Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board



Annual Report
2021/2022

Bwrdd Iechyd Prifysgol Cwm Taf Morgannwg University Health Board

Cyngor Bwrdeistref Sirol Merthyr Tudful County Borough Council

Voluntary Action Merthyr Tydfil Gweithredu Gwirfoddol Merthyr Tudful

Contents

1. Introduction and Foreword - Chair of the Regional Safeguarding Board

Welcome to the 2021-2022 Annual Report for the Cwm Taf Morgannwg Safeguarding Board.

The Cwm Taf Morgannwg Safeguarding Board is a statutory partnership made up of the agencies that are responsible for safeguarding children and adults at risk in Bridgend, Merthyr Tydfil and Rhondda Cynon Taf.

In March 2021, the Board published a **Plan** setting out its priorities for the coming year. At that time, the COVID19 pandemic was continuing to impact our partner agencies, on their ability to deliver high quality services during unprecedented demand and staffing pressures. This has continued throughout 2021-2022 but despite this, we have been able to make significant progress in many aspects of our work, including our ongoing work to tackle exploitation across the region, the prevention of suicides, and support to those who self-neglect.

The Board has responded to a number of serious and tragic incidents during the past year. The death of Logan Mwangi and the prosecution of those responsible has focussed attention on the vital importance of safeguarding the most vulnerable in our communities. The Board is committed to learning from the circumstances leading to Logan's death and will fully implement any recommendations from the Child Practice Review when it reports later in 2022.

As we move into 2022-2023, our services will continue to respond to the pressure of increasing demand, complexity and the ongoing impact of the pandemic. These are challenging circumstances and I would like to thank each and every person working for and on behalf of our partner agencies, in hospitals, care homes, in the community and on the front line of service delivery, for their hard work and commitment to safeguarding the people of Cwm Taf Morgannwg.

If anyone is interested in finding out more about the Cwm Taf Morgannwg Safeguarding Board please contact our Business Unit by e-mailing: ctmsafeguarding@rctcbc.gov.uk

Paul Mee
Chair of the Cwm Taf Morgannwg Safeguarding Board

2. Safeguarding in Cwm Taf Morgannwg

The region of Cwm Taf Morgannwg covers the local authority areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf with a population of approximately 428,000[1]

The **Cwm Taf Morgannwg Safeguarding Board** is a statutory partnership made up of the agencies that are responsible for safeguarding children and adults at risk in Cwm Taf Morgannwg. The aim of the Board is to ensure that people of all ages are protected from abuse, neglect or other kinds of harm. This also involves preventing abuse, neglect or other kinds of harm from happening.

The work of the Board is delivered via a Sub Group structure, which aims to support multi-agency safeguarding in Cwm Taf Morgannwg. The Lead Partner (Rhondda Cynon Taf County Borough Council) employs the staff of the Board's Business Unit and holds the Board budget, to which the statutory partner agencies contribute.

The two key **safeguarding** objectives of **protection** and **prevention** underpin the work of the Board and inform the priorities each year.

The responsibilities and functions of the Board are set out in the statutory guidance under Part 7 of the Social Services and Wellbeing (Wales) Act 2014. It has an overall responsibility for challenging relevant agencies so that:

- There are effective measures in place to protect children and adults at risk who are experiencing harm or who may be at risk as the result of abuse, neglect or other kinds of harm; and
- There is effective inter-agency co-operation in planning and delivering protection services and in sharing information.

Safeguarding Children

The Social Services and Well-being (Wales) Act 2014 and accompanying Statutory Guidance define a 'child' as a person who is aged under 18.

S.130 (4) of the Social Services and Well-being (Wales) Act 2014 defines a child at risk as a child who:

- Is experiencing or is at risk of abuse, neglect or other kinds of harm;
- Has needs for care and support (whether or not the authority is meeting any of those needs).

What do we mean by Harm?

Harm is defined as:

- ill treatment - this includes sexual abuse, neglect, emotional abuse and psychological abuse
- the impairment of physical or mental health (including that suffered from seeing or hearing another person suffer ill treatment).

[1] Source: Census 2011

- the impairment of physical, intellectual, emotional, social or behavioural development (including that suffered from seeing or hearing another person suffer ill treatment).

Types of Harm

The following is a non-exhaustive list of examples for each of the categories of harm, abuse and neglect included in vol 5 Working Together to Safeguard People: Volume 5 – Handling Individual Cases to Protect Children at Risk:

- **physical abuse** - hitting, slapping, over or misuse of medication, undue restraint, or inappropriate sanctions;
- **emotional/psychological abuse** - threats of harm or abandonment, coercive control, humiliation, verbal or racial abuse, isolation or withdrawal from services or supportive networks, witnessing abuse of others
- **sexual abuse** - forcing or enticing a child or young person to take part in sexual activities, whether or not the child is aware of what is happening, including: physical contact, including penetrative or non-penetrative acts; non-contact activities, such as involving children in looking at, or in the production of, pornographic material or watching sexual activities or encouraging children to behave in sexually inappropriate ways;
- **financial abuse** - this category will be less prevalent for a child but indicators could be:
    - not meeting their needs for care and support which are provided through direct payments; or
    - complaints that personal property is missing.

- **neglect** - failure to meet basic physical, emotional or psychological needs which is likely to result in impairment of health or development.

Safeguarding Adults

S126(1) of the Social Services and Well-being (Wales) Act 2014 defines an adult at risk as an adult who:

- is experiencing or is at risk of abuse or neglect,
- has needs for care and support (whether or not the authority is meeting any of those needs), and
- as a result of those needs is unable to protect himself or herself against abuse or neglect or the risk of it.

Abuse can be physical, sexual, psychological, emotional or financial (includes theft, fraud, pressure about money, misuse of money) and can take place in any setting, whether in a private dwelling, an institution or any other place.

Neglect describes a failure to meet a person's basic needs physical, emotional, social or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health). It can take place in a range of settings, such as a private dwelling, residential or day care provision.

Reporting Concerns

In Cwm Taf Morgannwg, all safeguarding concerns are reported to a Multi-Agency Safeguarding Hub (MASH). For the relevant contact details please refer to the information at the end of this report.

The **Cwm Taf Multi Agency Safeguarding Hub (MASH)** sits within the structure of the Safeguarding Board and acts as the single point of contact for all professionals to report safeguarding concerns across Merthyr Tydfil and Rhondda Cynon Taf. The MASH has been fully operational since May 2015, having been set up to enhance safeguarding practice, with agencies working together to receive all safeguarding referrals and share relevant agency information to make joint decisions. The Cwm Taf MASH partners are: South Wales Police, Cwm Taf Morgannwg University Health Board, National Probation Service, Rhondda Cynon Taf County Borough Council and Merthyr Tydfil County Borough Council Children and Adult Safeguarding Teams, Education, and Emergency Duty Team (EDT).

MASH activity comprises:

- Child Protection / Safeguarding
- Adults at Risk Safeguarding
- Domestic Abuse (MARAC - Multi-Agency Risk Assessment Conference)

The key aims of the MASH relate to the following themes:

- Improved co-ordination and consistency of threshold/decision making when a safeguarding report is raised
- Improved response times leading to earlier interventions
- Reduction of repeat referrals

Cwm Taf MASH procedures ensure that professionals act quickly to gather and process information, and new virtual meeting platforms have further enhanced this since 2020. The MASH continues to be well placed to make correct, appropriate, and proportionate decisions in relation to safeguarding children and adults at risk.

During 2021-2022 the Cwm Taf MASH has continued to ensure that the main focus is to respond to all safeguarding concerns promptly in a multi-agency setting. Partners have operated on both a virtual and physical platform with a combination of both office based and remote working working within Covid risk-assessed parameters.

The **Bridgend Multi Agency Safeguarding Hub (MASH)** has been operational since July 2018. The Bridgend MASH partners are South Wales Police, Cwm Taf Morgannwg University Health Board, National Probation Service and Bridgend County Borough Council (Adult Safeguarding Team, Information, Advice and Assistance Service (IAA) (Children and young people), Early Help, Education, Housing and Emergency Duty Team (EDT).

The key aims of the Bridgend MASH are:

- Streamlined decision making through enhanced intelligence
- Risk is collectively addressed

- Opportunity for early intervention and prevention of repeat referrals
- Demand being created but repeat referrals can be effectively reduced

Bridgend MASH is governed by the Bridgend MASH Operational Board and Bridgend MASH Executive Management Board with both boards including representation from all partners. These Boards and Groups have continued to meet throughout the year to guide Bridgend MASH on an operational and strategic level.

Bridgend MASH has continued to operate on a physical and virtual platform since 2020 to ensure individuals in Bridgend continue to be supported wherever there are safeguarding concerns. A comprehensive risk assessment was completed that has enabled people to work in a safe environment. Partners work on a rota basis within their agencies to ensure social distancing is maintained

The collaboration of both Multi Agency Safeguarding Hubs is a key focus of the Board to streamline multi-agency safeguarding across the Cwm Taf Morgannwg region.

3. Members of the Safeguarding Board

The Lead Partner for the Board is Rhondda Cynon Taf County Borough Council and the membership complies with the statutory guidance issued under Part 7 of the Social Services and Well Being Act 2014.

A list of members is attached as Appendix 1.

4. What did the Board do in 2021-2022 to meet its Outcomes?

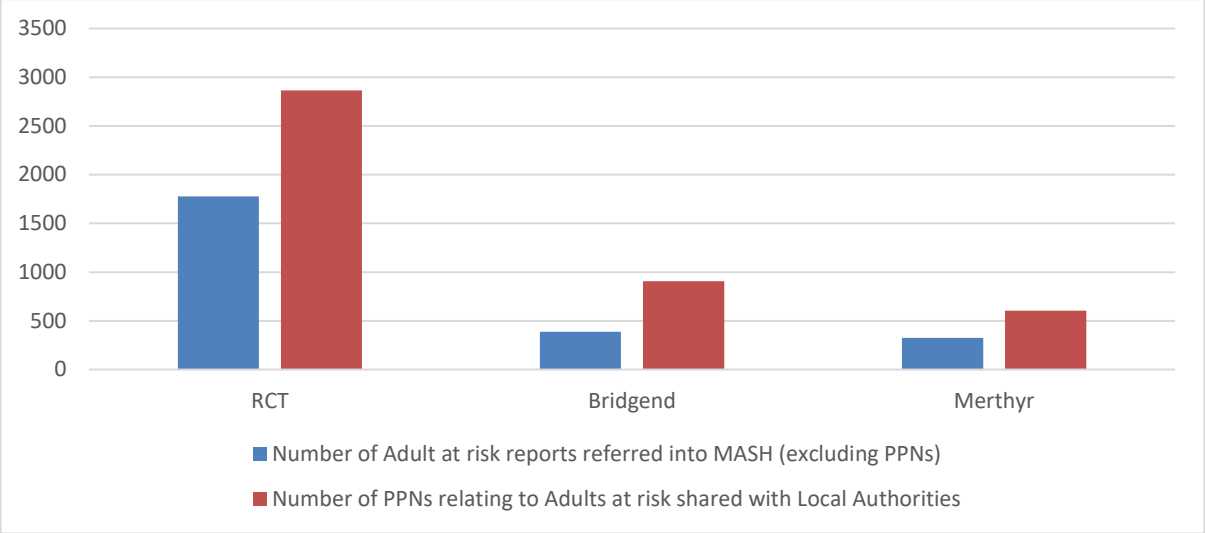
Governance

The Safeguarding Board has a robust governance structure in place (Appendix 2) that enables it to carry out its functions and achieve positive outcomes for children and adults at risk in Cwm Taf Morgannwg.

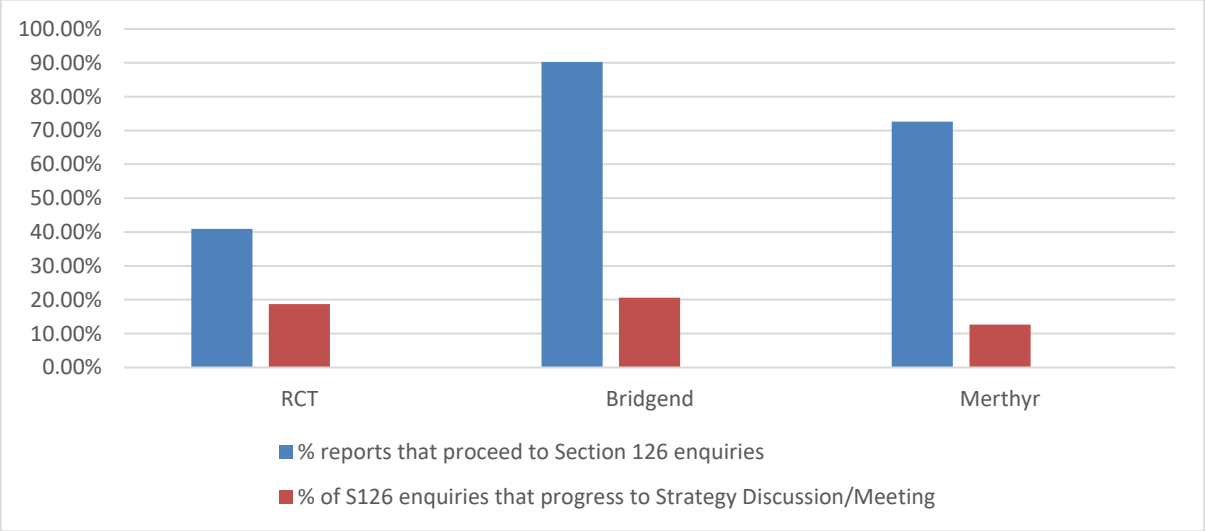
Performance

The Board has a performance framework in place to capture multi-agency safeguarding data.

The **volume of reports in relation to adults at risk** is presented in the table below:

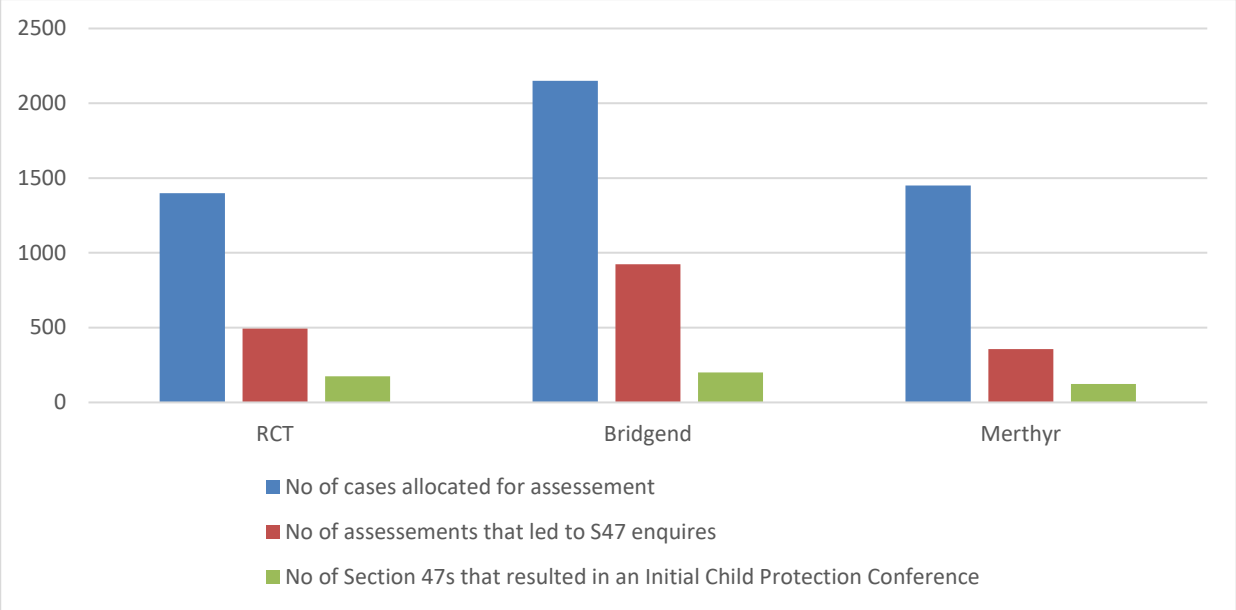


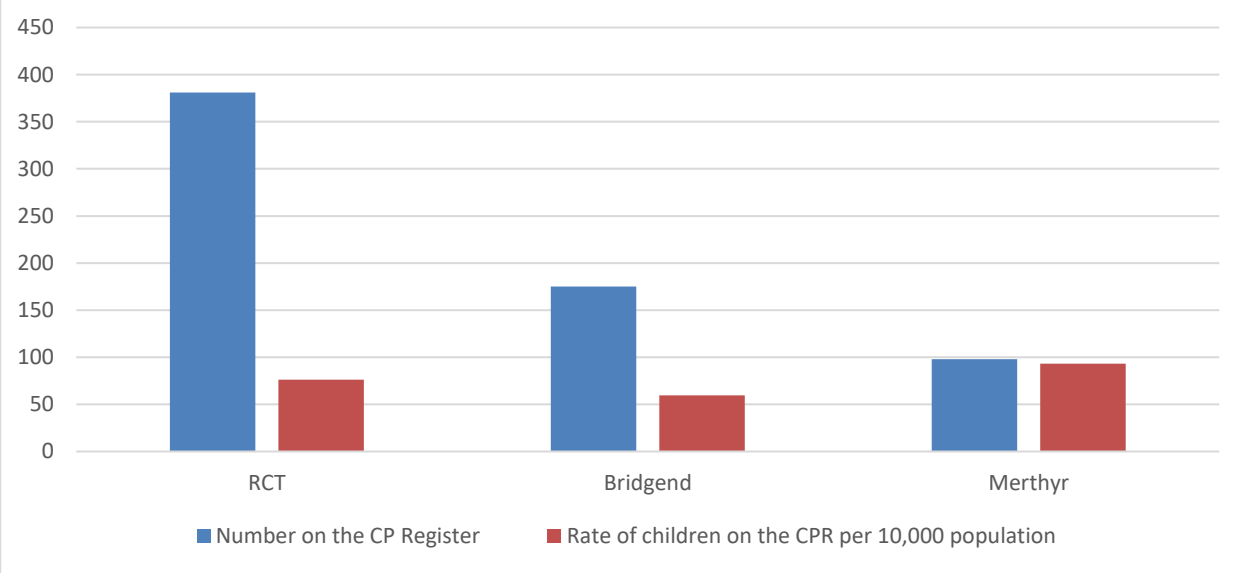
Of these reports, the outcomes were:



The differences in the percentages across the local authorities can be attributed to differences in reporting data.

Data relating to **child protection** is as follows:





Challenge and Scrutiny

The Board co-ordinates the safeguarding activities of each of its partner agencies through effective monitoring and challenge. This is carried out via Board and Sub Group meetings, reviews, inspection reports and audit activity. This year, we reintroduced the **Partner Agency Section 135 Compliance Audit** to scrutinise local arrangements and assess whether partners are fulfilling their statutory obligations in respect of safeguarding. Each agency completed a self evaluation of their compliance in relation to:

- Governance
- Safeguarding Effectiveness
- Policies and Procedures
- Communications and Engagement
- Learning Culture
- Collaboration

It was pleasing to note that most agencies rated themselves as having good or excellent compliance and overall progress has improved since the last audit which was completed in 2019-2020.The outcomes of the audit were reported to the Board Development Day, held in January 2022 and the results informed the priorities for the Board for the forthcoming year.

Good practice identified included:

- Safe Recruitment
- Representation on Board and Sub Groups
- Training
- QA Tools
- Methods of sharing protocols and policies
- Effective communications with staff
- Sharing of Learning from audits and reviews
- Strong collaboration

Areas for improvement included:

- Improvements to safeguarding effectiveness needed to cope with increased demand and impact of pandemic
- Plans for staff training and supervision
- Measuring the impact of protocols and policies
- Communications with the public
- Sharing of learning
- The availability of independent Chairs and Reviewers to carry out Practice Reviews
- Support/training for staff attending PRUDICs and IRGs

This year, the three local authorities and HMP Parc all presented their inspection outcome reports to the Safeguarding Board, outlining specific improvement actions relating to safeguarding.

Professional Disagreements

The Board's Concerns Regarding Interagency Safeguarding Practice (CRISP) protocol supports practitioners in finding a resolution when they have a professional disagreement or concern in relation to another agency's safeguarding practice.

Before using the protocol the practitioner should attempt to resolve the disagreement or concern with their counterpart in the agency involved. Professionals must ensure that resolution should be sought within the shortest timescale possible with the safety of the child or adult at risk being a priority.

If a disagreement can't be resolved the practitioner should speak to their manager or their organisation's safeguarding lead. The manager/safeguarding lead should discuss with their counterpart in the other organisation and attempt to resolve within 5 working days.

If the matter is not resolved at this stage then it can be escalated to the Safeguarding Board Business Unit to co-ordinate a response and this is reported to the relevant Quality Assurance Sub Group.

In 2021-2022, the number of cases escalated to the Board were as follows:

Rhondda Cynon Taf – 11
Merthyr Tydfil – 4
Rhondda Cynon Taf and Merthyr Tydfil (joint escalation) – 1
Bridgend - 0

Case Study
Following on from a Part 5, professional concerns strategy meeting, where it was identified that a bank member of staff had been employed without adequate checks being made, It was not clear what process was in place for the Health Board to undertake checks and whose responsibility it was to make a Disclosure and Barring Service (DBS) referral when concerns were substantiated. In this case, the local authority's Safeguarding Lead Coordinator made the referral. A CRISP was raised by the local authority and, as a result, a review was undertaken by the Health Board of current practice and policy. As a result, changes have been made that ensure safe recruiting of bank staff.

Business Management and Support

The Board is supported by the Safeguarding Business Unit which provides management, co-ordination and administrative support. Rhondda Cynon Taf CBC host the Board's Business Unit and holds a pooled budget for the Board.

5. How did we implement our Annual Plan and what were our key achievements?

The Board published an Annual Plan on the 31st March 2021, setting out its priorities for safeguarding children, young people and adults in 2021/22.

The Annual Plan for 2021/22 can be accessed at: www.ctmsb.co.uk

Key Achievements

Self Neglect

A regional approach to managing cases of self neglect in adults was introduced in October 2021. A Self Neglect Protocol and Guidance document were approved by the Board in June 2021. Three Self-Neglect Partnership Panels were set up, led by each local authority Adult Services department, with multi-agency representation.

Awareness raising sessions were delivered to 400 people across the region.

In the first 6 months, 31 referrals were submitted, with 15 being discussed at Panel. Early indications are that the Panels are making a real difference to outcomes for relevant citizens.

Case Study - Self-Neglect

Mr B, a middle-aged single man, lives alone in a one-bedroom Housing Association flat. He was referred to the Self-Neglect Partnership Panel by his Housing Support Worker, who was concerned at his recent weight loss and his level of daily alcohol consumption.

He presents with Autistic Spectrum Disorder traits but has no formal diagnosis. His living conditions are poor with accumulated rubbish; the floor cannot be seen in any room in the flat because of papers, cans and food covering it. He was 'knee-deep' in rubbish in his bedroom, keeps rotting food in his fridge and does not bath or shower as the bath is full of dirty clothes. He wasn't using the washing machine and was always wearing soiled clothes.

Housing Support have been involved for 18 months and the situation has deteriorated in that time. A referral was made to Adult Services, but Mr B would not engage with them. There is an action plan in place to improve the conditions in the property as he is in breach of his tenancy, but nothing has changed.

Mr B's case met the criteria for the Panel and his case was presented by the referrer. The Adult Services representative on the Panel agreed to allocate Mr B's case again to a social worker who could work closely with the Housing Support worker to try to secure access to Mr B in the first instance and then try to build trust and rapport to undertake an assessment of his needs.

This was a successful strategy and the social worker has worked hard to maintain contact and agree goals and priority actions with him, working alongside him to reduce and clear the rubbish in his flat. The Council's Facilities Team cleared the unusable bed, bedding and soiled carpets and the social worker assisted Mr B to purchase replacements.

The Social Worker has also managed to agree a Care and Support Plan with Mr B, to motivate him to see his GP with support and he has accepted a referral to alcohol services. He is working now on obtaining a direct payment so that Mr B can continue to have support to care for himself and maintain the improvements in his living conditions. Whilst the challenge will be to maintain progress, early indications are good and Mr B's quality of life is significantly improved.

Learning Framework

A regional Learning and Improvement Framework was approved by the Board early in 2022. This demonstrates how learning will be identified, disseminated and implemented in practice within a multi-agency context in order to improve outcomes for children, young people and adults within Cwm Taf Morgannwg. The Framework enables, not only a rigorous assessment of the quality of multiagency safeguarding arrangements, but also how we learn from this to drive forward improvements to safeguarding and in turn, outcomes for children and adults at risk.

As part of the development of the Learning Framework, a Learning Themes Database has been developed to record learning from Reviews and Audits. Going forward, this database will be presented to the Board's Training and Learning group on a quarterly basis to enable the Board to identify actions to address emerging and prevalent themes and issues. Common themes emerging include:

- Lack of communication and information sharing

- Disguised compliance
- Record keeping and accuracy of recording
- Efficiency of the assessment process
- Effectiveness of the reporting and referral process
- The transition from childhood to adulthood

Individual Learning Frameworks have been adopted in some partner agencies. For example, RCT Children Services' Learning Framework focuses on Embedding Learning and an Evaluation of Learning Impact.

Monitoring Group

This year, to manage the increasing number of Practice Reviews being carried out by the Board, and in line with the new Learning and Improvement Framework, a dedicated multi-agency Monitoring Group was set up. The group meets bi-monthly and has the responsibility for monitoring the action plans and ensuring that recommendations are completed in a timely manner.

Suicide Prevention

The Board has continued to collaborate with other partnerships and agencies to tackle the prevention of suicide and self harm agenda. A multi-agency Suicide Review Group was established this year. The group receives information held by the Board in respect of suspected completed suicides managed under the Immediate Response protocol, which allows us to identify themes, demographics and triggers that can support us in tackling this very important agenda. The key themes identified during 2021-2022 with regards contributory factors included:

- **Known to mental health services –** 52% were known to mental health services. This is consistent with the the latest National Confidential Inquiry into Suicide and Safety in Mental Health report that states that in all suicides in the last 10 years, 50% were known to mental health services. Should a person complete suicide within a year of being open to mental health services it will be considered as a local or national reportable incident and will be investigated by the Health Board to identify learning.
- **Relationship breakdown –** this was a factor in 41% of suspected completed suicides. Further work is planned to identify ways to address this.
- **Previous attempts –** 37% of the cases had previous attempts. This has prompted us to consider looking at significant near misses in the future.
- **Substance misuse –** 33% were recorded as having abused substances. The relationship between drug and alcohol misuse and mental health is one of concern as it was highlighted that often those people under the influence of drugs or alcohol are refused a mental health assessment. Therefore, they may not receive timely support and advice in respect of their mental health.
- **Criminal charges –** this was a factor in 28% of the cases. The criminal charges varied to include domestic abuse related crimes, possession of child images and child sex abuse. Further discussion has included those being released from prison. It was suggested that any case related to child abuse could benefit from a risk assessment to understand what has been done to pre-dispose a suicide.

It has been acknowledged by the group, that from reviewing the themes and trends over a one year period, recommendations for interventions and preventative work may reduce

the risk of some people-reaching crisis. However, it will require services throughout Cwm Taf Morgannwg to engage and adopt practices that will support those at risk of suicidal ideation. Signposting to support services is important, although, requires the practitioner to ensure it is accessible and meets the individual needs. With so many identified contributory factors, the group will need to decide in what order to prioritise training, education and resources to have a maximum impact.

Protocols and Procedures

The following Board protocols and guidance documents were reviewed and updated during 2021-2022:

- Complaints Procedure
- Baby and Infant Safe Sleeping Guidance
- Bruising and Injuries in Children Not Independently Mobile

The following protocols and guidance in relation to Child Protection Conferences were updated and regionalised this year:

- Child Protection Register Enquiry Protocol
- Child Protection Conference Protocol for Practitioners
- Core Group Guidance and Resolution Process

Partner Agency Achievements

- In Bridgend, the Safeguarding and Secure Estate Manager worked closely with HMP Parc to ensure our safeguarding responsibilities were met for the adults and young people serving a custodial sentence. There have been a number of challenging cases that required a multi-agency approach from people employed by G4S and the Local Authority.
- The Child Protection Medical Hub has enhanced safeguarding practice and collaborative working. Through feedback from agencies, families and children there has been a reported improvement in the experience of Child Protection medicals, with them being more timely and coordinated, ensuring the process remains child focused and causes less anxieties for all of those involved.
- Children Services commissioned a Multi-Agency Permanence Support Service (MAPSS) to provide a specialist therapeutic Intervention service for care experienced children, those with historic placement breakdowns and those with plans for and post adoption. It is available across the region for children with complex emotional and behavioural needs, and works with childhood aggression, self-harm, absconding, suicidal ideation, and experiences of sexual abuse, defiance, depression and many more.
- The change to more face-to-face activity in Cwm Taf Youth Offending Service has reduced the number of disengagements. Where possible, YOS has resumed the practice of seeing children in schools and this works but is still using virtual visits.
- HMP Parc appointed a new Safeguarding Lead in June 2021.
- Merthyr Tydfil CBC continued to strengthen its Early Help Hubs with Health and

Police staff being collocated within the Hub. During 2021-2022 there was a significant raise in those accessing Early Help within the Local Authority and 149 sessions have been held with partner agencies to increase their awareness of the Early Help Hub. This includes Education, Health, Twyn Community Hub, Local Authority Councillors, Mental Health Support Services, Women's Aid, and Change Step Military Veteran.

- South Wales Police continue to work closely with partners to make sure that safeguarding, community safety and neighbourhood policing are fully joined up to provide a better response to safeguarding concerns including preventative policing. This has been supported by a realignment of internal functions such as the neighbourhood policing teams to Safeguarding Superintendents portfolio

In relation to the Board's Strategic Priorities, a summary of the work carried out is below.

Strategic Priority 1: Ensure an Effective Response to the Impact of the COVID-19 Pandemic

Learning Lessons to Improve Multi Agency Safeguarding

This year, the Board continued to maximise opportunities to use virtual platforms to hold meetings and deliver training. Three virtual Learning Events were held to support Practice Reviews.

The Multi-Agency Safeguarding Hubs (MASH) were maintained throughout the pandemic. The Cwm Taf MASH operated virtually throughout the year and in Bridgend, a comprehensive MASH risk assessment was completed to ensure partner agencies within MASH worked in an environment which was safe and compliant with Welsh Government Guidance.

Cwm Taf MASH and Bridgend MASH reviewed their existing governance arrangements in order to reduce duplication and share good practice across the regions. This includes the collaborative information sharing system review and joined up audit performance work which is ongoing in 2022-2023.

Multi-agency practitioner workshops were held in July/August 2021 to review processes and scope out detailed requirements for a replacement safeguarding information sharing system. The outcome of this was a specification document which outlined the safeguarding requirements for a new platform. Various options were evaluated, including the possibility of developing functions in WCCIS, and a proposal to utilise Microsoft Office 365 technology is currently being considered.

Finalising the Outstanding Actions from 2020-2021

We ensured that outstanding actions from the previous year, which were delayed due to the pandemic, were completed. This included completing outstanding audits and protocols that were in development.

A multi-agency Domestic Abuse audit across both children and adult safeguarding was finalised. The learning themes identified and acted upon where appropriate, and included:

- Domestic Abuse agencies did not always attend conferences and/or core groups, even when they had been the referring agency
- Fathers (perpetrators) not always included in conferences and/or core groups
- Delays in sharing information
- Incidents responded to in a timely manner
- Unavailability of interprator to support mother
- Good evidence of children being spoken to alone
- Effective joint visits
- Timescales needing to be attached to action points

The learning from the audit was fed back into individual agencies quality assurance frameworks and appropriate improvement actions made.

In addition, a re-audit of a case from 2018 was carried out to evaluate the impact on practice. It was identified that good progress and a number of improvements to practice and policies had been made in the time since the original report was concluded.

Giving People their Voices Back

We wanted to ensure that those most at risk were able to re-engage with services. Agencies maximised virtual platforms and a variety of communication methods to facilitate this. Innovative approaches, such as facilitating family time in outside areas, were adopted.

A review of Child Protection Conferences was carried out with a focus on strengthening them as a positive vehicle for change. The new format will have an increased focus on coproduction of child protection plans with families and wider agencies. The review included partners and families sharing their views and experiences to inform positive change.

Agencies working to safeguard adults supported care providers through the administration of a hardship fund to ensure that services continue to be delivered to adults at risk.

Case Study - Bridgend County Borough Council

A social worker within the Information, Advice and Assistance team developed and trialed an approach aimed at reducing the level of anxiety a child may have when meeting a social worker for the first time.

This involved producing a simple profile of the social worker listing their hobbies, likes and dislikes and containing their photograph. This approach proved to have had a positive impact and has been rolled out across the team.

Safeguarding People Living in Care Homes

Following the devastating impact of the pandemic, we wanted to ensure that we continued to safeguard people living in Care Homes as lockdowns eased. COVID cases continued to fall throughout the year and arrangements for safe face-to-face visits for family members of residents were put in place.

The number of providers, including care homes, in escalating concerns was regularly reported to the Adults Quality Assurance and Performance Sub Group. The total reported during 2021-2022 was:

Rhondda Cynon Taf – 9

Merthyr Tydfil – 1

Bridgend - 0

Agencies working to safeguard adults jointly developed a safe discharge policy for those discharged into care homes.

The Wellbeing of the Workforce

The pandemic brought significant challenges to the workforce, with changes to working arrangements, shifts in priorities and staff sickness/isolation being key features of working practice. We wanted to ensure that staff are supported and their wellbeing prioritised.

Agencies were requested to report to the Board on the arrangements that were in place to support staff wellbeing. This included managers briefings, well-being surveys and tools and dedicated well-being officers to provide counselling and coaching. Bespoke training was provided for staff for example: considering the impact of Covid 19 and the experience of loss and bereavement on the workforce.

Managing Demand

Board partner agencies have operated an adapted 'business as usual' approach throughout 2021-22 and have responded flexibly to an increased demand and ever-changing situation across the health and social care system. Agencies have provided the Board with consistent performance data to monitor activity and identify changes in demand. Data demonstrated increasing demands in all areas, and quality assurance work was undertaken where a greater understanding on the reasons for this were required.

Recruitment and retention issues were reported, particularly in the Local Authorities, and this has been continually monitored by the Board, with Risk Management Plans shared. One of the greatest risk areas has been in maintaining business continuity in relation to hospital supporting admission and discharge and in domiciliary and residential care, where staffing shortages have been so acute at times as to threaten services' capacity to meet need.

Strategic Priority 2: Strengthen Safeguarding Links to other Partnerships in the Region

In the past year, the Board and its partner agencies continued the drive to align and strengthen links with a range of other partnerships across the region.

At an executive level, this has involved working with the Regional Partnership Board and its supporting governance structure.

Good links have been maintained with the Community Safety Partnership at both a strategic and operational level. There are good collaborative working arrangements with the Anti-Social Behaviour Team, Prevent/Channel Panel, Licensing and Domestic Abuse Services that sit within the Community Safety Partnership. A Regional Prevent Delivery Group has been established and partner agencies have been involved in the testing of a new Prevent e-learning platform, designed to safeguard individuals who are vulnerable to radicalisation.

Board partner agencies also have representation on the Regional Serious and Organised Crime Board, the MAPPA Strategic and Operational Groups, and the Violence against Women, Domestic Abuse and Sexual Violence Steering Groups.

The link between the Board's Immediate Response Group structure, Suicide Review Group and the Suicide Prevention Steering Group, has created a structural connection between the Board and Mental Health Services.

There have been efforts this year to strengthen the relationship between Children Services and CAMHS and work is ongoing to improve the health provision within the Youth Offending Services.

A high level scoping exercise of partnerships was undertaken to support the regional exploitation agenda and this work will continue into 2022-2023.

Strategic Priority 3: Improve our Approach to Public Protection Concerns

The work of the Safeguarding Board increasingly crosses over to the realms of Public Protection which has a wider focus on protecting and improving the health, safety and well-being of the general population of the region.

Our primary focus this year has been on Exploitation, an increasingly prevalent issue in the region. Structures were already in place in relation to child sexual exploitation but there was a need to expand our focus to consider the impact of additional areas of concern, including criminal exploitation, on-line abuse, modern slavery and human trafficking and radicalisation. The concept of contextual safeguarding has been a key feature in the development of our strategy to address these areas of concern.

At the end of 2021-2022, a draft strategy was in place and work is ongoing to develop a supporting toolkit and referral pathways. A Regional Steering Group and a Task and Finish Group was set up with participation from key stakeholders in the development. The Initial Strategy will be for children and young people transitioning in adulthood with a view to progressing the strategy to all adults in 2022-2023.

The Cwm Taf Multi Agency Child Sexual Exploitation Group and the Bridgend CSE Task Force strategically managed cases of Child Sexual Exploitation (CSE) and Child Criminal Exploitation (CCE) across the region. A pattern of diminishing CSE cases and increasing CCE cases has been emerging and this has and will inform the ongoing development of the Board's Exploitation Strategy and Toolkit. Professionals involved in these meetings are conscious to maintain a focus on CSE, believing that it has not in real terms reduced in volume or risk, but has become more of a hidden harm then ever e.g.increased online exploitation. This continues to be analysed. Data was collected for the RCT and Merthyr Tydfil local authorities in 2021-2022 and is summarised below. This will be extended to include Bridgend in 2022-2023.

Total number of high risk Child Exploitation cases discussed – 45

Number of perpetrators identified – 15

Number of hot spots identified - 44

Themes identified – rail travel, missing, peer abuse, social media/online abuse, fake IDs, drug and alcohol use.

In 2019, the Welsh Government published its National Action Plan on Preventing and Responding to Child Sexual Abuse. As part of the implementation of this plan, Cwm Taf Morgannwg Safeguarding Board, along with other safeguarding boards in Wales, has been disseminating information and resources to professionals, parents/carers and children and young people on child sexual abuse, child sexual exploitation, harmful sexual behaviour and online abuse.

Additional Focus: Independent Rapid Review

In October 2021 the Safeguarding Board commissioned the National Safeguarding Team (NHS Wales) to carry out an independent rapid review into multi-agency safeguarding arrangements in Bridgend. This followed five unexpected child deaths, which were all unrelated.

The independent review was completed separately to any forthcoming Child Practice Reviews, audits, or individual reviews in relation to the five cases. To achieve this, clear lines of responsibility and scope were agreed.

The overall outcome was to provide assurances to the Board that multi-agency safeguarding arrangements were effective in Bridgend. Other outcomes/benefits included:

- The identification of any areas for improvement that can be actioned immediately.
- The identification of any immediate learning from a local and/or regional perspective.
- An assurance that relevant staff have been supported appropriately, both during the pandemic and in light of the recent deaths.

A final report was presented to the Board in December 2021, which contained a series of recommendations which have since been monitored via an Executive Group of the Board. Appropriate actions have been taken to improve multi-agency safeguarding arrangements.

Additional Focus: Winter Pressures

The Board ensures that it receives updates from partner agencies in relation to winter pressures, with 2021-2022 being a particularly challenging time. Concerns around COVID 19 persisted and partner agencies worked closely together to address areas of critical concern, including staff wellbeing, improving the capacity of services, and the increased demand in the community.

6. Safeguarding Themes

Audit Activity

Achieving improvement in safeguarding policy, systems, and practice is a core function of the Board. Audit work is carried out via task and finish groups set up by the Quality and Performance Sub Groups. Any recommendations made by case audits are monitored by these groups to identify how practice is adapted to reflect any learning.The key learning themes from two completed audits are summarised below:

AUDIT ACTIVITY	THEMES IDENTIFIED
Cases where Advocacy needed to be used or the involvement of family members (adults)	▪ The importance of advocacy services needs to be considered by all, and this is not just the responsibility of the lead coordinator when a safeguarding concern is raised ▪ Case conferences are not always the preferred engagement outcome, and often the AAR/representative is satisfied with the communication via a number of different forms ▪ Recording is not always detailed enough, and rationales need to be clearly recorded and explicitly state why something has been done or not done ▪ If the allegation relates to a professional, feedback relating to the alleged abuse can be difficult to provide and what action was taken. ▪ If there is a lengthy police investigation, often lead coordinators have a case open for a significant amount of time with little engagement with the AAR/family during that period. This is often due to the investigation ongoing, or the case listed for court. Again, in this period updates should be provided to the AAR/representative/advocate ▪ Advocacy needs to be highlighted within the formal strategy discussion process, but also at the start of the process and not just following the strategy discussion. ▪ Consider implementing the service user/representative/advocate feedback process (Good practice of a clear advocacy strategy at the start of the safeguarding process) ▪ Being creative with available family and professional advocacy when the circumstances mean this can be effective.
Local Authority Audit in relation to Proportionate Assessments (children)	▪ Disagreements about the role of agencies and responsibility for actions ▪ Agency representation in strategy meetings ▪ Concern regarding another LA's response to a cross border case ▪ Difficulties in getting agreement for child protection medicals to be completed in non physical abuse cases ▪ Quality of the narrative in the assessment varied

Multi Agency Practitioner Forum – Child N	▪ The need to robustly challenge parents ▪ The need to see the unspoken & hear the spoken voice of the child ▪ A Procedure for the Management of Fabricated Illness would have supported this case ▪ The need for strategy meetings and ICPCs to be held in accordance with statutory timescales ▪ Professional Curiosity needs to be embedded into everyday business ▪ Verbal referrals need to be captured in a C1 written referral ▪ Professional meetings should include all agencies who are likely to be involved with the child ▪ Health agency needs to review the manner they record information in letters to other agencies ▪ Over-reliance on information on family instead of the professionals involved ▪ Initial CP Conferences should be effectively managed in line with statutory guidance

Cwm Taf MASH undertook an Adult Protection audit to understand the discrepancy between RCT & Merthyr local authorities (in relation to the rate of determination that further action to protect is necessary as an outcome of Section 126 enquiries). It was noted that Merthyr Tydfil Adults Services were taking considerably more cases to Section 126 enqury than RCT, and the purpose of the audit was to see if there were threshold differences.

The audit highlighted effective practice from a selection of cases, with all using the 126 enquiry to collect comprehensive information from a number of sources. There was mostly agreement around the 126 enquiry where there was little discrepancy, which is positive compared to a previous audit that took place. There was also evidence that in most cases the views and wishes of the adult at risk were considered in reaching outcomes.

The audit suggested improvement required with regards to the quality of the recording tool, which has since been addressed to improve consistency across RCT and Merthyr areas. As an outcome of the audit a learning event for the respective adult protection teams took place also.

Adult Practice Reviews and Child Practice Reviews

The Board published 2 Adult Practice Reviews and 2 Child Practice Reviews during the year and these are available on the Board's website via the following links.

CPR CTSB 02 - 2018
APR CTMSB 02 - 2019
CPR CTMSB 03 - 2019
APR CTMSB 01 - 2021

The Board also worked in collaboration with the Community Safety Partnership and published 2 Domestic Homicide Reviews which can also be found on the Board's website.

DHR 03 - 2018
DAPR 02-2018

Partner agencies report a variety of methods of sharing published reviews and sharing the learning, including:

- Reports and '7 Minute Briefings' disseminated to all staff, managers, designated safeguarding leads and teams
- Discussions in peer groups, team meetings/briefings, action learning events, communication workshops and evaluation/risk management sessions
- Included in Quality Assurance Frameworks
- Disseminating learning via Corporate Safeguarding web pages and Bulletins
- Learning from reviews is incorporated into relevant training
- Integrated our review learning priorities into our annual Training Needs Analysis.

The learning themes arising from each of the reviews published this year, along with a description of how Board partner agencies implemented the learning, is described below.:

CTSB 02-2018

Learning themes from this Child Practice Review included:

<u>The Child Protection Referral process</u>
Practitioners could have given more significance to an adult's long history of domestic violence.

<u>Assessments</u>
Important information was not recorded and a lack of sound judgment in making decisions regarding risk was evident.

<u>Social Worker Management</u>
The assessing social worker was inexperienced and did not have the confidence to ask for advice.

<u>Domestic Abuse & Child Protection</u>
Midwifery did not follow their own policy in respect of routine enquiry regarding domestic abuse.

<u>What have Agencies done as a result of this learning?</u>

- Increased awareness and understanding of best practice in relation to working with children and families and the importance of timely information sharing.
- Routine Enquiry audits undertaken and subsequent recommendations completed. Midwifery audits have seen a significant increase in Routine Enquiry following training and education within the service from the Named Midwife for Safeguarding.
- Ask & Act training delivered as a standalone training through a virtual platform.
- The Health Board has seen improved practice in the identification of those suffering domestic abuse, and the appointment of a Health MARAC Coordinator has allowed for continued learning.
- The Health Visiting service has developed a standard operating procedure to guide practitioners in their management of identified domestic abuse.
- Monthly samples of decision making on referrals into MASH and Early Help. This work has demonstrated that thresholds are sound, decisions are made promptly, and relevant agencies have been consulted.

- Dip samples of assessments have demonstrated that all relevant agencies are consulted as part of strategy discussions.
- The development of a Home Conditions Assessment Tool
- Reviewing the Protocol for working with people who are resistant to the safeguarding process
- Agency audit of a sample of core group minutes to consider how well we manage resistance in the safeguarding process. This audit found many examples of good practice but also recognised that further support and training is required for staff. In response we have established a process for holding multi agency reflective sessions for cases where children have been on the CPR for more than 12 months. Work resulting from this is also ongoing in relation to holding workshops for the management team and staff, aimed at enhancing our person focused planning
- Further actions from audits have included establishing a task and finish group of practitioners to consider how we work with resistance and feigned compliance.

CTMSB 02-2019

Learning themes from this Adult Practice Review included:

Family Relationships

Recognising the caring role of family members and the need to offer carers assessments periodically.

Professional Curiosity & Assessment & risk assessments

When practitioners are responding to allegations of abuse and neglect, professional curiosity should be exercised as this may have led to the insight of the need and levels of family support being provided, which subsequently may have led to an earlier assessment.

Communication & Recording

Evidence of the adult's deterioratiotion was not recorded and clear evidence of a safeguarding concern was not escalated to the line manager and the MASH.

What have Agencies done as a result of this learning?

- There have been changes implemented in relation to carers' assessments that have resulted in improved take-up.
- Increased awareness and consideration related to professional curiosity. Increased training has been provided.
- Professional Curiosity and the importance of clear documentation is discussed at length throughout training.
- Mental Capacity Act training has been reviewed to ensure the learning is included.
- Ensuring that where information came to light that the individual had involvement with an agency, that enquiries with that agency should be considered to obtain a holistic picture of events.

CTMSB 03-2019

Learning themes from this Child Practice Review included:

Pre birth Assessments

Information about fathers should be actively sought by health and social work professionals in all assessments of pregnant women and children's well-being. Professionals should make

every effort to involve and engage fathers in assessments and should seek collateral information when risks are identified. ACEs and their potential impact on both parents and their parenting should be identified.

Record Keeping
Whilst there was evidence of regular antenatal care being given, there is only one record of the 'routine enquiry' regarding domestic abuse and, likewise, one record of 'routine enquiry' by the health visitor post-natally.

Sharing of Information
Recordings made by the midwifery and health visiting service were not detailed: there were gaps and it seems that the PPN referral form shared by police was not contained within their records.

What have Agencies done as a result of this learning?

- Audit of a sample of cases that have progressed to Section 47 enquiries which demonstrated that all relevant agencies have been consulted in S47 enquiries
- Audit of a sample of core group minutes to consider the level of professional curiosity and corroboration of information provided by parents. The audit found that there was a good level of professional curiosity and corroboration in most cases but a need for support for staff to maintain this.
- Establishing a task and finish group of practitioners to consider how we work with resistance and feigned compliance.
- Communication sessions in relation to the engagement of males in the safeguarding process and a pre birth pathway has been designed with the engagement of males in mind.
- Adding identification of fathers/males into monthly audits
- The auditing of assessments will continue to include examining whether all relevant agencies have been consulted as well as all relevant family members
- Training on professional curiosity has been commissioned & delivered in relation to the adult services context.
- Emphasis on the importance of being aware of unconscious bias has been made in further training sessions to schools.
- Electronic sharing of information forms by Health Visitors and Midwifery, which has allowed for timely information sharing between the two professions.

CTMSB 01-2021

Learning themes from this Adult Practice Review included:

Trauma informed practice:
Would have been helpful in understanding this in relation to the person's mental health and polysubstance misuse.

Connecting with the wider family:
The challenge for professionals is how to work in partnership with families, who may be sources of support, whilst respecting the individual's right to confidentiality.

Working with someone who is difficult to engage with:

It is important to distinguish between contact and real engagement. This adult was difficult to engage with, and professionals felt they were always reacting to crises rather than working with clear and positive plans.

Domestic violence and coercive control:
It is insidious, powerful, far-reaching and difficult to challenge. Victims of coercive control often do not realise they are victims even when there is clear evidence. In this situation the adult described her abuser as a carer.

Professional curiosity
Agencies should ensure that their staff are aware of the psychology of unconscious bias

What have Agencies done as a result of this learning?

- There has been a renewed focus on the active offer of advocacy and the requirements of the Social Services and Well-Being (Wales) Act 2014.
- Trauma informed practice research carried out to look at personal disorder pathway and provision of psychological therapies in the Health Board.
- Mental Health services have encouraged all staff to attend Ask & Act training. We have subsequently seen improvement in the recognition and response to Domestic Abuse. In addition, there have been excellent examples of collaborative working to safeguard victims of domestic violence.
- An increase in the contacts from Mental Health services to MARAC. Work is ongoing to ensure effective coordination of appropriate representation from Mental Health and Drug and Alcohol services at MARAC meetings.
- Additional Domestic Abuse Matters training which has been disseminated to front line staff.
- Shared with Training department to reinforce the need for trauma informed training to be included within the current training programme.

Good Practice – South Wales Police
There was a case where an external reviewer had let a MAPF panel down and SWP stepped in to chair and author the review, identifying the learning for agencies and allowing the review to be completed in a timely manner. This demonstrated the resilience of the organisation, being prepared to step up when required.

Complaints

The Board's Complaints Procedure provides families with the opportunity to make a complaint with regards to the multi-agency child protection conference process and procedures, and the multi-agency adult protection meetings process and procedures.

In 2021-2022, there were no complaints escalated to the Board in relation to adult protection processes and procedures.

There were 2 complaints received in relation to the child protection process. Neither complaint was upheld by the Board's Independent Complaints Panel.

7. Information Training and Learning

The Board is required to review the training needs of practitioners in the area and ensure that there is a co-ordinated approach to safeguarding training, taking into account themes and learning arising from the delivery of the Board's functions. This work is monitored by the Board's Training and Learning Sub Group.

Cwm Taf training continued Safeguarding training during the course of 2021-22. On-line learning training was increased to reduce the impact of restrictions, although the situation remained challenging and courses were cancelled. There were limited face to face opportunities where it was identified this would be the best forum for learning.

167 courses were planned and 20 courses were cancelled during this period, due to covid related issues , however 1992 people attended training during this period.

The range of agencies accessing the training besides internal social care staff included Education, Health, Police, Voluntary sector, foster carers and housing

Bridgend saw that the pandemic significantly changed how training and learning were undertaken. The rapid shift to remote and digital learning has been challenging but successful. Investment has been made in developing on-line resources and virtual classroom learning. Also, in the purchase of hardware (iPads and laptop computers) to loan out to staff who do not have access to ICT equipment, and in supporting staff to develop digital literacy skills.

Bridgend maintained a programme of face-to-face essential training to ensure that care and support was provided safely both for the social care worker and the person cared for, for example manual handling, medication, infection control.

Adults and Childrens' core safeguarding training (single and multi-agency) has been facilitated on-line.

Covid response and recovery. To promote resilience and support recovery Bridgend mainstreamed a range of focussed courses which aimed to respond to supporting staff during and post Covid in a positive and practical way. For example, managing stress effectively, including a better understanding of vicarious trauma /moral injury and burnout and workshops on Loss and Bereavement

Over the year, 3838 learning activities were undertaken by staff, this figure includes attendances at face-to-face training and on-line events. Data is down compared to periods pre-covid. This is attributed to restrictions being placed on the number of people attending in-person events, and it not being possible to record data for some external on-line and e-learning events.

National Training Framework on Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

Since the commencement of the National Training Framework, **20,253** staff from Bridgend, Merthyr, and Rhondda Cynon Taf Local Authorities, and Cwm Taf Morgannwg UHB, have

completed group 1 training. These figures have been adjusted this year to only account for staff who have been trained and are still employed by the organisation.
Figures are not available locally for Welsh Ambulance Service Trust or the South Wales Fire and Rescue Service as they report directly to Welsh Government.

The table below outlines Cwm Taf Morgannwg's progress regarding the VAWDASV NTF in 2021-2022

Group	Numbers completed
1	1457(LA data only)
2	234
3	33
4	25 (93 specialist staff also attended additional specialist training)
5	7

It should be noted that during this period all locally delivered training in relation to the NTF was delivered online.

Welsh Government Training Grant

The Board receives an annual grant from the Welsh Government to support additional safeguarding training activities. This year the grant enabled us to support the following:

- An exploitation workshop which was delivered to 53 members of staff from a variety of agencies.
- Three sessions on staff wellbeing, delivered by Strongminds Resiliency Training Limited, took place online, with 35 people attending.
- Multi Agency Risk Assement Conferences training was held for 4 people who chair these conferences.
- Four training sessions on Professional Curiosity and Disguised Compliance were arranged for staff throughout the region.
- A face to face Staff Wellbeing Workshop was held for staff in Bridgend County Borough Council.
- Grassroots delivered Suicide First Aid Training which was attended by 6 people.

Multi Agency Practitioner Events (MAPF)

During 2021-22, several multi-agency practitioner events took place.

- A feedback event took place based on two adult practice reviews (CTSB 1/2018 and CTMSB 1/2019), involving assaults by an elderly resident in care settings. The two reviews were linked to each other and the findings and learning themes were of a similar nature. This feedback event took place online, with 40 people attending.

- A feedback event took place based on two child practice reviews (CTSB 2/2018 and CTMSB 2/2019). This event took place online, with 36 people attending.

- In October 2021, the Safeguarding Board launched its Protocol for the Management of Cases of Serious Self-Neglect, which sits alongside the Multi-Agency Staff

Guidance for Working with People who Self-Neglect. Five online awareness raising sessions took place, with a total number of 385 people attending.

- During Safeguarding Week 2021, two online workshops took place on Suicide and Self-Harm Prevention. The workshops highlighted and showcased some of the work happening nationally and locally to prevent suicide and self-harm, and also provided an opportunity for attendees to network and discuss opportunities for prevention. Over both sessions, 55 people attended.

Other Safeguarding Training

- The Disclosure and Barring Service held two workshops for the Safeguarding Board – one on disclosure which was aimed at managers and people involved in the recruitment process, and one on barring which was aimed at managers and anyone with a responsibility for making DBS referrals and those involved in professional concerns.

- Training for Child and Adult Practice Review Chairs and Reviewers was carried out for participants to understand the review process and feel confident and equipped to undertake these roles.

- Two Coercive Contol training sessions took place which were delivered by the Domestic Abuse Resource Team at Safer Merthyr Tydfil and RCT Domestic Abuse Services, with 114 people attending.

- The Wales Safeguarding Procedures were launched in 2019 to help ensure that those working in the public and voluntary sectors fully understood how and when they should take action to protect those at risk of harm or neglect. The e-learning module for the Procedures was released in November 2021.

  This module contains 13 sections and includes scenario questions to help users build a practical understanding of safeguarding and what action to take if they think someone may be at risk.

- Two Child Sexual Exploitation training workshops for practitioners within Cwm Taf Morgannwg were delivered online by Sophie Hallett, with 78 people signing up to take part.

- A workshop for practitioners on Child Sexual Abuse, was held in March by the 'Centre of Expertise on Child Sexual Abuse'.

- The Welsh Government's conference - 'The Right to be Safe - preventing and responding to child sexual abuse and exploitation in Wales' – which took place during Safeguarding Week 2021, was promoted withn Cwm Taf Morgannwg to encourage

practitioners to join. 25 people signed up to attend this. (There was cap on how many people could attend this session).

- As part of the Cwm Taf Morgannwg Safeguarding Board's activities programme for Safeguarding Week, Stop it Now! delivered a session online to practitioners on Child Sexual Exploitation.

- During Safeguarding Week, New Pathways delivered a session for practitioners on 'Dealing with Disclosures of Child Sexual Abuse' which 23 people signed up to

8. How have we collaborated with others?

Working in partnership with other agencies is integral to the work of the Board. We do this in a number of ways, with individuals, agencies, partnerships and organisations both within and external to Cwm Taf Morgannwg.

Community Safety Partnerships

Representatives from the Community Safety Partnerships sit on Safeguarding Board Sub Groups and joint work on Suicide Prevention and Domestic Abuse continues. See Section 5 for further details.

Wales Safeguarding Procedures Project Board

Representatives of the Board have continued to engage and participate in the Wales Safeguarding Procedures Project Board, led by Cardiff and the Vale Safeguarding Board. A theme has emerged with the implementation of Section 5: Safeguarding Allegations/Concerns about Practitioners and Those in Positions of Trust (Professional Concerns). Discussions are ongoing, with a view to achieving consistency and delivering training across Wales.

Welsh Government

The Chairs and Business Managers from all six Regional Safeguarding Boards across Wales meet on a regular basis with Welsh Government to provide updates on emerging safeguarding issues across Wales.

The Board has also worked collaboratively with the Welsh Government Suicide Prevention lead and the Regional Co-ordinator to take forward actions to prevent suicide and self harm, both regionally and across Wales.

Representatives from Cwm Taf Morgannwg have continued to contribute to the development of the Single Unified Safeguarding Review, due to be implemented later in 2022.

The Board contributed to various groups, consulations and discussions in the development of the new legislation around Ending Physical Punishment in Wales. This was implemented on the 21st March 2022.

In February 2022, a member of the Welsh Government Safeguarding and Advocacy Team attended a Board meeting to present their position on Child Sexual Exploitation and Child Criminal Exploitation. This has informed the Board's work on Tackling Exploitation across the region.

National Independent Safeguarding Board (NISB)

The NISB representative for the Cwm Taf Morgannwg region attended Board meetings during 2021-2022. They have also provided the Board with ongoing advice and support throughout the year.

A Thematic Review of Adult Practice Reviews, commissioned by the NISB, was presented to the Safeguarding Board in September 2021. Five key themes were shared:

- Safeguarding capacity and the duty to report
- Commissioning and inspection
- Transition
- The voice of vulnerable people
- Communication and family as carers

Other Regional Safeguarding Boards

The Board Chair and the Board Business Manager have continued regular contact with their counterparts across Wales to share good practice and resolve any common issues/barriers.

The Cwm Taf Morgannwg Business Manager collaborated with their counterparts from Gwent and Cardiff and the Vale to deliver additional Adult and Child Practice Review training to increase our pool of independent chairs and reviewers.

Social Care Wales

Representatives from Cwm Taf Morgannwg were involved in the development of a Wales Safeguarding Procedures e-learning module developed by Social Care Wales. This was launched during Safeguarding Week in November 2021.

9. PARTICIPATION AND INVOLVING

Children, young people or adults who are affected by the exercise of the Safeguarding Board's functions should be given the opportunity to participate in the work of the Board.

The information below highlights some of the work that has been carried out during 2021-22.

Bridgend Community Safety Partnership

- 690 engagements with young people on the street in twelve hotspot areas for Anti-Social Behaviour through Bridgend Youth Matters detached youth work.
- The detached Youth Team supported young people at local events including Elvis Festival.
- Four multi-agency operations on Youth annoyance, vehicle ASB, Grass fires, off road bikes.
- Review of Community Safety Partnerships aims to understand and map the existing meeting and partnership landscape for the Bridgend CSP and Cwm Taf CSPs

respectively. Ensure the current relationship with the CTM Safeguarding Board structures are strengthened. Review will be completed during 2022 to 2023.

Violence Against Women, Domestic Abuse and Sexual Violence

The Violence Against Women, Domestic Abuse and Sexual Violence Service worked with partners in South Wales Police, Victim Focus and Court Services to establish a remote evidence suite. This enables victims of domestic violence to give evidence at a safe site, fully supported by a Court Independent Domestic Violence Advisor (IDVA), without having to attend court.

This video explains more on this.

The Violence Against Women, Domestic Abuse and Sexual Violence Service helped to create and deliver the 'Snip it in the Bud' Campaign where hairdressers and barbers across Cwm Taf Morgannwg were supported to help them identify any potential warning signs and signpost to local services in the event of any disclosures.

Rhondda Cynon Taf County Borough Council's Children's Services

RCTCBC's Children's Services have achieved the following:

- Introduced Family Group Conferencing.
- Developed the 2Sides website for Children Looked After (CLA), with technical support from Wicid TV – the co-produced and interactive information, learning and support platform developed by the YEPS for young people aged 11+ in RCT.
- Revised the CLA consultation form for Children and Young People (CYP) which is now called My Voice - My Review. The planned proposal to gain CYP feedback on its accessibility and relevance will shape the document moving forward. The Independent Reviewing Officer Team Manager has also met with foster carers to encourage their active support to CYP to utilise this to maximise the Voice of child being heard at all reviews. This is due to go live imminently.
- A Participation Strategy has been developed**,** which is rooted in children's rights, and this will:
    - Listen to the public's experience of our services and systematically use this intelligence to drive improvement.
    - Prioritise people's rights
    - Re-engage with Voices from Care
    - Follow up Parent Advocacy
    - Set a pattern for involving service experienced people in our service developments and evaluation
- An RCT school has approached safeguarding regarding a group of pupils who have been participating in a school project linked to community safety, and further work with these pupils is going to explore their participation in the development of the exploitation strategy.

Wales Ambulance Service Trust

The Wales Ambulance Service Trust carried out several online sessions, with presentations and a question and answer section with the WAST panel. These sessions included:

- A Mental Health and Wellbeing session for the public, which included signposting people on where to find excellent sources of help in the community and online, without a GP referral. The Panel included the Mental Health and PECI Team.
- Health & Safety, preparedness carers to make themselves known and keep themselves safe physically and in terms of wellbeing, signposting to services.
- 111 Website awareness session for older people, which included a live demonstration of different aspects of the NHS 111 Wales Website to help people know how to navigate help and information, accessibility with the 'Recite Me' tool and symptom checkers online.

Merthyr Tydfil County Borough Council

Camau Babi, the Local Authority's pre-birth pathway, developed stronger links with Health to reduce safeguarding risks to newborn babies. Examples of service user feedback include:

- "It was a pleasure working with her and without her help I do not know whether the child would still be in my care".
- "Felt listened to and supported to make the changes needed to improve family life".
- "Brilliant workers who also listened to what I said".
- "This service has been a lifeline in such a difficult time".

Case Study - MTCBC Child Protection Conference – Parental Advocacy Pilot

With the support of grant funding from Welsh Government, MTCBC Children's Services commissioned a pilot of parental advocacy. This included an issues-based parental advocacy offer, along with a standard offer of parental advocacy for all parents attending Child Protection Conferences.

The initial pilot phase considered a control group which did not access parental advocacy, and a cohort that accessed parental advocacy, and analysed their experiences of attending a Child Protection Conference. The methodology of evaluation included:

- Consultation with all stakeholders
- Analysis of conference minutes from conferences involving parents who were offered an advocate and those who were not, in the same timeframe.

The feedback from all involved in the project, including parents/carers, Independent Reviewing Officers and Social Workers, was positive and the findings were that:

> 80% of parents reported that they found the service 'helpful'. 80% of parents said the service made a difference to their situation. 50% of parents said they knew more about their rights.

The evidence suggested that the parents who had advocates were more meaningfully engaged in the meeting and demonstrated better understanding of the concerns that instigated the conference meeting, in comparison to the cohort of parents who were not offered a parent advocate.

Feedback and analysis of conference minutes in this small scale project overwhelmingly indicated that having a parent advocate has enabled parents to engage with the conference process and to feel more confident in sharing their views, wishes and feelings. Their understanding of the process also appears to have improved as a result.

Based on the positive feedback, funding was identified for a 12 month project of parental advocacy where there is a standard offer of parental advocacy for all parents and people with parental responsibility for initial and Review Child Protection Conferences.

Dissemination of Information

As part of developing a positive culture of learning, the Board has disseminated best practice and learning within the workforce via Multi-Agency Practitioner Forums (see page 23), information within the Board's e-bulletin, and updating the website with reports and learning outcomes from Adult/Child Practice Reviews and audits.

Two bulletins were produced in 2021-22 and circulated amongst the Board and its partners. The information included:

- Ending physical punishment in Wales
- Working together to prevent child abuse
- All Wales Safeguarding Procedures training
- Violence Against Women, Domestic Abuse and Sexual Violence training
- Published policies and protocols
- Published practice reviews
- Suicide prevention

The e-bulletins can be accessed by selecting the links below:

- Spring 2021
- Spring 2022

Social Media

Throughout the year, information on a range of safeguarding issues for both the public and professionals was shared on the Board's Facebook page and its Twitter account, and posts from other organisations were also shared and retweeted, providing information and signposting to various support services.

The Safeguarding Board supported a number of awareness days, including:

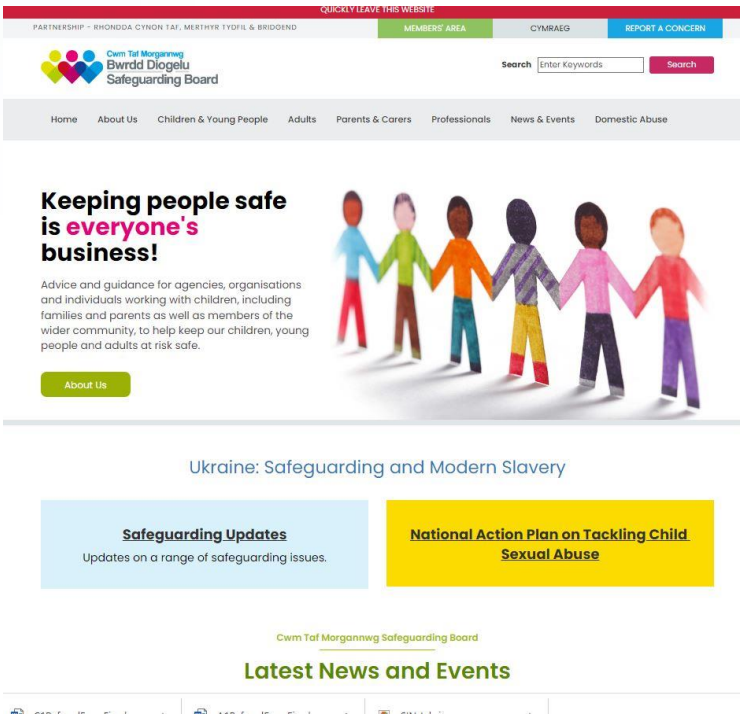
- Stalking Awareness week
- Mental Health Awareness Week
- Carers' Week

- World Elder Abuse Day
- Men's Health Week

Website

Information on a range of safeguarding issues was uploaded to the website throughout the year.

A section was created on the Safeguarding Board's website to contain information on various safeguarding related matters. Information from this section – Safeguarding Updates - was regularly sent out to members of the Safeguarding Board and its partners.



Campaigns

The Safeguarding Board and its partners have supported the following campaigns by sharing the information and resources for these internally, on websites, social media channels and with face to face events..

- Ending Physical Punishment in Wales
- White Ribbon Day
- Live Fear Free
- Hate Hates Wales
- Intra-familial Abuse
- 'Call Out Only'

Safeguarding Week

Safeguarding Week 2021 took place between 15th and 19th November. The theme for Cwm Taf Morgannwg was 'Safeguarding Our Communities'. This provided the Safeguarding Board, its partners and agencies within the region, with the flexibility to arrange events and activities on safeguarding issues pertinent to the services they provide, their service users and their experiences during the Covid-19 pandemic.

The events programme included training and awareness raising sessions on a range of safeguarding issues, such as child sexual exploitation, mental health, suicide and self-harm prevention, adult and child practice reviews, domestic abuse and child cri,minal exploitation. These were targeted at the general public, young people, parents/carers and professionals.

National Exploitation Awareness Day 2022

National Child Exploitation Awareness Day 2022 took place on 18th March. A multi-agency task and finish group was set up to discuss ways in which this could be promoted throughout Cwm Taf Morgannwg.

Online resources, such as social media posts, graphics and posters were shared, along with hard copy posters and leaflets on safeguarding and exploitation, providing information on the various types of exploitation, what the signs are if someone is being exploited, and what to do and how to report suspected cases of exploitation.

Cwm Taf Morgannwg Safeguarding Board merchandise such as notepads, pens and trolley coins, were also shared with partners for use in promotional activities to help raise awareness of the Board and to provide details on its website and social media channels.

Several activities took place for National Exploitation Awareness Day, including:

- The Health and Well-Being Team in Bridgend visited secondary schools during the week commencing 14th March, with a staffed information table during the lunch time period, to raise awareness of both Sexual and Criminal exploitation to students. On the 18th March, upon request by the Pupil Referral Unit, the Health and Well-Being Team were present all day, linking in with an event that the Unit already had in place.

- Cwm Taf YOS ran a campaign to raise awareness and provide information on exploitation for young people, particularly those in the NEET category, using the Outreach Service as a way of conveying the messages.

- A Child Exploitation Practitioners' event took place on 18th March, which was delivered via Microsoft Teams by members of the Cwm Taf Morgannwg Safeguarding Board Multi-Agency Child Exploitation Group and Barnardos' Independent Child Trafficking Guardian Service.

- Several partners, including Cwm Taf YOS, Barnardos, South Wales Police and the Wales Ambulance Service Trust took part in an event at Coleg Y Cymoedd (Nantgarw Campus), to speak to students and to raise awareness of exploitation.

Students engaging with partners of the Safeguarding Board for National Exploitation Awareness Day.

10. Contributions of Board Members

Each Safeguarding Board partner has a responsibility to ensure that the Board is operating effectively. There are clearly defined Terms of Reference as well as role profiles for Board members.

The Board continues to review the effectiveness of measures taken by partners and other bodies in relation to safeguarding via quality assurance, audits, and performance management. All the required statutory partner agencies in Cwm Taf Morgannwg are represented on the Board, Operational Committees, and Sub Groups, and attendance is monitored at these meetings.

Attendance at the Board and Joint Operational Committee meetings is presented in the table below:

AGENCY	ATTENDANCE AT BOARD (4 meetings)	ATTENDANCE AT OPERATIONAL COMMITTEE (4 meetings)
Director (RCT) **Director (MT)** **Director (BCBC)**	4 3 4	Not applicable
RCT Children Services	4	2
RCT Adult Services	4	4
RCT Public Protection	2	1
RCT Education	4	3
MT Children Services	4	4
MT Adult Services	3	4
MT Public Protection	0	0
MT Education	1	0
Bridgend Children Services	2	4
Bridgend Adult Services	2	4
Bridgend Public Protection	0	0
Bridgend Education	2	1
Cwm Taf Morgannwg University Health Board	4	4
South Wales Police	4	4
National Probation Service	3	4
Parc Prison	3	2

Partner agencies also provide the Board with an annual report demonstrating their contribution and commitment to safeguarding. This is summarised below.

Merthyr Tydfil County Borough Council (MTCBC)

MTCBC is represented on the Safeguarding Board by colleagues from Children's Services, Adult Services and Education. MTCBC also provides representatives to all Board Sub Groups and various task and finish groups held throughout the year.

MTCBC also contributes to the work of the Board in the following ways:

- Vice Chair of the Safeguarding Board
- Chairing of the Protocols & Procedures Group
- Leading on and co-producing regional guidance, e.g. Core Group Guidance
- Vice Chair of the Adult Quality Assurance & Performance Group
- Chairing and Reviewing Practice Reviews and MAPFs
- Supported the development of the Suicide Review Group
- Contributing to Immediate Response Groups and PRUDIC meetings

MTCBC provides performance data and contributes to audit work and sub-group activity as required. MTCBC also contributes to the facilitating of safeguarding training across Cwm Taf Morgannwg.

Bridgend County Borough Council (BCBC)

- The Director of Social Services and Wellbeing for Bridgend is the senior lead officer who holds the corporate responsibility for Safeguarding. The Director and Heads of Service for Adult and Children Social Care sit on the Safeguarding Board. The Director operates as vice chair.
- The Director and officers of the Council are active participants on Board Sub Groups and have chairing responsibilities.
- The Council has an identified senior manager who holds responsibility for Safeguarding across the Social Services and Wellbeing Directorate.
- Representatives from the Directorate have attended organised workshops, planning days and team meetings which have contributed to the setting of actions to meet the Board's priorities.
- BCBC utilises the regional Concerns Regarding Interagency Safeguarding Concerns protocol (CRISP) to escalate matters of a safeguarding nature.
- Safeguarding performance data is shared with the Quality Assurance and Performance Groups which is further scrutinised at the Safeguarding Board through highlight reports.
- Any independent safeguarding activity is also shared with the Safeguarding Board where appropriate and proportionate,
- The BCBC Education and Family Support Directorate has been well represented at all meetings across the regional Safeguarding Board over the course of 2021-2022. A review of representation has been taken to ensure that the right members of staff are present at the relevant meetings. This has assisted in ensuring a level of consistency in attendance and dissemination from those meetings.
- The Directorate has provided information related to Immediate Response Groups as and when requested. It has also contributed fully to meetings in terms of data and information. There have been occasions where this has been delayed but an improvement compare to previous years.
- BCBC has contributed fully to participation in Child and Adult Practice Reviews, learning events, and provided panel members where required.

Case Study - Bridgend Education

In 2021-2022, the Education Directorate created a new post (Group Manager) to ensure safeguarding responsibilities were being discharged effectively and consistently within schools and across the Directorate.

This post has a key responsibility in promoting and ensuring that all schools and services were fully informed of their safeguarding duties. This led to safeguarding audits being undertaken of all 60 schools in Bridgend. Schools will continue to review their audits on a termly basis and monitor their own progress against the audit tool.

Findings from the initial audits are as follows:

- 52 schools rated themselves as green.
- 3 schools rated themselves as amber
- 1 school was rated as red.

There was good reference to partner agencies supporting schools in relation to safeguarding issues and good evidence of schools undertaking surveys and consultations with learners or their parents. This has assisted schools in considering type of support required linked to safeguarding and wellbeing. There was strong evidence of schools having a wide range of support in place for learners.

Areas for improvement included the need to develop the robustness of their safeguarding approach and how effectively they communicate their safeguarding policies and procedures to staff, governing bodies, children, parents and carers. There is evidence in audits that governing bodies need to be clearer on their roles and responsibilities linked to safeguarding within their schools. The majority of schools highlighted that training for governors was a gap and needed to be addressed.

The one school rated as red related to the leadership of the school, in particular around implementation of safeguarding process, procedures and behaviour management. This school has been supported closely by the local authority and continues to be at this time and significant improvements are being noted since intervention.

The local authority will review each school's audit on an annual basis in their role as a "critical friend" providing challenge, questions and queries linked to schools response. The findings from the audits will be shared with schools to consider how they respond to this in preparation for their next annual review.

Rhondda Cynon Taf County Borough Council (RCTCBC)

RCT Adult and Children Services have maintained their commitment to the relevant Sub Groups of the Safeguarding Board. There is an excellent track record in attendance at meetings, and they make a significant and consistent contribution to the work of the Board, including the provision of Panel members, Reviewers and Chairs for Practice Reviews and MAPFs.

In 2021-2022, RCTCBC has:

- Chaired the Joint Operational Committee, Adults and Children Quality & Performance Sub-Groups and the RCT Self-Neglect Partnership Panel
- Vice-chaired the Cwm Taf MASH Quality & Performance Sub-Group, the Multi Agency CSE Group and the Engagement, Participation & Communication Sub-Group
- Been a member of all other Sub Groups of the Board and contributed to the Exploitation & SUSR Task & Finish Groups
- Attended and contributed to Immediate Response Groups
- Chaired one new Adult Practice Review, acted as a Reviewer in one Child Practice Review, provided Panel members to 4 Adult Practice Reviews and chaired 2 MAPFs.
- Increased our numbers of staff interested in Practice Review training in the last year

In addition, RCT Adult Services has:

- Worked with regional partners to develop and implement new case management documentation in line with the Wales Safeguarding Procedures 2019.
- Made a significant contribution to the Welsh Government's Single Unified Safeguarding Review project.
- Made a significant contribution to the Welsh Government Liberty Protection Safeguards (LPS) workstreams and has led a regional project to prepare for the implementation of the LPS.
- Continued to play a leading role with agency partners in the delivery of Level 3 Adult Safeguarding training during 2021-22 and have also delivered feedback events on behalf of the Safeguarding Board.

South Wales Police

SWP continue to remain an effective and contributing partner to the Board and its sub-boards.The DCI in particular has been instrumental in shaping the Board's response to the recovery phase of the pandemic as well as shaping the multi-agency response in the wake of several high profile child deaths in order to drive swift improvements to service provision.

SWP has significantly supported the Board's Practice Review processes during this period by agreeing to Chair a number of Panels, which has enabled the reviews to be completed in a timely manner.

SWP has representatives on the Board and its Sub Groups and has contributed to the development of the Single Unified Safeguarding Review and the potential impact on work of the Board.

South Wales Police has been a key contributer to the MASH change programme in information sharing to develop a new information sharing platform via Microsoft Teams as a more sustainable solution.

Her Majesty's Prison and Young Offenders Institute Parc

- Regular attendance to the Cwm Taf Morgannwg Safeguarding Board and relevant Sub Groups

- The Safeguarding Lead attended the Adult and Child Practice Review Training.
- Engagement in a Multi Agency Safeguarding Audit.
- The Safeguarding Team recognised the need to review Safeguarding Training for employees. Local Safeguarding Training has been developed and has been rolled out. All employees have been encouraged to complete the Safeguarding training on the CTM Safeguarding Website.

Cwm Taf Morgannwg University Health Board

- Reviewers and panel members for Practice Reviews and MAPFs
- Chair Suicide Review Group and MASH Quality Assurance and Performance Sub Group, providing relevant upward reports
- Attend and participate in all CTMSB meetings and sub groups.
- Members of task and finish groups to develop policies, improve practice and enhance performance framework.
- Contribute to the development of action plans and audit work.
- Facilitate learning events, ensure learning is widespread from Practice Reviews and Domestic Homicide Reviews throughout the UHB.
- Active participation during Safeguarding week to promote the priorities of the Board.
- Attend Training and Learning groups to ensure consistency in training packages and delivery of training across the region
- Attend and participate in the development of a regional Exploitation strategy.
- Ensure the priorities of the board are central to improvement plans within the UHB.

11. Managing our Resources

The Cwm Taf Morgannwg Safeguarding Board uses the national funding formula to assess and identify annual financial contributions from statutory partner agencies.

This is calculated as follows:

Agency	% Split	% Split
Rhondda-Cynon-Taf CBC	60%	55%
Bridgend CBC		32%
Merthyr Tydfil CBC		13%
Cwm Taf Morgannwg UHB		25%
South Wales Police		10%
Probation Service		5%
Totals		100%

In 2021-2022 expenditure was as follows:

Staff	£277,015
Premises	£7,440
Other	£6,381

Training costs are not included as this sits outside the Board budget.

Other Board Activities

Adult Protection and Support Orders (APSOs)

Adult Protection and Support Orders have been available since the 2016 implementation of the Social Services and Well-Being (Wales) Act 2014 but have been used rarely.

During the year, Rhondda Cynon Taff CBC became the third Welsh Local Authority to utilise the Order in order to be able to gain access to a suspected adult at risk, where it had not been possible to gain such access in other ways.

In this case, a young adult was reported to the Adult Safeguarding Team by the GP for not receiving any treatment for underlying health conditions. The efforts of the GP proved fruitless, a social worker was allocated to undertake S126 enquiries but attempts to make contact failed. A police welfare check confirmed that the person was safe, a strategy meeting took place, where it was agreed that the Authorised Officer would make an application to the Court for an APSO. The Order was successfully obtained and successfully served and the young adult was seen on two occasions by the Authorised Officer. There was no evidence of significant neglect or abuse, but it was likely, on the balance of probability, that they would not have mental capacity to make complex decisions about their health care needs.

Guidance and Advice received from the Welsh Ministers and/or the National Board

The Board continues to work closely with Welsh Government and the National Board and responds promptly to requests for information. A good relationship has been established with the NISB member for the region, and support has been provided on a number of occasions when seeking to commission independent reviewers or to influence national processes and guidance.

Section 137 requests for information

Section 137(1) of the Act provides a Safeguarding Board with the power to request specified information from a qualifying person or body provided that the purpose of the request is to enable or assist the Board to perform its functions under the Act.

In 2021-2022 the Board did not use its Section 137 powers to access information.

Are You Concerned About Someone?

If you suspect that a **child or young person** is being harmed or is at risk of being harmed then you have a duty to report it immediately. All calls concerning worries about children are treated seriously. Contact your local Safeguarding Team on the numbers provided below:

In Rhondda Cynon Taf: 01443 425006
In Merthyr Tydfil: 01685 725000
In Bridgend: 01656 642320

Opening Hours:
Monday - Thursday 8.30am - 5.00pm
Friday - 8.30am - 4.30pm

If you suspect that an **adult** is being harmed or is at risk of being harmed then you have a duty to report it immediately. All calls concerning worries about vulnerable adults at risk are treated seriously. Contact your local Safeguarding Team on the numbers provided below:

In Rhondda Cynon Taf: 01443 425003
In Merthyr Tydfil: 01685 725000
In Bridgend: 01656 642477

Opening Hours:
Monday - Thursday 8.30am - 5.00pm
Friday - 8.30am - 4.30pm

To contact Children or Adults Services outside office hours, at weekends and bank holidays, call:

Cwm Taf Morgannwg Emergency Duty Team on **01443 743665**.

If you suspect that a child, young person or an adult is at immediate risk of harm call 999 and speak to the Police.

If you would like to report a non-urgent incident, or have a problem or general query, you can call 101, the 24 hour non-emergency number for the police. ***Use 101 when the incident is less urgent than 999.***

APPENDIX 1 - BOARD MEMBERSHIP

NAME	TITLE	AGENCY
Paul Mee (Chair)	Director of Community and Children's Services	Rhondda Cynon Taf County Borough Council
Lisa Curtis-Jones (Vice Chair)	Director of Social Services	Merthyr Tydfil County Borough Council
Claire Marchant (Vice Chair)	Director of Social Services and Wellbeing	Bridgend County Borough Council
Cheryl Emery	Head of Public Protection	Rhondda Cynon Taf County Borough Council
Jackie Neale	Adult Safeguarding Service Manager	Rhondda Cynon Taf County Borough Council
Neil Elliot	Service Director, Adult Services	Rhondda Cynon Taf County Borough Council
Julie Clark	Head of Safeguarding and Support (Children)	Rhondda Cynon Taf County Borough Council
Gaynor Davies	Director of Education and Lifelong Learning	Rhondda Cynon Taf County Borough Council
Annabel Lloyd	Service Director, Children Services	Rhondda Cynon Taf County Borough Council
Cara Miles	Head of Legal - Community Care and Children	Rhondda Cynon Taf County Borough Council
Jon Eyre	Safeguarding Principal Manager	Merthyr Tydfil County Borough Council
Alyn Owen	Chief Officer, Community Regeneration	Merthyr Tydfil County Borough Council
Susan Walker	Chief Officer, Education	Merthyr Tydfil County Borough Council
Taryn Stephens	Head of Children Services	Merthyr Tydfil County Borough Council
Angela Edevane	Head of Adult Services	Merthyr Tydfil County Borough Council

Carys Kennedy	Head of Legal and Governance	Merthyr Tydfil County Borough Council
Jacqueline Davies	Head of Adult Social Care	Bridgend County Borough Council
Laura Kinsey	Head of Children's Social Care	Bridgend County Borough Council
Nicola Echanis	Head of Education and Family Services	Bridgend County Borough Council
Greg Dix	Director of Nursing, Midwifery & Patient Services	Cwm Taf Morgannwg University Health Board
Louise Mann	Assistant Director for Quality and Safety	Cwm Taf Morgannwg University Health Board
Mark Attwell	Superintendent, Mid Glamorgan BCU	South Wales Police
Sue Hurley	Independent Protecting Vulnerable Person Manager	South Wales Police
Emma Richards	Assistant Chief Officer	National Probation Service
Sharon Richards	Chief Officer	Voluntary Action Merthyr Tydfil
Maria James	Third Sector Representative, Merthyr Tydfil	Voluntary Action Merthyr Tydfil
Lyndon Lewis	Head of Service	Cwm Taf Youth Offending Service
Virginia Hewitt	Designated Nurse	Public Health Wales
Lin Slater	NISB Representative	National Independent Safeguarding Board
Nikki Harvey	Assistant Director Quality, Safety & Patient Experience	Welsh Ambulance Service Trust
Jason Evans	Head of Young Person's Unit	HM Prison & Young Offenders Institute, Parc
Ian Coles	Interim Deputy Director	HM Prison & Young Offenders Institute, Parc

Glossary of Terms

Adult Practice Review

The Regional Safeguarding Board must commission an Adult Practice Review in cases where an adult at risk has died, sustained potentially life threatening injury or sustained serious and permanent impairment of health.

Child Practice Review

The Regional Safeguarding Board must commission a Child Practice Review in cases where a child has died, sustained potentially life threatening injury or sustained serious and permanent impairment of health.

Child Sexual Exploitation

Child sexual exploitation (CSE) is a type of sexual abuse. Children in exploitative situations and relationships receive something such as gifts, money or affection as a result of performing sexual activities or others performing sexual activities on them.

Children Looked After

A child is looked after by a local authority if a court has granted a care order to place a child in care, or a council's children's services department has cared for the child for more than 24 hours.

Community Safety Partnership

Statutory partnership to develop and implement strategies to tackle crime and disorder including anti-social and other behaviour adversely affecting the local environment.

Domestic Homicide Review

A Domestic Homicide Review (DHR) is a locally conducted multi-agency review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:a person to whom he or she was related, or with whom he or she was or had been in an intimate personal relationship; or,a member of the same household as himself or herself.

Exploitation

Exploitation is a type of abuse. Exploitation involves being groomed, forced or coerced into doing something that you don't want to do for someone else's gain.

Immediate Response Groups (IRG)

A group which is convened to provide a rapid, multi-agency response to managing the consequences of a critical incidents, such as the unexpected death of an adult and is led by the Police Superintendent (or a suitable deputy).

MARAC

A weekly risk management meeting where professionals share information on high risk cases of domestic violence and abuse and put in place a risk management plan.

Modern Slavery

The illegal exploitation of people for personal or commercial gain. It covers a wide range of abuse and exploitation including sexual exploitation, domestic servitude, forced labour, criminal exploitation and organ harvesting.

Multi-Agency Practitioner Forum (MAPF)

Multi-agency professional forums are a mechanism for producing organisational learning, improving the quality of work with families and strengthening the ability of services to keep children safe. They utilise case information, findings from child protection audits, inspections and reviews to develop and disseminate learning to improve local knowledge and practice and to inform the Board's future audit and training priorities.

Public Protection Notice (PPN)

The forms have two main purposes. One is for police officers to make referrals to partner agencies when they have concerns about vulnerable people. The PPN is also used as a risk assessment tool for victims of domestic abuse and stalking and harassment (DASH).

Prevent

Prevent is about safeguarding and supporting those vulnerable to radicalisation

PRUDiC

This procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

Quality Assurance and Performance Groups

Two separate groups for adults and children whose objectives are to monitor the effectiveness of agencies' practice within the processes of safeguarding and encourage high standards of practice by all those involved in safeguarding work, promoting agency and individual accountability through the monitoring and evaluation of performance.

Self Neglect

Self-neglect is a general term used to describe a vulnerable adult living in a way that puts his or her health, safety, or well-being at risk.

Social Services and Wellbeing (Wales) Act 2014

The Social Services and Well-being (Wales) Act is the law for improving the well-being of people who need care and support, and carers who need support.

Strategy Discussion/Meeting

A meeting for social workers and other professionals to plan what they are going to do next about a case.

Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV)

The Violence against Women, Domestic Abuse & Sexual Violence (Wales) Act 2015 focusses on the prevention of these issues, the protection of victims and support for those affected by such issues.