been comprehensively assessed from a cognitive and emotional health and wellbeing perspective, to understand what help and support she needed and to ensure any potential risks were managed effectively. The reliance on father and child A to follow up on appointments and to contribute to assessments did not allow agencies to gather all the information they needed. There is a lack of clarity regarding outcomes from some health appointments. An A&E visit occurred in January 2022 when father and child A left before triaging could be concluded, but it is noted that they did attend the GP surgery afterwards to seek help, and the GP subsequently referred to CAMHS.

There is evidence of discussions taking place in multi-agency forums, but then a lack of tenacity in following up on these discussions with specific agreed actions and SMART plans. When plans were agreed, these were not always shared or understood by all the relevant professionals, and compliance to agreed actions was not always reviewed.

Whilst it is positive that strategy discussions and meetings took place, these were not always attended by those who had helpful information to share, leading to gaps in critical knowledge/understanding.

Working with parents who withdraw/don't engage

When parents or young people themselves are "non-compliant" or use avoidance strategies, this can be challenging. It is important that when this happens, it is reviewed, so the children in those families can still be monitored/helped. Whilst working in a non-statutory, strengths-based partnership with families is desirable, it is sometimes necessary to consider whether there are avoidance/withdrawal issues that may be preventing a child from being safe or receiving necessary help in a timely manner.

8.2 What do we do differently and what have we learned?

Communication and information sharing

As highlighted above, the arrangements and recording of strategy meetings need to be reviewed to ensure all relevant people attend and there is clear record keeping for all agencies of the plan for the child.

There needs to be more effective information sharing across wider systems and professional discussions to create a greater awareness and understanding of what the shared information means.

The School Nurse Team Leader noted that where health referrals were delayed or had not been followed up, the School Nurse could have a role in oversight and support in coordinating referrals and appointments.

Schools' capacity to process multi-agency information could be improved if there were better integrated systems, with in built 'flags' where there are concerns.

It is important that agencies recognise the need to involve and share information with those adults who have parental responsibility.

Information sharing across schools and with health and social care colleagues during periods of transition could be strengthened. This could help ensure relevant history and current risks/concerns are captured.

More robust electronic information sharing across agencies could assist with ensuring easy access for professionals needing to know the background or history of young people that they may be concerned about.

Guidance on weapons in schools

There is information and guidance available on dealing with pupils who bring weapons and dangerous items into school. This needs to be regularly reviewed and updated. It is essential that a proportionate response to the risks is maintained, and individual circumstances are assessed and proportionately managed without creating an environment that is too risk averse and restrictive.

Helping vulnerable children and young people

Consideration needs to be given to ensuring there is help for children, young people and families when they are subjected to long waiting lists – there needs to be ways of tracking those waiting, with a graduated response to avoid deterioration of any issues.

The impact of COVID, economic challenges and increased child poverty is contributing to greater numbers of children in schools who need help, with resources stretched across all agencies. This requires greater creativity and resourcefulness to ensure those who need help can get it at the right time. Maintaining good joined-up working and a shared culture of trauma informed practice is essential.

8.4 What are the actions we need to take to ensure any learning changes what we do in the future?

Training and awareness raising

There is a need for more availability of multi-agency training in recognising and helping children who may be neurodivergent and/or emotionally vulnerable.

The provision of trauma informed practice and the impact of ACEs needs to continue as a training priority for all agencies. There is the potential to consider whether a new role of a 'Trusted Adult' who is skilled in this work be created in all agencies.

Support for vulnerable learners

There is a need to consider how to provide adequate resources to support relationships and early help in schools and other agencies. There is a demand for more pastoral support to help those children and young people who are struggling with emotional health and well-being issues, which has increased post COVID. Support in this area needs to be strengthened. Consideration could be given to whether the role of the educational psychology team could be reviewed to seek ways of utilising their skills.

Communication and information sharing

There is an opportunity to consider how agencies share information and concerns for children who are presenting as vulnerable and posing a risk, but do not meet the threshold for PREVENT, care and support or child protection. This is particularly pertinent for children who may be transitioning from one school to another, or when parents do not accept non-statutory help.

The outcomes of strategy meetings need to be reviewed to ensure all relevant people attend and there is clear record keeping for all agencies of the plan for the child.

There is an opportunity to consider how technology can be utilised to gather relevant information to inform strategy meetings, to ensure multi-agency information can be gathered and shared in a timely manner.

Managing risks

Individual risk assessments need to be maintained as a standard response when a weapon is brought into school, and it is essential that the agreed procedures are followed.

9. The recommendations

1. Consideration be given at a local and national level to secure sufficient resources and capacity for agencies, across all sectors, to be able to respond to ongoing increasing levels of complexity and need of children and young people, particularly in schools. This includes increasing resources nationally to meet the growing demand for pastoral and wellbeing support including educational psychology capacity.

2. A multi-agency review of strategy meetings should be considered focusing on the recording and plans devised for children and young people. Where thresholds are not met for the agreed service provision, there needs to be contingencies in place to ensure that the need can be addressed through alternative avenues.

3. All agencies to consider prioritising training, and awareness raising around the procedures to follow regarding 'Prevent Duty' and that those procedures include actions to be taken, for referrals that do not meet the agreed criteria.

4. Explore the potential for facilitating better inter-agency sharing of comprehensive, relevant and chronological information to inform strategy and other review meetings, utilising digital solutions and platforms.

5. All agencies should offer training on the impact of ACEs and be trauma informed. They need to have their knowledge updated regularly (*the research referred to earlier highlights initiatives to promote collaboration between Schools and other agencies; such as The Ace Hub's Wales Trauma and ACE (TrACE) Informed Organisations Toolkit*).

6. There is a need for ongoing training and awareness raising for staff who work with children and families who may refuse help, to understand the implications of non-engagement and levels of risk when they are working without statutory powers.

7. There is a need to further strengthen and embed the training for staff who work with children who may show signs of neurodivergence or high levels of emotional vulnerability.

8. Review school electronic recording systems to consider whether a single system could be introduced to ensure information sharing, and for records to follow pupils into subsequent education settings.

9. Continue to reinforce in inductions, training, policies, and supervision the importance of effective multi-agency information sharing and good communication through formal and informal systems – 'supporting professional curiosity'.

10. When children are subject to delays for assessments, diagnosis or treatment, due to long waiting lists, agencies need to consider how such children are monitored and helped during that time.

11. Ensure that education and awareness raising messages in schools and across communities is consistent (based on what research tells us) in helping young people understand the consequences of carrying weapons, and for them to seek help if considering this as an option.

10. Action required

This report is submitted to the Carmarthenshire Local Operational Group (LOG) for ratification. Once ratified, contact will be made with the child, family and victims for the report to be shared with them, if they choose to take up this offer.

The ratified report will be published as agreed by agencies.

The linked action-plan to meet the recommendations will be overseen by the Carmarthenshire LOG. All agencies involved with the MAPF have responsibility to implement their respective recommendations.

The MAWWSB Case Review Sub Group will receive the learning from MAPF reports, to ascertain whether any learning should be shared across the region.