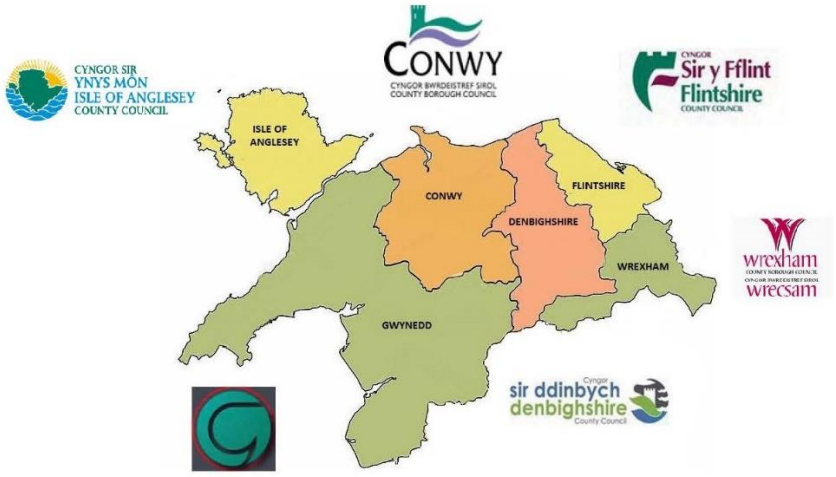
NORTH WALES SAFEGUARDING BOARD

Annual Report 2022 – 2023



See Something – Say Something

SAFEGUARDING IS EVERYONES BUSINESS!

Index

Introduction by the Chairs of the Adults & Childrens Boards:

It gives us pleasure to jointly present the North Wales Safeguarding Board Annual Report.

This Annual Report outlines the progress we have made against the outcomes set by NWSAB and NWSCB as part of our joint Annual Strategic Plan for the year 2022-23. As we proceed to publication, we as a Regional Safeguarding Board and the agencies we represent are more than ever mindful of the increasing hardships felt by the citizens of North Wales as the Cost-of-Living Crisis continues to bring more pressure to bear on their finances. As with the Covid-19 pandemic, there continues to be a need for agencies across the strategic partnership to work together collaboratively, to ensure those most at risk and in need continue to be protected and safeguarded from harm.

The resolve and resilience as accountable public agencies has been, and continues to be tested to the limits, in the most challenging and complex circumstances. As a region, we have been able to recognise and value the strength and benefits of a collaborative response through excellent partnership working.

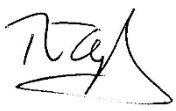
Recruitment and Retention of staff has impacted all agencies in the region following the pandemic and a number of experienced safeguarding staff in the region have made the decision to move away from frontline safeguarding practice.

Safeguarding Practitioners continue to highlight the complexity of cases that are being referred into all agencies. These unprecedented challenges have demonstrated the paramount importance of the Regional Safeguarding Boards in ensuring a multi-agency response to challenges in the safeguarding of children and adults at risk.

In the coming year, we remain committed to continuing to work together to meet the needs of the most vulnerable in our communities, and to learn any lessons to aid the future delivery of high quality, resilient and effective multi-agency safeguarding services.

Finally, we would not only like to thank the members of the North Wales Safeguarding Boards and sub-groups for their engagement, commitment and progress made in the last year but most importantly the whole safeguarding workforce across the region.

Jenny Williams
Chair North Wales Safeguarding Children's Board



Neil Ayling
Chair North Wales Safeguarding Adults Board

Objective of The Safeguarding Boards:

The North Wales Safeguarding Boards serve the citizens and diverse communities of the North Wales region which encompasses six Local Authority areas this does not come without significant challenges. The Board and its' members however continue to be proud of the strong ethos of collaboration and partnership working that has been established at a senior executive board and subgroup level. We look forward to the year ahead and continuing to build upon the strong foundations established in the preceding five years to deliver against our objectives and our aspiration to achieve excellence in Safeguarding Work, Professional Practice, and within the services we provide to our communities.

Protecting and preventing children and adults at risk from experiencing harm and promoting the wellbeing of the people of North Wales enabling them to achieve better outcomes remains central to the Board's work.

Areas have been identified for continuing improvement and will enable the Board and its members to fulfil their statutory responsibilities as outlined in Part 7 of the Social Services and Well-being Act (Wales) 2014 to protect and prevent children and adults at risk in the region from experiencing abuse and neglect and other kinds of harm.

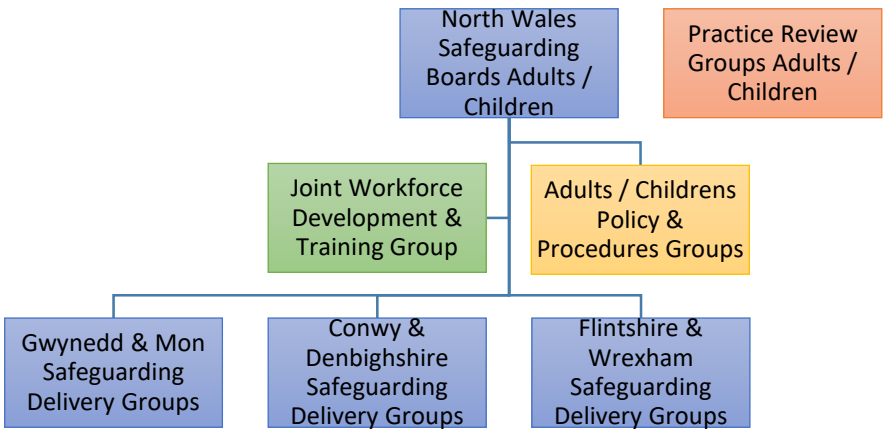
1. About The North Wales Safeguarding Boards:

1.1 Structure & Membership:

The North Wales Safeguarding Boards currently meet three times per year and jointly once a year. In addition, there is also a joint Business Development Day held annually to set the priorities for the coming year and self-assess the progress of the Boards.

The Board's Practice Delivery Groups and the Children's Policies and Procedures Group currently meet on a quarterly basis. The Practice Review Groups, the Adults Policies and Procedures Group and the Joint Workforce and Training Group meet bi-monthly. Meetings are held mainly virtually but the Boards are partially returning to face to face meetings.

Structure: The Adult and Children's Safeguarding Boards have identical structures and subgroups.



Board Membership

North Wales Safeguarding Adults Board

Chair: Neil Ayling, Chief Officer Social Services, Flintshire County Council.

Vice Chair: Michelle Denwood, Director of Safeguarding & Public Protection Betsi Cadwaladr University Health Board BCUHB)

Isle of Anglesey Council: Director of Social Services & Head of Adults Service.

Public Health Wales: Designated Nurse National Safeguarding Team

Conwy County Borough Council: Director of Social Care and Education, & Head of Children, Family & Safeguarding Services

North Wales Fire & Rescue Service: Business Education and Arson Reduction Team Manager

National Probation Service: Head of Probation Delivery Unit, North Wales

North Wales Police: Detective Superintendent, Protecting Vulnerable People Unit

Age Cymru: Head of Safeguarding and Advocacy, Hope Project

Denbighshire County Council: Corporate Director Communities & Head of Community Support Services

Cyngor Gwynedd: Corporate Director &Head of Adult Health and Wellbeing Services

Flintshire County Council: Chief Officer Social Services & Senior Manager Safeguarding and Commissioning

National Independent Safeguarding Board Member

Wrexham County Borough Council: Director Social Services / Head of Adult Social Care

Care Forum Wales: Chief Executive

Betsi Cadwaldr University Health Board: Director of Nursing Mental Health & Learning Disabilities

HMP Berwyn: Deputy Governor / Head of Public Protection

Welsh Ambulance Service Trust: Safeguarding Specialist Quality, Safety & Patient Experience Directorate

North Wales Safeguarding Childrens Board

Chair: Jenny Williams, Director of Social Care and Education, Conwy County Borough Council.

Vice Chair: Simon Williams, Detective Superintendent, Protecting Vulnerable People Unit, North Wales Police.

Wrexham County Borough Council: Chief Officer, Social Services & Head of Childrens Services

Flintshire County Council: Director of Social Services & Head of Children's Services

National Probation Service: Head of Probation Delivery Unit, North Wales

NSPCC: Safeguarding Representative

Barnardo's: Assistant Director Children's Services

Isle of Anglesey Council: Director of Social Services & Head of Children and Family Services

Denbighshire County Council: Corporate Director Communities & Head of Education & Children's Services

National Independent Safeguarding Board Member

Youth Justice Service: Service Manager Prevention & Support

Cyngor Gwynedd: Head of Children & Support Families and Corporate Director

Public Health Wales: Designated Nurse National Safeguarding Team

Betsi Cadwaladr University Health Board: Director of Safeguarding and Public Protection & Named Doctor Children's Safeguarding.

Welsh Ambulance Service Trust: Safeguarding Specialist Quality, Safety & Patient Experience Directorate

2. Action The Safeguarding Boards Have Taken to Achieve Particular Outcomes:

2.1 Transition following Covid-19

Subsequent to the easing of the Covid 19 restrictions during 2022, arrangements have been put in place by agencies to allow their staff to return to the office with some operating a hybrid working policy which is working well.

Across the region there continues be hard work by all staff during an uncertain period where we are facing a post Covid cost of living crisis which has exasperated many of the inequalities within our communities. For some areas within the region, job losses following the closure of large organisations has had a "catastrophic" impact on many families, and coupled with the current demands on their finances, has resulted in a rise in the demand for services.

2.2 Self-Neglect and Hoarding:

In response to the increases seen in reports of self-neglect and hoarding behaviours, in addition to the recommendations from a recent Child Practice Review, the Board's Policy & Procedures Group have reviewed and updated the Regional Hoarding Protocol. Dissemination across agencies has been via the NWSB website and associated 7-minute briefings, and all of the sub-groups.

2.3 Financial Abuse and Scams

North Wales has seen an increase in reports of financial abuse and scams and in response, a guide to Financial Abuse has been produced together with awareness raising about various scams and fraud. All information has been posted on the NWSB website which is then disseminated via a newsletter every week to over 1400 individuals across various agencies.

2.4 Protocol re Unexpected Death of an Adult

As a consequence of a number of referrals that were made to the Adult Practice Review Group that did not meet the review criteria, it was agreed that a protocol is required to deal with

cases of unexpected deaths of adults, similar to the PRUDiC process for children. A task and finish group was set up in December 2022 and it is hoped that work will be concluded in June 2023.

3. The extent to which the Safeguarding Board has implemented its most recent Annual Plan.

3.1 Strategic Priority 1 - To respond effectively to the learning identified from Regional Adult / Child Practice reviews, Regional Multi-agency professional's forum and the National and UK safeguarding reviews. (NWSB)

In relation to the above, child neglect training has been delivered and review of NWSB Hoarding Protocol undertaken to reflect issues if children present – identified learning from CPR.

Cases that do not meet the threshold for review are considered for alternative types of scrutiny to enable any learning to be identified. This includes the development of the protocol around unexpected deaths of adults and a proposed audit of cases, where mental health, homelessness and alcohol / drug abuse were present. Anticipated that this will be completed Autumn 2023.

A learning programme around CPR's has also been developed and delivered via action learning sets, workshops, and forums.

In cases where independent reviewers were commissioned, they were subsequently invited to work with staff from the authority involved to talk about the review, the rationale around the recommendations and answer any questions.

Agencies have been delivering Action Learning Sets around the common themes arising from APRs, within organisations across the region and audits are currently being conducted on action plans to gauge how successful implementation of the actions coming from the recommendations has been.

The NWSB has continued to engage in the Single Unified Safeguarding Review (SUSR) development process, with discussions taking place across both Boards and their subgroups. Further work is programmed in relation to the structure of the subgroups and Boards in order to facilitate the changes in relation to SUSR.

The Board also continues to respond to the Thematic Review of Adult Practice Reviews, with agencies providing updates around the work being undertaken in their area.

3.2 Strategic Priority 2 – Effective engagement and communication: To improve engagement and consultation with children and adults at risk, vulnerable groups, professionals, and partnerships (NWSB).

Several avenues of engagement have been sought by the Boards, including the use of social media, website and surveys, Peer and Advocacy groups which have not been successful.

The North Wales Safeguarding Adults Board has welcomed a new member from the Hope Project, Age Cymru who has agreed to help the Board develop mechanisms for meaningful engagement with adults at risk.

Discussions with other Boards across both England and Wales, have highlighted that this is a problem area that all are struggling with, and was highlighted by the Safeguarding Lead

from the Older People's Commissioners office, as being problematic for them also, when she recently attended the Board.

Individual agencies such as Conwy have reported that they use the Schools Health Research Network reports [SHRN] to provide rich data and feedback from children and young people. This informs what's working well in their schools and areas for improvement, so that resources can be focused in the right areas. Secondary schools continue to use their Wellbeing Ambassadors who share information and offer peer support on a whole range of topics.

The promotion of Mind of My Own has continued with the development of Practice Standards outlining what is expected of workers and carers across the authority. This compliments the continued direct work completed with young people to ensure their voice is heard and promoted within early intervention, care and support, child protection and children looked after.

Both Board Chairs continue to meet with Chairs from other Boards, Welsh Government, and the National Independent Safeguarding Board on a regular basis. Meetings also take place with both Children and Adults Boards in Cheshire & Cheshire West, the Coroner and CIW.

Board members also attend other Strategic Partnership Meetings such as the North Wales Vulnerability and Exploitation Board and the Regional Partnership Board amongst others.

The Regional Business Manager also meets with colleagues across Wales, the NISB and Welsh Government on a regular basis.

Raising awareness of the Boards continues throughout the year, not only via the website, it's newsletter and 7-minute briefings and blogs, but via face-to-face interaction with a variety of organisations including presentations to student social workers in universities and colleges.

The Boards Business Unit recently delivered a workshop around Person Centred Practice to 75 Health and Social Care Students at a local college. A series of workshops were funded by the Board across the region to enable workshops to take place around DBS and Safe Recruitment delivered by Carole Eland, Disclosure and Baring Service to third sector, and voluntary organisations.

3.3 Strategic Priority 3 – To support the implementation of new legalisation in 2022 including End Physical Punishment and Liberty of Protection Safeguards alongside responding to national action plans on Child Sexual Abuse and prevent of abuse of older people.

Highlight and performance reports inform of any issues/themes occurring across the region. Groups are updated and encouraged to participate in consultations regarding changes to legislation, development of National Action Plans and updates are recorded on the NWSB Website with a weekly newsletter sent out.

We are awaiting Welsh Government's Action Plan to Prevent the Abuse of Older People following consultation. In the meantime, discussions continue within the subgroups around raising the profile of adult safeguarding.

Presentations received from OPC's office on the work the Commissioner is undertaking in relation to Elder Abuse etc.

Liberty Protection Safeguards /Deprivation of Liberty Standards – Agencies continue to prepare their staff for LPS, raising awareness of Human

Rights and MCA. DoLS remains a significant safeguarding issue i.e. the numbers of individuals across the region who may be unlawfully deprived of their liberty as LAs hold waiting list in terms of processing the standard authorisations request. Agencies are aware of the need to focus on improving and strengthening the process despite LPS being put on hold.

During National Safeguarding Week workshops were provided on the following themes assist preparations for the anticipated work programme:

- Preparation for LPS.
- Adult Safeguarding & Human Rights.
- Learning & Reflection from Operation Jasmine.
- Professional Curiosity in Adult Safeguarding.
- Overview of the work of the OPC.
- Person Centred Practice – For Adult Safeguarding Practitioners.

Messages around Ending Physical Punishment were disseminated on a regular basis via social media and the website.

3.4 Strategic Priority 4: To continue to ensure a robust, resilient, and consistent approach to safeguarding practice during the Covid-19 pandemic.

The impact of Covid – 19 on staffing is an issue across agencies. Agencies are reporting that whilst there has been evidence of good multi-agency working, concerns with regards to non-engagement or availability of other statutory partners to be an integral and effective part of the whole Adult Safeguarding process, continues to be a challenge.

Issues re social care provision availability and the balance of keeping people well in the context of increasing demand, limited provision and increasingly complex needs is a challenge that is being consistently highlighted.

The Impact of Covid on Children is becoming apparent through the number of CPRs being undertaken for incidents that occurred during and just after the pandemic, however, the impact on Adults at Risk has yet to be seen.

4. How have the safeguarding boards collaborated with other persons or bodies engaged in activities relating to the board's objectives?

North Wales Vulnerability & Exploitation Board

The Safeguarding Boards Chairs (Adults/Children) regularly meet with the Vulnerability and Exploitation Partnership Board Chair ensuring alignment of work streams and provide a progress report for their Board. In 2020, following a substantial amount of work and consultation, it was decided that the VAWDASV agenda would join with Modern Slavery, Human trafficking, Organised Immigration Crime, and other areas of criminal exploitation. This is now the Vulnerability and Exploitation Board.

Plans for the V & E Board to become integrated within the Safeguarding Board are currently on hold.

Cheshire & Cheshire West Safeguarding Boards

Meetings take place bi-annually between the Boards, recent collaboration with the Cheshire & Cheshire West Safeguarding Adults Board ensure that learning from a

recent Adult Practice Review which involved the Countess of Chester Hospital, could be shared across their region. Collaboration during the review and the learning event was positive and all agencies involved from both England and Wales were able to share their experience and examples of good practice.

Norfolk Safeguarding Adults Board

Helen Thacker – Safeguarding Lead for Norfolk Safeguarding Adults Board was happy to share details around Professional Curiosity in Adult Safeguarding and gave a presentation to practitioners from across Wales during National Safeguarding Week.

Safeguarding Boards across Wales

Regular meetings with colleagues from across the Safeguarding Boards in Wales take place on a quarterly basis. The Business Managers communicate and share information, resources and knowledge on a regular basis.

Welsh Government

Meetings with Welsh Government and the National Independent Safeguarding Board take place with the Chairs of Safeguarding Boards every few months.

North Wales Coroner's Office

Chairs of both Boards and members of the Business Unit attend bi-annual meetings held with the North Wales Coroners, to discuss key issues and themes coming out of practice reviews and anything highlighted within the local practice delivery groups that are deemed to be in the realm of the coroner.

Care Inspectorate Wales (CIW)

Regular communication between the Boards and CIW takes place. CIW presented a reflections event during National Safeguarding Week in relation to Operation Jasmine which was well attended by a wide range of professionals from third sector, providers, as well as staff from the Board's statutory agencies.

North Wales Regional Commissioning Board & the North Wales Partnership Board.

A number of Safeguarding Board members also attend the Regional Commissioning Board and the North Wales Partnership Board. Collaboration has taken place between the Boards in relation to the review of the North Wales Escalating Concerns Process to ensure reference to safeguarding procedures, protocols and guidance were in place. Further collaboration is taking place in relation to the work streams that have potential cross-over with safeguarding.

5. Any requests the Safeguarding Board has made to qualifying persons under section 137(1) of the Act for specified information, and whether the requests were complied with.

No requests were made under section 137 (1) of the act. The Board has been able to resolve any issues through direct communication with Board members.

6. Achievements of the Safeguarding Boards during the year.

6.1 Completion and Publication of Guidance

Hoarding Protocol

As a recommendation from a recently published Child Practice Review, the Regional Hoarding Protocol has been reviewed and updated to include guidance around the presence of children within a hoarding environment.

📖 North Wales Safeguarding Adults Board Hoarding Protocol

NWSB Financial Abuse Guidance

Following a reported rise in the incidence of financial abuse, this practice guidance is designed to support professionals in understanding what financial abuse is, how to spot the signs of financial abuse, and highlight the impact it can have on individuals.

📖 NWSAB Financial Abuse Guidance

Multi Agency Practice Guide: Responding to Risk & Need for Unborn Babies, including Concealed Pregnancies

This practice guidance has been drawn up by multi- agency professionals. Its aim is to ensure that all agencies know what to do and how to exercise safeguarding responsibilities in respect to the risk to and the needs of unborn babies including concealed pregnancies.

📖 Responding to Risk & Need for Unborn Babies, including Concealed Pregnancies

NWSCB Practice Guidance Professional Curiosity

Professional curiosity is the capacity and communication skill to explore and understand what is happening within a family rather than making assumptions or accepting things at face value.

📖 NWSCB Practice Guidance Professional Curiosity

Supporting Children, Supporting Parents with severe mental health problems and or substance misuse issues - A framework for safeguarding children.

The overarching aim of this practice guide is to ensure that children, including unborn children of parent(s) experiencing mental ill health and/ or misusing substances receive appropriate support, safeguarding and protection.

📖 Supporting Children, Supporting Parents with severe mental health problems and or substance misuse issues - A framework for safeguarding children

NWSAB Guidance Tool for Adult Safeguarding

The Regional Practice Guidance Tool for Adult Safeguarding Decisions has been updated to include a falls matrix.

📖 NWSAB Guidance Tool for Safeguarding Adults Decisions

Modern Day Slavery & Human Trafficking Referral Pathways

Referral pathways have been developed in partnership with the North Wales Violence and Exploitation Board, which details what everyone's responsibilities are.

📖 Modern Slavery & Huma Trafficking Referral Pathway

6.2 National Safeguarding Week

The North Wales Safeguarding Board and partner agencies across the region held a series of events and awareness raising sessions during National Safeguarding Week. All NWSB sessions were very well attended and were open to third sector, college and university students and provider organisations.

The following events were held during National Safeguarding week 2022:

- Social Care Wales: Launch of the National Training Standards Framework.
- Person Centred Practice – Adult Safeguarding.
- Could curiosity save lives? Ann Anka UEA, Helen Thacker (Norfolk Safeguarding Adults Lead Conference – Celebrating Good Practice.
- Human Rights & Adult Safeguarding: Dr Laura Pritchard-Jones.
- Learning from Adult Practice Reviews: Dr Tom Slater/ Dr Alyson Rees.
- An overview of the All-Wales Practice Guides which accompany the Wales Safeguarding Procedures for Children.
- Prevent Training Sessions.
- Meet the Board Session for Universities and Further Education.
- An overview of the work of the Older Peoples Commissioner for Wales: Andrea Cooper.
- Learning from CPR/ MAPF: Val Owen
- Preparing for Liberty Protection Safeguards: Neil Allen (Essex Chambers)
- Operation Jasmine Learning & Reflection Event: Margaret Rooney CIW.
- Professional Curiosity (Children): Paul Jones.
- Engaging Fathers in Child Protection: Paul Jones.

6.3 Learning and Development Programme:

The following learning and development programmes were delivered during 2022 – 2023 to evaluate the effectiveness of holding learning events following publication of APR/CPR reports:

Learning from Adult Practice Reviews about Transitional Safeguarding – Michael Preston Shoot:

Sessions focused on the ways in which the gaps between children and adult's systems play out through inter-agency and multi-professional working, as well as how "lifestyle choices" of young people are understood and interpreted are key issues. Attended by practitioners from Adults and Children's Social Services, Substance Misuse Services, Health, Education, Police, Probation, and the Voluntary Sector.

Understanding the lived experiences of neglected Children:

Sessions were delivered to 250 practitioners across the region during March and April. The sessions focused on recognising, understanding and responding to child neglect.

Transitional Safeguarding:

Regional learning events took place following a Multi-Agency Professional Forum that was undertaken on behalf of the Board. The sessions encouraged discussion and highlighted learning around transition from Children to Adults Services across agencies and cross

boarder issues.

Child Sexual Abuse – Community of Practice Workshop:

The workshops considered the following areas:

Current position in Wales; Supporting children and families: Identifying and responding to child sexual abuse with confidence; Good Practice across the region and working with adult survivors of child sexual abuse.

Person Centred Approach and Wales Safeguarding Procedures:

Sessions were delivered to practitioners across the region and to 75 Health & Social Care Students at a local college.

Recognition of Physical Abuse for Multi-Agency Practitioners:

Sessions included recognition of the pattern of 'everyday bruising' in children. Recognition of how inflicted bruising in children differs from everyday bruising (include photographic evidence). Children with Disabilities and NAI. Understanding the notion of a 'sentinel injury' in child maltreatment. Other non-accidental injuries and cutaneous mimics. How to record your findings/ how the medical process/ examination and arriving at a decision about the injury fits in to the wider process of conducting a safeguarding investigation- the timescales, the need for a clear opinion by medics as it is their opinion that is often the basis of a care order. Medical Language / terminology within the NAI process report.

Effective work with adults who self-neglect: the evidence-base from research and reviews: Michael Preston-Shoot.

A session was delivered around the themes and issues taken from APR's and Serious Case Reviews and highlighted effective practice.

A review of the key findings from the IICSA report on Child Sexual Exploitation by organised networks: Delivered by Sophie Hallett.

The key findings from the IICSA report were discussed and practitioners were able to consider both the research in Wales and the wider research in the UK, to reflect on how we can respond to the learning.

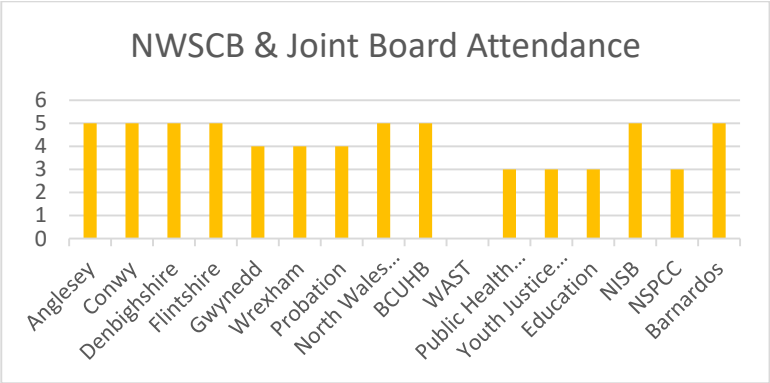
Solihull Approach online parenting courses

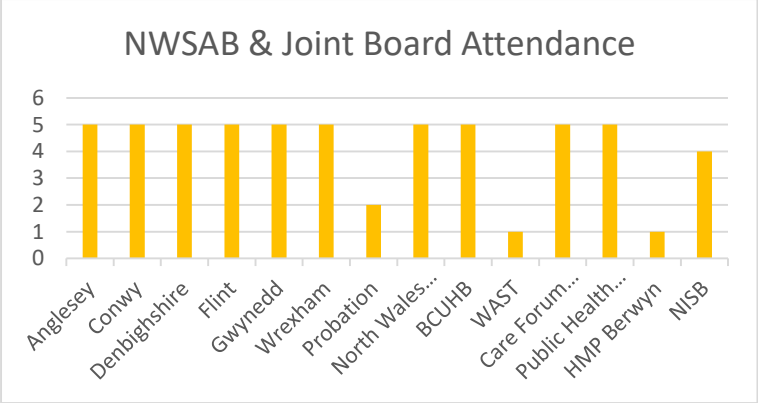
To date over 5,951 individuals from North Wales have started or completed one or more of the courses. To expand the reach to families across North Wales even further we have undertaken some analysis to establish how learners heard about the courses. The highest number of referrals has come from school settings at 31%.

7. The extent to which each member of the safeguarding board contributed to the board's effectiveness.

7.1 Board Attendance:

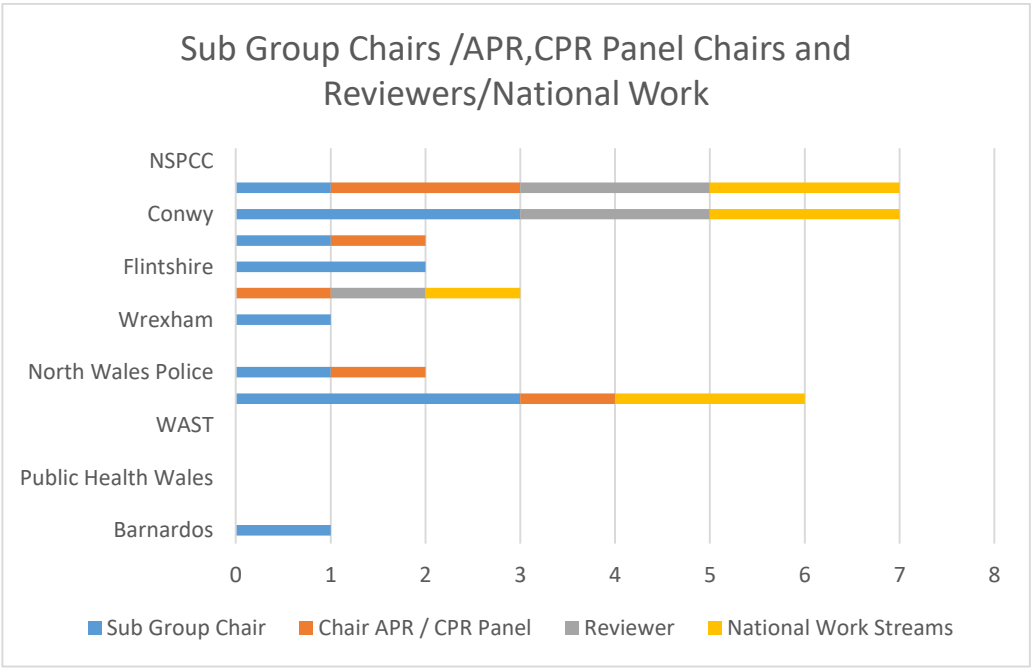
Board attendance was discussed at the Business Development Session held on 9th March 2023. It had been identified that there was a lack of attendance at Board by some agencies, and this was addressed following the session.





7.2 Partner Agency Work Contribution

The graphic below shows each agencies contributions to the work of the Boards. Details include attendance on behalf of the Board in relation to national pieces of work, Chair arrangements of the sub-groups and contributions to Adult and Child Practice Reviews as either a Panel Chair or a Reviewer.



Sub Group Attendance and Chair Arrangements:

Challenges remain with regards to Chair arrangements for the Board sub-groups with some groups being chaired on a rotational basis due to lack of a permanent Chair. Despite numerous requests agencies are not coming forward. The Board's sub-groups have also seen a decline in attendance by both statutory and third sector partners and this was also addressed following the Business Development Session.

Challenges in relation to Child and Adult Practice Reviews:

The lack of availability of internal Chairs and Reviewers has caused delays in commencing reviews, and has resulted in external commissioning which cannot be sustained due to increased demand and costs. As more reviews are being undertaken, agencies are reporting that their staff do not have capacity to undertake the roles due to their own increased work load within their organisations and staff shortages.

7.3 Partner Agency Reports

Partner Agency Reports are produced and received annually to provide information and assurance around work undertaken in relation to the Board's priorities, each agency is asked to present their report and a critical friend is assigned to ask questions or seek further information.

This practice ensures that the Boards are aware of any emerging issues or themes and highlighting good practice. Some of these themes will assist to inform the Board's priorities for the coming year.

Themes and Issues identified during 2022 / 2023:

Conwy County Borough Council:

- Child to Parent/ Carer Abuse - Increase in referrals, hidden form of abuse and more families asking for help.
- Unaccompanied Asylum-Seeking Children [UASC].
- Elective Home Educated [EHE].
- Multi-disciplinary working – good practice.
- Effectiveness of MASH.
- Providers & Safe Recruitment challenges.

Betsi Cadwaldr University Health Board:

- Deprivation of Liberty Safeguards and the Mental Capacity Act.
- Training, Education and Learning.
- Section 5 Process.
- VAWDASV & Child at Risk.
- Complex cases of Children and Young People open to CAMHS and Delayed Transfer of Care.

Flintshire County Council:

- Engagement with Adults at Risk.
- Children's: Placement sufficiency.
- Hybrid Working.
- Adult Safeguarding Reports – Increasing Demand.

North Wales Police:

- Organised Immigration Crime.
- Impact of COVID-19 on the mental health of children and any associated risk of suicide.
- Voice of the Child.
- Multi-Agency Safeguarding Hubs/ Arrangements.

Probation Service

- Overall MAPPA demand and complexity.
- Enhanced safeguarding and Domestic Abuse enquiries.
- SFO profile.

Isle of Anglesey Council:

- Liberty Protection Safeguards.
- Learning APR / CPR.
- Effective Engagement & Communication.
- The need for effective collaboration.
- A Trauma Informed Island.
- Efficiency of core multi-agency groups.

Denbighshire County Council:

- Deprivation of Liberty in Domiciliary Settings (DiDS).
- Examples of Innovative Practice.
- Voice of the child & family.
- Impact of pandemic on behaviour and wellbeing.

Wrexham County Borough Council:

- Improve services of an effective and efficient SPOA (Single Point of Access).
- Section 5 and responsibility of agency partners to inform the LA of outcomes.
- Timeliness of Occupational Therapy assessments and support.
- Meeting the needs of unaccompanied asylum-seeking children and the increased number of these children becoming accommodated by the local authority.

Cyngor Gwynedd:

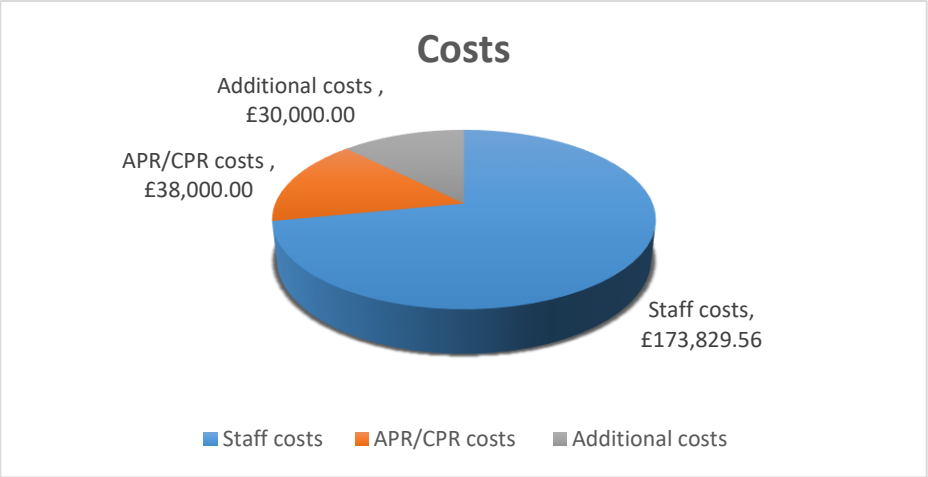
- Continued embedding of Effective Child Protection in Gwynedd and its roll out to other Authorities in North Wales; aware of new challenges such as revised PLO processes.
- Resolution by National Safeguarding Board of the remaining areas of Section 5 which require improvement.
- Resolution by Welsh Government of the approach nationally to child exploitation including SERAF replacement risk assessment tools.
- Advocacy – ensure that individuals are central to the Safeguarding process by referring to an IMCA service if they lack capacity to consent.
- Consent to report –numerous Adult at Risk reports which have been sent without the individual's consent.
- DoLS - The need to address any waiting lists to ensure that individuals are not deprived of their liberty without authorisation.

HMP Berwyn:

HMP Berwyn will be presenting their update report to the Joint Board in September 2023. However, an update was received at the NWSAB in November 2022 with regards to the HM inspectorate of Prisons report for Berwyn carried out in May 2022. Themes arising from that report included:

- There had been improvement since the 2019 inspection, regarding prisoner's safety, respect and purposeful activity.
- Improvement required regarding rehabilitation and release planning.
- Protection of adults at risk and adult safeguarding is being reviewed and is being included in the induction programme.

8. An assessment of how the Safeguarding Boards used its resources in exercising its functions or achieving its outcomes.



8.1 Safeguarding Board Budget

Apart from Staffing Costs, the commissioning of Reviewers and Chairs for Child and Adult Practice Reviews has seen the highest spend from the Board's budget. It is anticipated that with the expected move to the Single Unified Safeguarding Review Process, that these costs will continue to rise. The internal resources for Chairs and Reviewers have been depleted due to the number of reviews being undertaken across the region, this does not consider the inclusion of Domestic Homicide Reviews, Mental Health Homicide Reviews and the Offensive Weapons Homicide Reviews that is to come under the remit of the Regional Safeguarding Boards.

The increasing number of reviews is adding pressure to organisations to ensure appropriate review panel representation, and the capacity of their staff to undertake extra duties as Reviewers and Chairs, in addition to their day jobs. This has meant a decline in the number of people available to undertake these roles, and an increase in commissioning external agencies to fill the gap.

The Business Unit staffing is at the minimum operational level, with 1 x Business Manager and 2 x Business Coordinators and 1 x part-time Administration Officer. It is anticipated that with implementation of SUSR, an additional staff member will be required.

8.2 Child & Adult Practice Reviews:

No practice reviews were published in 2022 / 2023; however, 6 Child Practice Reviews were commissioned.

From the 6 practice reviews that are being undertaken, 8 independent external reviewers and 3 independent chairs have been commissioned.

It is evident that this is a trend that may continue as demand is outstripping supply and increased pressure on agencies own staff is increasing.

8.3 Training and Awareness Raising:

More resources are being put into training and awareness raising each year. In addition to the Welsh Government contribution to National Safeguarding Week the Board committed an equivalent amount to the week to enable further resources to be

developed to highlight key safeguarding messages with providers, third sector and the public.

Training continues to be a priority for the Board, with a continued programme of S47 training, and achieving best evidence. Six regional sessions were held during 2022 / 2023 in addition to the learning and development sessions that have already been highlighted.

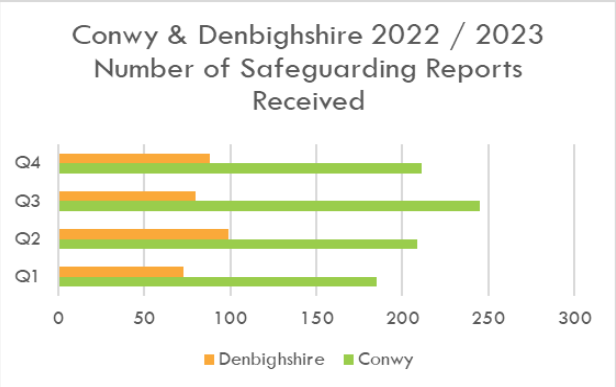
9. Any underlying themes in the way the safeguarding boards exercised its functions as shown by an analysis of cases it has dealt with, and any changes it has put into practice as a result.

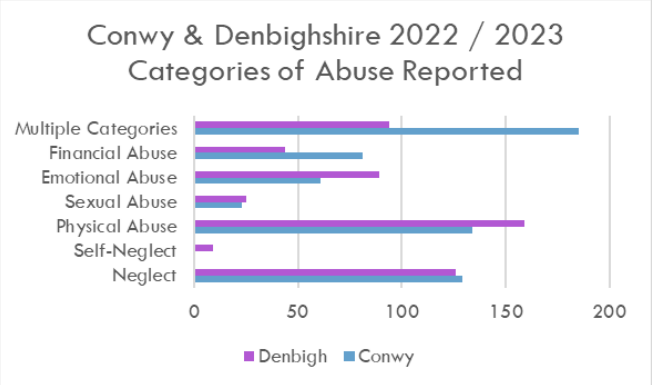
9.1 Adults

Changes to the Partner Agency performance and highlight reports have been made in order to give a complete overview of any themes and issues. Data around the number of reports received, categories of abuse, 7-day enquiries are all included. Also reporting on practice issues in relation to Section 5 of the procedures, the number of reports received and the outcomes. Escalating Concerns are also discussed together with information relating to DoLS applications, training that the agency has provided and how learning has been disseminated. Reference is also made to any incidents or issues that have been identified throughout the quarter. This information is shared across the three Regional Safeguarding Delivery Groups.

Volume of Safeguarding Reports 2022 / 2023 & Categories of Abuse Reported

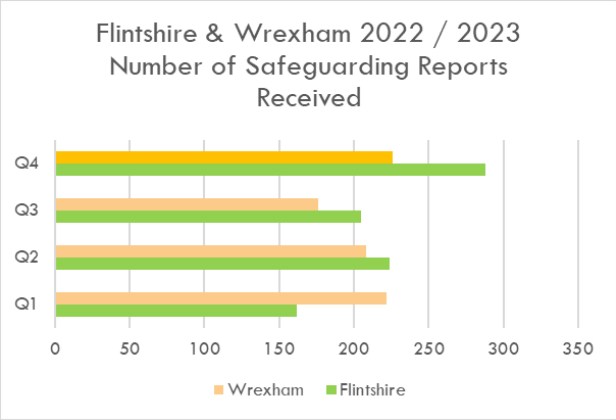
Conwy & Denbighshire:

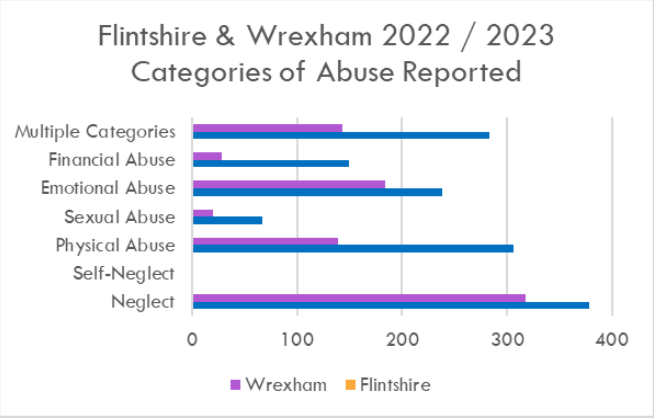




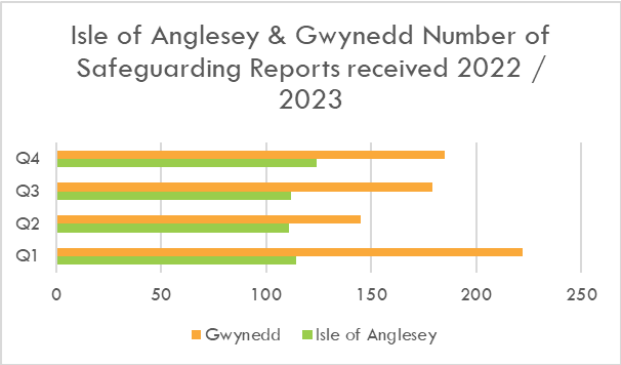
Note: Some LA's do not to record Self-Neglect as a separate category at present.

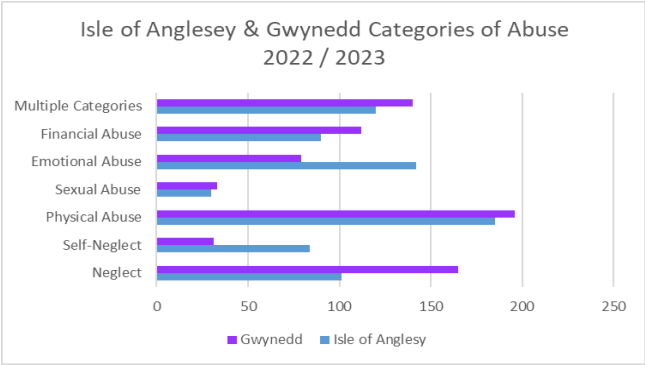
Flintshire and Wrexham:





Gwynedd & Anglesey:





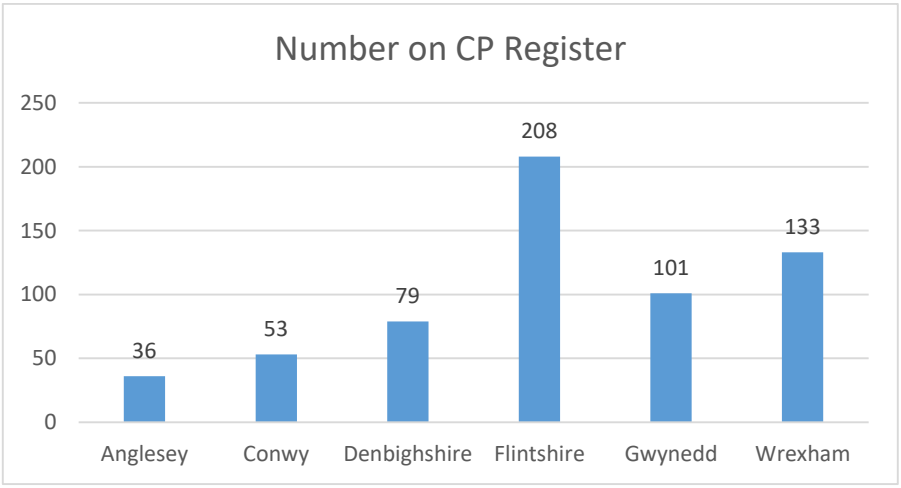
9.2 Children

Partner Agency performance and highlight reports are submitted in order to give a complete overview of any themes and issues. Data around the number on the Child Protection Register and the primary category of abuse is received, as are updates on the NWSB Priorities, good practice examples, any practice issues that may have arisen, and any themes/ trends/ concerns.

Reference is also made to any incidents or issues that have been identified throughout the quarter. This information is shared across the three Regional Safeguarding Delivery Groups.

Child Protection Register

Data was received by the children's practice delivery sub-group in relation to the number of children on the CP register during 2022 / 2023.



Categories of Abuse:

The primary category of abuse reported by all six Local Authorities is Emotional with Anglesey reporting Psychological also a primary category.

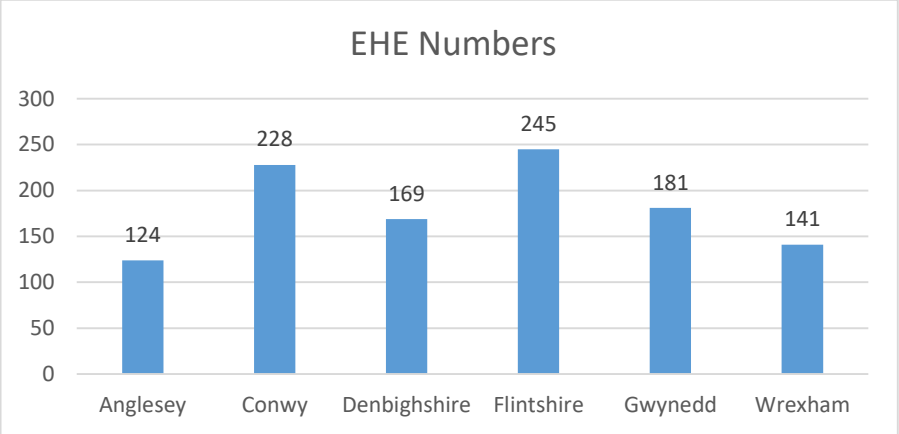
Electively Home Educated (EHE):

The increase of learners becoming Electively Home Educated (EHE) continues to rise. There are a large number of children not able to attend school due to Emotional Based School Avoidance (EBSA) relating to issues following the pandemic is considerable, with long

waiting lists for children and young people to be seen, with very little movement in terms of how we address this issue to get them back into education.

There is also recognition that some families are struggling financially, so Education Services have signposted parents requiring support to debt management via parent pay.

Number of Electively Home Educated (EHE) Children across the region:



Joint inspection of the multi-agency response to keeping children and young people safe

Between February and March 2023, Care Inspectorate Wales, His Majesty's Inspectorate of Constabulary and Fire & Rescue Services, Healthcare Inspectorate Wales and Estyn carried out a joint inspection of the multi-agency response to keeping children and young people safe.

It is anticipated that reports will become available from April / May 2023 onwards.

9.3 Issues and themes reported across the region:

Increase in the Number of Safeguarding Reports:

Referrals are becoming more complex and financial abuse is an increasing trend within Adult Safeguarding. The number of Adult Safeguarding reports have continued to increase putting pressure on the team to screen initial referrals and undertake enquiries. Year on year the number of safeguarding referrals has increased as has the complexity of those referrals.

Section 5 (Position of Trust) – Wales Safeguarding Procedures:

All areas are reporting increased activity in relation to Section 5 of the Wales Safeguarding Procedures. Issues identified within the process includes the differences within how the process is interpreted between LA's, the lack of national guidance and training. Some LA's are reporting an 84% increase in the number of section 5 reports received during 2022 / 23 compared to the previous year.

Ambulance Delays:

All Local Authorities in the region are reporting Ambulance delays remain an area of concern where we are identifying instances of up to 24-hour delays. Also receiving police reports concerning WAST response times. The dialogue is now shifting to professionals and partners asking if they should progress these delays via the AAR route.

These challenges have been highlighted by the Board Chairs in their meetings with Welsh Government and the National Independent Safeguarding Board. Discussions at the North Wales Boards have not been able to take place due to WAST not being present at the Board meetings.

Providers and Safe Recruitment Challenges:

There has been wider regional links to the original modern slavery investigation reported last year within Conwy, which demonstrates that the initial concerns were linked to wider criminal activity across the whole region.

An update from Gang master's and Labour Abuse Authority is due to be given at the Joint Board in September2023, together with an overview of the current picture in North Wales.

There have also been instances where care homes have been approached by individuals calling at the homes to request care work positions within the home. When further checks or enquiries have been made, concerns have been raised as regards what qualification or training they have, DBS checks and false or swapped profiles being provided. Given the current difficulties care homes are experiencing in recruiting staff, this is a potential worrying development.

Members of the NWSB Workforce Training and Development Group together with the Disclosure & Barring Services and WCVA have undertaken a series of Safer Recruitment and Safeguarding Roadshows for providers, third sector organisations and volunteer organisations across North Wales in response, to highlight the importance of safe recruitment and the role of the Disclosure & Baring Service.

The workshops included information in relation to:

The National Training Standards, DBS, Safeguarding policy amends and updates. Organisational process around DBS responsibilities and refresh organisations approach to safeguarding training

Incidents between Adults at Risk:

An audit was recently conducted by the Isle of Anglesey Council on the number of safeguarding reports received from a specialist dementia ward at the local peripheral hospital.

The audit identified: -

- that they do not always receive safeguarding reports on both victim and perpetrator where both individuals lack capacity.
- It is unclear how we jointly monitor and review risk assessments and protection plan when there has been a number of safeguarding reports received and clear escalation in individual's behaviour.

It was identified that reports should be completed on both the victim and perpetrator if identified as being and Adult at Risk, to ensure that we record their safeguarding journey and ensure that we monitor and review effectively. This was discussed at both regional and local area and as a result an amendment to the 'North Wales Protocol for the Management of Multiple Reports of Incidents Between Adults at Risk', was made to highlight the need for two safeguarding reports.

Alcohol and substance misuse:

Alcohol and substance misuse in parents has increased following the pandemic, with this increasing domestic incidents and parental mental health, with the sad consequence of emotional damage on children. Due to this

increase, there has been an increase in family safety plans, as well as an increase in the use of family group conferences, aiding the identification of extended family members where children can reside safely.

Supporting Children Supporting Parents:

The NWSB Practice Guide has been updated. This Practice Guide is for considering the needs of children when working with adults with severe mental illness and/ or substance misuse.

The overarching aim of this is to ensure that children, including unborn children of parent(s) experiencing mental ill health and/ or misusing substances receive appropriate support, safeguarding and protection.

Online sessions were held with an external facilitator, Martin Calder and multi-agency practitioners from across North Wales to raise awareness of this guide in relation to this issue/ theme.

10. The number of adult protection and support orders which were applied for in the safeguarding board area.

There were no adult protection and support orders applied for in the North Wales area during 2022 / 2023.

11. When and how children or adults exercised an opportunity to participate in the safeguarding board's work.

It has continued to be extremely difficult to engage with Adults that have been through the safeguarding process and to find an appropriate group that may be able to facilitate conversations around the work of the safeguarding board. The increased use of Advocacy and additional advocacy membership on the Boards may enable it is hoped, wider exploration of engagement with Children and Adults at Risk.

The Safeguarding Boards continue to deliver awareness raising and training sessions to Health & Social Care Students across the region, and deliver sessions to third sector and voluntary organisations, giving them the opportunity to engage in question-and-answer sessions and promote safeguarding messages.

The use of NWSB Website, Twitter Accounts and Facebook pages are also used to try and engage with Adults, Children and Young People, however new communication strategies need to be developed to engage all groups.

In line with Adults, it has also been difficult to engage with the appropriate, hard to reach children; we have been

unable to find an appropriate group to facilitate these conversations around safeguarding and what this means for young people.

There is a work package planned between the Business Unit and the North Wales Regional Innovation Coordination Hub in respect of an online consultation around exploitation.

12. Any information or learning the safeguarding board has disseminated or training it has recommended or provided.

Single Unified Safeguarding Review:

Progress in relation to SUSR is discussed at both Boards and within all the regional subgroups as we consider the impact of this work. Board members and the Business Unit continue to attend all the associated work stream meetings and provide further updates for Board members and sub-groups.

National Safeguarding Training Standards:

Work is being undertaken across the region via the Workforce Training and Development Subgroup – messages are also being circulated wider to provider, third sector and volunteer organisations via roadshows and workshops.

Recommendations from the IICSA Report:

The report and its recommendations have been circulated widely, including the Boards website to ensure the messages from the report are heard. Concerns have been discussed as part of the agenda within the Safeguarding Practice Delivery Groups and the Child Practice Review Group.

Learning from Practice Reviews:

Learning from reviews in other areas has been disseminated. As part of the agenda for the Adult and Child Review Groups and the Safeguarding Practice Delivery Groups, case reviews from other parts of the UK are included within the agenda for discussion and sharing. This assists in identifying common themes and enables good practice to be further developed.

In addition, reflection and learning is being shared via workshops and sessions delivered following the completion of a review within the area. This is something that is being taken forward as it has been found to be an effective way of ensuring learning is shared.

Welsh Government Consultations:

Consultations are shared across the region, and all are encouraged to respond individually as well as contributing to the response of the NWSB.

Training. Learning Events, Workshops and Awareness Raising Sessions:

The North Wales Safeguarding Board has provided the following during 2022 /2023:

- PREVENT: Anti-radicalisation training x 5 Sessions
- Understanding the lived experiences of neglected children x 7 Sessions.
- Person Centred Practice – Adult Safeguarding.
- Person Centred Practice – for Health & Social Care Students.
- Promoting awareness of Supporting Children Supporting Parents NWSB Practice Guide x 2 sessions.
- Professional Curiosity x 2 sessions.
- Learning from Child / Adult Practice Reviews & MAPF.
- An Overview of the Role of the Older People's Commissioner.
- Findings from a thematic analysis of Adult Practice Reviews in Wales.
- Human Rights & Adult Safeguarding.
- Learning from Adult Practice Reviews about Transitional Safeguarding.
- Recognition of Physical Abuse x 3.
- National Safeguarding Training Standards Consultation Event –

Voluntary Organisation's / Third Sector x 5.
- An overview of the role of the Domestic Abuse Commissioner.
- Effective work with adults who self-neglect: the evidence-base from research and reviews.
- A review of the key findings from the IICSA report on Child Sexual Exploitation by organised networks.
- Role of the Child Practice Reviewer Workshop.

13. How the safeguarding board has implemented any guidance or advice given by the welsh ministers or by the national board.

Ending Physical Punishment - Implementation of legislation.

It is 12 months since the introduction of the new arrangements on the 21st of March 2022. Across the region it has been reported that the removal of defence has not impacted on referral numbers; neither have matters that were clearly child protection been dealt with differently because of this change in legislation. However, challenges remain regarding raising awareness with those who are visitors to the area, and how the messages can be conveyed to them.

Local Authorities are reporting that there has been ongoing outreach work to speak to parents about the new law and signpost to support in positive behaviour, updates via websites to include 'hints and tips' for when parents and carers are at the 'end of their tether'. Also, authorities report that legislation has been cascaded and formed part of the training to schools and staff across education services and whole school staff awareness to respond to this change where concerns were apparent and required intervention. Information was also sent out to parents / carers of children across some regions at the time of implementation.

Other agencies such as BCUHB have formed T & F Groups to disseminate information to their staff, including additional training on mental and emotional wellbeing, escalating behaviours, 7-minute briefings and information provided via their intranet.

North Wales Police report that an internal communication plan was devised for launch of legislative changes following consultation with external partners and child protection teams to ensure adopted processes were effective. To date there have been no significant barriers encountered.

Liberty Protection Safeguards

Across the region there has been ongoing work around LPS, with some agencies setting up implementation groups, work programmes and whilst the legislation will now not come into force during this current Parliament, partners are continuing to deliver MCA training and enhance knowledge around Community DOLS.

Impact assessments have been commissioned by some agencies in relation to the implications of Liberty Protection Safeguards (LPS): to identify financial, workforce and system changes required.

In the meantime, Agencies are considering how to strengthen the current DoLS system and continue to

protect and promote the human rights of those people who lack mental capacity.

Single Unified Safeguarding Review

7-minute briefing updates are shared via the website and subgroups.
Discussions regarding preparing for implementation are ongoing within those groups and at Board level.

Reflective events are held to enable sharing of learning from practice reviews and have been taking place to better disseminate the recommendations and key messages.
Key discussions are taking place in relation to implementation and Board re-structure to accommodate the changes in relation to the Board's responsibilities for overseeing the process.

Guidance on reducing restrictive practices in childcare, education, health, and social care settings.

Messages have been shared via the NWSB website and the weekly website newsletter and for adding for information and noting on the agenda of the Board and its subgroups.

Reducing the criminalisation of children in care and care leavers: All Wales Protocol

Shared via the NWSB website and newsletter and via Board subgroups and their safeguarding forums.

14. Other matters relevant to the work of the safeguarding boards.

14.1 Updates on issues as a result of Covid-19 and other key themes:

- Staff vacancies and difficulties in recruitment.
- The increasing number of Domestic Homicide Reviews with a theme of victims taking their own their own lives in four out of nine reviews.
- The increasing number of Child Practice Reviews has put a considerable challenge on resources.
- Complexity of cases has increased, especially within CAMHS.
- Delayed discharge of Young People because of a lack of social care placements and/ or court activity.
- Securing placements for children who require a Low Secure Unit or PICU placement.
- Probation report issues around recruitment of staff and DA Enquires Administration Officers.
- Section 5 process still proves to be a challenge in many areas, but specifically in relation to the operational element of this process i.e., poor practice verses abuse / neglect etc.
- Recruitment of social care staff across the board, but especially professional staff which impacts the capacity available to carry out DoLS work.
- Ambulance Response - there continues to be significant challenges regarding Welsh Ambulance responses times to request for emergency assistance with significant waiting times for often very frail and vulnerable citizens.
- Deprivation in Domiciliary Settings - there is significant delay in processing these applications within the Court of Protection leading to duplication of work for practitioners when assessments presented are out of date by the time they are considered by the Court and

requests received for new applications.

- Return Home Interviews – It remains a concern that despite positive relationships and attempts to align process, differences in approach are still noted across partners.
- Overall, a continuation in the number of Adult Safeguarding reports received has continued to increase over the past 12 months.
- A lack of placement sufficiency, particularly for residential and secure accommodation placements for children whose needs are more complex.
- Supporting Unaccompanied Asylum-Seeking Children (UASC) and refugees. the pace of referrals through national initiatives such as the National Transfer Scheme exceed our pace and capacity to ensure that there is sufficient local placements and support to meet the linguistic, cultural, and religious needs of this vulnerable cohort of young people.
- Continuing to see a high number and complex adult safeguarding reports. Work with Individuals whose actions are deemed self-neglectful have, and continue to be, increasing in numbers and complexity.
- The pressure to provide increased volume of care and support to adults in their own homes continue; and there are on-going issues regarding staffing within the community care, nursing, and care homes. This continues to be particularly challenging in North Wales.
- The quality of safeguarding reports being received is inconsistent: and it is important that agencies monitor how their staff are implementing the duty to report and the need to secure the individual's consent or evidence why that was overridden.
- Covid 19 has exasperated many of the inequalities within our communities and has had an "catastrophic" impact on many and the impact is seen in the demand for services. For many families it is compounded by the current period of financial hardship.
- Within education more families have chosen 'elective home education' and therefore having sight of pupils can be more challenging.
- A higher number of children have found it difficult to re-engage with education and the risk of NEETS are increased.
- There is a change in working arrangements in North Wales around the process of applying for Court Orders. These are PLO processes. The judiciary have announced clear timescales with very demanding timescales for presenting Court cases. To manage this, Local Authorities will have to undertake more work at 'pre-proceedings'. This may impact on safeguarding as more cases may be kept in child protection whilst there are preparations for Court processes.
- Themes of neglect and substance misuse coming through in child practice review referrals.
- Pressures on staff/ staffing issues impact on the work of the Board – e.g. difficult to replace chairs of NWSCB Sub Groups.
- Increase in children being placed in this area from out of county and encountering difficulties in obtaining their health information.
- Increase in Child Protection medicals.

15. Good Practice Case Studies

All agencies were asked to provide a good practice case study for inclusion in the Annual Report.

Anglesey:

Individual – resident at a local nursing home. The adult service social worker spoke with the individual on a number of occasions where the individual raised concerns about her care, and in particular the care provided by some staff members. Initially she was too fearful to agree to the social worker completing a safeguarding report.

The social worker was mindful that she did not want to complete the safeguarding report against the individual's wishes if this could be avoided. The social worker was very mindful of the risks and considered the over-riding principles but felt, in this instant, that there was no immediate risk of harm that needed her to complete a safeguarding report. It was agreed that she continued to work with the individual to gain her trust and confidence. Over the course of a few visits the social worker spent time explaining the safeguarding process in detail so that the individual understood the safeguarding process. The social worker reassured the individual that the process was not about punishing people or her word against theirs; it was a joint process to identify improvements that could be made to her care experience. When the individual was reassured that there would be no significant implications to her sharing the concerns, she agreed to the social worker making the report. Her main concern was that she wanted to remain living at the home and was anxious that if she reported the incidents then she may not be allowed to stay.

The social worker worked alongside the individual and her advocate throughout this process – always ensuring her safety and well-being. The social worker and the advocate spent an afternoon with the individual listening to her views and interpretation of events that had happened. The safeguarding report submitted is extremely thorough and detailed – with the individual's voice and lived experience clearly noted. The social worker ensured that she wrote down the exact words the individual used about how she felt and about the impact of these incidents on her.

Once the report was submitted, the social worker kept in contact with the individual and her advocate. Both the individual and the advocate were invited to the initial strategy meeting, however due to technical difficulties they were unable to attend.

To resolve this, the social worker arranged a meeting with the individual, her advocate, and the home manager, to enable the individual to express her concerns directly to the manager, whilst also allowing the home to respond to the individual with the findings of their investigation. This ensured open communication channels between everyone.

The main issue identified was lack of communication and inappropriate communication between the staff / managers and the individual. The outcome was extremely positive in terms of opening communication and building a relationship of trust between all.

Betsi Cadwaldr University Health Board:

Trauma Risk Management (TRiM)

Following the introduction of Trauma Risk Management by the Safeguarding and Public Protection Team in May 2020 there have been in excess of one hundred (100) incidents within BCUHB that have been referred to the Team for support and action.

Feedback received both verbally and via the evaluation forms highlight that staff have found the process, helpful, supportive, and beneficial. Comments received include.

“It was helpful to have the debrief with most of the members of staff who had been involved in the incident and discuss it with them. It was upsetting at the time but definitely helped.”

“It was extremely beneficial, having the time to speak to the TRIM practitioner about the incident and being able to say how I felt without judgement etc. was the most helpful part of the process.” It was really good to hear that the feelings and emotions were normal and would improve (even if it didn’t feel like it at the time!).”

Conwy:

Background: The matter was brought to Initial Case Conference in August 2022, following a domestic incident whilst the parents and their two children (Child B – 8 years & Child C – 2 years) were on holiday. The parents were also heavily intoxicated and openly using cocaine. The children were made subject to a Police Protection Order and then subsequently placed in foster care under a Section 76, with parents agreeing to engage with the Local Authority.

Due to the historical concerns, which stemmed throughout both of the children’s lives, along with Child B reporting that he wished he could learn karate so he could protect his sibling when his parents fight, both children’s names were placed on Conwy’s child protection Register under the category of Emotional Abuse and likely physical abuse. The Local Authority also progressed to PLO/ Interventions. Whilst the dual plans of care and support protection plan and child looked after plan ran alongside one another, the PLO process also ensured that parents were aware that if they did not adhere and engage with the process, then consideration would be for care proceedings.

Parents engaged well and were appropriate with their children during family time at the contact suite, with this progressing to more natural family time with support from the foster carers. It was positive that the relationship between foster carers and parents was effective as this reassured the children.

Interventions from health were also required for Child B as he required an operation, to which was attended by parents and supported by foster carer. The Strengthening Families Team were allocated to work separately with the parents to aid parents understanding of the impact of alcohol and substance misuse on children, as well as domestic incidents. Parents also attended Substance Misuse Services with them both being abstinent of substance and alcohol use by the first review.

The parents were noted to be engaging within the core groups, with the social worker ensuring that the child’s views were taken into account as they were missing their parents, with parents being informed of how they could support their children understand why they were currently not residing with them, as well as regular family time reviews to ensure that there was sufficient time for the children to feel reassured.

Outcomes: The PLO had ended in December 2022, with the children experiencing a transition back to the care of their parents prior to the Christmas period. Parents had remained abstinent from alcohol and substances, with them both stating how their own wellbeing had improved along with their ability to communicate more effectively with one another. Both parents express that due to this intervention, conversation previously would have resulted into an argument, whereas now they make their difficulties into light humorous situations.

The children reported that they were happier times in the home now, with Child B expressing no worries about his family life. There had been no concerns raised in school with Child B noted to be settled back into his parent's care, with parents being able to manage a significant health concern for Child C without them reverting to previous unhealthy strategies. Strengthening Families had continued to complete individual work with parents, with the joint sessions also being noted as beneficial.

The children were removed from Conwy's child protection register in March 2023, with them remaining open under a care and support plan, with a closure transition from Strengthening families being agreed over a period of 3 months to consolidate the progress they had made. It had also been agreed for the parents to link in with Family Centres during this time, so they are aware and able to utilise this service once the care and support plan ceases.

Denbighshire

A is a 77-year-old male with a diagnosis of vascular dementia. He originates from South Wales and comes to stay with a friend in Denbighshire approximately 3 years ago. It appears his original intention was to come and stay for 2 weeks, however over time his health deteriorated, and he remained living with his friend.

Overview of concern raised: Concerns were raised by A's family and the safeguarding report alleged that A's friend was financially abusing him, and their relationship was based on elements of coercion and control. There were additional concerns relating to preventing contact from A's family and neglect of his health and care needs.

Action taken:

On receipt of a Safeguarding Report a social worker and GP visited A at the house he shared with his friend. During the visit A indicated his wish to return to his home in South Wales.

During the visit, a Mental Capacity assessment was carried out in relation to A's capacity to manage his finances and make decisions about his care and support. The outcome of both assessments indicted A lacked capacity.

Safeguarding Strategy Meetings (4 over a period of 3 months) were held, and safeguarding measures put in place.

An Independent Mental Capacity Advocate (IMCA) was appointed to support A.

Best Interest Meetings held.

Due to the complexities of the situation and the difficulties ascertaining A's views and wishes, as well as conflicting views from A's friend and A's family an application was submitted to the Court of Protection.

A was placed in a residential home in Denbighshire for a period of assessment. During his time at the care home A had regular contact with his friend and with family members.

The period of assessment enabled practitioners to gain a clearer picture of A's care and support needs and to ascertain his views and wishes supported by the IMCA.

The final Court Order indicated it was in his best interest for A to move to live to a care home located in his home area in South Wales.

A moved 'back home' on the 13/4/23

The difference/impact to the Citizen and or the service:

This was a particularly challenging case for all concerned, but A was always kept at the centre of proceedings and time was taken to explore his views and wishes and consider all options to support him.

Flintshire:

Background

67-year-old male who is a hoarder with alcohol and mental health issues. He had been victim of fraud and a victim of historical sexual abuse. At the point of referral, he was residing in his own home left to him by his mother. This large, detached home was inhabitable. The Adults at Risk Team began supporting this individual following a referral from North Wales Police regarding living conditions.

Focus of the Referral:

Focus of the support was to tackle the hoarding issues and offer support clearing the house. The whole house was cluttered due to his hoarding. Kitchen and bathroom are not in use. The gentleman admitted he didn't want to live like that and occasionally considered ending his own life. There was no heating in the home, he did not shower and hasn't done so for several years, nor did he flush the toilet. The gentlemen admitted that he saved drain water from the rain and uses this instead to wash himself. The garden was overgrown, and he used the trees to air his clothes and rubbish thrown across the garden.

Numerous referrals had been made and received over the years and the individual had been open to the Adult at Risk team a couple of times in the past. The Adult at Risk Support Worker had accompanied the individual to his GP appointment to support him with his mental health needs.

The gentlemen were supported in obtaining a skip to encourage him to begin clearing out the rubbish from within his home. He was very clear that he did not want help with this as he wanted to do it himself so nothing of value is accidently thrown away. The individual was also supported with ongoing issues he had with an electric company and in contacting our Flintshire Care and Repair Services who could sort out his drains and fit new locks to his doors. He was supported with his finances and making essential phone calls to utility providers and others. The Adult at Risk Support Worker also assisted him with his understanding of how businesses would invoice him for work done and how he could make those payments.

Summary

This individual remains open to service and will be provided with care and support for the foreseeable future. Thanks to the support around him he is now able to attend the GP and has built a good relationship with the doctors who support him with his ongoing mental health issues. This gentleman is also known to North Wales Police as he lives near a police station, and the Support Worker has built relations between the two so that the police now also undertake regular welfare checks. Thanks to the intervention work by the Adult at Risk Team this gentleman in now managing his home environment and keeping on top of essential tasks, he is working on addressing his hoarding nature and through the support facilitated by the team he is now able to access GP support and assistance from NWP.

Gwynedd:

This case reflects the use of Effective Child Protection (ECP) model within a complex case. This is a case where the 'Letter Before Proceedings' (LBP) process of PLO was running in parallel with the Child Protection Plan.

The background to this concern involves a case which did not become known to agencies until very late in pregnancy. She was in hospital due to give birth when safeguarding concerns emerged. She had presented very late to Maternity Services and despite this, no concerns had been raised by Health agencies. The concerns became evident when she was in the Maternity Ward and emergency response was necessary without following the usual pre-birth pathways.

At the time of referral, it emerged that she had two older children who was no longer in her care – a matter of private family proceedings. During assessment she made a series of statements and allegations that proved to be unfounded. This illuminated a pattern of behaviour that was difficult to assess. For example, about domestic abuse and that her ex-partner was stalking her. Yet, she chose to remain in contact with him. She lied to domestic abuse services about the names of the alleged abuser, whilst living at a safe location. This created difficulties for staff to effectively safeguard her. She also claimed to have a third child. Checks have not resulted in any record of this child existing. In relation to her new baby, various fathers were mentioned. She was unrelenting about fact she could not substantiate, and in cases where there was proof her statements were without foundation; she remained adamant and unrepentant.

In contrast to these concerns about her truthfulness, there were several positives and strengths identified. There was no general concern about basic day to day care. She demonstrated good emotional responses and emotional care towards the child. She engaged well with child protection and LBP process. A new partner was identified as a safeguarding factor.

The biological father has now been identified. He has now become involved in the life of his child and attended the RCC. His intention is to take an increased role in the child's life. He is cooperating well with assessment processes.

This demonstrates aspects of good practice. We have already identified the focus on strengths in the case. In contrast there are many concerns about her truthfulness. A new partner and the biological father are safeguarding figures in the child's life.

Features of Effective Child Protection are also evident in this case. In particular, the impact of 'change statements' and 'Steps to Change.' Change statements define the changes necessary to reduce the risk of significant harm. They represent outcome statements. These tend to be limited to less than 5 changes, usually about three. Their advantage in child protection is that they make it clear to the parents, and the Core Group what the unrelenting focus should be. Steps to Change is a map related to each Change statement, developing the journey with the family from care that is 'not good enough', to care that is 'good enough. 'It makes it clear the evidence and behaviours that indicate progress and when the journey ends.

This case illustrated the use of both Change statements and Steps to Change. It showed focus and persistence to keep on track. There was little drift, both parents knew what work needed to be addressed and their role in it. The risks were clear and were being managed.

In the Review Case Conference, the Child Protection Plan and Steps to Change were referred to. There was clear consistency between the Child Protection Plan and the work of the Core Group. The 'Steps' guided a robust and at times challenging conversation about progress. In the most recent Conference, new concerns that had been identified between the ICC and the RCC were discussed. These raised further questions about the behaviour and choices of the mother.

There are ongoing risks which are being assessed and monitored. There needs to be better understanding about the mother's fabrication of information and her conscious dishonesty about several matters. This needs to be balanced against strengths with consideration how these factors influence the risk of significant harm.

Several matters require further assessment. The question of truthfulness and whether this compromises the child's safety is particularly challenging. Whilst this assessment is ongoing the focused Child Protection Plan promotes safe care and opportunities for both parents to demonstrate progress towards good enough care.

National Probation Service

Wales Offender Personality Disorder Pathway, the Wales Offender Personality Disorder Pathway (OPDP) is part of a jointly commissioned service between the NHS & Criminal Justice System and is underpinned by four main objectives:

- To improve the Person on Probation's psychological health & well-being.
- To help reduce the risk of re-offending.
- To increase workforce confidence & competence.
- To communicate the work of the OPDP.

The OPDP team in North Wales involves psychologists (NHS) and personality disorder Probation Officers (HMPPS) working collaboratively with the Probation Practitioner and/or Person on Probation using a trauma-informed approach to provide psychologically led formulations that help shape the supervision process. Using a specific screening tool which identifies personality difficulties but does not offer a diagnosis, People on Probation who present as High or Very High. Risk of Harm are 'screened' into the OPDP to access additional support/ OPDP interventions alongside supporting Probation Practitioners.

Within the MAPPA process, Wales OPDP attends Level 3 meetings as part of the multi-agency arrangements and has close working relationships with its colleagues. Each MAPPA case undertakes the screening process and, if eligible, is discussed within a

consultation resulting in psychologically framed formulation which suggests most effective ways of engaging with individuals presenting with complex needs. Signposting is often suggested and OPDP staff help make links with other services where required.

Specialised personality disorder training, in the form of the national Knowledge and Understanding Framework, is offered to Probation Practitioners to help with the supervision process and OPDP staff also offer regular case reviews to ensure the formulations remain dynamic. Whilst the formulations are not a risk assessment, they influence the risk management process and can guide a 'best approach' for staff working within the MAPPA arena. Wales OPDP is also responsive to the needs of MAPPA managed cases by, when appropriate, undertaking psychologically informed specific work and, going forward, will continue to build on existing relationships.

North Wales Police:

Operation Blue MAMBA. A proactive investigation led by the Exploitation team (Onyx) which treated a perceived cohort of "unruly" children as victims rather than suspects. By patiently building relationships with the children and working closely with external partners (children's services) disclosures of abuse were made over time. These enabled an improved understanding of the risk posed and, safeguarding requirements.

The approach taken by Onyx, included improving working relationships with local policing teams so that any contact with a victim was positive and one which encouraged cooperation with police and partners. This tactic culminated in a local male being charged with child sexual exploitation offences but moreover vulnerable children avoiding repeated stays in custody and unexplained absences from homes and care facilities.

Wrexham County Borough Council:

The Department successfully embedded its process regarding the European Union Settlement Scheme, creating a policy and procedure launched across Social Care to ensure all children and families eligible for the scheme were identified and supported with their applications in line with the published government deadline. Wrexham were identified as a best practice local authority by the Independent Monitoring Authority and the IMA have referenced our efforts, policy and process in their nation-wide workshops and podcasts.

The Adult Safeguarding and DoLS Team have evidenced the advantages to working as one team with a timely response to an Adult Safeguarding report identifying an individual with a significant level of neglect. The Adult Safeguarding Team were able to take swift action to address all safeguarding issues and through team discussion, included the involvement of a DOLS assessor who was able to ensure conditions are in place to ensure this person's needs are continuing to be met and monitored by a paid Relevant Person's Representative.

GLOSSARY:

AMH	Adult Mental Health
APR	Adult Practice Review
AWCPP	All Wales Child Protection Procedures
BCUHB	Betsi Cadwaladr University Health Board
CAMH	Children Adolescent Mental Health
CCBC	Conwy County Borough Council
CHC	Continuing Health Care
CPR	Child Practice Review
CRC	Community Rehabilitation Company
CSE	Child Sexual Exploitation
DCC	Denbighshire County Council
DoLS	Deprivation of Liberty Safeguards
LDG	Local Delivery Group
DHR	Domestic Homicide Review
EAPR	Extended Adult Practice Review
ECPR	Extended Child Practice Review
FCC	Flintshire County Council
GC	Gwynedd Council
HASCAS	Health and Social Care Advisory Service
HSB	Harmful Sexual Behavior
IOAC	Isle of Anglesey Council
KPI	Key Performance Indicator
LA	Local Authority
SMART	Specific, Measurable, Achievable, Realistic, Timely
LDU	Local Delivery Unit
LSCB	Local Safeguarding Children's Board
MAPF	Multi-Agency Professional Forum
MAPPA	Multi-Agency Public Protection Arrangements
MARAC	Multi-Agency Risk Assessment Conference
MHLD	Mental Health Learning Disabilities
NISB	National Independent Safeguarding Board
NPS	National Probation Service
NSPCC	National Society for the Prevention of Cruelty to Children
NWP	North Wales Police
NWSB	North Wales Safeguarding Boards
NWSAB	North Wales Safeguarding Adults Board
NWSCB	North Wales Safeguarding Children's Board
POVA	Protection of Vulnerable Adults
P & P	Policy & Procedure
PCC	Police Complaints Commissioner
PHW	Public Health Wales
PRUDIC	Procedural Response to Unexpected Death in Childhood
PVPU	Protecting Vulnerable Persons Unit
SCWDP	Social Care Workforce Development Partnership
SERAF	Sexual Exploitation Risk Assessment Framework
SUSR	Single Unified Safeguarding Review
WAST	Welsh Ambulance Service Trust
WCBC	Wrexham County Borough Council
WG	Welsh Government
YN	Ynys Mon