



**National Independent  
Safeguarding Board Wales**

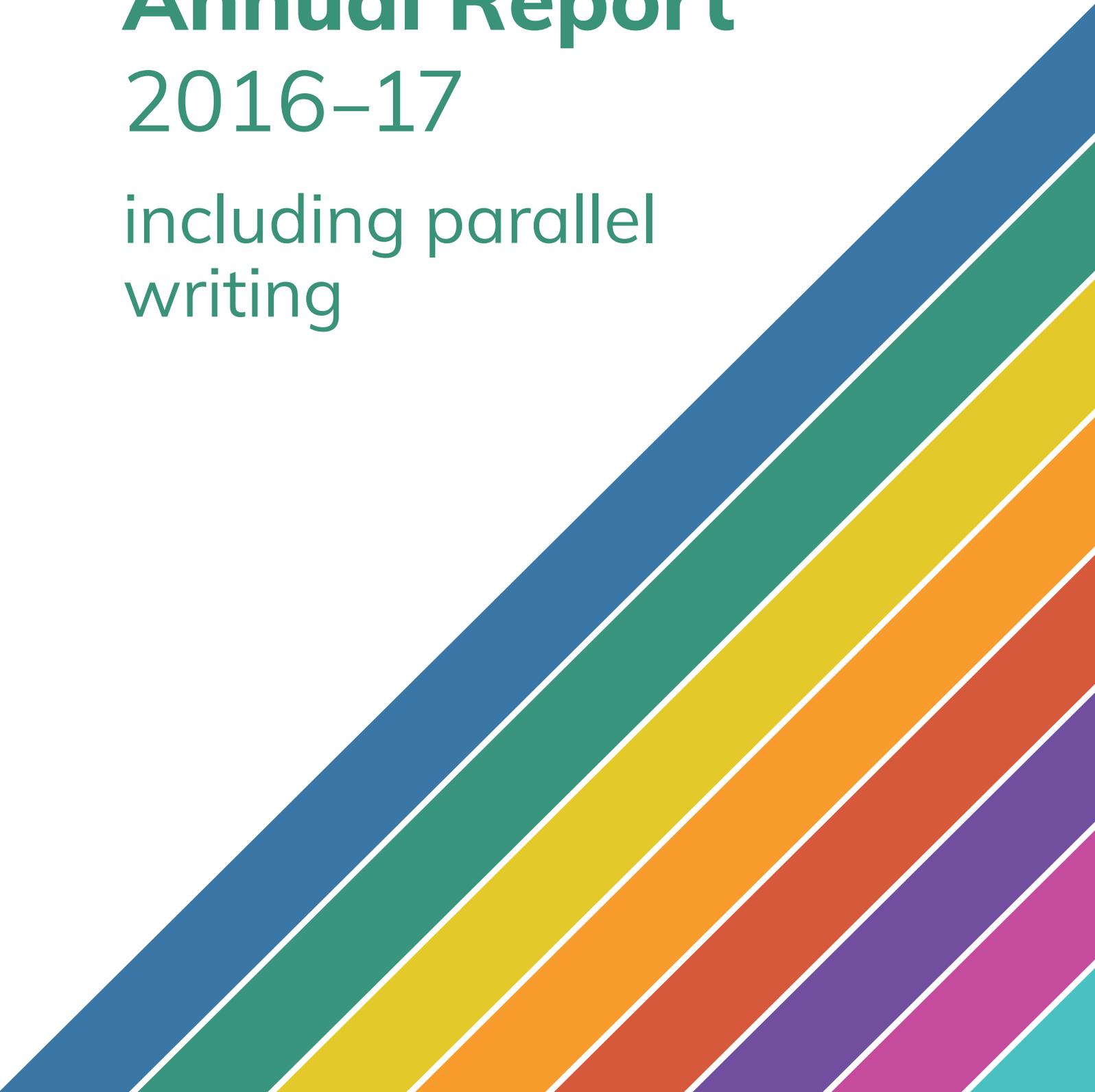
**Bwrdd Diogelu Annibynnol  
Cenedlaethol Cymru**



# Annual Report

## 2016–17

including parallel  
writing



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This is the National Board's second report. The Board has told Welsh Ministers that:

- guidance is important
- paperwork about reviews is important, and that
- young people with mental health problems need services.

It is hard to say whether or not the Regional Boards are working well.

Not all of the Regional Boards have done what the law says they must do.

The Regional Boards are producing a lot of instructions telling professionals what to do.

The Chairs of the Regional Boards agreed that their Annual Reports could be better.

The National Independent Safeguarding Board is pleased to present this annual report about its own work and that of the six Regional Safeguarding Boards in Wales. We are privileged to attend Regional Board meetings, commission work and contribute to work which is relevant to safeguarding leadership and learning. During 2016-2017, we have recommended to Ministers the urgency concerning the introduction of statutory guidance; alerted them to the confusion concerning the governance of documentation arising from Child and Adult Practice Reviews; and advised of the paucity of provision for children who are known to mental health services. We have learned that the practice of safeguarding that is reported to the Regional Boards reflects the pressures of schedules and workloads.

The Social Services and Well-being (Wales) Act 2014 brought into being new duties to report children and adults at risk and to ensure co-operation between agencies. The Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015, which seeks to improve the response of the public sector in Wales in addressing gender-based violence, also features on Regional Board agendas. The specifics of interpretation and compliance vary across Wales.

Much of this report and the appendices address "the adequacy and effectiveness of arrangements to safeguarding children and adults in Wales." It brings together information from the Regional Boards' annual plans and reports. It reveals that since statutory guidance has not been adhered to (in terms of the publication and content of these reports), it has compromised the planning and reporting cycle; a preliminary overview of safeguarding training; and our ability to reflect on the content topics which Boards "must include" in structuring their annual plans and reports.

Individual Regional Boards are overseeing the generation of lots of protocols, tools, strategies and policies without reference to existing materials within and beyond Wales. We are uncertain that the practice is indispensable to informing effective and efficient practice and we advise caution. Typically, attendance at meetings, networks and statistics are cited as evidence of collaboration with the Regional Boards. We suggest that citing specific outcomes and inviting colleagues from different sectors to co-author the assessments of the individual contributors would be more illuminating.

It is our view that the Regional Boards have short-changed themselves by relying on their business support personnel to write their reports, without assuming final responsibility for the content. These do not engage with matters which have been reported in the media and, most disappointingly, they downplay some of the significant gains which arise from the expertise of safeguarding practitioners and communities.

At a meeting with Regional Board Chairs to discuss the National Board's annual report, it was heartening that all recognised the need to pay particular attention to the preparation, drafting and publication of plans and reports. Their passion and determination to ensure that the prevention and amelioration of abuse – of which there are many examples across Wales – sustain and respect effective safeguarding structures and the humanity of all.

**Margaret Flynn, Keith Towler, Simon Burch, Ruth Henke, Jan Pickles and Rachel Shaw**

**31 October 2017**

This report describes what the National Board has been doing.

The National Board must help the Regional Boards to work well. It must report on how well they are protecting people from being abused and it must tell the Welsh Government how the work of the Regional Boards could be better.

This is the second Annual Report of the National Independent Safeguarding Board established under the Social Services and Well-being (Wales) Act 2014.

Although the National Board became operational on 6 April 2016, this is the first Annual Report to present information about its own activities during 2016-2017 and its reflections on those of the six Safeguarding Board Areas.

The National Board has three primary statutory duties. These are:

- 1. To provide support and advice to Safeguarding Boards with a view to ensuring that they are effective**
- 2. To report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales**
- 3. To make recommendations to the Welsh Ministers as to how those arrangements could be improved (S.132 (2)).**

The most basic task of this report is to illuminate the extent to which the National Board has met its primary duties. To do this, the report begins with the basics - the Act's principles.

The building blocks to safeguarding work include:

- People’s well-being, their views and involvement
- Making sure that people get help when they need it and
- Being answerable.

## The Principles Shaping the Social Services and Well-being Act 2014

The Act is shaped by principles.<sup>1</sup> These are the fundamental bases of systems of thought or belief. They are as follows:

- The Act supports people who have care and support needs to achieve **well-being**
- **People** are at the heart of the new system by giving them an equal say in the support they receive
- **Partnership** and co-operation drive service delivery
- Services will promote the **prevention** of escalating need and the right help is available at the right time
- **Co-production** – encouraging individuals to become more involved in the design and delivery of services.<sup>2</sup>

In addition, the Act’s Statutory Guidance<sup>3</sup> states:

“The purpose of the annual plans and annual reports .... is to be a useful tool of **accountability** [emphasis added]...In this context accountability has three components. They are:-

- accountability to the public;<sup>4</sup>
- accountability to the statutory agencies from which the Safeguarding Boards’ partners are drawn; and
- accountability to the inspectorate bodies (para 203).

Publication is a key component in ensuring accountability...” (para 204).

1 <http://gov.wales/docs/dhss/publications/160127socialservicesacten.pdf> (accessed 3 September 2017)

2 <https://socialcare.wales/hub/sswbact> (accessed 24 October 2017)

3 Social Services and Well-being Act 2014: Working Together to Safeguard People. Volume 1 – Introduction and Overview

4 This includes Ministers. Elected governments carry out the ‘will of the people.’

### The National Board's duties

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The Act sets out the National Board's three overlapping duties.

Its assistance to the Regional Boards feeds into its understanding of the ways in which these Boards are prioritising their activities.

The National Board's recommendations to Ministers are based on matters with which Regional Boards are seeking assistance.

The following sections address each of the National Board's duties.

Members of the National Board go to Regional Board meetings.

The National Board shares ideas and information.

The National Board reminds members of the Regional Boards about what the Act says they must do.

## 1. To provide support and advice to Safeguarding Boards with a view to ensuring that they are effective

Under this duty, the **ongoing** work of the National Board includes:

- attending Regional Board meetings; contributing to discussions and events; and updating our understanding of (i) the challenges facing safeguarding practitioners in Wales, (ii) their best practice achievements and (iii) ways of linking learning
- sharing materials relevant to the work and interests of particular Regional Boards e.g. the recommendation to Ministers arising from meeting Directors of Social Services about the resource implications of addressing multiple Freedom of Information requests concerning Child and Adult Practice Reviews; exploring the implications of Disclosure and Barring for elected council members by consulting with the Director of Safeguarding, Strategy and Quality of the Disclosure and Barring Service (which led to a request for (i) routine briefing about its activity in Wales and (ii) the production of bilingual disclosure certificates); advising Chairs about a free book for Safeguarding Board Chairs;<sup>5</sup> and discouraging Welsh Government from commissioning a self-assessment tool for Regional Boards
- promoting compliance with the Act and addressing the challenges which are exercising particular Regional Boards e.g. alerting Health Boards to S.134, concerning the expectations of Board partners and S.137 requirements, which enable a Board to request specified information; and since reviews in children's and adult safeguarding are overusing the noun "concern" (rather than "reasonable cause to suspect that a child/ adult is at risk") the National Board has cautioned against its use in practice and in drafts of the statutory guidance: *Handling individual cases*.

5 Fenge, L-A., Lee, S. and Brown, K. (2017) *Safeguarding Adults: Scamming and Mental Capacity* London: Sage Learning Matters

**To help the Regional Boards to work well**, the National Board

- asked researchers at Cardiff University to pool information about children and young people who are educated in their own homes and to make suggestions to Welsh Ministers.
- Asked the Regional Boards about their safeguarding training. Because two of the Regional Boards responded it is not possible to say anything about safeguarding training opportunities in Wales

The National Board's work plan 2017-2018 identified four sets of activities with implications for practice:

## Following through a Child Practice Review

During **February 2017**, the National Board commissioned Cascade at Cardiff University to undertake a desk-top review and analysis of the safeguarding, health and well-being implications of elective home education.

**Why?** CYSUR Mid and West Wales' Safeguarding Children's Board published a Child Practice Review arising from the death of eight year old Dylan Seabridge who was home educated and had not been seen by any professional since he was a baby. Also, during 2016, the Supreme Court upheld a ban on term-time holidays for school children. This paradox is given expression in a Private Members' Bill: Home Education (Duty of Local Authorities) Bill (2017-2019).<sup>6</sup>

**The outcome?** The Cascade report is to be published during National Safeguarding Week (13-17 November 2017). The National Board will provide a briefing for Ministers.

## Creating an overview of safeguarding training in Wales

During **February 2017**, the National Board and Social Care Wales requested information<sup>7</sup> about safeguarding training activities across Wales from the Regional Safeguarding Boards. The Regional Boards were asked to set out in their annual reports information about their goals, bilingual resources, and favoured information sources for example.

**Why?** Because the National Board and the Regional Boards are required to address training in their annual reports; each of the Regional Boards have subgroups addressing training and workforce matters; Social Care Wales is tasked to scope and support safeguarding training and "training" is a typical recommendation arising from Child and Adult Practice Reviews.

**The outcome?** Two Regional Boards responded to the request. The next steps include contact with the Regional Board Chairs since the non-compliance of the Boards with this statutory request means that there is no preliminary overview of safeguarding training in Wales.<sup>8</sup>

<sup>6</sup> <https://services.parliament.uk/bills/2017-19/homeeducationdutyoflocalauthorities.html> (accessed 5 October 2017)

<sup>7</sup> This was a S.139 (a) request: A Safeguarding Board must cooperate with the National Board and must supply the National Board with any information it requests. It was made with a view to assisting the Boards to illuminate the training it has recommended or provided (Schedule 3, Reg. 6 (1) (l))

<sup>8</sup> One Regional Board noted of the National Board's use of S.139 that the request for data and intelligence about overall workforce resilience and expertise in terms of safeguarding exposed clear deficits in terms of the safeguarding community's ability to understand the needs of our workforce, either at an agency or regional level

Also, the National Board...

- Talked to researchers about how different how we can learn from the findings of different kinds of reviews
- Created a bi-lingual website

## Creating a public learning agenda

During **March 2017**, the National Board decided to commission a thematic review to enhance learning from reviews.

**Why?** There is an unknown number of different kinds of reviews and investigations undertaken in Wales, for example, Child Practice Reviews, Adult Practice Reviews, Domestic Homicide Reviews, Serious Further Offences, Post Incident Reviews, Serious Untoward Incidents, plus police investigations within the remit of the Independent Police Complaints Commission.

**The outcome?** The National Board's budget prompted a reining in of its ambition. However, additional funding was identified during **September 2017** enabling a realistically priced commission to commence in 2018.

## Creating a NISB website

During late 2016 and the beginning of 2017, the National Board began the process of setting out what an engaging, accessible, bi-lingual website might deliver. It is intended that this will connect with the six Regional Boards, put spotlights on high profile topics, reflect the National Board's work plan and engage with the arts and media.

**Why?** The creation of the National Board's website is a requirement of the statutory scheme (Part 7, para 265) and acknowledges the requirement to be accountable. Our interconnectedness matters. Abuse places severe demands on social care, the NHS and the police because there are many barriers to reporting abuse. A website has the potential to engage with the challenges of learning about lowering or removing these barriers.

**The outcome?** During **August 2017**, the National Board's website <http://safeguardingboard.wales> was added to the social media world. It contains a blog about the use of the Social Services and Well-being Act 2014.

Members of the National Board meet every month.

The National Board also meets people whose work concerns safeguarding.

The National Board is interested in learning and practical action in safeguarding.

## 2. To report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales

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The **ongoing** work of the National Board includes:

- meeting each month to (i) act as an information exchange, as a study group, as critical friends in sharing ideas, developing the work plan and taking stock; and to (ii) generate a shared sense of direction and commitment to the duties and work of the Board. In addition, individual National Board members meet in different combinations to shape particular projects
- meeting with key individuals and groups whose roles have the potential to improve safeguarding practice e.g. Police and Crime Commissioners, NHS safeguarding leads, lead directors for local authorities and the regulators, with a view to developing greater effectiveness and efficiency in safeguarding practice
- identifying ways of encouraging sustainable, inter-professional learning e.g. acknowledging that the 'sectored expertise' of domestic abuse practitioners is aligned to safeguarding adults and children.

## To report on how well the Regional Boards are protecting people from being abused, the National Board

- Hosted a meeting about “Leadership in Safeguarding”
- Thought about different ways of measuring the impact of safeguarding
- Began to bring together some of Wales’ criminal cases and inquiries about safeguarding children and adults which have been widely reported

The work plan identified six sets of activities with implications for safeguarding practice.

## Hosting two Safeguarding Summits concerning (i) leadership in safeguarding and (ii) measuring the impact of safeguarding

During **March 2017**, the National Board hosted a leadership summit in Cardiff.

**Why?** (i) Because safeguarding leadership is distributed across individuals, which includes people with experience of safeguarding services and their relatives. It is distributed politically as well as within and across organisations. Safeguarding boards have vulnerabilities which include their expanding workload, to include domestic violence, for example. Their openness and adaptiveness to the experience and “voices” of people who become known to safeguarding practitioners and the prevalence of risk and risk management at all levels are acknowledged weaknesses.

**The outcome?** (i) A paper was circulated to all participants (all of the Regional Boards were represented) – a summary of which may be seen on <http://safeguardingboard.wales> – with the intention that it would promote further discussion among leaders, most particularly following the National Board’s 2016-2017 reflections on *the adequacy and effectiveness of arrangements to safeguarding children and adults in Wales*. (ii) The National Board awaited the Regional Boards annual reports to consider their analyses of cases/ impact information and has initiated contact with Welsh Government statisticians before designing and hosting a summit concerning measurement.

## Providing on our doorstep learning for the Regional Boards and the Independent Inquiry into Child Sexual Abuse

By **July 2017**, the National Board had decided which memorable cases and inquiries should feature in a resource of significant cases and inquiries to complement the work of the Independent Inquiry.

**Why?** The increasing number of practitioners involved in safeguarding children and adults may be overwhelmed by the task of “learning lessons.” Memories can be short and because the National Board does not want the lessons of significant Welsh cases and inquiries to be forgotten, the resource highlights the crimes which are likely to be lodged in people’s memories – or those of their families. It includes judges’ summing up at criminal trials; the media coverage; and the question: if these individuals were to embark on their criminal careers now, what would be different?

**The outcome?** The work to develop this resource is ongoing.

Also, the National Board...

- Considered ways of gathering the views and ideas of people with learning disabilities and mental health challenges for example
- Asked Safelives to help Regional Boards to put a price on working with a family which is “well known” to all services

## Making visible the populations outwith the remit of the children’s and older people’s commissioners – people with learning disabilities / autism / sensory losses / mental health challenges / addictions

**Why?** People’s mental health, mental capacity, autism, sensory losses and limited articulacy, for example may be cited as the reasons for downplaying the task of gathering their views and experiences.

**The outcome?** The National Board’s contact with people with dementia and their carers shaped the Board’s response to the Draft National Dementia Strategy during **April 2017**; meeting with All Wales People First led to their assistance in writing the “easy read” version of the National Board’s first annual report which was published during **January 2017**; a member of All Wales People First is to speak at the Safeguarding in Sport conference during **November 2017**; the National Board invites organisations if it may use their premises to host its meetings such as Bawso<sup>9</sup> in Wrexham and Hillside secure children’s home. National Board members are encouraged by contacts with established and mutually supportive groups of people who are seeking to make changes in their lives and in the lives of others. This includes advocacy services and family carer-givers’ groups. The National Board is making flexible use of its budget to enable the participation with people who face practical problems in attending formal meetings.

## Identifying a cost-conscious approach to strengthening safeguarding responses within Wales

**Why?** Although some families are very visible to lots of services – the parents may be known to the police and Domestic Abuse services, the children may be known to social services, and individual family members may be conspicuous users of NHS provision – opportunities for multi-agency collaboration may be underdeveloped or missed altogether.

**The outcome?** With the blessing of Gwent’s Police and Crime Commissioner, during **June 2017**, the Regional Safeguarding Board has undertaken to identify a family which is a high user of multiple services. Managers and practitioners are “mapping” the nature and cost of agency responses within a specific timeframe. The National Board has commissioned SafeLives to evaluate this work with a view to initiating (i) credible multi agency engagement and (ii) more focused interventions.

<sup>9</sup> A voluntary organisation providing specialist services to victims and BME people affected by or at risk of domestic abuse and all forms of violence. See <http://www.bawso.org.uk> (accessed 12 October 2017)

Also, the National Board...

- Asked organisations to join the National Board in giving awards and thanking individuals and teams for their safeguarding work
- Looked at different arrangements for safeguarding adults in England, Scotland and Northern Ireland

## Sponsoring safeguarding awards which recognise, reward and give national coverage to valued practice in Wales

**Why?** Typically, safeguarding practitioners across sectors have to deal with incomplete information – perhaps because a person is too traumatised to recall what has happened, too loyal to a relative who is harming them, or too humiliated or unable to tell someone. There are heart-lifting successes and yet these are typically invisible and the individuals and teams responsible are rarely thanked publicly.

**The outcome?** In **August 2017**, Social Care Wales has confirmed that it would co-sponsor an award with the National Board. The Board is continuing to seek other potential co-sponsors.

## Working with colleagues in England, Northern Ireland and Scotland

**Why?** The four UK countries have different legislation, policies and structures in place to respond to harm, abuse and neglect.

**The outcome?** The National Board is familiar with the Economic and Social Research Council seminar series exploring the different arrangements across the UK;<sup>10</sup> National Board members met with children and adult safeguarding leads and attended a safeguarding conference in Northern Ireland during **March 2017**; the National Board receives information from the Chairs of the National Network of adult safeguarding boards in England, with which it shared its first annual report; and with reference to placing children in secure accommodation in England and Scotland, the Office of the President of the Family Division, together with other judges, including Lady Black and Lord Justice Moylan, is looking to promoting closer cooperation between the various legal jurisdictions in Scotland, England and Wales, especially in the light of various cross border issues that have arisen in recent family cases.

<sup>10</sup> The Journal of Adult Protection produced a special edition, *Safeguarding adults and legal literacy: approaches from UK devolved nations* (2017) 19 (4)

## The Regional Boards

The six Regional Boards had to send their annual plans to the National Board by the end of March 2016 and their annual reports by the end of July 2016.

## The Regional Boards

The six Safeguarding Board Areas have been operational since April 2016. They were required to submit their annual plans and annual reports to the National Independent Safeguarding Board *no later than 28 days after publication*, as required by the reporting timetable (S.136 of the Act, Part 7, para 205). Although the National Board reminded the Regional Boards of the submission deadline for their annual reports during December 2016, adherence was partial. Regional Boards should have reported in their annual report on the extent to which their plans which shaped their 2016-2017 programme yielded results.

Section 136 of the Act states that by 31 March of each year, "*...a Safeguarding Board must publish...its "annual plan" setting out its proposals for achieving its objectives in that year.*" Also, by 31 July of each year, "*...a Safeguarding Board must publish a report on (a) how it has exercised its functions in the preceding financial year, and (b) the extent to which it implemented the proposals in its annual plan...*" Three annual reports were submitted on or within a week of the July 31 deadline, two arrived within a month and one Regional Board submitted its annual report 10 weeks after the deadline.

The figure shows that the regional plans come before their reports. The reports rely on the plans.

**Figure 1: The Planning and Reporting Cycle**



The figure shows the interdependency of the planning and reporting cycle. The Act's timetable establishes an annual rhythm and routine for the National Board and the Regional Safeguarding Boards.

*The intention of publishing the annual report by 31 December each year is to allow time for the Safeguarding Boards to take account of any identified national themes or recommendations that have been made by the National Board whilst preparing their Safeguarding Board annual plans which **must** be published by the end of each financial year (Part 7, para 269).*

The table shows that Regional Boards produced different kinds of plans and reports, most of which are on their websites.

The following Table indicates where the Boards annual plans/ priorities and associated timetables feature on their websites.

**Table 1: Planning documentation, timeframes and links**

Safeguarding Board Area	Planning Documents	Timeframe	Website link
<b>Cardiff and Vale</b>			
Children	Business Plan	2016-2017	<a href="http://www.cardiffandvalelscb.co.uk/">http://www.cardiffandvalelscb.co.uk/</a>
Adults	-	-	-
<b>Cwm Taf</b>			
Children	Annual Plan	2016-2017	<a href="http://www.cwmtafsafeguarding.org/children/about-us/annual-reports/">http://www.cwmtafsafeguarding.org/children/about-us/annual-reports/</a>
	Annual Report	2016-2017	
Adults	Annual Plan	2016-2017	<a href="http://www.cwmtafsafeguarding.org/adults/about-us/annual-reports/">http://www.cwmtafsafeguarding.org/adults/about-us/annual-reports/</a>
	Annual Report	2016-2017	
<b>Gwent</b>			
Children	Strategic Plan	2016-2019	<a href="http://www.sewsc.org.uk/">http://www.sewsc.org.uk/</a>
	Annual Report	2016-2017	
Adults	Annual Plan	2016-2017	<a href="http://www.gwasb.org.uk/">http://www.gwasb.org.uk/</a>
	Annual Report	2016-2017	
	Strategic Plan	2017-2020	
<b>Mid and West Wales</b>			
Children	-	-	-
Adults	Annual Report	2016-2017	<a href="http://cysur.wales/home/about-us/">http://cysur.wales/home/about-us/</a>
<b>North Wales</b>			
Children	Annual Report	2016-2017	<a href="http://www.northwalessafeguardingboard.wales/board-documentation/nwscb/">http://www.northwalessafeguardingboard.wales/board-documentation/nwscb/</a>
Adults	Business Plan	2017-2018	<a href="http://www.northwalessafeguardingboard.wales/board-documentation/nwsab-board-documentation/">http://www.northwalessafeguardingboard.wales/board-documentation/nwsab-board-documentation/</a>
	Annual Report		
<b>Western Bay</b>			
Children	Annual Report	2017-2018	<a href="http://www.wbsb.co.uk/5456">http://www.wbsb.co.uk/5456</a>
	Strategic Priorities and Business Plan		
Adults	-	-	-

Planning is about defining and accomplishing results which would not happen otherwise. The absence of published annual plans for 2017-2018, for example, would suggest to the person in the street that most Regional Boards do not yet have an outcomes focus. Scrutiny of several documents, business plans, updates, strategic plans (not all of which are published) and annual reports is required to find the Regional Boards' plans/ priorities.

Mid and West Wales' rationale for *not* publishing a plan during 2016 is that its three-year business plan for 2013-2016 *was used as a framework*.

## So what did the Regional Boards deliver?

The statutory guidance on safeguarding sets out what the Regional Boards' annual reports must include.

All Regional Boards provided **a list of the members**.

Typically, Directors of Social Services chair the Regional Boards. Where there are Vice Chairs, these are from probation, the police and NHS Wales.

The Regional Boards keep registers of attendance.

Four Regional Boards include people from Housing. Three include legal services and agencies responsible for supporting people who have experienced domestic abuse.

In terms of how Regional Boards are structured, there are similarities between children's and adults boards in the same area and differences between the Regional Boards.

## So what did the Regional Boards deliver?

The statutory guidance sets out the contents of the annual report. There are 14 headings.<sup>11</sup> The first requires a list of **the members of the Safeguarding Boards**.

Reference to Table (a) in Appendix 1 highlights the variation in the membership of the Regional Boards in addition to the core partners of (i) local authorities (ii) the police (iii) local health boards and trusts and (iv) providers of probation services. Members of the Regional Boards' Business Units are members of all Boards.

Gwent's Children's Board is the only one that is independently chaired – by the Chief Executive of a Housing Association. Four of the six Regional Boards include people with responsibility for housing services and three of the six include (i) legal services and (ii) people responsible for supporting people who have experienced domestic abuse.

Typically, Directors of Social Services chair Wales' Regional Boards. Where there are Vice Chairs, these are drawn from probation, the police and NHS Wales as well as constituent social services authorities. Cwm Taf has opted for Co-Chairs.

Although all of the Regional Boards take registers of attendees, only Cwm Taf undertook to set out membership attendance. Its annual report will be uncomfortable reading for one service in Cwm Taf. No Regional Board presented information concerning the continuity of membership although this is known to have compromised the principle of partnership and cooperation across Wales.

The Boards do not account for the variation in membership in terms of the problem solving potential or the value creation that comes from working in partnership. What the membership does suggest is the readiness of statutory and other partners to assist in the tasks of safeguarding children and adults.

Table (b) in Appendix 1 shows the structural diversity across Regional Boards. The structures adopted by Wales' Regional Boards are depicted figuratively in planning documents or annual reports. Although there are similarities between children's and adults boards in the same safeguarding board area, there are differences between Regional Boards. While the creation of Regional Board Structures is a milestone, the structures are a means to ends. That is, the objectives of children's boards are to protect children who are experiencing or are at risk of abuse, neglect and other kinds of harm and to prevent children from becoming at risk of abuse, neglect or other kinds of harm. Similarly, the objectives of safeguarding adults boards are to protect adults who have needs for care and support (whether or not a local authority is meeting any of those needs) and to prevent adults becoming at risk of abuse or neglect (S.135 of the Act).

The extent to which the arrangements determined by Regional Boards reproduce the structures which pre-dated the Social Services and Well-being Act is partially acknowledged since it is rare that old organisations and identities are entirely abolished.

<sup>11</sup> The headings have been amended to refer to the six Regional Boards rather than a single board

There is a range of subgroups. Practice reviews and separately, training, feature in all Regional Boards.

The rationale for Mid and West Wales' Executive Board, which is timetabled between the Children's and the Adults' Board, is because it covers such a vast geographical area, it makes sense for the boards to be hosted on the same day.

There is a range of subgroup types. The functions of reviewing individual cases and/ or practice exist in all Regional Boards. Similarly, training, learning and development and workforce development subgroups feature in the work of all Regional Boards.

More generally, it is not known whether or not the structural arrangements of the Regional Boards facilitate and enhance frontline practice. The outcome of Mid and West Wales' scrutiny of its Multi-Agency Safeguarding Hub (MASH) which is one means of addressing safeguarding referrals, is that it will cease to be funded. Similarly Cwm Taf has made decisions and adaptations concerning their structures as a result of consultation and scrutiny during 2016-2017.

In order to put the **particular outcomes** of the Regional Boards in context, this Table sets out the priorities of each of the Children’s Regional Boards. These demonstrate the considerable ambitions of Regional Boards.

## The action the Safeguarding Boards have taken to achieve particular outcomes

The following two tables present the stated priorities of the Regional Boards. These offer an explanatory framework for the *particular outcomes* which should be traceable to these priorities.

**Table 2: The Priorities of Children’s Regional Boards**

Safeguarding Board Area	Priorities	Safeguarding Board Area	Priorities
Cardiff and Vale	<ul style="list-style-type: none"> <li>Child Sexual Exploitation</li> <li>Safeguarding Practice in Preventative Services</li> <li>Missing Children/ Risky behaviour</li> <li>Female genital mutilation, forced marriage and honour based violence</li> <li>Attention to the Board’s functions and compliance with the Act</li> <li>Domiciliary Care and Nursing Homes</li> <li>Dementia</li> </ul>	Mid and West Wales	<ul style="list-style-type: none"> <li>Strengthening Regional Board arrangements re governance, accountability and learning from reviews</li> <li>Communication and stakeholder engagement</li> <li>Multi agency information sharing arrangements</li> <li>Raising awareness of Child Sexual Exploitation and developing an action plan and strategy</li> <li>A workforce training analysis</li> <li>Policy Protocol, Guidance and Best Practice</li> <li>Website and Board branding</li> <li>Pilot models of practice</li> <li>Enhance business support arrangements</li> </ul>
Cwm Taf	<ul style="list-style-type: none"> <li>Prevention of suicide and self-harm</li> <li>Child Sexual Exploitation</li> <li>Neglect</li> <li>Children Looked After</li> <li>Effective Inter-agency safeguarding practice</li> <li>Sharing learning</li> <li>That children at risk are able to live safe lives</li> <li>Proactive engagement and participation in the Board’s work</li> <li>A multi-agency workforce supported by inter-agency training</li> <li>The active pursuit of collaborative working</li> <li>Assurance concerning inter-agency practice and processes</li> </ul>	North Wales	<ul style="list-style-type: none"> <li>Child Sexual Exploitation and Missing from care</li> <li>Children who display sexually harmful behaviour</li> <li>Improved outcomes for children living with domestic abuse</li> <li>Operating effectively and meeting statutory obligations</li> </ul>
Gwent	<ul style="list-style-type: none"> <li>Reducing the effects of compromised parenting on children’s well-being</li> <li>Improving work with adolescents who exhibit risky behaviour</li> <li>Ensuring the continued effectiveness of safeguarding practice during the implementation of the Act</li> <li>Maintaining an effective Board</li> </ul>	Western Bay	<ul style="list-style-type: none"> <li>Effective safeguarding from neglect</li> <li>Child Sexual Exploitation</li> <li>Domestic Abuse</li> <li>Prevent and reduce the harm concerning New Psychoactive Substances</li> </ul>

This Table sets out the priorities of each of the Adults Boards. These demonstrate the Regional Boards' interest in self-policing.

**Table 3: The Priorities of Adults' Regional Boards**

Safeguarding Board Area	Priorities
Cardiff and Vale	Developing a robust and cohesive adults' board
Cwm Taf	<ul style="list-style-type: none"> <li>The Board's structure, governance and compliance with the Act</li> <li>Collaboration to develop earlier identification and preventative services</li> <li>Proactive engagement and participation in the Board's work</li> <li>Assurance concerning inter-agency practice and processes</li> <li>A multi-agency workforce supported by inter-agency training</li> <li>The active pursuit of collaborative working</li> </ul>
Gwent	<ul style="list-style-type: none"> <li>General functions of the Board</li> <li>Violence Against Women, Domestic Abuse and Sexual Violence</li> <li>Quality of Care</li> </ul>
Mid and West Wales	<ul style="list-style-type: none"> <li>Establish the Board</li> <li>Governance and alignment with the Children's Board</li> </ul>
North Wales	<ul style="list-style-type: none"> <li>Outcomes improved for adults subject to Adult Protection Plans</li> <li>Assurance of the quality of safeguarding services</li> <li>Risks to adults reduced as a result of awareness</li> <li>Effective Board operations to ensure statutory obligations addressed</li> </ul>
Western Bay	<ul style="list-style-type: none"> <li>Governance</li> <li>Establish links with partner agencies</li> <li>Engage with citizens</li> </ul>

At first glance, the creation of the adults' safeguarding boards has constrained priority setting. It is difficult to comment on priorities that have no direct performance effects unless these are nested in a long range plan with a schedule of milestones.

Self-policing or governance means having clear

- goals and leadership
- divisions of responsibility
- understanding about why certain organisations are included and their roles
- plans and
- lines of accountability

Having effective governance arrangements is a shared priority spanning children's and adults' boards. Research<sup>12</sup> has identified five components of effective governance:

- clarity of goals, scope of activity and purposes, including shared principles, multi-agency commitment and strategic leadership
- structures, including clear divisions of responsibility and mechanisms for communication, and explicit linking between functions or activity
- membership, including a clear rationale for inclusion of agencies, understanding of roles, responsibilities and commitments, evidence of engagement and protocols for chairing, quoracy, resource contributions and business management
- functions, including strategic planning and operational oversight, appreciation of the difference between governance and executive management, and a strong developmental and improvement agenda which embraces audit, performance management and quality assurance
- accountability, including standards for and assessment of committee performance, clarity about decision-making authority and reporting channels and explicit links to other partnerships.

To different degrees the Regional Boards' priorities are attentive to these components. More broadly, the goals of Regional Boards remain to be clearly distinguished from the means by which they are pursued.

12 Braye, S., Orr, D. and Preston-Shoot, M. (2012) The governance of adult safeguarding: the findings from research *The Journal of Adult Protection* 14 (2), 55-72

The ways in which the Regional Boards have **implemented annual plans** and **specific improvements** was a challenging task. There was no clear distinction between achieving goals and the ways in which the Boards worked to achieve goals.

Preventing harm matters to all Regional Boards.

Possible levels of intervention are described.

The Regional Boards are dealing with forms of abuse which may be less familiar than crimes of assault and theft. These include “hate crime,” bullying and cyber bullying. The prevention of abuse in residential services requires similar skills to those used by people working with people in their own homes.

## The extent to which the Safeguarding Boards have implemented its most recent annual plan with particulars of how far any specific proposed improvements were implemented

The statutory guidance acknowledges at the outset that planning takes time. Selecting what the Regional Boards should accomplish is the preface to designing interventions and solutions. Table (c) (Appendix 2) outlines what the Regional Boards have done to implement their plans.

Although prevention, one of the Act’s principles, is cited by several Regional Boards, it is not yet linked to outcomes such as enabling individuals and families to have more say and control for example. There are disjunctions between action taken against harmful individuals, actions taken to support individuals who are too stressed to care in the way that they may wish, and actions taken to ensure that service provision is well designed and well-resourced with a trained and supervised workforce. Also, the distinction between potential levels of intervention is not explicit, that is:

- **primary prevention** is directed at people with few or no support needs and may include the provision of information about financial scams or healthy relationships, for example. It may also relate to the commissioning and design of safe services
- **secondary prevention** aims to assist people to improve their situation, perhaps by focusing on people with learning disabilities or dementia who live alone. It may also allow prompt identification and intervention
- **tertiary prevention** aims to halt preventable deterioration, perhaps by ensuring that families and support personnel are attuned to the seriousness and signs of fraud and domestic violence, for example. It may also act to ameliorate the harm individuals have endured.

Policies such as *In Safe Hands*<sup>13</sup> were instrumental to secondary prevention which in turn fed into primary prevention in the form of service design and quality assurance.

The Regional Boards are addressing forms of abuse which do not fit neatly into the categories of physical, sexual, psychological, neglect and financial abuse (Part 7, para 26). Some are addressing **hate crime, bullying and cyber bullying** which require public engagement, youth education and safe havens, for example; and **parasitic abuse**, in which individuals move into the homes of adults at risk. This form of harm requires concerted intervention from housing providers, emergency services, Post Offices, banks and local communities. Addressing abuse in **institutions and residential homes** requires sound commissioning, policies concerning recruitment, training and supervision, and with reference to behaviour which is perceived to be challenging, an evidence-based policy concerning control and restraint. Alert relatives, teachers and health and social care professionals are critical to addressing the needs of people who reside in family homes that are characterised by violence. Finally, there are **ethically challenging situations** which may require the use of the Act and Independent Mental Capacity Advocates, for example.<sup>14</sup>

13 National Assembly for Wales (2000) *In Safe Hands: Implementing Adult Protection Procedures in Wales* Cardiff: National Assembly for Wales

14 Flynn, M. and Brown, H. (2010) Safeguarding adults with learning disabilities against abuse, In G. Grant, P. Ramcharan, M. Flynn and M. Richardson (Eds) *Learning Disability: A life cycle approach*, 2<sup>nd</sup> edition, Maidenhead: McGraw Hill, Open University Press

Regional Boards are writing a lot of instructions – protocols, policies and procedures.

There are lots of protocols, tools, strategies and procedures being developed, reviewed and revised. It would appear that some are being drafted without reference to existing/ tried and tested materials or even the practitioners who are expected to use them. The merit of generating lengthy documents and even supporting documents is not known. One Regional Board stated that its priorities had... *focussed on improving the usage of the Assessment Tool for Neglect amongst practitioners. This has identified a need to review and update the guidance that supports the tool.*

Mid and West states that the Board's Policies and Procedures Sub Group: *seeks to provide guidance to professionals by the development of regional policies and procedures. A number of local policies and procedures are in place within each member organisation. A key objective is to work towards the development of these into regional policies and procedures to help promote a more consistent regional response.*

Other Boards listed their (i) drafted policies and (ii) policies in preparation:

- i. *Protocol for the Management of Self-harm in the Community – supports the Strategy for the Reduction of Suicide and Self-harm; Schools Child Safeguarding Policy; Guidance and Information for Foster Carers and Kinship Carers when an allegation has been made against you; Protocol for Responding to Challenging Cases who are on the Child Protection Register; and a Critical Incident Policy for schools (the latter drafted by education colleagues)*
- ii. *Safeguarding Disabled Children Policy; Risky Behaviour Policy; Protocol between Providers of private children's residential placements and partner organisations.*

Cwm Taf's protocols include: *Resolving Concerns about Inter-Agency Safeguarding Practice; Disclosure of Childhood Abuse by a Person who is now an Adult; and Protocol for the Immediate Response to Critical Incidents.*

There is no evidence that new protocols, policies and procedures are helping people who are known to safeguarding practitioners.

Four examples of “successful” safeguarding interventions are described by two Regional Boards.

To the above may be added:

- *a hoarding protocol; a safeguarding policy for mosques and other Islamic settings; a missing persons protocol; self-neglect protocol; protocol concerning elective home education; protocol for parents with identified mental illness; a professional concerns protocol; a medical illustration process protocol; a practice review protocol; an Escalating Concerns protocol*
- *a case audit tool; a tool for use with children at risk of sexual exploitation; use of the NSPCC’s harmful sexual behaviour audit toolkit*
- *multi-agency strategy meetings; Child Sexual Exploitation Strategy and plan; a participation strategy; a training strategy review; a regional training strategy; a missing from care multi-agency strategy.*

Since no protocols, tools, strategies or procedures have been abandoned as a result of reviews, arguably a much needed discussion is required.

- How are individuals who are known to have been at risk of harm involved in the development of protocols, tools, strategies and procedures?
- Do the Regional Boards have evidence that protocols, policies, tools and procedures are increasing the predictability of practice and reducing variability between practitioners?
- How are practitioners assured that these documents are relevant and indispensable to informing effective and efficient practice?
- Do the Regional Boards take the view that human behaviour has significant commonalities and that their protocols have applicability across diverse groups and situations?
- Are the Regional Boards assured that their protocols are ultimately helpful to the individuals receiving safeguarding services?
- How does the creation of non-statutory protocols ensure accountable implementation?

The terms “best practice” and “good practice” feature in some annual reports. Typically, these terms are asserted on the basis of “successful cases.” Regional Boards do not yet describe *how* they determine that alleged best practice is genuinely responsible for observed successes. Only four examples of “successful” cases are described by the North Wales and Cwm Taf Regional Boards (see the text following Table (h) (Appendix 3).

The proportion of time the Regional Boards and Business Units’ personnel allocate to particular priorities is not reflected in the annual reports. This is a pertinent consideration since several Regional Board members have noted that the subject of Child Sexual Exploitation appears to eclipse all others.

The Regional Boards describe action plans and infrastructure for example as **achievements**. It is not clear what outcomes have been achieved at different levels.

The reports tend to describe **collaboration** in terms of attending meetings and being part of networks.

## Achievements of the Safeguarding Boards during the year<sup>15</sup>

Reference to Table (d) (Appendix 2) outlines the stated achievements of the Regional Boards. It shows that action plans, governance, infrastructure and collaborations are cited as exemplifying achievements. A north Wales conference underlined the principle of giving people an equal say by asserting that a child's direct testimony must be evidenced in practice and in reviews of practice. What is absent is clarity concerning the outcomes achieved which bring findings to closure at different levels, for example:

- **The child or adult at risk** – their immediate safety; long term protection and support for recovery
- **The person(s) responsible for the harm** – the criminal justice system; employment law/ disciplinary; barring from the workforce; injunctions; additional support if (i) training or supervision has been wanting (ii) relatives are implicated
- **The service** – improved practice; increased funding/ professional advice/ scrutiny of regulatory action; regulatory enforcement; closure
- **The commissioners** – changes to contract/ funding; service re-provision; inter-agency support
- **The national agenda** – child and adult practice reviews; domestic homicide and public inquiries; and acknowledgement of gaps in powers and duties.<sup>16</sup>

## How the Safeguarding Boards have collaborated with other persons or bodies engaged in activities relating to the board's objectives

It is difficult to abstract from the annual reports (see Table (e), Appendix 2), *how* the Regional Boards have collaborated. Typically attendance at meetings, networks and statistics are cited without identifying the individual/ agency responsible for the initiatives. Neither is it clear where in time the beginnings of collaborative efforts may be located. It is usual for participants to underestimate the time it takes to produce results.

The steering capacity of the Regional Boards will be shaped by accumulated experience and skills relevant to collaboration and leadership. Trust among membership will grow as statutory partners and participants share problem solving and invest in understanding one another's strengths and limitations. If Regional Boards are to assist people of all ages to be safe and to respond effectively to those who have been harmed, then interpersonal collaboration, merited challenge and less bureaucratic approaches are critical.

<sup>15</sup> The ordering of the *Content of Annual Report* has been amended to introduce this section before the sections concerning collaboration and separately, requests made by safeguarding boards

<sup>16</sup> Brown, H. (2009) The process and function of serious case review *The Journal of Adult Protection* 11 (1) 38-50

North Wales' Regional Board requested **specified information** (under S.137) concerning Tawel Fan ward from Betsi Cadwaladr University Health Board. It received an interim briefing.

Regional Boards were asked to provide information about the **effectiveness of individual board members**.

It is unlikely that the self-assessments of board members are sufficiently revealing. It may be more helpful for these to be co-authored.

### **Any requests the Safeguarding Boards have made to qualifying persons under section 137 (1) for specified information, and whether the requests were complied with**

Only the North Wales Safeguarding Adults Board made a S.137 (1) request. It was during 2014 that the Ablett Unit's Tawel Fan ward (Betsi Cadwaladr University Health Board) featured in UK and local newspaper headlines.<sup>17</sup> The adult safeguarding arrangements which pre-dated the creation of the Regional Board were alerted to this via press coverage. Information concerning internal and external investigations, which were commissioned independently of multi-agency safeguarding arrangements, was not shared with the Regional Board. Since the contributions of Betsi Cadwaladr University Health Board to the Board were compromised by inconsistency in attendance, the Chair invoked S.137. An interim briefing was received.

### **The extent to which individual members of the Safeguarding Boards contributed to the Boards' effectiveness**

The creation of six safeguarding board areas from 22 safeguarding children's boards and 22 safeguarding adults' boards is a significant administrative reform. The principle of partnership and cooperation driving service delivery is pertinent to the consideration of the Regional Boards' effectiveness since they must reach and maintain consensus on basic goals and create cultures which facilitate working relationships. Effective collaboration emerges slowly because trust and consensus-building processes require time and effort. Table (f) (Appendix 3) is primarily based on the narrow self-assessments of individual partner agencies, their membership of particular groups and listings of processes and outputs. It is not known whether or not agencies invited colleagues from different sectors to co-author the assessments of their contributions.

<sup>17</sup> <http://www.dailymail.co.uk/news/article-2798576/is-shaming-hospital-care-scandal-dementia-patients-restrained-broken-limbs-ignored-swearing-staff-claimed-expos-desperate-relatives-breach-human-rights.html> (accessed 27 September 2017)

The Regional Boards' Business Units receive most of the funding.

## An assessment of how the Safeguarding Boards used their resources in exercising their functions or achieving their outcomes

The Regional Boards' Business Units receive the lion's share of funding. Where specified, the funding dedicated to Child and Adult Practice Reviews varies between £4k and £10.5k. Although general information concerning funding is distributed across documents, the rationale is not detailed. No Regional Board reflected on the extent to which it is delivering value for money.<sup>18</sup>

**Table 4: Funding for the Regional Boards**

Safeguarding Board Area	Overall resource	Business Unit
Cardiff and Vale	-	-
Cwm Taf	£176,010.00	
Gwent	£355,000.00	£289,000.00
Mid and West	£110,058.46	£ 73,343.41
North Wales	£218,562.00	£173,148.00
Western Bay	£185,323.00	£138,023.00

<sup>18</sup> The National Board does not have an auditing function, that is, it cannot state whether or not public money is being used wisely

Although Child and Adult Practice Reviews occupy a lot of discussion time in Board meetings, their **underlying themes** are not reflected in the annual reports.

## Any underlying themes in the way the Safeguarding Boards exercised their functions, as shown by an analysis of cases they have dealt with, and any changes they have put into practice as a result

Although Child Practice Reviews and Adult Practice Reviews exercise children's and adults' Regional Boards in terms of the proportion of discussion time during board meetings, this is not reflected in their annual reports.

**Table 5: Themes from safeguarding cases**

Safeguarding Board Area	Underlying themes and practice changes
Cardiff and Vale	-
Cwm Taf	Identification of the need to...improve the management and coordination of a multi-agency response to young people who are at risk of harm due to Child Sexual Exploitation; a multi-agency process has been developed for pooling intelligence about perpetrators, locations and our most vulnerable young people; the number of children in the care of the local authority has decreased; 0-4 years is the highest age range for child protection registrations
Gwent	-
Mid and West	Child suicide and attempted suicide; allegations against professionals; care [practice] in care and nursing homes and the duty of this sector to cooperate in reviews and learning events; death in hospital; safeguarding children with parents with identified mental illness
North Wales	63 recommendations emanated from reviews and a Professionals Forum; process related matters were progressed with development of the Learning Event Good Practice Guide; the priority of a multi-agency pre-birth pathway was identified by three reviews; guidance for Chairs and Minute takers has been developed in hand with a peer review
Western Bay	-

The **participation** of children and adults in the work of the Regional Boards is “work in progress.”

## When and how children or adults exercised an opportunity to participate in the Safeguarding Boards’ work and how this contributed to the Boards achieving their outcomes

Consultation with the Chairs of the Regional Boards during August 2016 identified engaging with those using safeguarding services as “work in progress.” Mid and West Wales’ is leading the way.

**Table 6: Examples of opportunities to participate**

Safeguarding Board Area	Participation
Cardiff and Vale	The charity Parents Against Child Exploitation is promoted by South Wales Police child advocates; the Communication and Participation sub group developed a participation strategy; a children’s safeguarding DVD was developed as a basis for awareness raising
Cwm Taf	Looked after young people contributed to the production of a DVD. The key messages include: having someone to talk to; having photographs; knowing about their early lives and why they are being looked after; talking to others who are looked after; having photos of where they are moving to; and meeting foster carers before moving to live with them; young people have reviewed the Board’s website; they have helped to design promotional items for Safeguarding Week
Gwent	-
Mid and West	The children’s board commissioned an Independent Advocacy Service to run its Junior Safeguarding Board which meets four times a year. The Junior Board (i) provides advice and information to the Executive Board on topics that are important to them (ii) assists in the development of the strategic annual plan (iii) provides feedback on the Board’s social media presence. There are local junior safeguarding groups which are aligned to the Local Operational Groups. “Junior Safeguardians” hosted a conference which considered Child Sexual Exploitation; Ceredigion’s “Safe Stars” produced an anti-bullying video; Carmarthenshire Youth Council has incorporated junior safeguarding arrangements; and Powys’ “Eat carrots” group has undertaken consultation events concerning healthy relationships and has advised that there is a need for better support and information in schools around diversity and sexuality; the Board has commissioned and begun working with Pembrokeshire People First to assist in the development of an easy read version of the Board’s annual plan; practitioners, family and adult groups, many of whom were receiving preventative services, were consulted about the Regional Threshold and Eligibility Support documents; and National Safeguarding week included joint events with Dyfed Powys Police
North Wales	A bilingual film made by secondary school pupils and the police about Child Sexual Exploitation was shown at the Eisteddfod in 2016 and shared on the website; the delivery groups are exploring the use of a questionnaire to capture people’s experience of using safeguarding services
Western Bay	-

It would appear that the practice of giving people of all ages a voice in safeguarding is not yet established. The few references to advocacy in the annual reports are inconsistent with the commitment to secure “strong voice and control” (para 21).<sup>19</sup>

No Regional Board reported the use of **adult protection and support orders**.

All Regional Boards have subgroups dealing with training, learning and workforce development. They are seeking to address deficits in knowledge and skills for example.

## The numbers of adult protection and support orders which were applied for in the Safeguarding Board areas, how many were made and how effective they were

The purpose of Adult Protection and Support Orders is set out in S.127 of the Act. Broadly, the Orders enable an authorised officer and an accompanying person the power of entry to “premises” to speak in private with a person suspected of being an adult at risk; to ascertain whether or not the person is making decisions freely; and to assess whether or not the adult is at risk and to make a decision about what, if any, action should be taken. The definition of “premises” is deliberately wide and underlines the local authority responsibility for safeguarding in institutional settings, including hospitals.

No Regional Safeguarding Adults Board has reported the use of Adult Protection and Support Orders during 2016-2017. The topic is contentious and although it is surprising that there were no applications during 2016-2017, the Scottish experience would suggest that the use of statutory powers is rare.<sup>20</sup>

## Any information or learning the Safeguarding Boards have disseminated, or training they have recommended or provided

Safeguarding training features in the work streams of all Regional Boards. Each has a subgroup dedicated to training, workforce development, learning and development and it is assumed that these have given rise to such activities as guiding training, undertaking organisational audits, analysing learning needs, disseminating learning, commissioning training, providing training and evaluating training.

Table (g) (Appendix 3) sets out how the Regional Boards have framed safeguarding training in their planning documentation. Table (h) reveals that there is no shortage of ambition in terms of nurturing a competent workforce. The training within the safeguarding board areas is seeking to address deficits in knowledge, skills, awareness, mutual understanding and experience as well as promoting consistency in training.

<sup>20</sup> Williams, J. (2017) Adult Safeguarding in Wales: one step in the right direction *The Journal of Adult Protection* 19(4) 175-186

It is not clear how training is shaped by the building blocks of the Social Services and Well-being Act. It is not clear whether people with first-hand experience of safeguarding are involved in training or how the training provided connects with professional and educational programmes.

In five Regional Boards the safeguarding training budgets spans £15k-£22k.

What does *not* feature in the safeguarding training planning programmes are the challenges of:

- remaining true to the principles which shape the Social Services and Well-being Act
- making sense of the learning arising from Child and Adult Practice Reviews in ways that are useable – including the involvement of individuals and their families
- training by people and caregivers with first-hand experience of safeguarding
- reflecting institutional constraints, pressures and value for money in safeguarding training, e.g. “we use e-learning even though we know people don’t like it”
- training people who come into contact with children and adults who are potentially “at risk” e.g. councillors, housing officers, chiropodists, support workers, volunteers, drivers and transport staff, faith community workers; training qualified professionals and those who manage and supervise staff who are providing direct services to children and adults who are potentially “at risk”; training Executives, senior managers and heads of services, for example
- sustaining investment in training
- connecting with broader professional and educational programmes provided at colleges and universities
- clarifying the levels of collaboration required within and across organisations to address the array of safeguarding scenarios
- ensuring the influence of practitioners in designing training programmes
- “on the job” experience and training being vulnerable to staff turnover
- personnel movement from one agency to another or from one role to another.

Reference to the funding of training within the safeguarding board areas suggests the modest investment of all boards. North Wales’ annual report noted that the £18k allocated to training *does not take into account in-house delivery*. It would appear that the same is true of other Regional Boards.

**Table 7: Funding allocated to Safeguarding Training 2016-2017**

Safeguarding Board Area	Safeguarding Training Funding	Total Board Expenditure
Cardiff and Vale	-	-
Cwm Taf	£15,550.00*	£176,010.00
Gwent	£22,000.00	£355,000.00
Mid and West	£16,524.10	£110,058.46
North Wales	£18,000.00	£218,562.00
Western Bay	£20,000.00	£185,323.00

\*General Expenditure – the sum remaining after staffing and accommodation costs have been removed

Some activities and programmes associated with training include professional interest groups and practitioner forums for example.

The Regional Board's training topics are wide ranging.

Table 8 identifies some of the specific activities associated with training identified by the Regional Boards.

**Table 8: Associated training activities**

Safeguarding Board Area	Associated training activities
Cardiff and Vale	The Child Sexual Exploitation professional interest group supports professional learning and skills development across agencies; presentations to the Board concerning Adverse Childhood Experiences, Female Genital Mutilation, the Medical Illustration Process protocol, the work of the Independent Inquiry into Child Sexual Abuse, Modern Slavery,
Cwm Taf	A work plan and an audit programme were developed to generate learning and improvements re good practice and areas for development; a new case audit tool and learning tool were developed; methods of disseminating learning include the Cwm Taf safeguarding website...via "own agencies"...the bi-annual e-bulletin, staff meetings and practitioner forums; a regional process concerning Adult Protection and Support Orders has been put in place
Gwent	Developed a training programme to equip professionals to keep young people safe when using technology; worked closely with the Regional pilot on Violence Against Women Domestic Abuse and Sexual Violence to improve access to training and advice; agreed a number of task and finish groups to look at quality assurance of training provision, putting adults training provision on an equal footing with children; moved away from the "train the trainer" model to that of a delivery group model which is more supportive and inclusive for professionals
Mid and West	Identifying the learning outcomes arising from Child and Adult Practice Reviews; training needs analysis; identification of good quality e-learning packages; the development of a five year regional training strategy; the design and development of a Child Sexual Exploitation tool, a flowchart for Female Genital Mutilation and a leaflet to support adult safeguarding training; developing a process for undertaking Multi-Agency Professional Forums; Hywel Dda...has developed a health and dental pathway for looked after children; the Youth Justice Service has strengthened the reporting of critical learning events to capture and report any learning themes; considering how to best disseminate the key messages from (commissioned) training about working with difficult, dangerous and evasive families
North Wales	Child Sexual Exploitation podcasts were created by North Wales Police... accompanied by role specific briefings; policies have been reviewed, bulletins and presentations provided, questionnaires sent and information gathered to inform training needs in respect of training/ awareness raising; learning log is continually updated to reflect learning from Adult Practice Reviews and Multi-Agency Professional Forums and other reviews...a standing item on the work programme
Western Bay	Have agreed on a regional Safeguarding Training Needs Analysis. The Annual Report's Foreword states the Board cannot and should not 'provide' training; but it ensures that where required, agencies do

Thus the Regional Boards are delivering products, such as strategies and protocols, and processes such as identifying learning themes.

Table (g) (Appendix 3) shows that the topics addressed in safeguarding training are diverse. The extent to which these connect with significant safeguarding events in their area is not known.

Two Regional Boards responded to the National Board's request for information concerning safeguarding training (S.139).

Only north Wales and Western Bay responded to the S.139 request about safeguarding training which was drafted with Social Care Wales.<sup>21</sup> A summary of their responses features in Appendix 3.

The array of safeguarding training and activity described in the Regional Boards' annual reports suggests that the Regional Boards:

- are adapting to the Social Services and Well-being Act and the Violence Against Women, Domestic Abuse and Sexual Violence Act
- prioritise what is mandatory
- are engaged in identifying the strengths and weaknesses of their workforce
- want safeguarding practitioners to make reasoned decisions in unfamiliar situations
- want generic professionals to be alert to the possibility of abuse and to make referrals
- want to nurture productive collaboration to enhance the practice of individuals and teams.

It is not clear from any report that the corporate education programmes of Regional Boards have delivered specific outcomes. Positive course feedback is gratifying and helpful in identifying engaging trainers, but little is known about the attendees, their first language, experience, prior learning, the hours worked each week, how active they are in posing questions, for example, and how their learning will be linked with opportunities to practise the application of what it is that they have learned. Given that such opportunities may not be uniformly distributed across a workforce, part time, shift and contractual workers may lose out on opportunities for workplace learning. Workplace practices such as mentoring by experienced workers and shadowing expert co-workers in non-routine tasks shape the impact of learning.

Only Mid and West Wales cited the action plans which arise from Child and Adult Practice Reviews. Given that these may be extensive, the process of "signing off" completed actions may span several Regional Board meetings and yet this process appears tenuously associated with practitioners' and agencies' learning.

Two Regional Boards described how they had **implemented any guidance or advice**.

## How the Safeguarding Boards have implemented any guidance or advice given by the Welsh Minister or the National Board

Safeguarding Board Area	Guidance and advice
Cardiff and Vale	-
Cwm Taf	-
Gwent	-
Mid and West	The Boards have contributed to Welsh Government consultation events concerning non-statutory guidance concerning electively home educated children; and statutory guidance
North Wales	The All Wales Action Plan to Tackle Child Sexual Exploitation Social Services and Well-being Act training Child and Adult Practice Review Guidance Handling individual cases guidance Violence Against Women, Domestic Abuse and Sexual Violence
Western Bay	-

Finally, Appendix 4 contains “word clouds” which have been generated<sup>22</sup> from the Regional Boards’ annual reports. Each gives prominence to the words which appear most frequently in the annual reports.

22 <http://www.wordle.net/> (accessed 13 October 2017)

### The National Board made recommendations to Welsh Ministers.

The recommendations concerned the publication of statutory safeguarding guidance, the ownership of paperwork about Child/Adult Practice Reviews and the paucity of provision for children and young people known to mental health and youth offending services.

The annual reports hold back from describing **matters relevant to the work of the Boards**. For example, topics which have received extensive media coverage such as the external reviews commissioned by Betsi Cadwaladr University Health Board and a Cardiff case concerning “modern slavery.”

## 3. The National Board has made recommendations to Welsh Ministers as to how safeguarding arrangements may be improved

**Why?** It is a duty of the National Board.

**The outcome?** During **February 2017**, the National Board highlighted (i) the urgency concerning the publication of the statutory safeguarding guidance because of the legal challenges which arise when professionals default to using out of date guidance;<sup>23</sup> (ii) the gap in the regulations concerning the ownership of all documentation about safeguarding reviews because there is confusion concerning the governance of the reviewing process; and (iii) the paucity of provision for children who are known to children’s mental health and youth offending services. During **August 2017**, the National Board repeated recommendations (ii) and (iii).

### Matters relevant to the work of the Safeguarding Boards

The Regional Boards’ annual reports do not reference matters which have exercised some of them during their board meetings and which have received extensive coverage in the media. In reporting these matters, the media typically presents partial accounts of failures in keeping people of all ages from harm’s way, for example:

- During October 2015, Betsi Cadwaladr University Health Board was placed in “Special Measures” for two years.<sup>24</sup> Tawel Fan ward was the subject of two external reviews commissioned independently of safeguarding adults’ arrangement – by Donna Ockenden Ltd (whose review concluded in September 2014) and the Health and Social Care Advisory Service (its open-ended review commenced during July 2015). No safeguarding referrals have arisen from either review. The police investigation concluded that no individual could be prosecuted and yet the HASCAS “review” remains to report its findings. Donna Ockenden Ltd was separately commissioned to review governance, systems and processes within Betsi Cadwaladr UHB during 2017.
- The interface is unclear between independently and internally commissioned reviews by Health Boards and Child/ Adult Practice Reviews. The rationale remains to be set out for Health Boards commissioning reviews which are pertinent to safeguarding people of all ages and yet are not disclosed to Regional Safeguarding Boards.
- During May 2016, “the reality of modern slavery in the UK” became visible at Cardiff Crown Court when the circumstances of “vulnerable” victims, were set out.<sup>25</sup> Connors’ family members, consisting of father, son, nephew and son in law, ran a building business. Their exploited employees were physically assaulted and made to work long hours which funded the lavish lifestyles of their employers. In contrast, the employees resided in fear in squalid and insanitary conditions.<sup>26</sup>

23 The National Board advised a Regional Board to remove a statement concerning its continued use of “interim guidance” which pre-dates the Social Services and Well Being Act

24 <http://www.bbc.co.uk/news/uk-wales-politics-34602975> (accessed 2 October 2017)

25 <https://www.theguardian.com/uk-news/2016/may/24/four-relatives-jailed-for-making-vulnerable-men-work-like-slaves-in-wales> (accessed on 18 October 2017)

26 <https://www.theguardian.com/society/2017/oct/18/slavery-alive-wales-exploitation-supply-chain> (accessed on 18 October 2017)

Other relevant topics include the use of seclusion in some schools for children with learning disabilities; the Care and Social Services Inspectorate Wales' findings concerning Anglesey County Council's and Powys' Children's Services; and high profile prosecutions.

- Directors of Social Services sought the advice of the National Board about the ownership and control of Child Practice Review and Adult Practice Review documentation in the light of Freedom of Information requests.
- The Healthcare Inspectorate Wales' published *Learning Disability Services: thematic report 2015-2016* during December 2016. This noted the unmonitored use of seclusion in some services in the absence of safeguards. It resonates with observations of practitioners concerning the unmonitored use of seclusion in some schools responsible for the education of children and young people with learning disabilities.
- Anglesey County Council's Children's Services were inspected by the Care and Social Services Inspectorate Wales during November 2016 and its report was published during March 2017.<sup>27</sup> This noted that *there had been insufficient attention given to improving practice in children's services in recent years... We found that management oversight of safeguarding, access and assessment arrangements were insufficient and the pace of change in improving the provision of help, care and support and/ or protection for children and families in Anglesey must be accelerated.*
- During August 2017, Kris Wade began a 21 year prison sentence for killing his neighbour.<sup>28</sup> He had been an employee of Abertawe Bro Morgannwg University Health Board.<sup>29</sup> He worked with people with learning disabilities and his father was the Health Board's Clinical Service Director for Mental Health and Learning Disability. Allegations of sexual assault had been made by people with learning disabilities during 2012 and 2013.
- Decision-making concerning a man who believed that his "electromagnetic hypersensitivity" rendered him eligible for Direct Payments formed the subject matter of the first challenge in the Administrative Court under the 2014 Act.<sup>30</sup>
- During September 2017, Thomas Jenkins, a junior doctor was struck off the list of practitioners registered with the General Medical Council for attempting to groom an underage boy online. He had worked at Wrexham Maelor Hospital.<sup>31</sup> He had been sentenced to a Community Order during April 2016 and was ordered to sign the sex offenders register having admitted to inciting a child to engage in sexual activity.
- During October 2017, the Care and Social Services Inspectorate Wales published a report concerning Powys' children's services.<sup>32</sup> This states that poor management and weak leadership has led to children being at risk of harm.

27 <http://cssiw.org.uk/docs/cssiw/report/170307angleseyen.pdf> (accessed on 31 March 2017)  
<http://www.bbc.co.uk/news/uk-wales-north-west-wales-39182630>  
<http://www.dailypost.co.uk/news/anglesey-councils-childrens-services-slammed-12701175> (accessed on 2 October 2017)

28 <http://www.walesonline.co.uk/news/wales-news/health-board-failings-revealed-over-13504551> and <http://www.express.co.uk/news/uk/843892/Health-board-sex-assault-claims-hospital-worker-killer-Kris-Wade> (accessed on 2 October 2017)

29 <http://www.wales.nhs.uk/sitesplus/863/news/45953>

30 <http://www.bbc.co.uk/news/uk-wales-south-east-wales-40497411> (accessed on 2 October 2017)

31 <http://www.bbc.co.uk/news/uk-wales-north-east-wales-41516913> (accessed on 5 October 2017)

32 <http://www.bbc.co.uk/news/uk-wales-politics-41651441> (accessed on 17 October 2017)

There are also scenarios which are familiar to Regional Boards which have not featured in their annual reports. For example, the interface between criminal and child protection proceedings, the slippage of timeframes in conducting reviews and accessing advocacy.

Less visible but no less distressing for the individuals and families concerned are care home closures and the significance of these for local families and employees.<sup>33</sup> In addition, the National Board is aware of individual stories, activities and processes which become problems of proliferating complexity:

- Disquiet that Child Sexual Exploitation (i) is primarily a criminal matter and (ii) multiple, emergent CSE processes are not following child protection procedures.
- “Some partners just highlight their agency’s name in the Regional Board’s minutes. They speak about the immediate concern and aren’t interested in what multi-agency working means and requires.” Arguably there are ways of auditing multi-agency working which do not rely on individual agencies asserting that they are making effective contributions.
- Complaints about the decisions and actions of health care and social care practitioners with implications for safeguarding.<sup>34</sup>
- Practice which ensures that young people, adults and families are consistently informed of the fact that safeguarding procedures are being invoked and what this means for them
- Practice concerning the participation of families in Child Practice Reviews, Adult Practice Reviews and Multi-Agency Professional Forums.
- The slippage of timeframes in conducting and reporting on Child/ Adult Practice Reviews.
- The perception of collusion between safeguarding practitioners and home owners/ managers at meetings where care homes are invited to investigate allegations of harmful practices.
- After the review of neglect in care homes in south east Wales (Operation Jasmine), evidence that senior clinicians, Registrars, General Practitioners and Tissue Viability Nurses are assuming lead roles in preventing avoidable pressure ulcers and associating evidence of poor care with particular services.
- Advocacy services being accessed for the purposes of supporting children/ adults at risk of harm who are known to safeguarding practitioners.
- Some social workers responsible for taking children into care in Wales are being demonised on social media by aggrieved relatives.
- The Regional Boards’ Business Units are carrying a lot of responsibility and yet not all have professional backgrounds in either social care or health care.

<sup>33</sup> <http://www.dailypost.co.uk/news/north-wales-news/flintshire-care-home-closes-following-12886140> (accessed on 2 October 2017)

<sup>34</sup> See for example <http://www.dailypost.co.uk/news/north-wales-news/number-health-complaints-doubles-decade-13710979> (accessed on 11 October 2017)

Also, safeguarding practices are affected by the inefficient and bureaucratic processes of the Deprivation of Liberty Safeguards.

Other matters over which Regional Boards have no control include the impact on local resources of public authorities in England placing people in Welsh services; the implications of sustained austerity and future migration arrangements for the care sector; and planning services which the families of people with learning disabilities do not want.

There are also matters over which the Regional Boards have no control and yet their potential to impact on safeguarding practice is considerable. To different degrees they may be relevant to some Regional Boards, for example:

- The Deprivation of Liberty Safeguards are acknowledged to be inefficient and out of step with the empowering philosophy of the Mental Capacity Act 2005. They are bureaucratic, overly technical and incapable of dealing with the increasing numbers of people considered to be deprived of their liberty.<sup>35</sup> As a Director of Social Services noted, “They are a distracting drain on resources.”
- The placement of people of all ages by public authorities in England impacts on the provision of local resources, including the police. It is atypical for their high support needs to be met by the services in which they have been placed.
- In localities where Universal Credit has been piloted, families have been forced to wait for six weeks before they receive any money. Although this is causing hardship, food poverty and debt, it remains to be “rolled out” in England and Wales against a backdrop of sustained austerity.<sup>36</sup>
- The responsiveness of mental health services to children, young people<sup>37</sup> and adults of all ages.<sup>38</sup>
- The squeeze on local authority funding of residential care and the increasing workforce costs of the sector<sup>39</sup> is resulting in home closures.
- The care sector’s reliance on European Union workers may result in crises because of unknown future migration arrangements.
- The digital divides across services which may compromise information sharing.
- The building of a low secure hospital for 40 people in Wrexham. This will include an assessment unit “to cater for those in crisis, who can be brought in for assessment and recovery.” Such units are neither sought nor valued by the families of people with learning disabilities. Since the exposure of abuses at Winterbourne View Hospital, such units are associated with the long term removal of people from their families.<sup>40</sup>

35 Spencer-Lane, T. (2017) Mental capacity and deprivation of liberty: the Law Commission’s review of the deprivation of liberty safeguards, *The Journal of Adult Protection*, 19 (4) 220-227

36 <https://www.theguardian.com/society/2017/oct/17/we-went-days-without-eating-properly-universal-credit-misery-inverness> (accessed on 18 October 2017)

37 <https://www.theguardian.com/society/2015/may/02/crisis-in-childrens-mental-health-nhs-insider-speaks> (accessed on 18 October 2017)

38 <https://www.mentalhealth.org.uk/sites/default/files/FF16%20Wales.pdf> (accessed on 18 October 2017)

39 <http://www.walespublicservices2025.org.uk/2017/03/23/can-wales-fill-the-social-care-funding-gap/> (accessed on 18 October 2017)

40 <http://www.ashealthcare.co.uk/news-story/wrexham-low-secure-hospital/> (accessed on 1 October 2017)

Some of the Regional Boards' very positive developments include Mid and West's Junior Safeguarding Boards and its Junior Safeguardians and the collaboration which led to the Online Grooming Communication Project.

Other examples include the work of a north Wales social worker; a resource co-produced with young people about gender based violence and sexual violence; and the work of Gender and Education Association.

On a different note, there are practices and developments which have received modest or no coverage in the Regional Boards' annual reports. They are too good to leave unmentioned:

Beginning with **Mid and West's Junior Safeguarding Boards and its Junior Safeguardians**, these are tangible means of demonstrating to children and young people that their ideas and experiences matter and that they can influence the thinking of a Regional Board. Also, they are vehicles for young people to (i) develop their aspirations for safeguarding at their own pace; (ii) learn about ways of capturing ideas, seeking consensus and dealing with dissent in meetings; (iii) experience the importance of sustaining a supportive environment; (iv) understand the many contexts, some of which are ambiguous, in which young people are hurt and harmed; and (v) be willing to notice and take responsibility for speaking out when they know that something is wrong.

A Professor of Applied Linguistics at Swansea University, Nuria Lorenzo-Dus has led **The Online Grooming Communication Project** since 2012. By looking in detail at the language used by online groomers, the project has led to the identification of online "lead-ins" resulting in requests for offline meetings for sexual purposes. The key process of "deceptive trust development" relies heavily on persuasion. With funding from Cherish-DE, a Swansea University Impact Fund, the NSPCC and Swansea University, this collaborative project engaged with young people and professionals across Wales. It has resulted in an Anti-Online Grooming Activity Pack which is being piloted at NSPCC Service Centres in Wales and elsewhere.

A **north Wales social worker's** close work with very young siblings resulted in tangible evidence of their thriving. Having experienced severe neglect at their family home, which was not abated by daily visits from their social worker, the children were removed to a foster home. They stayed in regular contact with their social worker who visited the children six months after their removal and on the occasion of a birthday party hosted by their foster parents. The party included new school friends. One of the children wept and explained to the social worker that she was "so happy." Another said that they had never had parties before and wanted assurance that they did not have to return to where they had lived. The children were benefitting from the new experience of attentive parenting, having a regular diet, attending school and playing with friends.

**Agenda: A Young People's Guide to Making Positive Relationships Matter**<sup>41</sup> is a free, bi-lingual toolkit that provides ideas and resources for young people about how they may safely and creatively speak out about gender-based violence and sexual violence. Putting equality, diversity, children's rights and social justice centre stage, the guide supports young people's rights to speak out and engage as active citizens on issues that matter to them. The resource was co-produced with young people and includes illustrative case studies on topics that address gender discrimination, gender diversity, consent, Lesbian, Gay, Bisexual and Transgender rights, bullying, street harassment, Female Genital Mutilation, sexual exploitation, and relationship violence. It provides a range of innovative and creative "starter" activities to support young people express what matters to them, and what they would like to change individually and collectively with others. It includes over 100 hyperlinks to organisations and resources of where to find out more about key issues.

41 Renold, E. (2016) *Agenda: A young people's guide to making positive relationships matter*, Cardiff University, Children's Commissioner for Wales, NSPCC Cymru, Welsh Women's Aid and Welsh Government, [www.agenda.wales](http://www.agenda.wales) (accessed 1 October 2017)

Also, the initiative of a south Wales nursery teacher; a tool to help professionals to measure the quality of a child's care; and an inpatient mental health centre co-produced with people with mental health challenges.

The sheer energy of the Gender and Education Association<sup>42</sup> - this brought together girls at Mountain Ash Comprehensive School who set out to challenge the distorted representations of women with impeccably made up faces because they do not reflect reality. A few pupils decided to create an alternative "image bank" and went to school with one half of their faces made-up. By the end of the day, more girls had participated by removing half of their make-up. Similarly, pupils from Ysgol Gyfun Plasmawr, whose drama production *Hidden* uncovers the unseen harm of homophobic bullying and highlights the instability of hidden sexual identities. The *Outlook* group from Tonypandy's Community College has exposed the hazards of "sexting" and through music and painting, Tonyrefail comprehensive school students have represented the survival skills of respect and Ysgol Gyfun Plasmawr has developed pledges for schools. Such leadership and fabulous initiatives remain to become invaluable to Regional Boards.

The new curriculum which is being developed for settings and schools in Wales<sup>43</sup> stresses the importance of children and young people developing healthy relationships, understanding interpersonal power and the difference between assertion and aggression for example. There is scope for some of Agenda's excellent materials to be widely disseminated.

A **south Wales** nursery teacher has begun the task of "starting early" by introducing the concept of consent to very young children. They are encouraged to ask if they might hold or touch their peers during games. The children are learning the importance of saying either "Yes" or "No" and acting accordingly.

The prevalence of neglect and its destructive impacts may be measured in human and financial terms over the life course. Noticing and intervening in the hostile climates of some families requires attention to the many forms of distress which arise from child neglect. The NSPCC has developed an evidence based assessment tool which helps professionals to measure the quality of a child's care. The Graded Care Profile<sup>44</sup> focuses on a child's experience and enables parents to understand the background to professionals' interest and scrutiny.

April 2017 heralded the opening of the UK's first co-produced, inpatient mental health centre - the **Gellinudd Recovery Centre**. It was designed by people with first person experience of mental illness and their families. It is a user-led, not for profit service with an overarching, recovery purpose and ethos, run by the charity Hafal. It is the first time that the Welsh Government's *Invest to Save* funding has been awarded to a charity.<sup>45</sup>

42 [http://www.genderandeducation.com/conferences-and-events/past\\_events/young-people-light-up-the-agenda-for-a-better-sex-and-relationships-education/](http://www.genderandeducation.com/conferences-and-events/past_events/young-people-light-up-the-agenda-for-a-better-sex-and-relationships-education/) (accessed 1 October 2017)

43 <http://gov.wales/topics/educationandskills/schoolshome/curriculuminwales/curriculum-for-wales-curriculum-for-life/?lang=en> (accessed 20 October 2017)

44 <https://www.nspcc.org.uk/services-and-resources/services-for-children-and-families/graded-care-profile/> (accessed 22 October 2017)

45 <https://www.theguardian.com/healthcare-network/2017/may/10/nhs-mental-health-gellinudd-recovery-centre> (accessed 1 August 2017)

The National Board invited the Chairs of the Regional Boards to assist it in writing the **conclusions**.

The Regional Boards' annual reports do not comply with the Social Services and Well-being Act.

The task of writing the reports was delegated to the Regional Boards' business and administrative personnel.

Although the tasks of the Regional Boards are far-reaching, it appears that some partners are not doing as much as others.

On 23 October 2017, the National Board presented to the Chairs of the Regional Boards an overview of its Annual Report concerning "the adequacy and effectiveness of arrangements to safeguard children and adults in Wales." The National Board sought to harness the insights and experience of the Chairs and reflect the Social Services and Well-being Act's principle of co-production.

The Regional Boards' annual reports short change the six safeguarding board areas because they do not comply with the Act in terms of (i) the planning and reporting cycle and (ii) content. Their use of acronyms, not all of which are explained, and service language mean that the reports may be perceived as inaccessible to the person in the street.

Since the annual reports are one part of the crowded agendas of Directors of Social Services, the Chairs acknowledged that the task of writing them was delegated to the Regional Boards' business and administrative personnel. It was proposed at the Chairs' meeting that in some localities the Annual Council Reporting Framework, which all local authorities are required to publish, arguably contained more safeguarding information than the annual reports. One Chair acknowledged that its annual report had not been discussed by their Regional Board.

The governance arrangements were described as "complex" because the different cultures, constituencies and interests of Regional Boards' membership intrude on the common ground of safeguarding. From the standpoint of a Regional Board member, the Board may blur an agency's mission and accountability for pursuing this. The following observations glimpse the experience of steering Regional Boards: "There's too much expectation about what they can do...nothing is co-terminous...they are difficult things to pull together...some partners are passive...there are varying degrees of commitment...money – including a deficit – is a bigger driver to change than the expectation of collaboration...you can't tell people off...it is tough to quality assure safeguarding across such a huge area."

The National Board undertook to group the information in individual annual reports under the content headings set out in the statutory guidance. However, gaps in information are revealed since loyalty to these headings is inconsistent across the annual reports and plans. In this less than ideal situation, it is possible that the National Board's attempts to extract and categorise useful information are imperfect.

The Chairs reflected that "the Regional agenda is huge but it's the same small core driving it...the one or two willing horses...we're talking about large scale reorganisation here...some partners are insistent that they cannot chair a subgroup." The structural diversity of Regional Boards across Wales and the array of subgroup types arguably arise from "a structural flaw...they sit outside other regional arrangements...insufficient focus – we're trying to do everything."

# Parallel Writing

The Chairs acknowledged that safeguarding outcomes should be connected to intentions and plans and that “a core set of data” would be helpful. They accepted that the unchecked drafting of protocols and procedures requires attention.

Assessing the contribution of partners brings challenges.

The challenges include maintaining working relationships with partners outside the Regional Board.

There is a case for inviting safeguarding practitioners and solicitors who advise them to comment on the annual reports.

There is an important distinction to be made between “what was responsible for this outcome?” and “Who was responsible for this outcome?” This should be known all contributors to Child/Adult Practice Reviews.

The approach of the Act is “outcomes-oriented,” that is, the National Board is expected to reflect on the connection between the plans and the outcomes achieved by the Regional Boards. Listing actions which are not anchored to plans, without identifying which are safeguarding means or ends, reveals little in terms of the adequacy and effectiveness of safeguarding. Chairs noted that “actions have been lost in the detail...there is not yet coherence...focusing is important...we’ve got to agree a core set of data...[and work through] the practicality of sharing data in a meaningful way.”

The reliance on writing protocols, strategies, tools and procedures is remarkable. Technology provides an insight. Technology is familiar with the phenomenon of “security overload” – the risk that systems are so overwhelmed by security features that they create insecurity. Although safeguarding is complex it does not require reliance on the unchecked generation of disparate documents with a limited evidence base. The observation “They may result from practice review recommendations” points to one means of halting the unchecked production of documentation. “Testing” the credibility of annual reports with safeguarding practitioners in all sectors may be another useful corrective.

The ways in which the Regional Boards’ annual reports evidence the “contribution” of individual members typically hinges on membership of particular groups. The self-assessments of individual members do not reveal the challenges of setting aside the turf protectiveness of organisations, the failures of sector leaders to step forward, the turnover of the personnel involved and the mistakes arising from seeking to provide an integrated approach, for example. “We have to maintain relationships...it’s back to what being accountable means...one partner is insistent that they will not chair a subgroup...are the right level of people attending?”

The perspectives of safeguarding practitioners and solicitors who advise practitioners are not evident in accounts of “underlying themes and practice changes.” Neither is the crucial distinction between what was responsible for this outcome vs who was responsible for this outcome. This must be centre-stage and explicit if the participation of people who are known to have been at risk and their families are to participate in practice reviews.

How people of all ages participated in the work of the Regional Boards remains “work in progress.” The exceptional examples set out in the annual reports concern children and young people only.

Although all Regional Boards have training subgroups, the National Board cannot present a preliminary overview of safeguarding training.

There was some disquiet concerning the inclusion of significant local events in the Regional Boards' annual reports.

Setting out what the leadership across sectors is doing to limit the harms and risks reported in the media is essential.

Finally, the Chairs acknowledged of the practice concerning the annual reports that they "Could do better!"

The National Board made a single S.139 request (with Social Care Wales). Section 139 of the Act states: *A Safeguarding Board must co-operate with the National Board, and must supply the National Board with any information it requests.* Furthermore, the statutory guidance specifies that annual reports should include, *any information or learning the Safeguarding Board has disseminated or training it has recommended or provided.* Given that each Board has a subgroup addressing training and workforce matters, it is disappointing that no preliminary overview of safeguarding training in Wales has resulted. Two Regional Boards provided incomplete responses and the rest listed activities and the titles of training courses, for example. The terms "learning lessons" and "learning organisation" are familiar to most Regional Boards and yet it is not clear how each interprets these. It is possible that

- a. Multi-Agency Professional Forums and Action Learning initiatives are facilitating the linking between reflecting on events and day to day practice
- b. training events engage people in examining their understanding, skills and values
- c. supervision and team supervision encourages people to explore the ways in which they communicate safeguarding matters, and that
- d. conferences and seminars promote the Social Services and Well-being Act and shape professionals' sense of agency – but there is no evidence that this is so.

The discussion concerning safeguarding training was revealing, "It's a vast subject...We've never had full oversight...disparate commissioning is a barrier." Such explanations, which did not feature in any report, do not set aside the fact of non-compliance with the Act and specifically with the S.139 request.

The discussion concerning significant events which have been omitted from the annual reports was backlit with challenge. Although the media has a complex relationship with public opinion, local papers are an important source of information about harm and abuses. Arguably TV and local papers have a key role in "awareness raising," even if reported events are partial and inaccurate. Annual reports which ignore or overlook reported local and regional events which pertain to safeguarding are anomalous. Silence concerning such matters neither offers reassurance nor enhances understanding. Annual reports play a vital role in influencing the tone of reporting by setting out what has happened and what the leadership across sectors is doing to ameliorate harms and risks. "If we are not sighted on something, if people don't bring the issue we cannot make them...how do you report this without compromising the partnership?...These things aren't neutral and yet you're expecting us to describe them neutrally?" Yes – the National Board is.

Finally, the Chairs were invited to offer the National Board some summary points concerning the annual plans and reports. "There's real enthusiasm and passion to improve all of this...there's commitment too – it's an evolving process...we have to share good practice and working practices...we have to improve the dialogue...we have to provide more examples and more detail...effective collaboration takes time...it all takes time and we need to give it time...Could do better!"

**Margaret Flynn, Keith Towler, Simon Burch, Ruth Henke, Jan Pickles and Rachel Shaw**



National Independent  
Safeguarding Board Wales

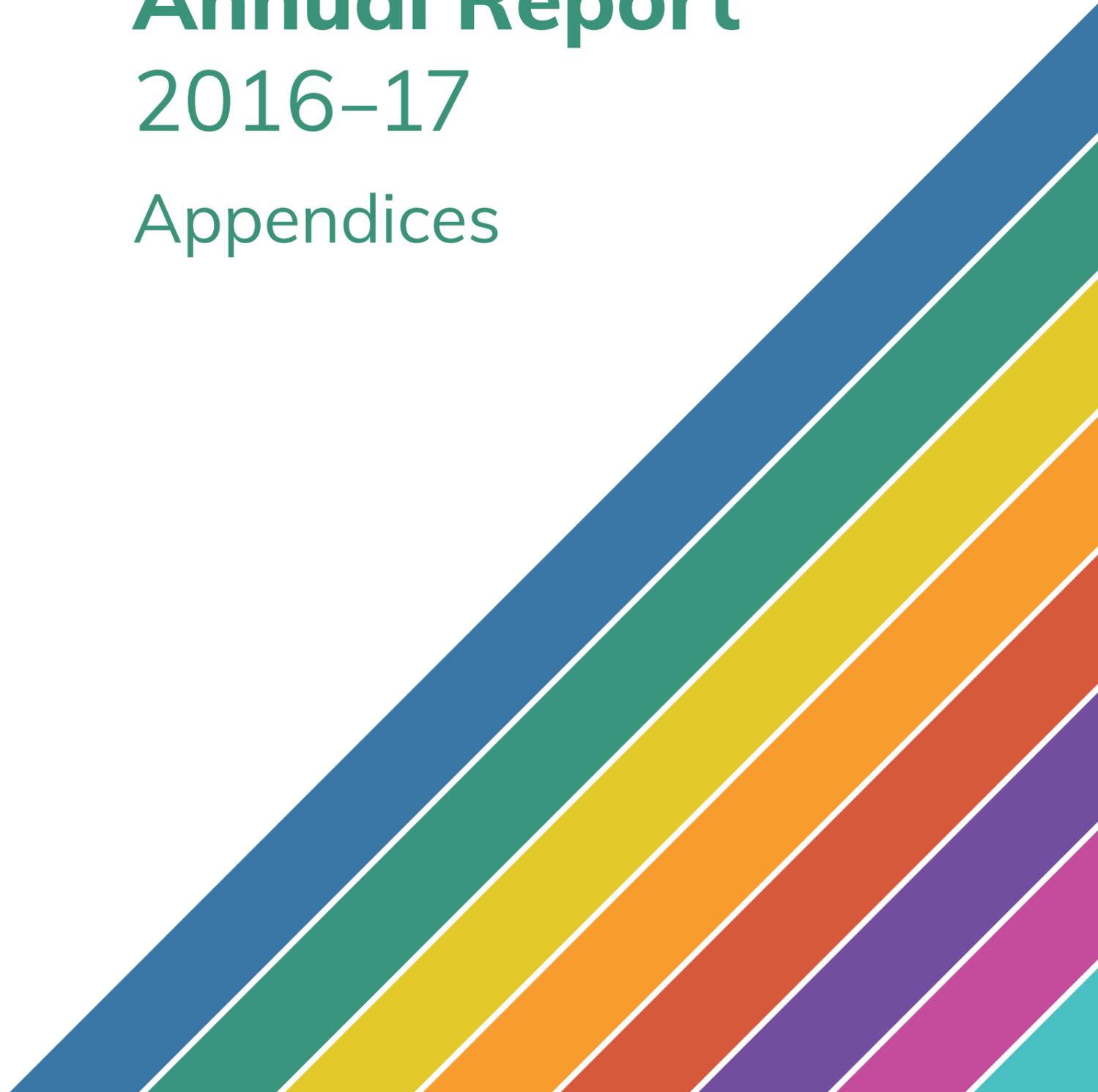
Bwrdd Diogelu Annibynnol  
Cenedlaethol Cymru



# Annual Report

2016–17

Appendices



# Appendix 1:

## The members of the Safeguarding Boards and their structures

Table (a) Regional Board Membership

Name of Safeguarding Board Area	Principal Board Members	Additional Board Members
Cardiff and Vale  Cardiff City and County Council Vale of Glamorgan Council	<p>Chair of Children's Board: Director of Social Services; Vice Chair: Director of Social Services</p> <p>Chair of Adults' Board: Director of Social Services;</p> <p>Vice Chair: Director of Social Services<sup>1</sup></p> <p>Assistant Director of Social Services; Head of Service; Operational Managers;</p> <p>South Wales Police; Youth Offending Service; Probation; Community Rehabilitation Company</p> <p>Cardiff and Vale UHB; Public Health Wales; Directors and Assistant Directors of Nursing; Welsh Ambulance Services Trust</p> <p>Business Unit</p>	<p>Legal services; Learning and skills; Education; Head Teachers; Community Housing and Customer Services; NSPCC; Barnardo's; Safeguarding Lead, UK Visas and Immigration; Training Advisor, Llamau; Cardiff Women's Aid; Mental Capacity Act and Deprivation of Liberty Safeguards Manager; South Wales Fire and Rescue; Vale Centre for Voluntary Services; Age Connect; Care Homes Association; Learning Disability and Supported Living Care Providers; NISB</p>
<b>Cwm Taf</b>  Merthyr Tydfil County Borough Council  Rhondda Cynon Taf County Borough Council	<p><b>Co-Chairs of Children's Board:</b> Director of Community and Children's Services</p> <p><b>Co-Chairs of Adults' Board:</b></p> <p>Director of Community and Children's Services</p> <p>Adult Safeguarding Managers; Service Director; Heads of Service; Service Director</p> <p>South Wales Police</p> <p>National Probation Service; Community Rehabilitation Company; Youth Offending Service</p> <p>Cwm Taf UHB; Director of Nursing; Head of Safeguarding; Public Health Wales; Welsh Ambulance Services NHS Trust</p> <p>Business Unit</p>	<p>Treatment and Education Drug Service; Voluntary Action Merthyr Tydfil; Community Housing Services; Education and Lifelong Learning; Heads of Legal; Chief Officer Community Regeneration; NISB</p>

Name of Safeguarding Board Area	Principal Board Members	Additional Board Members
<b>Gwent</b>  Blaenau Gwent County Borough Council  Caerphilly County Borough Council  Monmouthshire County Council  Newport City Council  Torfaen County Borough Council	<p><b>Chair of Children's Board:</b> Chief Executive of Bron Afon Housing Association; <b>Vice Chair:</b> Assistant Director of Barnardo's Cymru</p> <p><b>Chair of Adults Board:</b> Director of Social Services; <b>Vice Chair:</b> Director of Nursing</p> <p>Gwent Police; Youth Offending Service</p> <p>Aneurin Bevan UHB; Public Health Wales; Welsh Ambulance Services NHS Trust;</p> <p>South Wales Fire Service</p> <p>Business Unit</p>	<p>SE Wales Emergency Duty Team; Torfaen Education; HMP Usk; Violence Against Women, Domestic Abuse and Sexual Violence Regional Advisor; Legal services; Monmouthshire Housing; Charter Housing and Derwen Cymru; Torfaen Voluntary Alliance; Office of the Police and Crime Commissioner; Older People's Commissioner for Wales; Chairs of Local Safeguarding Network; Head of Adult Services; NISB</p>
<b>Mid and West Wales</b>  Carmarthenshire County Council  Ceredigion County Council Pembrokeshire County Council Powys County Council	<p><b>Chair of Children's Board:</b> Director of Community Services, <b>Vice Chair:</b> Director of Nursing</p> <p><b>Chair of Adults Board:</b> Director of Social Care and Leisure, <b>Vice Chair:</b> Detective Superintendent</p> <p>Dyfed Powys Police</p> <p>National Probation Service</p> <p>Community Rehabilitation Company</p> <p>Regional Representative of Youth Justice Managers</p> <p>Hywel Dda UHB; Powys Teaching Health Board; Public Health Wales; Wales Ambulance Services NHS Trust</p> <p>Business Unit</p>	<p>Regional Third Sector Representative; Regional Representative for Heads of Commissioning; Regional Representative of Directors of Commissioning; NISB</p>

Name of Safeguarding Board Area	Principal Board Members	Additional Board Members
<p><b>North Wales</b></p> <p>Conwy County Borough Council Denbighshire County Council Flintshire County Council</p> <p>Gwynedd County Council Isle of Anglesey County Council</p> <p>Wrexham County Borough Council</p>	<p><b>Chair of Children's Board:</b> Strategic Director of Education and Social Services; <b>Vice Chair:</b> Head of North Wales Local Delivery Unit Community Rehabilitation Company</p> <p><b>Chair of Adults Board:</b> Chief Officer, Social Services; <b>Vice Chair:</b> DS NW Police Protection of Vulnerable People Unit</p> <p>North Wales Police; Youth Justice Service;</p> <p>Betsi Cadwaladr UHB; Welsh Ambulance Services NHS Trust;</p> <p>Public Health Wales</p> <p>National Probation Service; Community Rehabilitation Company</p> <p>Business Unit</p>	<p>North Wales Fire and Rescue Service; NSPCC; Barnardo's; NISB</p>
<p><b>Western Bay</b></p> <p>Bridgend County Borough Council; Swansea City and County Council; Neath Port Talbot County Borough Council</p>	<p><b>Chair of Children's Board:</b></p> <p>Director of Social Services Health and Housing</p> <p><b>Chair of Adults Board:</b> Corporate Director for Social Services and well-being</p> <p>Children's Heads of Service; Adults Health of Service;</p> <p>South Wales Police; Probation</p> <p>Aneurin Bevan UHB; Assistant Nursing Director; Head and Deputy Head of Safeguarding Adults; Lead Nurse Safeguarding Children; Public Health Wales; Assistant Medical Director, Primary Care; Assistant Nurse Director;</p> <p>Business Unit</p>	<p>Parc Prison; Swansea Prison; SCVS; NSPCC; Barnardo's; Domestic Abuse Coordinator; IMCA Services Manager; Chief Officer Education; Head of School Support Unit;</p> <p>NISB</p>

**Table (b) the Regional Board Structures**

Safeguarding Board Area	Reporting Groups	Subgroup Types
<p><b>Cardiff and Vale</b></p> <p>- Children</p>	<p>Main Board and Executive Board</p> <p>Business Unit</p>	<p>Child Practice Review</p> <p>Audit</p> <p>Training</p> <p>Communication and Engagement</p> <p>'Key Thematic Area' Group</p> <p>Task and Finish Groups</p>
<p>- Adults</p>	-	-
<p><b>Cwm Taf</b></p> <p>- Children</p>	<p>Children Operational Committee</p> <p>Multi Agency Safeguarding Hub Executive Board (MASH)</p> <p>Multi Agency Safeguarding Hub Operational Committee</p>	<p>Child Review Group</p> <p>Children Quality Assurance</p> <p>Engagement Participation and Communications</p> <p>Training and Learning</p> <p>Protocols and Procedures</p> <p>Multi-Agency Safeguarding Hub</p>
<p>- Adults</p>	<p>Deprivation of Liberty Safeguards Operational Committee</p> <p>Adults Operational Committee</p> <p>Multi Agency Safeguarding Hub Executive Board (MASH)</p> <p>Multi Agency Safeguarding Hub Operational Committee</p>	<p>Deprivation of Liberty Safeguards Quality Assurance</p> <p>Adult Review</p> <p>Engagement Participation and Communications</p> <p>Training and Learning</p> <p>Protocols and Procedures</p> <p>Multi-Agency Safeguarding Hub</p> <p>Business Planning</p>
<p><b>Gwent</b></p> <p>- Children</p>	<p>Violence Against Women Domestic Abuse and Sexual Violence</p> <p>South East Wales Safeguarding Children's Board</p> <p>Safeguarding Network: Blaenau Gwent, Caerphilly, Monmouthshire, Newport and Torfaen</p>	<p>Engagement and Communication</p> <p>Protocols and Procedures</p> <p>Learning and Development</p> <p>Quality Assurance and Performance Group</p> <p>Case Review Group</p> <p>Case Review Panels</p> <p>Business Planning</p>
<p>- Adults</p>	<p>Violence Against Women Domestic Abuse and Sexual Violence</p> <p>Gwent Adult Safeguarding Board</p>	<p>Engagement and Communication</p> <p>Protocols and Procedures</p> <p>Learning and Development</p> <p>Quality Assurance and Performance Group</p> <p>Case Review Group</p> <p>Case Review Panels</p>

Safeguarding Board Area	Reporting Groups	Subgroup Types
<b>Mid and West Wales</b> - Children	Executive Board Local Operational Groups Junior Local Safeguarding Children Boards Junior Regional Safeguarding Children Board	Training Policies and Procedures Child and Adult Practice Review
- Adults	Executive Board Local Operational Groups	Training Policies and Procedures Child and Adult Practice Review
<b>North Wales</b> - Children	Child Sexual Exploitation Executive Group Child Sexual Exploitation Victim Support Group Flintshire and Wrexham Delivery Group Conway and Denbighshire Delivery Group Gwynedd and Mon Delivery Group	Child Practice Group Joint Adult and Children Training and Workforce Development Policy and Procedure Group
- Adults	Flintshire and Wrexham Delivery Group Conway and Denbighshire Delivery Group Gwynedd and Mon Delivery Group	Adult Practice Review Group Joint Adult and Children Training and Workforce Development Adults Procedure and Policy Group
<b>Western Bay</b> - Children	Safeguarding Children Board Bridgend, Neath Port Talbot and Swansea Service Boards	Child Practice Review Management Group Policy Procedure and Practice Management Group Quality and Performance Management Group Joint Strategic Training Group
- Adults	Safeguarding Adults Board	Quality Monitoring and Escalating Concerns Management Group Policy Procedure and Practice Management Group Joint Strategic Training Group

## Appendix 2: Planning, Collaboration and Achievements

Table (c) Implementing Plans

Safeguarding Board Area	Implementation activities
Cardiff and Vale	Established a multi-agency Child Sexual Exploitation strategic group, an Action Plan and a multi-agency professional forum; the multi-agency Professional Forum resulted in "a robust action plan developed by the CSE strategic group"
Cwm Taf	Placed links to preventative services on the website  Developed an improvement plan for care homes (following the Operation Jasmine Review and the Older People's Commissioner's Care Home Review); creating opportunities to share good practice among care home providers; reinforcing "emotional neglect" as a form of abuse; using advocacy to ensure that voices are heard  Expanded the scope of the Protocol for the Immediate Responses to Critical Incidents to include adults at risk  Established a Deprivation of Liberty Safeguards governance structure and introduced mitigating actions to manage the increase in assessments and reassessments
Gwent	Developed neglect guidance; held a neglect conference; trained thousands of volunteers and workers; consulted with children, young people and parents; developed a range of leaflets; developed websites providing advice; delivered practice improvements; developed a group to look at Child Sexual Exploitation issues and produced a suite of information re CSE across a variety of different media; developed a training programme re keeping young people safe when using technology; developed a range of protocols and procedures; worked closely with the Regional Adult Safeguarding Board and Regional pilot on Violence Against Women Domestic Abuse and Sexual Violence; undertaken a review of how we work and established how we can best provide a more holistic approach to safeguarding; consulted with citizens in a variety of engagement events re safeguarding; agreed 'branding' and a logo for the Board; produced a quarterly newsletter; developed a data set to benchmark activity; monitored the performance of care home provision; developed a group to undertake an audit around falls in care settings; supported the scoping of the Multi-Agency Safeguarding Hub; developed a range of training modules; worked closely with the Regional Safeguarding Children's Board; reviewed and revised the terms of reference and membership of all of our subgroups and combined the work of some
Mid and West	Hosted a regional Child Sexual Exploitation Conference which included a performance by Arad Goch Theatre Company called "sexting" which was used as the basis for workshops in all secondary schools in Ceredigion; a CSE "task and finish" group led and implemented the development of a strategy and action plan; a framework for the development of multi-agency CSE meetings has been put in place with terms of reference; has worked with Barnardo's and CASCADE (Cardiff University) in implementing the Gwella project and a project worker has been appointed; the development of a regional threshold and eligibility for support document which provides guidance to professionals on how to respond to children and their families...in need of services with a series of workshops; a multi-agency referral form has been developed which complements the Regional Threshold document; regional Domestic Abuse Conference Call and Multi-Agency Information Sharing Hubs were piloted and discontinued; the Quality Assurance and Reporting Framework has been strengthened by the Operation Jasmine Action Plan; the children's and adults' safeguarding boards are in very strong alignment; the Board's website was launched and branding established; a comprehensive training needs analysis was undertaken; the business unit capacity has been strengthened; a practice review protocol was commissioned; and governance arrangements have been strengthened

Safeguarding Board Area	Implementation activities
North Wales	There is a Child Sexual Exploitation and Missing from Care multi-agency strategy and an executive group established; there is an action plan which is continually reviewed; the Gwella project is in place with a practitioner from Barnardo's; a CSE drama is being developed for secondary school age children; the Board contributed to a consultation review of the statutory guidance for CSE; Project 84 hub is a new service...working to develop a pathway for victims of CSE; all but Gwynedd have CSE/ Sexual Exploitation Risk Assessment Framework panels; there is a dedicated police team tackling on and offline CSE which has been involved in training staff and the development of podcasts which have been shared with partner agencies; there is a leaflet re how to refer any concerns; policies have been reviewed; the NSPCC is offering the Protect and Prevent intervention to deliver and develop a CSE social work post; work with the NSPCC re Harmful Sexual Behaviour audit toolkit and the local authorities have parallel initiatives, some of which involve Youth Justice; all partner agencies have undertaken to support and participate in Multi-Agency Risk Assessment Conferences; the Health Board is piloting the use of Read Codes in primary care to flag victims of domestic violence; the Board's business support arrangements have been agreed; information about best practice and learning from reviews was disseminated at a Roadshow; action plans are routinely reviewed; there is a rolling programme of audits across all Delivery Groups; the Escalating Concerns protocol is undergoing multi-agency review; a professional concerns protocol is undergoing review; a good practice template is being shared; a common data set is being developed; Safeguarding Week hosted 45 awareness raising events; a pilot of a missing person's protocol was launched as well as a self-neglect protocol; a business unit is in operation which supports both boards; a business development session has been hosted; and joint work is evidenced across the two Boards; an extensive programme of safeguarding training has been undertaken; increasing the capacity of the Board to undertake Adult Practice Reviews is ongoing
Western Bay	<p>Developing and reviewing a suite of assessment tools for neglect</p> <p>Receiving performance data concerning neglect and Child Sexual Exploitation</p> <p>Applying the All Wales Child Sexual Exploitation Protocol and holding partners to account</p> <p>Hosting the Gwella project (for three years) which will be a Single Point of Contact for Child Sexual Exploitation</p> <p>Establishing performance information from Community Safety Partnerships and creating "reporting frameworks" with them</p> <p>Involving family members in Domestic Homicide Reviews</p> <p>Linking with the Western Bay Area Planning Board and contributing to the work plan of the children and young people's subgroup (NB this does not feature in the listing of subgroups)</p> <p>[Re governance]Developing a performance framework, effective data collection and consistency of practice</p> <p>[Re establishing links with partner agencies] Being informed about relevant national reports, linking with other Boards, the National Board and the Domestic Violence Forum and ensuring that lessons from practice reviews are disseminated</p> <p>[Re engage with citizens and providers] ensure that they, and the wider workforce are fully informed and engaged in the work of the Board</p>

**Table (d) The Achievements of the Regional Boards**

Safeguarding Board Area	Achievements
Cardiff and Vale	The Child Sexual Exploitation Strategic Group contributed to the review of the All Wales CSE Protocol; the plans are aligned with the local authority corporate plans and departmental delivery plans; Vale of Glamorgan has a Task Force and Cardiff run multi-agency strategy meetings and multi-agency child exploitation meetings; a CSE professional interest group ensures a coordinated approach; the board has the infrastructure, leadership, governance and planning arrangements in place to enable it to function more effectively; it has been responsive to such emerging priorities as Adverse Childhood experiences, Female Genital Mutilation; three workshops have developed the resilience of the Board
Cwm Taf	There is a clearly defined Terms of Reference and role profiles for Board members; the Board's functions are implemented via committees and subgroups; the Business Unit provides management, coordination and support; the sub group structure is continuously being reviewed and improved; a Children's and an Adults Operational Committee are responsible for the annual work plan; a review of third sector preventative services; raised an awareness among professionals of the importance of good care and ensuring that appropriate safeguarding training is being delivered; collaboration with the Together for Mental Health Partnership and an inclusive protocol; a Deprivation of Liberty Safeguards governance structure and an associated risk monitoring process. The Annual Report presents referral data; Child Protection Register data; referrals to the Multi-Agency Safeguarding Hub and the number of daily domestic abuse discussions; percentages of repeat referrals; and Board attendance data
Gwent	-
Mid and West	A coherent board structure; a clear strategic focus; a regional performance and quality assurance framework; a strong Board identity; strategic buy-in from Board members and partners; a solid alignment between the children's and adult's Board; and a strong relationship between the Executive Board and the junior board
North Wales	There is a stable membership and the Boards have continued to provide appropriate challenge; the subgroups have regular attendance; there has been a single Adult Practice Review which recommended the development of a self-neglect protocol; there were six referrals to the Child Practice Review Group...action plans facilitate the monitoring and quantifying of outcomes; the Voice of the Child Conference highlighted the importance of ensuring that a child's direct testimony is evidenced in practice and in reviews of practice; the success of Safeguarding Week was achieved via multi agency collaboration; both boards have continued to develop pages on the website
Western Bay	The Annual Report presents the number of Child Practice Reviews considered and Child Sexual Exploitation statistics, that is, children at risk broken down by locality, by age, by gender, looked after status, child protection registration status, and children with a history of going missing.

**Table (e) – Purposeful collaboration**

Safeguarding Board Area	Collaborations
Cardiff and Vale	The Business Manager has established close links with other Regional Boards, the Welsh Government and an English safeguarding board concerning a Child Practice Review; there is regular contact with the Welsh Government concerning Child Practice Reviews
Cwm Taf	Bi-monthly Regional Business Managers meetings with Welsh Government; working jointly to deliver the annual National Safeguarding Week; there is an agreement to share published Child and Adult Practice Reviews with other Regional Boards; interest in Adult Practice Reviews have resulted in collaborations with four English safeguarding boards; the Multi-Agency Safeguarding Hub (MASH) has supported Cardiff in creating a MASH and has hosted a London Borough and the Metropolitan Police in order for them to make improvements to their own MASH structure. There are links with the Public Service Board, the Community Safety Partnership and Together for Mental Health, the National Independent Safeguarding Board, Local Authority Public Protection (Trading Standards) and the Children’s Commissioner.
Gwent	The Annual Report presents data concerning delivered training courses and the employers of attendees; data concerning Violence Against Women Domestic Abuse and Sexual Violence training and the employers of attendees
Mid and West	The Regional Board has worked with the Violence Against Women Domestic Abuse and Sexual Violence Executive Board is to be incorporated into the Regional Board; the National Independent Safeguarding Board representative attends the cross-cutting section of the Executive Board meetings; work with Social Care Wales and the Association of Directors of Social Services Children enabled a reflective discussion concerning safeguarding training; CASCADE at Cardiff University and the Board jointly facilitated a multi-agency consultation concerning Child Sexual Exploitation; the Board supported the Police and Crime Commissioner at a conference about coercive control as a form of domestic violence; Carmarthenshire has undertaken a Multi-Agency Professional Forum on behalf of the Western Bay Board; the Regional Board Managers meet regularly and the Boards’ Business Managers meet with Welsh Government and the National Independent Safeguarding Board
North Wales	Membership on subgroups includes representatives from statutory partners as well as advocacy groups, housing groups, voluntary organisations and councils; practice reviews have been undertaken with independent reviewers and learning events attended by multi-agency representatives; Safeguarding Week engaged with agencies and other Boards to promote awareness raising; Trading Standards updates the Board; a missing persons protocol was piloted with the police and care home managers; Adult Practice Review “concertina card” was developed with the police; Escalating Concerns is the focus of joint work with the Regional Commissioning Board; the business manager/ coordinators attend the All Wales Business Managers’ meetings; the boards have hosted successful conferences and a “roadshow” as a result of multi-agency working
Western Bay	-

## Appendix 3:

# The effectiveness of Regional Boards and safeguarding training

**Table (f) The effectiveness of Regional Boards**

Safeguarding Board Area	Effectiveness
Cardiff and Vale	-
Cwm Taf	Abuse categories and recording methods have changed; a Policies and Procedures Group ensures that there are processes in place for the development and review of protocols and procedures e.g. Managing Large Scale Safeguarding Investigations; the Adults Quality Assurance Group developed a case audit tool and learning tool to support good practice and areas for development. Ten case practices were completed; the adult review group considered seven new cases; and the Board supported the completion of a Domestic Homicide Review. The report presents referral data since 2014 and shows an increase in reports for 2016-2017
Gwent	-
Mid and West	<p>Powys Teaching Health Board, Hywel Dda UHB and the Welsh Ambulance Services Trust contribute to the Executive Board, the Local Operational Group and the subgroup meetings. Hywel Dda presents safeguarding performance data and is raising awareness of safeguarding in its workforce; it has designed and developed a tool for use with children at risk of sexual exploitation, a flowchart for Female Genital Mutilation, a health and dental pathway for Looked After Children. Powys Teaching Health Board’s Director of Nursing is the Vice Chair of the children’s board and the Health Board’s staff are involved in bespoke groups; it links with a Junior Safeguarding Group. Public Health Wales provides independent expert advice to the Executive Board and the Practice Review Sub Groups; nationally PHW have specific expertise as practice reviewers and have led on the dissemination of research concerning Adverse Childhood Experiences. The Welsh Ambulance Services Trust has contributed information to an Adult Practice Review.</p> <p>Dyfed Powys Police provide a vice chair to the adult’s board and the Youth Justice Service and probation services participate in Executive, subgroup and local operational groups. The police have specialist Child Sexual Exploitation investigators who have promoted multi-agency meetings; it has a schools liaison programme; and its work with the junior board concerned missing children. The National Probation Service and Community Rehabilitation Company have worked with the police in the creation of a Public Protection Hub.</p> <p>Carmarthenshire County Council’s Director of Communities has Chaired and provided consistent strategic leadership to the children’s board for several years. The County has implemented Signs of Safety – a model for undertaking child protection case conferences and the reduction in the number of children on the Child Protection Register is attributed to the implementation of this model. It has undertaken specific work on missing children, with the police; and on electively home educated children; it has created a group to share good practice and resources concerning Deprivation of Liberty Safeguards; and having successfully piloted a dedicated Safeguarding Officer in the “front door” team, this role has become a permanent arrangement. Pembrokeshire’s Director of Social Services and Leisure chairs the adults board and the Director of Education provides the strategic lead for education; the County Council has contributed to the development of the Regional Threshold document and the protocol concerning elective home education; it has a Signs of Safety model of practice; and its unified team combines children and adult safeguarding enabling an “all age” approach. Powys County Council’s Director of People chaired the adult’s board until October 2017; the County Council contributed to the regional threshold document and has close links with the junior “eat carrots” group. A Learning Needs Manager is working with (i) local schools to raise awareness of safeguarding practice and procedures and (ii) parent groups for children who are electively home educated. Ceredigion County Council is represented at all Board meetings; its Senior Safeguarding Manager chaired the regional Child Sexual Exploitation group which developed the CSE strategy and plan. It provided support to other areas in the implementation of Multi-Agency CSE meetings; it has introduced an Electronic Outcome Record; commenced an Adult Practice Review which has presented opportunities for improving the process, including additional guidelines for future reviews; undertaken a review of Ceredigion’s Corporate Safeguarding Policy; and developed a regional protocol for parents with identified mental illness.</p>

Safeguarding Board Area	Effectiveness
North Wales	<p>All statutory board members contributed to board meetings and sub group meetings. Betsi Cadwaladr UHB's attendance is inconsistent and this has compromised partnership working. Efforts to seek assurance from the UHB that safeguarding matters concerning Tawel Fan were being addressed were unsuccessful; the Executive Director of Nursing currently attends the Board; senior clinicians were review panel members for an Extended Child Practice Review; UHB members have contributed to an Adult Safeguarding Report Form, a refresh of the Escalating Concerns process and a review of the Professional Concerns Protocol; the availability of an "out of hours" Child and Adolescent Mental Health Service and S.136 suites<sup>2</sup> has been challenged. An increasing number of young people perceived to be in mental health crisis are presenting to Emergency Departments. The Welsh Ambulance Services Trust has participated as a panel member on an Adult Practice Review Appeal Panel. The National Safeguarding Team members of Public Health Wales NHS Trust regularly update on national pieces of work on which the Team provides collaborative leadership.</p> <p>A North Wales Police representative is the vice chair of the children's board; the police have chaired a Multi-Agency Professionals Forum; it has also revised the process for ensuring best practice in cases with parallel criminal proceedings. A process chart has been devised; the police have been represented on Child and Adult Practice Review panels and at learning events. Wales Probation Service has contributed to the Child Practice Review process but "would benefit from internal refresh." The Community Rehabilitation Company fields a vice chair for the children's board. The member has chaired an independent review appeal panel and the budget sub group. The Youth Justice Service is represented on the children's board and its managers are involved with the delivery groups.</p> <p>Conwy's Strategic Director of Social Care and Education Services chairs the children's board and attends the adults' board. Conwy's practitioners have established a monthly Child Sexual Exploitation forum which discusses practice issues and a Sexual Exploitation Risk Assessment Framework panel has been created. All children's cases subject to the process are presented and reviewed. Conwy provided a reviewer for a Child Practice Review. Denbighshire's Strategic Director of Social Services is a member of the children's and adults' board; representatives have contributed to an Extended Child Practice's Action Plan Review and two Adult Practice Reviews. Flintshire's Chief Officer chairs the adults' board. The senior manager for Safeguarding and Commissioning is working on an Adult Practice Review. The Director of Gwynedd Social Services attends the adults' board and the head of Children and Supporting Families attends the children's board. They have chaired an Adult Practice Review and three Child Practice Reviews respectively. Two senior managers have contributed to the reviewing process. The Isle of Anglesey Council's Head of Adult Services has chaired an Adult Practice Review for which the department's Safeguarding Coordinator acted as a reviewer. The Head of Children's Services chairs meetings of the Gwynedd and Anglesey Child Sexual Exploitation and Missing Children sub group. It has committed to using the NSPCC's Harmful Sexual Behaviour audit toolkit. Wrexham County Borough Council's Head of Department has chaired a Child Practice Review and two members of staff have undertaken reviews, including a Multi-Agency Professionals Forum.</p> <p>The North Wales Fire and Rescue Service contribute to the local delivery groups and is represented on the Adult Practice Review group.</p> <p>Care Forum Wales is represented on the adults' board and the adult delivery groups. Barnardo's is represented on the children's delivery groups and chairs the Child Practice Review Group. The NSPCC is represented on this review group and the children's board. It provides a recovery service for children and young people who have been victims of sexual abuse; and to those who are risk of sexual exploitation; its Share Aware campaign is delivered to schools; and information concerning child protection research is shared across the region.</p>
Western Bay	-

Table (g) Planning for Safeguarding Training

Safeguarding Board Area	Training plans
Cardiff and Vale	Ensure that the risk and impact of Child Sexual Exploitation forms part of safeguarding training for all staff...this includes awareness raising, warning signs and the responsibility to report and respond...review of revised approach to training (predominantly strategic oversight by the Board, although delivery of working together will be maintained along with some multi-agency access to single agency delivered events); the planning and preparation of a safeguarding policy for mosques and other Islamic settings which also ensured a training plan was developed; a training mapping exercise was undertaken at the beginning of 2017
Cwm Taf	The Board ensures that safeguarding inter-agency training and dissemination of learning and research is used to support a more confident and knowledgeable multi-agency workforce...a review and analysis of the training needs of practitioners. A strategy for safeguarding training should take account of themes and learning arising locally and nationally from audits, adult practice reviews, investigations and research findings...develop a training calendar...ensure that learning is disseminated on a multi-agency basis...learning from Adult reviews, case audits and inspections is shared with practitioners on a multi-agency basis...develop a format for a Multi-Agency Practitioner Forum to disseminate learning...ensure that action plans continue to be monitored
Gwent	Support the workforce with the implementation of the Act through the provision of training and information...new policy and procedures written and issued with training on its application...develop a preventative training package for vulnerable groups...Violence Against Women, Domestic Abuse and Sexual Violence training courses...identify the range of training that is available for staff in residential settings and share as a best practice guide...support residential settings to prevent abuse and neglect by learning lessons...thematic reviews of cases in the care settings and share the lessons with frontline care staff...training and guidance will reflect learning from audit (of child protection planning)...a training strategy review (concerning Child Sexual Exploitation) will consider invisible siblings, historical issues, activating preventative services...raising awareness of the 'top three concerns' for internet safety/ the level of substance misuse amongst young people (and its) misuse as a grooming tool...mental health concerns
Mid and West	Mapping Regional multi-agency training needs; identifying gaps; commissioning and delivering cost-effective, specialist training; ensuring best use of resources. In the wake of a Child Practice Review, multi-agency training was commissioned; the attending agencies are "considering and planning how to best disseminate the key messages...across their organisations"
North Wales	To learn from Adult Practice Reviews, Serious Untoward Incidents, Serious Further Offences etc and ensure that the learning is shared across North Wales...regularly updating learning log...circulating lessons reports...making safeguarding a priority for all the workforce...Safeguarding Training Planning...Ensuring that the workforce has the necessary skills to meet current and future demands...targeted training is delivered relating to the Board's priorities...establish links between the Workforce Development and Training Group and the Workforce Development Business Manager; outcomes for vulnerable adults are improved because the workforce is safe, skilled, proactive and family focused
Western Bay	Promote the Strategic Management Group to become an enabler for safeguarding training across the region...focus on adults and children...enquire and ensure training delivery...undertake a training needs analysis to identify gaps...identify resources...develop a quality assurance framework to measure quality of multi-agency safeguarding training

2 S.136 of the Mental Health Act 1983 allows a constable to remove a mentally disordered person from a public place to a place of safety for up to 72 hours. The place of safety could be a police station or a hospital

**Table (h): An inventory of the training topics and recipients cited in the Regional Boards' annual reports**

Safeguarding Board Area	Training topics
Cardiff and Vale	Training opportunities are provided to all agencies concerning Child Sexual Exploitation
Cwm Taf	Adult Protection and Support Orders to nominated staff; an awareness raising/ training session delivered on a multi-agency basis; Child Sexual Exploitation and awareness raising with transport, licensed premises, voluntary sector and schools; 113 safeguarding children related courses delivered to 1833 delegates across 14 agencies; 21 safeguarding adults training courses delivered to 320 people from seven agencies; Deprivation of Liberty Safeguards and Mental Capacity Act training delivered to 179 people; practitioner feedback event
Gwent	Trained thousands of volunteers and workers to be able to identify and report concerns about children and work with families where there are issues about abuse and/ or neglect; child protection; hidden sentence; managing young people engaged in Harmful Sexual Behaviour; neglect; awareness of "legal highs"; level 2 "Recognition and Referral" training; introduction to safeguarding; safeguarding children – Recognition and Referral and Child Protection Planning; safety with technology; Sexual Exploitation Risk Assessment Framework; sexual awareness; self harm and suicide; coercive control; domestic abuse awareness; Domestic Abuse Stalking and Honour based violence and Multi-Agency Risk Assessment Conference; Forced marriage and honour based violence; sexual violence; understanding perpetrators; working with victims; working with men who suffer domestic abuse
Mid and West	Hywel Dda has contributed to the delivery of training for newly recruited foster carers... Dyfed Powys Police has delivered vulnerability training to all front line officers and Llamau has been commissioned to undertake debrief sessions with children and young people who have been reported missing...a Learning Needs Manager has been working with local schools to raise awareness of safeguarding practice and procedures...also linked with parents who are home educating with a view to engaging them in improving safeguarding practice...multi agency training concerning working with difficult, dangerous and evasive families...working with children who display sexually harmful behaviour...Prevent...hate crime and Team Around the Family support
North Wales	Child sexual exploitation awareness training for taxi drivers and escorts; Child Sexual Exploitation training for teaching and non-teaching staff, liaison officers, school nurses, school counsellors, governors, designated safeguarding individuals; extensive programme of safeguarding training for local authority staff undertaken across north Wales; training on the Board's function and responsibilities; from January 2016 to February 2017 the Board provided Virtual College with a series of e-learning courses for all partner agencies; and training on the Board's function and responsibilities
Western Bay	Child Sexual Exploitation; Operation Jasmine; Workshop to raise awareness of Prevent; domestic abuse awareness; Social Services and Well-being Act 2014; Violence Against Women, Domestic Abuse and Sexual Violence Act 2015

## The Response to the S.139 request

North Wales (NW) and Western Bay (WB) responded. Western Bay's Regional Board designed a survey monkey questionnaire so the replies do not consistently tally with those of north Wales' Regional Board.

**Identifying skill gaps:** NW - the local authorities use a combination of supervision and appraisal feedback. To different degrees they are responsive to the specific needs of new employees and requests from (i) safeguarding personnel (ii) external agencies (iii) employees (iv) managers (v) providers (vi) inspections and (vii) feedback from solicitors, for example. The Social Care Workforce Training Directory, Quality Assurance monitoring and course appraisal forms play a part in mending identified skill gaps. In addition, Wrexham's Practice Development Manager facilitates Action Learn Sets<sup>3</sup> and Conwy hosts an Adult Safeguarding Forum.

Betsi Cadwaladr UHB uses a Core Skills Training Framework and compliance reports are reported each month. The ambulance service determines gaps by reviewing safeguarding materials. It identifies organisational learning through near miss and adverse incident reporting. Public Health Wales conducts annual development reviews. Its Training Matrix sets out the level of training required for specific roles.

WB: -

**Undertaking training needs analyses:** NW - the local authorities respond to the Welsh Government's annual Workforce Survey and as members of the Local Social Care Workforce Development, topics are defined by discussion concerning induction programmes, contracts and commissioning, escalating concerns meetings and the findings of Credit and Qualifications Framework assessors for example. Internally, questionnaires are used and the findings are considered with staff development and training officers.

Betsi Cadwaladr UHB uses an Organisational Learning Management system which links to the NHS e-learning platform. The ambulance services' safeguarding team and the National Ambulance Training College lead their analysis and Public Health's Training Strategy and Training Matrix are the means by which training needs are determined.

WB: -

**Training and staff/ manager turnover:** NW - the local authorities repeat essential training on an annual basis. Flintshire has identified independent training agencies via a procurement exercise and created a voucher scheme. This gives autonomy to independent social care providers by permitting them to exchange vouchers for core courses – that is on the basis of their own training needs analysis and any training needs arising from staff and management turnover. Denbighshire promotes the Social Care Passport which enables logged training to be transferred to new employment. In addition, its Designated Lead Managers are provided with one-to-one coaching and mentoring sessions. Conwy's Human Resources software is used to identify training needs according to roles and functions.

Betsi Cadwaladr requires new staff to attend "an orientation process." The ambulance services provide induction training and new posts are supported with bespoke training. Monitoring ensures that existing staff maintain statutory and mandatory training requirements. Similarly, Public Health employees receive induction training and are informed about the staff directory and intranet which includes safeguarding intranet pages.

WB: -

**Rationale for training:** NW - the local authorities provide mandatory safeguarding training and are responsive to new and existing legislation and needs analyses for example. Gwynedd provides bilingual courses and the Isle of Anglesey takes account of language needs when organising training.

Safeguarding training, which is delivered in English, is mandatory for the Health Board. Although multi-agency training has been discussed it is not delivered. The ambulance services support staff to achieve personal safeguarding training goals and encourages staff to attend multi-agency safeguarding events. It has also co-hosted learning events with partners. The services conduct most courses in English and have conducted some in Welsh. The National Safeguarding Team of Public Health Wales has contributed to the development of Levels 1 and 2 of safeguarding competency which are accessed via e-learning. Level 3 training is delivered by the corporate safeguarding team via classroom based sessions. The National Safeguarding Team also organises Level 4 training events for NHS Wales. All courses are provided in English.

WB: states that mandatory training is prioritised and the principal rationale is to raise care standards and manage risk. Agencies state that their principal "improvement goals" are "All relevant staff to be trained appropriately," and "continuing professional development."

**Implementing legislation and policy:** NW - the local authorities have updated their training resources to reflect new legislation. Social Care Wales' training hub concerning the Social Services and Well-being Act is widely promoted in social care.

Betsi Cadwaladr has invested in (i) "train the trainers" events (ii) a review of its mandatory training to ensure that the Act's implications are incorporated and (iii) training delivered by local authorities. The ambulance services' continuing professional development courses reference the Act and the intranet enables access to Social Care Wales' hub concerning the Act. Public Health Wales' programmes have been updated to reflect key legislative changes.

WB: the legislation is reflected in training activities.

**Sites of learning:** NW - the local authorities use a combination of their own training facilities, Glyndwr University facilities, Venue Cymru, the Llandudno Rugby Club. Typically external locations are identified to accommodate larger numbers.

All Betsi Cadwaladr UHB and ambulance services' training is conducted on organisational premises. Public Health Wales employees access and complete e-learning training via their Electronic Staff Record and may be completed at any convenient location. The classroom based training is delivered in a variety of locations within north Wales, Mid and West Wales and South East Wales.

WB: "in-house" is the most typical training location, perhaps since seven agencies stated that training occurs "via team meetings."

**Resources for practitioners:** NW - the local authorities use resources such as the Welsh Government website for legislation and policy, e-learning modules, Child and Adult Practice Reviews, Social Care Wales' information and learning hub, case studies and Community Care Inform.

Betsi Cadwaladr UHB uses e-learning and the ambulances services' stakeholder and partner agencies on-line learning. Public Health Wales similarly rely on the staff intranet.

WB: cites non-specific "on-line resources" and "research materials" and six agencies cited "journals."

**Training content:** NW - the local authorities offer basic safeguarding induction, Child Sexual Exploitation, Modern Slavery, Female Genital Mutilation, Human Trafficking, Appropriate Adult, Approved Mental Health Practitioners, Best Interests Assessors, understanding sex offenders awareness training, suicide and self-harm, Deprivation of Liberty Safeguards, investigation training and risk training.

Betsi Cadwaladr UHB uses the Child Sexual Exploitation podcast. The ambulance services' training includes people trafficking and modern slavery. All Public Health Wales staff are required to complete Violence Against Women, Domestic Abuse and Sexual Violence training via e-learning.

WB: cites training concerning legislation, policy concerning adult protection and child protection planning with Child Sexual Exploitation cited by nine agencies.

**Methods of learning:** NW - the local authorities offer case-study work/ problem solving, team meetings, Action Learning Sets (in Wrexham and Flintshire), classroom and practice based learning.

The Health Board promotes during face to face training, feedback opportunities during and learning events concerning complex cases, including external learning events. The ambulance services use classroom based training and problem-based learning and links to e-learning sites are promoted. Public Health Wales combines e-learning and face to face training.

WB: cites internal and externally delivered training and four agencies referred to "multi-agency training." "Face to Face" training, learning and practitioner events were cited by 12 and ten agencies respectively. "E learning" is used by eight agencies.

**Training audiences:** NW - the local authorities hosted several courses which attracted over 100 attendees. These concerned the Act, joint (safeguarding) awareness – with the independent sector, safeguarding awareness, safeguarding refresher training and Deprivation of Liberty Safeguards made simple. Numbers of attendees were not supplied by other organisations.

WB: "Social care" and "the third sector" head the "types of audience" agencies "have for training."

**Training frequency:** NW - varies across the local authorities and health services with training programmes typically set out in plans and brochures.

WB: -

**Training evaluation:** NW - the local authorities typically evaluate training immediately after delivery. These are reviewed in relation to content and style. This may result in additional commissioning of particular trainers. It has resulted in feedback to the Welsh Government concerning unclear codes of practice for example. Health services similarly review training after delivery.

WB: "Feedback sheets," appraisals, supervision and professional development meetings are the typical means by which training is evaluated.

**Annual spend for safeguarding training:** NW - the six local authorities spend between £12,200k and £22k with an average spend of £18k. Betsi Cadwaladr UHB spent £3,314. The ambulance services and Public Health Wales could not identify their spending.

WB: £20K

The North Wales Board provided contrasting accounts of **safeguarding exemplifying poor and good practice**. The former concerned a widower of 83 who had been in a nursing home for six months. A fall resulted in his admission to hospital where he remained for several weeks. On return to the home a Tissue Viability Nurse was asked to review him. He had a necrotic, deep pressure ulcer and the nurse advised a safeguarding enquiry. When the nurse visited a month later the man was without specialist equipment, there was no relevant documentation and no safeguarding enquiry had resulted. The home had also been urged to complete a safeguarding enquiry by other healthcare professionals. The local authority was informed that there were five additional safeguarding concerns about the nursing home. Ultimately it was found that the man's tissue damage could not have been prevented due to "complex co-morbidities". The learning associated with this man's circumstances included: the reluctance to outreach staff to escalate or undertake an adult at risk inquiry; professionals' misgivings concerning the home should have been discussed with the home prior to initiating an enquiry; the number of safeguarding enquiries is not a proxy for establishing the quality of a home's provision.

In contrast, a primary school's head teacher discussed the poor attendance and unkempt appearance of a 7 year old girl with the school nurse. The girl's mother asserted that her daughter had an immune system problem. The mother was described as "aggressive towards staff". The nurse advised a child protection referral and sought to arrange a home visit. The girl's mother declined the visit but gave the nurse permission to contact the GP for further information. When it was established that the child had no specific health issues, contact with the Health Visitor highlighted the mother's failure to bring her youngest child for routine checks. The nurse called a multi-agency professionals' meeting at which it was established that the children's mother had poor mental health and misused alcohol. A resulting S.47 investigation<sup>4</sup> confirmed the intelligence shared at the professionals' meeting and in addition identified the 7 year old as a young carer. The children's names were added to the Child Protection Register. A multi-agency child protection plan was made and support put in place.

WB: provided no practice examples.

**Separately**, Cwm Taf identified three case studies in its annual report:

1. The mother of two children, whose mental health was compromised, disclosed that she was hearing voices telling her to harm one of her children. Multi-agency information sharing determined that the household was associated with domestic abuse, neglect and poor home conditions and since there had been previous child protection proceedings, a S.47 was invoked.
2. When a woman informed children's services that she had been sexually abused as a child by her father and uncle, support was provided to her and safeguarding arrangements were put in place for her grandchild who had regular contact with one of the men. The men were arrested and a criminal investigation began.
3. A woman who was receiving support from adult services had been subject to domestic abuse. She was stalked and harassed by her ex-partner. The Multi-Agency Safeguarding Hub determined that he had previous convictions and he had absconded to England. Information was shared with the relevant police force and he was arrested. The case featured in the and was referred to the Multi-Agency Risk Assessment Conference. The woman's support was supplemented with that of the Independent Domestic Violence Advisory Service.

<sup>4</sup> Of the Children Act 1989 - if a child is taken into police protection, is the subject of an Emergency Protection Order or there are reasonable grounds to suspect that the child is suffering or likely to suffer significant harm, a S. 47 enquiry determines what actions are required

## Appendix 4:

# The words which appear most frequently in the Regional Boards' annual reports

### Cwm Taf Safeguarding Board

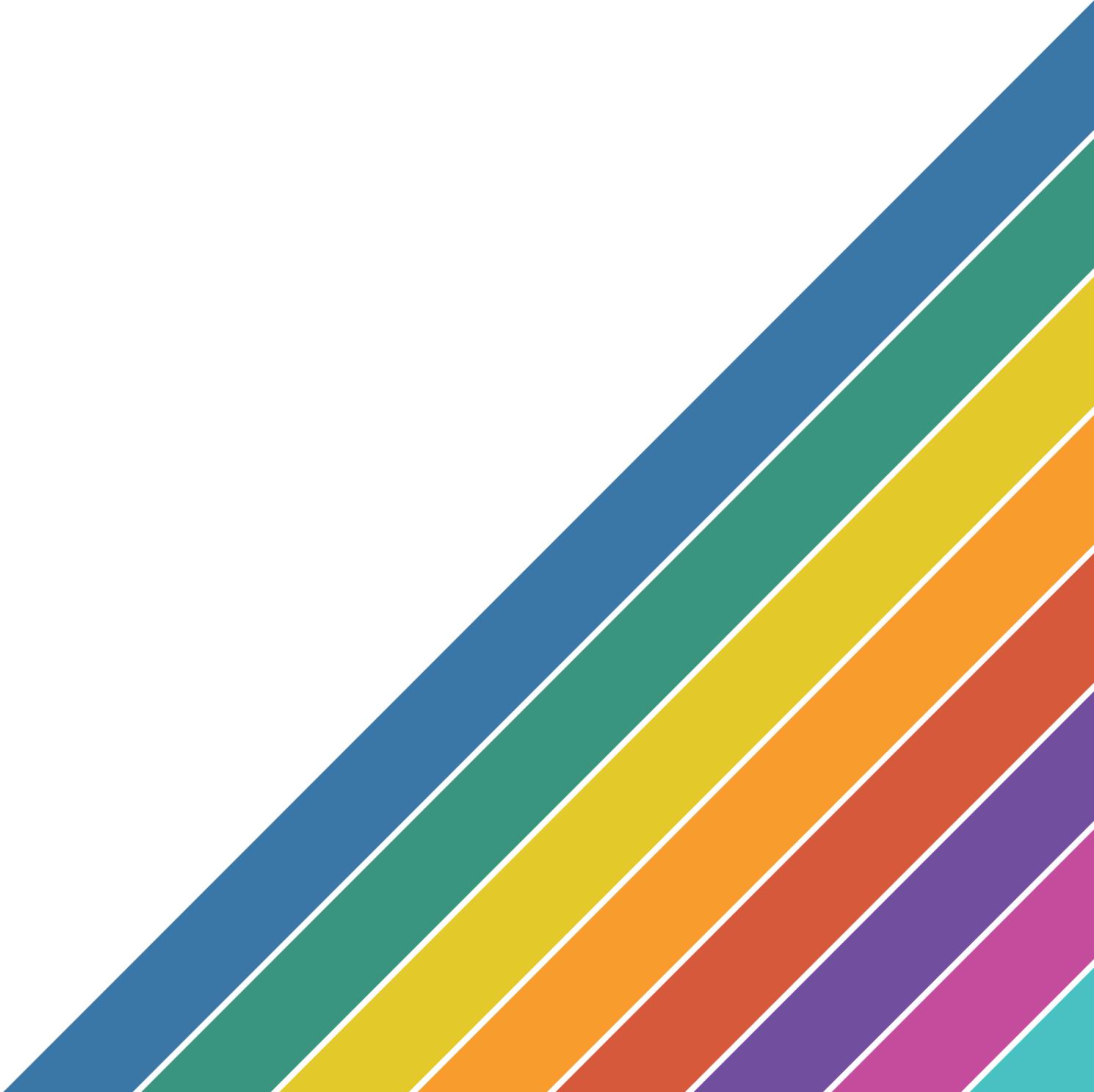


### Cardiff





Services Bay Act  
**Board**  
Wales Group  
CSE Bridgend  
plan 2016/17 representative  
Swansea risk cases year Child  
Business WBSCB children Service Management  
**Safeguarding**  
**Children**  
**Western**  
identified



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