Manchester Metropolitan University

UNIVERSITY OF LIVERPOOL

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

Risk, Response and Review: Multi-Agency Safeguarding

A THEMATIC ANALYSIS OF CHILD PRACTICE REVIEWS IN WALES 2023

BRIEFING REPORT
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AUTHORS

Professor Michelle McManus, Professor of Safeguarding and Violence Prevention at Manchester Metropolitan University.

Emma Ball, Research Associate of Safeguarding and Violence Prevention at Manchester Metropolitan University.

Professor Louise Almond, Professor of Investigative and Forensic Psychology at University of Liverpool.

> **“Further work is needed to support practitioners to work with confidence, particularly in ‘grey’ areas of professional uncertainty where concerns exist, sometimes long-standing, but where the threshold for statutory intervention is not met”**

Risk, Response and Review: Multi-Agency Safeguarding

A THEMATIC ANALYSIS OF CHILD PRACTICE REVIEWS IN WALES 2023

This Briefing Report summarises the findings of an analytical review of 33 Child Practice Reviews (CPRs) that were undertaken by the six Regional Children's Safeguarding Boards (RCSB) in Wales between 2013 and 2021.

Where children suffer significant harm resulting in serious and permanent damage or death within their families, a Child Practice Review (CPR) provides the opportunity to understand issues and improve professional and organisational practice. A CPR is a multi-agency review involving practitioners, managers and senior officers and explores the detail and context of agencies' work with the child and their family. Each review represents often deeply distressing events for victims, their families and the practitioners involved. We are grateful for their contribution.

Our research team conducted descriptive, inferential and thematic analyses of 33 CPRs. The analyses identified common trends in terms of risk factors and the multi-agency safeguarding response across this cohort of reviews. In addition, we analysed the quality and consistency of the reviews themselves. We sought to highlight the challenges, support better practice and remove barriers to effective safeguarding across the entire professional safeguarding network.

The authors wish to emphasise that these reviews represent a very small minority of safeguarding scenarios, which should not be taken as being representative of professional safeguarding practice in general. However, this minority represents an important group of cases, where it is imperative to reduce likelihood of future incidents and maximise actions to improve and strengthen practice. Whilst we cannot guarantee that the recommendations set out in this briefing would have helped avoid the tragic outcomes which prompted these CPRs, we are confident that they will support the development of improved safeguarding practice in the near future.

This briefing report, alongside the full report, aims to be constructive, not critical. Just as every CPR exists to promote improvement in multi-agency and child protection practice, our research exists to minimise harm and maximise learning – across Wales, and well beyond.

KEY FINDINGS

1. RISK FACTORS

Our analysis of the children who were subject to a review (index child) and their parents/carers revealed trends which highlight the need for greater awareness and monitoring of risk factors, particularly when these co-occur or accumulate. We found that:

- Two thirds of CPRs were prompted by a child's death.
- Suicide, other medical/health issues and non-fatal physical abuse were the most common incidents.
- A fifth of the children were up to 3 months old when the incident occurred, while a fifth were 13 years old and over.
- Three quarters of the children had a sibling. Of these, a third had half-siblings and two thirds were the youngest in the family.
- The most common parental/carer risk factors were drugs/alcohol misuse, mental health issues and domestic abuse relationship.
- There were significant correlations across these risk factors – in particular, mental health issues, criminal history, ACEs (Adverse Childhood Experiences), domestic abuse relationship and young parents.
- Parents/carers with historical experiences of trauma, or ACEs themselves, being a looked-after child or being a young parent – often correlated with behavioural risk indicators (such as criminal history and domestic abuse), or internal manifestations (like mental health illness or drugs/alcohol abuse).
- The children's most common vulnerabilities were emotional abuse, neglect and living in poor home conditions.
- In these children, mental health issues and ACEs correlated with 12 other risk factors.

- There were two clusters of co-occurring vulnerabilities for children – one of factors internally experienced (self-esteem issues, suicidal thoughts, neurodiversity issues and learning difficulties), and another of factors inflicted upon them (neglect, physical abuse, and emotional abuse).

2. RESPONSE: MULTI-AGENCY INVOLVEMENT

Through a descriptive analysis of the CPRs, we identified which organisations and agencies were aware of the child and/or family members prior to the incident, and what depth of information and intelligence these organisations held. We found that:

- A third of CPRs involved a child that was on the Child Protection Register and/or was a looked-after child at any point in the 6 months before the event.
- 94% of index children/families had been flagged or were known to Children's Services. Just 2 were unknown to authorities, with no safeguarding concerns prior to the incident.
- Over half of CPRs recorded a referral/report to Children's Services, which they deemed to be below the level of seriousness which requires threshold for intervention.
- Other key agencies aware of the child or their family included the Police (20 cases out of 33), Midwife/Health Visitor (19) and GPs (17).
- Common topics raised by the CPRs included increased whole-family approaches, professional curiosity, inclusion of child's voice, health information sharing and missed health appointments.

In seeking to understand the barriers, challenges and successes within safeguarding identification and response, we identified **three broad themes** across the CPRs – challenges for practitioners and agencies, structural and procedural issues, and wider influences impacting practice and processes.

THEME 1 – AGENCIES AND PRACTITIONERS

The CPRs revealed that when assessing risk, there were examples of overreliance on self-reporting from families and a lack of challenge of information, sometimes including disguised compliance. Many CPRs encouraged greater professional curiosity from practitioners – though they did not detail how this curiosity can be encouraged, facilitated and embedded within practice.

The reviews also highlighted instances whereby a comprehensive understanding of co-occurring harms was lacking, with examples showing that an accumulation of risk factors was not always considered or recorded. To develop a holistic viewpoint, the interaction between different risk factors – historical, present and potential – must be taken into account.

CPRs acknowledged that there should be a whole-family focus but revealed challenges around the practice of implementing the approach in **three key areas**. Firstly, in understanding the daily lived experience of children and impact upon siblings. Second, ensuring that parents' needs are met and how this impacts the child. And third, a focus on mothers which often resulted in a reduced understanding and inclusion of father's circumstances and perspectives.

Finally, there were repeated references to capturing the child's voice. This included how their views are recorded, how they reflect the daily lived experience of the child and, crucially, how these voices are utilised within decision making.

THEME 2 – STRUCTURES AND PROCESS BARRIERS

The reviews highlighted issues regarding clarity in understanding decision-making and '**threshold uncertainty**' – where an agency makes a safeguarding referral or report, but it does not reach the threshold for statutory intervention. CPRs noted that agencies should *"continue to refer to Children Services should neglect concerns persist"*. There was also uncertainty around escalating and monitoring safeguarding concerns internally and a lack of confidence in challenging decisions by senior members of staff.

Information sharing is a longstanding issue. The CPRs showed that the infrastructure which is in place to routinely share information is not always clear and there is confusion around **coordination ownership**. In instances where safeguarding concerns do not reach a threshold decision that warrants statutory intervention, the pathways for coordinating safeguarding responsibilities between agencies can be unclear. A key barrier is the lack of logistical structures for sharing accumulative information, with one CPR noting that *"information sharing platforms that support multi-agency information sharing being absent or not compatible"*.

A common theme was the complexity of health as a sector. Health is segregated by diverse remits, complex structures and fragmented IT systems. The CPRs show that information is often known but not routinely shared. There is limited infrastructure to support standardised and efficient sharing of information, particularly when some records are electronic and some manual. Ultimately, the *"Health Board does not have a single patient record"*.

Model of Health **Complexity**

Health is not a single unified organisation. Aspects of the system operate separately, presenting logistical challenges to aligning and coordinating services. The GP surgery is potentially the most likely single health commonality across family members, where key information could be collated and understood.

Adult's Health Needs Touch Points

Child's Health Needs Touch Points

THEME 3 – WIDER INFLUENCES ON PRACTICE AND PROCESSES

The CPRs also identified external influences on practice – the challenges around the workforce and the difficulties of safeguarding during the Covid-19 pandemic.

The CPRs highlighted issues around a shortage of sufficiently experienced safeguarding staff. This valuable experience can enhance practitioners' ability to respond to concerns, understand the wider picture and to build trust with families. Ensuring that practitioners are confident and competent at working with the whole family within a challenging environment requires regular training and a supportive work culture, with capacity to facilitate effective supervision across all levels of the workforce.

The Covid-19 pandemic and the social distancing measures to combat it had a profound impact on safeguarding for all agencies. Scaling back face-to-face contact made many families far less visible, while school closures had a similar impact – even though some children known to authorities were allowed to attend, many did not. Practitioners were put under immense pressure to balance the risks posed by Covid with other safeguarding concerns. Even as new policies and technological developments were implemented to mitigate restrictions, it is imperative to highlight that there is no substitute for face-to-face interactions when assessing risk.

GOOD PRACTICE

CPRs highlighted instances where practitioners demonstrated professional curiosity and considered historical information and the potential of co-occurring risks in addition to responding to the whole family. This was evident across sectors. There were reports of agencies undertaking good quality assessments and procedures being followed. There were instances of collaborative working, such as joint visits with different departments and between agencies, and transitional agency support being considered after statutory involvement. Good practice of information sharing was highlighted as being facilitated through informal meetings but also formal channels, with practitioners proactively seeking and sharing information.

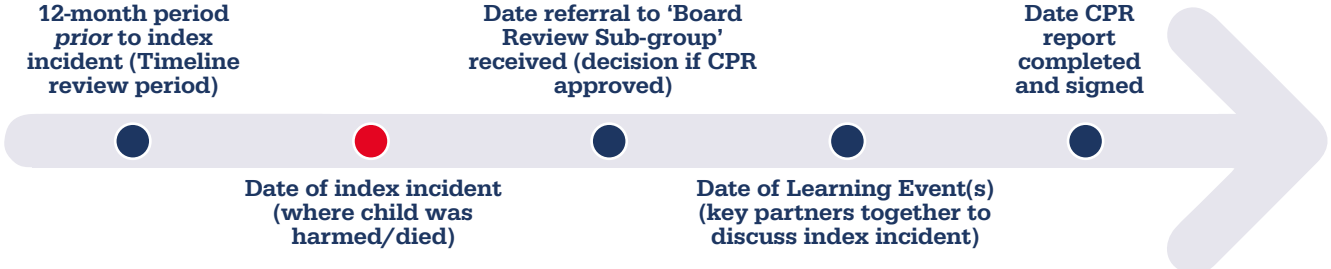
The CPRs highlighted examples where practitioners had the clarity, confidence and competence and capacity to work together effectively to safeguard, in addition to the processes and systems functioning operationally to support this. Whilst this may be standard practice, there are occasions where practice does not operate consistently in this way.

3. REVIEWING THE REVIEWS

Given the aims of a CPR, it is vital that they are clear, consistent and offer recommendations which can be translated into meaningful actions. As such, we examined the quality of CPRs, in terms of structure, content and adherence to established processes. We found that there was variability across CPRs:

- Many CPRs did not include key dates – of the index incident, of referral to the CPR sub-group, of the learning event or of final publication. This makes assessing their adherence to processes difficult.
- All CPRs failed to complete the CPR process within 6 months of referral to completion of CPR report (as per Working Together to Safeguard People, Vol 2). The average was 20.7 months.
- It took an average of 4 months for the index incident to be referred to the Board Review Sub-Group.
- CPRs took an average of 28 months from index incident to completion of CPR report (range 14.6 months – 66.3 months).
- It took an average of 18 months for a Learning Event to be held after the index incident – presenting challenges for recalling details, decisions and actions.
- Social Services and Well-Being (Wales) Act 2014 states a maximum 12-month timeline preceding the index incident should be the focus of the CPR report. However, half exceeded this timeline (some over 2 years), though most provided a rationale for taking longer.
- Around two-thirds of CPRs noted the incident time-period and/or the review period occurred during Covid-19 restrictions.

Key dates within the CPR Process

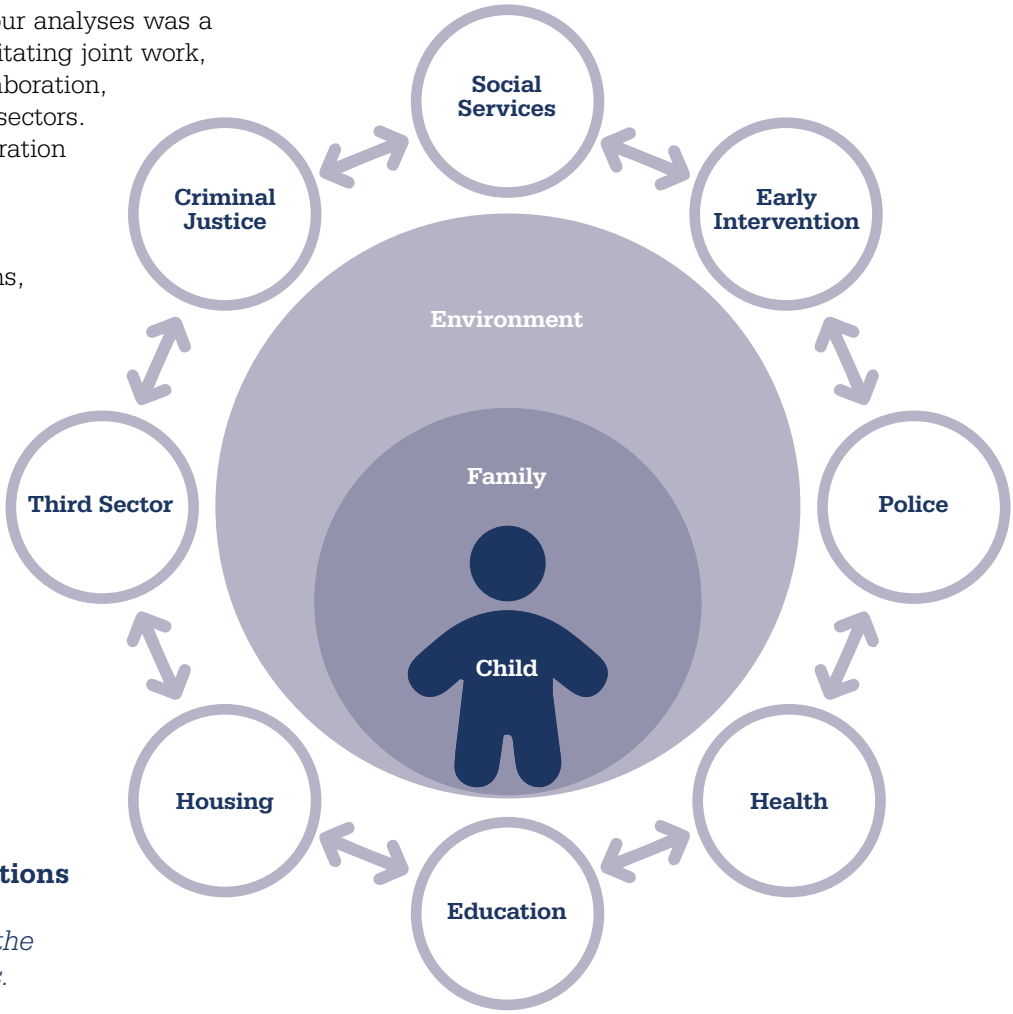


Strengthening Collective Safeguarding **Responsibility**

There are no simple answers to the issues described in the CPRs. Complex challenges demand a multi-agency response. Although safeguarding is everyone's responsibility, the CPR sample revealed clear examples where there were challenges in establishing a **collective safeguarding responsibility**. One where there is a consistent, systemic response and all practitioners can meaningfully contribute. The remit of working with a whole family and their environment does not easily align to any single practitioner or agency. Multi-agency working is imperative, but agreement and consensus is not the same as logistical facilitation. This requires effective working relationships between competent practitioners, all of whom must have clarity over what is expected of themselves, fellow practitioners and the system itself. This must operate collaboratively and be aligned across all levels, not just at the point of crisis when a safeguarding concern reaches the threshold for statutory intervention.

Yet an overriding feature of our analyses was a lack of infrastructure for facilitating joint work, information sharing and collaboration, not just between but within sectors. There are barriers for collaboration between GPs, Midwives and Health Visitors and School Nurses – they have different information-recording systems, different structures, remits and objectives. Although all considered a part of 'Health', there is limited shared access to central information or routine information and thus collaboration must be enabled and not assumed.

Practitioners are continually asked to be 'professionally curious'. This not only demands confidence and competence, but also assumes that there is a supportive infrastructure to pursue, progress and act on potential concerns. The reality of safeguarding is that it is not a linear journey and the number of potential agencies who are involved with a child, family member or their environment at any one time is often underestimated. Moreover, the assumption that there are direct pathways for these agencies to collaborate using compatible systems, is not always the case. The Model of Multi-Agency Connections, Considerations and Complexities illustrates the various complexities a multi-agency response is required to consider and highlights the potential avenues for disconnect. While this is not a new phenomenon, it remains a challenge.



Model of Multi-Agency Connections, Considerations and Complexities

See Discussion Section in the Full Report for more details.

Missed Appointments and **Opportunities**

It is a reoccurring theme in previous reviews (Rees et al., 2021; The Child Safeguarding Review Panel, 2022, NSPCC, 2022) that the biggest challenge is 'Information Sharing'. Many CPRs raised the issue of missed health appointments, with reference to the 'Was not Brought' Protocol needing to be followed and actioned. But even for this one aspect of intelligence, there is a lack of ability to record, collate and share this information. Questions remain around ownership, accountability and coordination of future action required to respond to this information through a safeguarding lens. See 'Deep Dive: Missed Health Appointments' within the Discussion section of the full report for further information and a case example.

The absence of an effective and singular patient or family record, or shared IT system across Health services is an everyday barrier for practitioners. There are multiple layers of intelligence alongside missed health appointments that can build a more accurate picture, including poor home conditions and police domestic abuse attendances. Currently, our safeguarding infrastructures fail to record and centralise this intelligence – there is no coordinator or central hub receiving these 'softer' intelligences, which are ultimately identified as key risk factors when critical incidents do occur.

Our **recommendations**

The following recommendations are for the commissioners of this research, the National Independent Safeguarding Board (NISB), to consider and review how best to take forward.

1. RECOMMENDATIONS FOR PRACTITIONERS AND MANAGERS
For those professionals and agencies who work within safeguarding, our review highlighted several areas to consider:

1.1 Multi-Agency Partnership Training
We recommend that regular multi-agency training ensures common understanding, facilitates regular discussions of different agency perspectives and strengthens roles and expectations in recognising and managing safeguarding concerns. This can help to overcome collaboration barriers and enable more proactive responses where there is uncertainty about decision-making regarding thresholds for intervention, agency expectations and individual responsibilities. Training should specifically address:

- Understanding the child's voice as the daily lived experience of the child within their environment, how to best record, appropriately share and utilise within decision-making and interventions.
- Undertaking a 'Whole Family' approach and developing competent and confident workforce in applying 'Professional Curiosity'. Practitioners need to be clear on individual agency responsibilities and the processes and pathways for collating intelligence in identifying emerging risk. This includes co-occurring and interacting risk factors and with an understanding of the dynamic impact of past, present and potential risks in the continuing assessment of harm and risk.
- Key thematic areas in case studies of neglect and poor home conditions, which were identified as key interacting risk factors within the analysis, as well as within wider reports. Training should explore the roles and responsibilities of different agencies, but also the real-life challenges in transferring knowledge and theory into practice to identify pathways of interventions and support.

1.2. Professional Curiosity
We recommend that strategic discussions are initiated at LA and RSB level which focus on how Professional Curiosity is encouraged, facilitated and embedded into practice as a shared approach within and between all relevant professional agencies. Issues around agency expectations and limits within sectors and roles can be addressed in training. However, more clarity is required to explore how curiosity is embedded, supported, reviewed and monitored for maximum and continued effectiveness.

1. RECOMMENDATIONS FOR PRACTITIONERS AND MANAGERS (continued)

1.3 Prioritising Support and Supervision for all practitioners:
Managers should ensure there is clarity on expectations for formal safeguarding supervision for relevant practitioners. This should include details on the frequency, duration and objectives of supervision and demonstrate an understanding of how this will be internally reviewed and monitored.

- RSBs must be assured that regular and effective supervision is taking place across sectors, which may require, for example, returned reports from relevant agencies to the RSBs. This monitoring will provide confidence that supervision across safeguarding partners is purposeful, impactful and of sufficient quality. Supervision should also seek to include how best to facilitate collaboration with key partners.
- Managers should also seek to provide and review informal opportunities for practitioners to access safeguarding support.

2. RECOMMENDATIONS FOR AUTHORITIES AND BOARDS

For those organisations responsible for the delivery of safeguarding, our review highlighted several areas to address:

2.1. Threshold Uncertainty, improving Decision-Making, Agreement and Challenge
Whilst we acknowledge there are debates about the term 'thresholds', within this review it is used to describe a decision-making process in determining next steps and access to service intervention/response at a particular point in time. This review identified the need for:

- Multi-agency Thresholds – guidance should be agreed regionally to clarify expectations and as a point of reference for practitioners when making safeguarding referrals. Areas of concern, often subject to ambiguity and different interpretations, for example neglect, should be addressed. This should also include clear pathways for progressing concerns and challenging decisions should a safeguarding concern remain after a threshold decision has been reached.
- Local polices and protocols relating to managing emerging or escalating concerns and resolving professional differences should provide transparent and accessible pathways and processes. This should be referenced in the Multi-agency Threshold guidance and monitored as part of internal reviews.

2.2. Working towards a unified health record
This review has highlighted the key, but complex, nature of Health agencies within safeguarding. Whilst acknowledged as challenging, urgent work is required to further drive the facilitation of a unified health record. This requires:

- Bringing information from a range of Health services such as GP surgeries, Midwifery Services and Health Visitors is particularly vital to enable a whole family focus, when identifying emerging safeguarding concerns. In the absence of shared IT systems, consideration must be given to develop mechanisms which enable prompt routine information sharing and which promote relationship development between these practitioners.
- To address the complexity of the NHS and its divisions, **we recommend the development of a nationally led Safeguarding Health Working Group, with stakeholders to consider the barriers and opportunities for collaboration and effective information sharing of low level and emerging safeguarding concerns**.
- Any working groups should seek to liaise with the Department for Education (DfE) regarding their pilot work to improve multi-agency information sharing using a 'Consistent Child Identifier[1]'.

2.3. Measuring Effectiveness within Safeguarding Arrangements
Clearer evidence is required from RSBs/ LAs in demonstrating the effectiveness of their multi-agency safeguarding arrangements.

- RSBs and Local Authorities are encouraged to adopt the Collective Safeguarding Responsibility Model: 12Cs (Ball & McManus, 2023) as a toolkit. The 12Cs model details 12 components across "Practitioners and Agencies" as well as "Structures and Processes". This will help to identify challenges and inform more targeted work, as well as identify best practice.
- RSBs need to improve transparency in meeting the recommendations of CPRs. Each RSB CPR completed should be subject to internal annual review (e.g., as part of annual audits/corporate safeguarding reports). Given all CPRs provide a list of recommendations and required actions, the RSB should seek to collate all recommendations and actions required to improve safeguarding responses. This process should seek to identify common themes, share lessons and to better understand the improvements required across the region.

[1] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/1168239/Improving_multi-agency_information_sharing.pdf

3. RECOMMENDATIONS FOR POLICY MAKERS

For those individuals responsible for shaping the continued development of our approach to safeguarding, our review highlighted several areas to address:

3.1. Development of Automated Safeguarding Referral/Report Portals

Given the complexities identified within safeguarding agencies and organisations that circle the family unit (see Model of Multi-Agency Connections, Considerations and Complexities), alongside the various potential Safeguarding Pathways (see Appendix 4 in full report), prioritisation should focus on building automated portals for professional safeguarding concerns to be received, reviewed and managed. This would enable increased opportunities for effective information sharing of softer intelligence and concerns.

- In receiving notifications of submissions alongside unique referral reference numbers it would encourage follow-up from referrers regarding any decision making and feedback. This would increase capabilities in searching and collating information on a child, wider family and household in determining a holistic picture of concerns raised.
- We note that this would require additional resource to implement and would need to work within current systems and pathways, such as MASHs/Safeguarding Hubs and Information, Advice and Assistance (IAA) front door processes.

3.2. Recording and Guidance relating to neglect and home conditions

Several CPRs identified issues with practitioners being unsure what detail was required to be reported to ensure accurate capturing of information. As per other recommendations within this review, the impact on all family members needs to be considered in these assessments and recording.

- Safeguarding records should detail the various, cumulative, and continuing concerns raised, what action was taken, and the longevity of any changes made. This would allow for increased application of current guidance such as the All-Wales Safeguarding Procedures; All-Wales Practice Guide on Safeguarding Children from Neglect (2021).
- RSBs should seek to review how neglect and concerns regarding home conditions are recorded, and who takes ownership and responsibility for these concerns, using their ability to extract information identifying escalating and/or continuing lack of progress from relevant agencies.
- Authorities should seek to develop multi-agency infrastructure nationally, to promote the sharing of softer safeguarding intelligence and to build a more accurate understanding of harms being recorded.
- Wider and more consistent use of the Information Advice and Assistance system may also offer a route to develop this.

3.3. Review of the 'Not Brought' Protocol to maximise this policy into practice

The 'Not Brought' Protocol was identified in many CPRs as requiring further implementation into practice, particularly regarding missed health appointments.

- A national 'Not Brought' protocol for all agencies needs to be developed to sit across RSBs. This should allow for a clear pathway of action, specifying the roles and responsibilities of each agency that is notified of information, should it require actioning.

3.4. Implementation of the 12Cs as a Guidance Framework and Audit Toolkit

Consideration must be given to how agencies can facilitate collaboration, joint-working and instil a collective responsibility for safeguarding. The Collective Safeguarding Responsibility Model: 12Cs (Ball & McManus, 2023) was developed as part of the National Evaluation Shaping the Future of Multi-Agency Safeguarding Arrangements in Wales (McManus et al., 2022).

- We recommended that this model be implemented to support existing Guidance Frameworks, and Audit Toolkits across RSBs and LAs to help demonstrate any measures adopted locally to facilitate, coordinate, and evidence the implementation of multi-agency safeguarding.
- Implementing the 12C framework would require RSBs/ LAs to respond to each of the 12Cs in turn to evidence what has been put in place or is planned to be implemented, to address this area. There is also an option to grade progress made within each of the 12Cs, which can be reviewed annually and monitored.

3.5. CPRs Quality Assurance

The full report undertook detailed analysis of the CPRs themselves, including the quality of the report and adherence to processes within guidance and legislation. Recommendations highlight that:

- CPRs should complete the 'core tasks' aspect of the review process, as defined by the terms of reference. We have drawn attention to the full list of recommendations and the template provided in our full report. This template should be adopted to ensure detailed information is consistently provided within CPRs.
- The timelines from case referral to sub-group to report completion should be reviewed. Many CPRS took more than double the suggested 6 months. Expectations must be managed and challenges acknowledged for future review processes.
- Moving towards the Single Unified Safeguarding Review (SUSR) process in Wales, these recommendations should be considered by The National Steering Group to improve the quality and optimise learning across all multi-agency reviews.

Model of **CPR Quality and Consistency**

Please see our full report for more details on these recommendations

“Needs to be a better understanding of the roles and responsibilities of agencies supporting the family, in order for the right information to be shared”

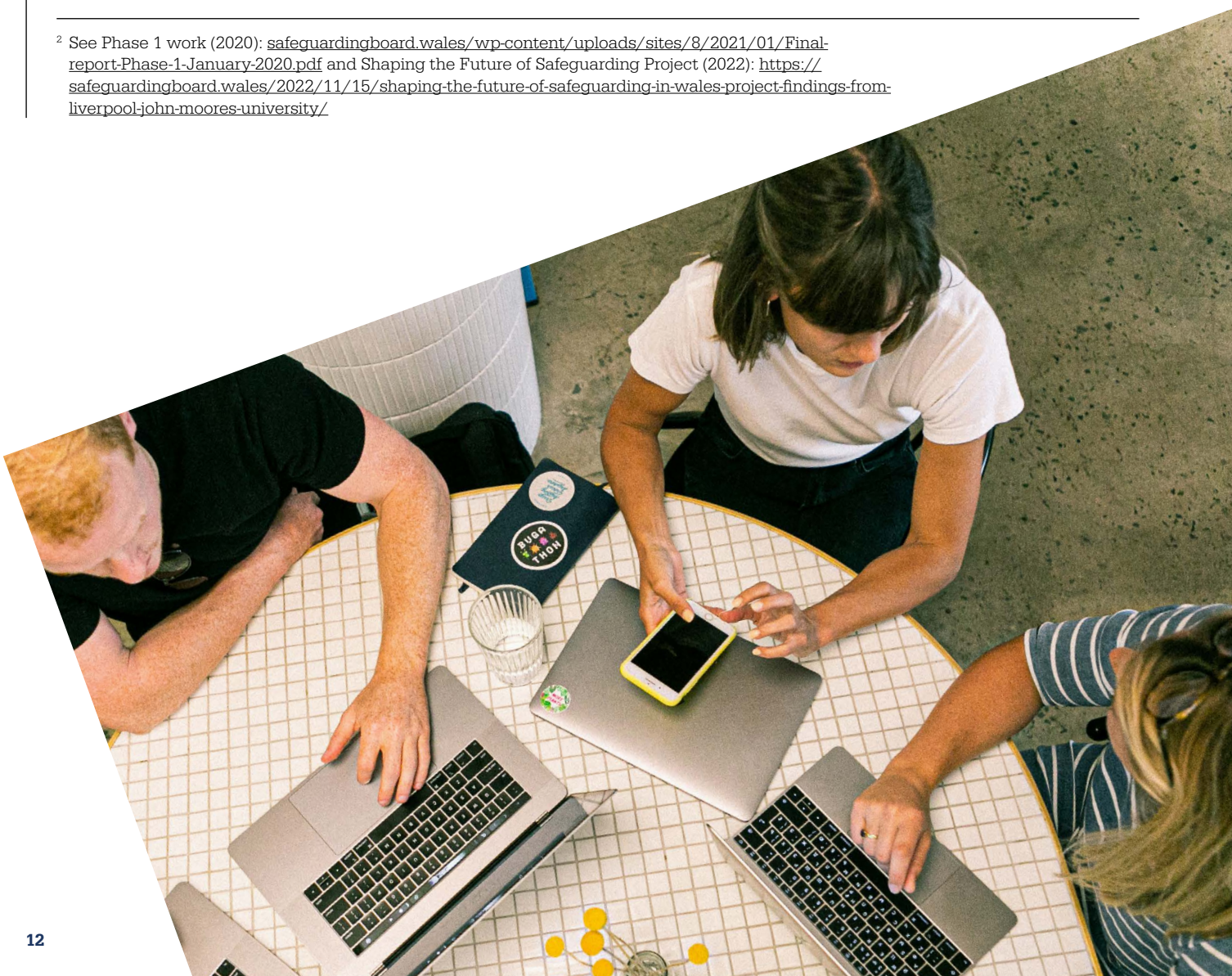
Concluding **Remarks**

The CPRs reviewed represent a minority of safeguarding scenarios. Throughout our wide portfolio of work in multi-agency safeguarding in Wales over the last 3 plus years[2] we have seen countless examples of dedicated professionals going above and beyond to support children, young people and their families. In the face of unprecedented demand, funding cuts and recruitment challenges, it's vital that we acknowledge their contribution in keeping children safe.

Many of the findings of this review echo those of previous research, policy and guidance, which identified challenges within multi-agency safeguarding working. We hope that this thematic analysis provides a deep dive into the underlying factors which underpin these challenges, as well as highlighting the complex task of translating policy into practice.

The implementation of effective multi-agency safeguarding is achieved by ensuring a collective safeguarding responsibility is enabled and maintained across relevant agencies. Whilst our review revealed several critical issues that require urgent prioritisation, it also highlighted examples of good practice which should be recognised and commended. Practitioners and leaders across agencies are working tirelessly and continuously with families to provide a robust safeguarding response and achieve positive outcomes. Effective safeguarding requires adequate resource to invest in a workforce who are confident, competent and supported to deliver a quality service response.

[2] See Phase 1 work (2020): safeguardingboard.wales/wp-content/uploads/sites/8/2021/01/Final-report-Phase-1-January-2020.pdf and Shaping the Future of Safeguarding Project (2022): https://safeguardingboard.wales/2022/11/15/shaping-the-future-of-safeguarding-in-wales-project-findings-from-liverpool-john-moores-university/



ABOUT THE AUTHORS

Professor Michelle McManus is Professor of Safeguarding and Violence Prevention at Manchester Metropolitan University.

Emma Ball is Research Associate of Safeguarding and Violence Prevention at Manchester Metropolitan University.

Professor Louise Almond is Professor of Investigative and Forensic Psychology at University of Liverpool.

For further information, please contact
Professor Michelle McManus, M.McManus@mmu.ac.uk

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National Independent Safeguarding Board Wales

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