Powys County Council, Powys Teaching Health Board, Dyfed Powys Police

Report of Joint Inspection of Child Protection Arrangements

October 2023

Mae'r ddogfen yma hefyd ar gael yn Gymraeg.
This document is also available in Welsh.

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Introduction

Between 16 and 20 October 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Education and training inspectorate for Wales (Estyn) carried out a joint inspection of the multi-agency response to abuse and neglect of children in Powys.

This report outlines our findings about the effectiveness of partnership working and of the work of individual agencies in Powys.

Scope of the inspection

The Joint Inspection of Child Protection Arrangements (JICPA) reviewed:

- the response to allegations of abuse and neglect at the point of identification
- the quality and impact of assessment, planning and decision-making in response to notifications and referrals
- protecting children aged 11 and under at risk of abuse and neglect
- the leadership and management of this work
- the effectiveness of the multi-agency safeguarding partner arrangements in relation to this work

We have endeavoured to use plain language to describe the findings from the JICPA. We refer to several terms throughout the report which are defined as follows:

Terms of reference

ACEs - Adverse Childhood experiences

CAMHS - Child and Adolescent Mental Health Services

CASPP - Care and Support Protection Plan

CLA - Children Looked After

CME - Children missing in education

CP/ CPR - Child Protection/ Child Protection Register

CRU - Central referral unit (police)

DPP - Dyfed Powys Police

DSL - Designated Safeguarding Lead is the person appointed to take lead responsibility for child protection issues in schools.

EHE - Elective home education

ELSA - Emotional Literacy Support Assistant is a social and emotional intervention programme delivered by trained staff in primary and secondary schools.

ESR - Electronic Staff Record

FCC - Force Communications Centre (Police)

FCR - Force Control Room (Police)

IAA - Information, Advice and Assistance

IRO - Independent Reviewing Officers

MARAC - MARACs are Multi Agency Risk Assessment Conferences. They are regular meetings of professionals who discuss how to help individuals who are most at risk of serious harm due to domestic violence and abuse.

MIU - Minor Injuries Unit

NICHE - The police intelligence and information system

Operation Encompass - Operation Encompass is a partnership between police and schools, a school can only join if the local police force has already joined Operation Encompass. One of the principles of Operation Encompass is that all incidents of domestic abuse are shared with schools, not just those where an offence can be identified.

PCC or LA - Powys County Council or Local Authority

Philomena protocol - An agreement between the local authority, the police, and providers of children's residential care about steps to be followed by care staff if they are concerned about children not being at home.

PPN - Public Protection Notices

PTHB - Powys Teaching Health Board

PRUDIC - Procedural Response to Unexpected Death in Childhood

Section 47 (S47) - Under Section 47 Children Act 1989, a local authority has a duty to investigate if it appears to them that a child in its area is suffering or is at risk of suffering significant harm.

SoS - Signs of Safety approach is a relationship-grounded, safety-organised approach to child protection practice, created by researching what works for professionals and families in building meaningful safety for vulnerable and at-risk children.

TAC - Team around the Cluster (TAC) model aims to support schools to identify and support families earlier when the needs arise by collaboration with key partners.

UASC - Unaccompanied Asylum-Seeking Children

WSP - Wales Safeguarding Procedures detail the essential roles and responsibilities for practitioners to ensure that they safeguard children and adults who are at risk of abuse and neglect.

1. Summary

Safeguarding organisations in Powys have systems and arrangements in place for effective joint working when children are considered at risk of abuse or neglect. Senior leaders in the local authority, police and health boards demonstrate a joint approach to regional safeguarding arrangements. Leaders and managers have established a highly positive culture of joint multi-agency working.

We generally found effective information sharing between agencies resulting in appropriate referrals to children's services. However, the multiple recording systems in the health board can sometimes make the finding, and sharing, of relevant safeguarding information a challenge for staff. The Mid and West Wales Regional Safeguarding Board covers four local authorities and two health boards. Useful regional threshold guidance helps professionals analyse risk when submitting a referral, or duty to report. In general, a shared understanding about how to respond to harm is evident across partner agencies.

Opportunities for partnership working are positively taken up. There is good representation and contribution from key partners at strategy discussions, meetings, and case conferences. Actions usually happen within appropriate timescales, with support and protection in place to meet children's needs. Multi-agency contribution is evident in addressing the child's safety through care and support protection plans (CASPP).

Schools across Powys work well with a wide range of services to support children and families. There is good multi-agency attendance and participation in child protection meetings arranged under the Wales Safeguarding Procedures (WSP). This includes the initial and review child protection case conference and core groups. Parents spoke highly about school support and pupil well-being and safety is a high priority across all schools.

In common with many areas across Wales, the ability to recruit and retain key staff is impacting on children's safeguarding arrangements. This is exacerbated by the high demand on services and the increasing complexity of children and families' needs. In social services, agency staff have bolstered workforce resilience, but there are plans in place, with some success, to safely reduce reliance on agency staff and make permanent appointments.

2. Key findings and evidence

2.1 Well-being

Partnership Arrangements

Strengths

Professionals accurately identify children in need of help and protection. The safeguarding organisations respond promptly and effectively to meet these needs, especially where acute risk is identified. For example, we saw practitioners arranging strategy meetings and visits to children at short notice to ensure their welfare. Healthcare professionals frequently attend initial strategy discussions. The subsequent planning was focused and based on a good exchange of information across agencies.

There is good multi-agency attendance and participation in child protection meetings arranged under the Wales Safeguarding Procedures (WSP). Partners understand their roles and responsibilities in relation to safeguarding children well. Strategy meetings and child protection conferences are effective forums for information-sharing, planning and decision-making. Information from these meetings is recorded on police systems so it can be used in responses to future incidents. This is essential for ongoing monitoring and reviewing safety.

What needs to improve

There is a clear process in place to support professionals making safeguarding referrals about children. However, referrers are not consistently told about the outcome or the rationale supporting subsequent decisions. Following the conclusion of a Section 47 enquiry, outcome strategy meetings are not always arranged. This can result in missed opportunities to share essential information and discuss the outcome of the enquiry. This doesn't comply with the expectations of the WSP.

Children's voices, wishes and feelings are promoted at child protection conferences by professionals, but rarely through children's direct contribution to the conference.

Strengths

Powys Teaching Health Board

The pathway for child protection medical examination is clear and has been shared with relevant professionals. All child protection medical reports are reviewed jointly by the named doctor for safeguarding and senior members of the safeguarding team. This is to ensure consistency of examination from all commissioned services. A new initiative to discuss all child protection medicals in a multi-agency forum is

planned to commence in January 2024. This is in line with the Royal College of Paediatric and Child Health Standards.

School nurses and health visitors are notified of children attending Minor Injuries Units (MIU) and where there are concerns, MIU staff can access recording systems to check if a child's name is flagged as on the child protection register (CPR).

School nurses complete a holistic health assessment when a child's name is placed on the CPR. Health representatives regularly attend and contribute to strategy meetings, conferences, and core group meetings. A child's General Practitioner (GP) is invited to attend child protection conferences and is provided with feedback in relation to registration, recommendations, and conference minutes. GP practices routinely flag the records of children whose names are on the CPR, and the safeguarding team update the out of hours GP system daily. GP's provide reports to conference, though this is often a printout of consultations or immunisations.

The safeguarding team share relevant information they receive from police with key healthcare professionals and GP practices. Overall, GPs know which children are looked after by the local authority or named on the CPR.

The child protection reports we reviewed were timely and appropriate. We found evidence of key safeguarding assessments and subsequent documentation within the clinical records, and these were updated accordingly. Healthcare staff felt well supported by the safeguarding team to challenge decisions on a child's behalf if required.

It was positive to find that when an adult is admitted to the health board's mental health services, as part of the initial assessment process, consideration is given to any children associated to the patient, and whether there is a history of domestic abuse. When the patient is discharged, a Risk Enablement Panel is convened, which includes a discussion as applicable, regarding the safety of any children who may be residing or visiting the patient's home. This demonstrates a proactive approach to risk management.

Education

Parents spoke highly about the support they receive from schools. Schools prioritise pupil well-being and safety. For example, schools support with childcare, pupil's personal hygiene, and provision of free school trips. Teachers plan purposeful activities about the importance of healthy and safe relationships, including how to stay safe online. In all schools visited, pupils felt happy, well cared for, safe and listened to. They all gave relevant examples of how school staff keep them safe and develop their understanding of having positive emotional and mental health.

Schools say they receive valuable support and advice from children's services when referring new concerns. School staff feel listened to and able to challenge decisions. Many schools report that relevant agencies within the local authority are forthcoming in sharing information with them when it is necessary. Schools are well represented in a wide range of multi-agency meetings. The role of the Designated Safeguarding Lead (DSL) in schools is particularly effective in bridging children's services and education. This ensures relevant information is shared with schools and that there is consistent support for headteachers with their queries.

Processes and systems have greatly improved over the last few years. There has been a strengthening of safeguarding culture at a corporate and school level. The schools' service is the strategic link between the local authority as a whole and schools. Local authority education officers at all levels understand their roles and responsibilities in respect of keeping learners safe.

Dyfed Powys Police

The force records allegations of crimes effecting children and assigns them without delay to investigating officers. Investigating officers make effective safeguarding plans and use bail conditions to protect vulnerable children and their families.

The Force Communication Centre (FCC) managers routinely sample calls to make sure the risk assessments are accurate and are responded to appropriately. FCC managers train their personnel to research information on the force's systems to back up their decisions.

The FCC system identifies previous calls and incidents at addresses. The system includes risk markers for vulnerable children, such as those on the CPR. This information helps personnel to assign the right level of response. It means many vulnerable children are identified at an early stage, and relevant information is sent to responding officers to help them assess the risk to children, for example, from domestic abuse. Warning markers on the system alert officers about the locations of persons who are a risk to children, such as registered sex offenders. FCC managers check that these markers are accurate. But we saw some markers for children who were no longer on the CPR were still on the force system.

The specialist intelligence personnel in the FCC use local and national information to support frontline responses when children are thought to be at risk of harm. Such as those who are missing, being trafficked, and exploited.

We found that FCC personnel don't routinely prompt responding personnel to record the voice of the child when they attend a domestic abuse incident. But when we raised this, the FCC manager immediately issued new guidance to staff with instructions, *'Can I remind you to use your body-worn video and please remember to capture the voice of the child'.*

The Force and the Police and Crime Commissioner support a scheme where youth workers complete return home interviews with children who have been missing. The

information the youth workers get from the children is used to update risk management plans for these children.

Children's Services

Skilled practitioners assess situations effectively, balancing what is working well for children with any risks and concerns, and closely tracking change and progress. We saw consistent evidence of direct work with families including well-run family network meetings to support people. Newly created innovative posts such as well-being officers help support the delivery of care and support plans.

Children's assessments are comprehensive and include historical and situational context. Complex family situations are well understood and documented in reports. Care and support plans incorporate a positive use of support services. Practitioners use case summaries and chronologies to develop an understanding of the child's lived experience.

Children's services practitioners use the Signs of Safety approach to child protection. Improvements could be made to support the model, including through more proportionate recording which succinctly captures information about strengths and risks. Plans are in place to review the child protection forms to make them more child friendly and to improve engagement with children and families.

When plans do not sufficiently reduce the risk of harm for children, appropriate decisions are taken to escalate. Parents receive clear letters helping them understand what needs to change for children to remain safely in their care prior to public law outline proceedings.

What needs to improve

Powys Teaching Health Board

Multiple IT recording systems used within the health board can make the finding and timely sharing of relevant safeguarding information challenging for staff. This was supported by 40% of 114 health care staff survey responses. It presents a risk that key information could be missed, or multi-agency decisions might be made without the availability of all relevant health information.

Education

It is positive that schools now complete annual safeguarding audits. The local authority officers have quality assurance processes in place which are at an early stage of development. There is further work to be done to improve the effectiveness

of these school audits to drive improvement. For example, linking fixed-term exclusion figures to the safeguarding audit.

A small number of headteachers noted that they are not routinely invited to take part in strategy discussions or meetings concerning their pupils. A few schools noted that although the police adhere systematically to Operation Encompass to share information about domestic abuse incidences, they do not always share information about offences involving their pupils in the community.

In a very few cases, frontline professionals in children's services do not have a clear enough understanding of how schools work. To this end, beneficial joint professional learning would further strengthen the working relationship of all professionals.

Dyfed Powys Police

Staff working in children's homes make many reports of children missing to the police. Often the same child is reported missing repeatedly. Children's carers are responsible for making the initial enquiries to locate children who have not returned home. But on too many occasions, these basic enquiries are not done before they are reported as missing to the police. The Philomena protocol[1] is inconsistent and underdeveloped in Powys.

Inappropriate reports of missing children can stigmatise looked after children who feel they are treated differently by professionals. It also diverts police time and resources from dealing with other high-risk incidents. In other areas where the Philomena protocol has been implemented, there are reductions of up to one third in looked after children being reported as missing.

The force policy for recording information about missing children on public protection notices (PPNs) is inconsistent. In October 2023, personnel didn't complete PPNs for 43 of the 73 missing children. It means that in too many cases information which can help the force find a child quickly isn't recorded on force systems or shared with safeguarding partners.

Children's Services

Children whose names are on the CPR are not always seen alone in accordance with the expectations set out in the WSP. We found occasions when child protection visits were mainly announced; it is important some visits are unannounced to provide a balanced perspective of the child's quality of life.

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[1] **Philomena protocol:** An agreement between the local authority, the police, and providers of children's residential care about steps to be followed by care staff if they are concerned about children not being at home.

We found limited evidence to confirm that the Welsh active offer is consistently being made, other than at the first point of contact via the automated response. Managers informed us Welsh speaking practitioners are available but further work is required to ensure people's language preference is recorded and facilitated. We found variable practice in relation to recording and considering a child's ethnicity and religion, in addition to recording who has parental responsibility for the child.

2.2 People

Partnership arrangements

Strengths

Leaders and managers understand the prevalence of need and risk in their area. They have a good understanding of the experiences of children and families who need help, and they work together to plan strategically for this. A child-centred approach is evident at an operational level particularly when children are seen in school.

We found competent and experienced professionals working in child protection in Powys. Despite the context of increasing volume and complexity of work, we found good operational relationships. There is commitment to continuous improvement with robust scrutiny and learning processes in place. This includes thorough child practice reviews, incident reporting, and promoting a culture of continuous learning and openness.

The police and other safeguarding organisations work effectively in several themed multi-agency risk management meetings. Such as the multi-agency risk assessment conferences (MARAC) for domestic abuse, multi-agency public protection arrangements (MAPPA) for sexual and violent offenders, the multi-agency exploitation meeting (MACE) and a weekly meeting to manage the risk for missing children.

What needs to improve

There has been a large increase in the population of electively home educated (EHE) children in the region and we consider this may represent a risk to some of these children. The EHE guidance[2] from Welsh Government outlines an overriding objective for agencies to ensure that these children's development is protected from significant harm. This area requires a multi-agency response to provide assurance about the safety of children in these arrangements.

The police force contributes to some multi-agency child protection audits. An example is the audit of incidents where children were taken into police protection

[2] Elective Home Education Guidance (gov.wales)

across the Mid Wales area. Multi-agency audits need to be completed routinely to disseminate the good practice we have seen from some agencies in this area.

Strengths

Powys Teaching Health Board

Due to its geographical location, the health board commissions all tertiary care. Within the contract with the commissioned service, the health board's safeguarding team sets out the minimum safeguarding processes expected for its population using cross border services.

The health board demonstrates full commitment to working in partnership in all areas of safeguarding, both at an operational and strategic level. The health board's safeguarding team is a valued resource, offering support, advice, supervision, and training to staff. This was supported by almost 96% of the 114 healthcare staff surveyed, who said they felt supported when they have a concern regarding a child's safety or well-being.

We also found the health board responds proactively to learning from practice reviews, such as, Child, Adult and Domestic Homocide Reviews. Examples of this include newsletters, training videos, and expansion of domestic abuse routine enquiry into sexual health clinics and minor injuries units. All referrals from healthcare staff are sent to the safeguarding team for information and quality assurance. The safeguarding team offer support via a debrief session when staff attend Procedural Response to Unexpected Death in Childhood (PRUDIC) meetings and a referral to external support via the third sector organisation 2Wish.

The health board demonstrates a commitment to continuous improvement, which is evident through the scrutiny and learning processes in place. This includes reviews of serious incidents, concerns, reports, and the shared learning from this. Operational and strategic meetings have a clear governance structure, with effective monitoring of improvements and actions, and generally completed within appropriate timescales.

We found the voice of the child; their wishes and feelings were highlighted in the healthcare records. There are several initiatives in place to capture the voice of the child. These include the provision of QR codes for children looked after (CLA) and their carers to access, to feedback on their experiences, and school nurse initiatives including 'CHAT', where young people can text the school nurse for advice and support.

We found that the children's records seen contained genograms[3] and chronologies, and the healthcare assessments highlighted the religion, ethnicity and first language of a child. There was evidence of staff advocating for the health and social care needs of children, and we found positive efforts to involve family members and wider support networks in decisions being made about children.

Education

The Director of Education has a clear, strategic, and well considered vision to ensure schools are safe, and supportive learning environments for the children and young people of Powys. This vision is shared effectively across all service areas. The high priority given to safeguarding across the local authority has strengthened the understanding that it is everyone's responsibility.

Senior management restructure has resulted in clear roles and responsibilities. This allows for effective working arrangements which maximise the capacity of the local authority officers well. The interim Chief Executive places a high priority on the safety and well-being of pupils. Together with the Director of Education and heads of service they maintain a clear focus on safeguarding. The lead elected member demonstrates a high priority and commitment to safeguarding as a key focus for the local authority.

There has been beneficial work developed around, for example, Children Missing in Education (CME) which has been underpinned by the CME policy completed in September 2023. The policy has purposeful information which is helping to increase awareness of CME processes and ensure cases are reported and resolved appropriately.

School leaders are confident in the safeguarding support and guidance they receive from the local authority. Partnership working has been strengthened recently, and this allows for more effective sharing of information to support pupils and families. For example, the Team Around the Cluster (TAC) approach is viewed as a strength by schools. Schools highly value the support and advice from the local authority education safeguarding manager and the wider safeguarding team. The capacity of this service has been further strengthened recently and is viewed by schools as extremely positive.

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[3] **Genogram -** This is in effect a family tree covering two to three generations. It is an effective, visual tool that helps practitioners and families understand familial relationships Using established symbols and connecting lines family members work with practitioners to depict develop a graphical representation of their inter-and intra-generational family structure.
Safeguarding Wales

School staff undertake regular safeguarding training at the appropriate levels, and this normally includes governors. Relevant school staff also have child protection, PREVENT and violence against women, domestic abuse, and sexual violence (VAWDASV) training. School designated safeguarding leads (DSL) highly value the support, guidance, and training opportunities from the local authority. For example, the training to support staff in completing multi-agency referral forms.

The local authority expects all governors and elected members to undertake safeguarding training. As a result, they have a deeper understanding of safeguarding arrangements and are better equipped to offer support and challenge in their schools. Governors are beginning to have an increased involvement in the safeguarding audit tool processes in their schools. Where practice is effective, governors can hold schools to account in meeting the safeguarding audit action plan.

Dyfed Powys Police

Police leaders understand the importance of their personnel speaking to children and recording their voices. Positively we saw no police records with victim blaming language.

A senior police leader chairs the daily management meeting. They check domestic abuse incidents and records for the recording of children's voices. They also scrutinise the recent force responses to high-risk incidents, crime, and vulnerability to make sure that the necessary resources and capability is in place.

Police supervisors audit some investigations and PPNs each month. The results are reviewed by managers and personnel are tasked if additional action is needed. These audits provide a useful insight about the quality of the safeguarding services and the focus on outcomes for children. But currently the small numbers audited limit the positive benefits of this practice.

Specialist personnel in the force's central referral unit (CRU) research force systems to complete risk assessments. The CRU follows the multi-agency threshold policy to make referrals to other safeguarding organisations. This process is effective, and we found no delays in sharing information about children who needed help with other organisations.

When officers place children into police protection there is always a strategy meeting. At night, police inspectors hold these with the local authority emergency duty team staff. This means there is a multi-agency approach to safeguarding these children.

But sometimes there are delays in finding these children suitable accommodation meaning they are kept in police stations for too long. The CRU reviews all these incidents to make sure the children remain safe until the incident is resolved.

CRU supervisors hold timely strategy meetings with local authority and health staff. If joint investigations are agreed, these are allocated to investigators who then hold

further strategy meetings with locally based professionals from the other safeguarding organisations. These meetings are well attended but we saw that some of them lacked a focus on the safeguarding priorities.

Positively most detectives in the force are trained specialist child abuse investigators following the College of Policing specialist child abuse investigators development programme.

Children's Services

Corporate support for children's services has been prioritised amongst competing Council demands. There are effective governance arrangements across children's services. This provides visibility on the delivery of duties and risks, coupled with an understanding of the quality of children's experiences. Leaders and managers have an accurate understanding of the quality of practice as data is used in sufficient depth to scrutinise performance. Senior leaders accurately evaluate the performance of children's services with an effective quality assurance framework. Detailed analysis of performance means leaders can target resources where needed.

Senior managers in children's services are visible and supportive. Practitioners spoke positively about the support offered to each other and the ethos of a team approach. We heard about excellent peer support, informal and formal supervision, and approachable and available managers. There is clear investment in newly qualified social workers, with identified management posts in the structure to target support for these workers. Practitioners have access to a clinical psychologist within the local authority. Complex situations can be discussed as a team with psychology input and oversight to help support and upskill staff to achieve positive outcomes for people.

Supervision occurs frequently and promotes staff induction, development, and well-being. In the best examples supervision is reflective, considers the link between research and practice, and promotes opportunities for professional development.

What needs to improve

Powys Teaching Health Board

Whilst there is evidence of commitment to a learning culture, compliance with level 3 safeguarding children training is significantly lower than the national target of 85%. A recent data cleansing of the electronic staff system (ESR) will support the accuracy in recording of compliance data, however, the availability of the safeguarding team to deliver additional training sessions to meet demand is an issue. Therefore, improving access to and compliance with level 3 safeguarding training should be prioritised.

Safeguarding supervision is a self-identified area for improvement by the health board. Consequently, a recent policy change to reduce group supervision from 3 to 6 monthly has been introduced to align with the wider national picture and to support greater compliance. However, there needs to be a greater focus on ensuring the triggers for individual supervision are used, as outlined in the health board's policy, to ensure the safeguarding team has oversight and scrutiny of individuals who meet this threshold.

The health board acknowledges the continuing expansion of its safeguarding responsibilities, such as the new Serious Violence Duty, and the lifting of the cap on numbers of unaccompanied asylum seeker children (UASC). The impact of these changes will require further monitoring to ensure adequate resourcing to meet these requirements.

The health board's safeguarding team need to raise awareness of the triggers for requesting one-to-one case specific supervision in complex cases, where there is drift or disguised compliance in line with the PTHB safeguarding supervision policy.

Education

Processes for monitoring children and young people who are electively home educated (EHE) involving multi-agency working require strengthening as they are at an early stage of development.

There is currently a lack of regular opportunities, facilitated by the local authority, for school designated safeguarding leads (DSL) to meet to support each other, share effective practice and concerns.

Dyfed Powys Police

The force's audits focus on child protection and domestic abuse investigations. These audits are reviewed by senior leaders. But the force would benefit from developing its qualitative focus further. And embedding a stronger audit culture within its routine management practices.

Not all police personnel have received vulnerability training. Frontline personnel responding to incidents don't always speak to the children. So, they don't always record information about these children's demeanour, lived experiences and wishes.

We found police supervisors didn't always direct investigations effectively. There are supervisory entries on records, but these don't always focus on the risk to children. Such as from repeated incidents or when safeguarding action should be escalated. Some investigations are closed without information about the risks to all the children being considered and shared with other safeguarding organisations.

We found inconsistency in how personnel record information about children on PPNs. Some included the voice of the child, ethnicity, risk, and vulnerability. But some personnel didn't identify the impact of all vulnerability factors, such as a disability, on the lived experience of the child.

PPNs are not consistently used when children are perpetrators. In one incident, a child who was on the CPR was racially abused by other children. This information was not recorded as a separate crime, or on a PPN and shared with other organisations.

Not recording vulnerability on PPNs also means the CRU do not identify other relevant information and inform other organisations about the risks to a child. Some PPNs didn't include other children in the family who were affected by the incident.

Children's Services

In common with many local authorities across Wales, the challenges in recruitment and retention have affected child protection arrangements. We acknowledge recent successes in appointing to managerial posts permanently but do not underestimate the challenge of moving away from a reliance on agency workers. It is positive workloads are manageable, and no children are left unallocated.

Proportionately only a small number of children and young people are attending their child protection meetings. The reasons for this need to be explored further. There is a welcome focus on the participation agenda, including the Momo App, use of advocacy and family network meetings. At a strategic level, the participation agenda does need to be developed further to provide children with opportunities for meaningful input into the design of services.

2.3 Partnership and Integration

Partnership Arrangements

Strengths

Powys contributes significantly to the Mid and West Wales Regional Safeguarding Board and leads on many aspects of its work, for example, the regional exploitation strategy and training sub-group. Relationships are now well established with clear leadership responsibility across agencies for child protection. For example, the police assistant chief constable attends the Safeguarding Board executive and chairs the force's strategic vulnerability board. This means strategic decision making is informed by both police and partnership information and in consideration of multi-agency priorities. The Junior Safeguarding Board (CYSUR) represents the views of children and young people by actively contributing children's voices at a strategic level.

There are many examples of innovative multi-agency working in Powys. For example, between the local authority and health board with proactive Child and Adolescent Mental Health Service (CAMHS) arrangements and resource for a new joint therapeutic team. There is also the effective commissioning of an organisation to complete the return home interviews for missing children which are detailed and meaningful.

At all levels we found strong and established professional working relationships in child protection. Within the social care staff survey, 47 practitioners rated partnership working as excellent or good (71%), with 25% recording this as adequate. The local authority has a professional support network from which it can draw expertise, knowledge, support, and constructive challenge. We found record keeping in respect of child protection was detailed across agencies. Key stakeholders share valuable information within strategy meetings, core groups, and conferences.

What needs to improve

The frequency of multi-agency training should be increased to ensure there is a consistent approach to safeguarding practice. Police personnel are not benefitting from more regular multi-agency safeguarding training. They do receive some inputs during continuous professional development training from non-police subject matter specialists, such as domestic abuse, but would benefit from joint training. Recent multi-agency training on subjects such as professional curiosity has been welcomed.

The Safeguarding Board covers four local authorities and two health board areas and has a regional threshold guidance which is due to be reviewed. Ensuring a joint understanding of the threshold for significant harm is an area which requires strengthening. Feedback from the safeguarding team in PTHB reported that there has been little to no need to use the dispute protocol which is in place as these are usually resolved at operational level.

For some families, actions outlined in the CASPP need to be progressed more quickly. This is particularly noted in complex family situations with longstanding neglect. Partners need to consistently work together to ensure measurable actions which improve outcomes for children living in these circumstances. Clear supervisory direction is needed in the police force to ensure child abuse investigations are timely and effective and prioritise all the safeguarding issues affecting the outcomes for the children.

Strengths

Powys Teaching Health Board

There is evidence that CAMHS teams work in close partnership with multi-agency colleagues to safeguard and engage children. It is noteworthy that the presence of senior CAMHS practitioners with backgrounds in social work has markedly enriched the team dynamics and multi-agency collaboration. In one example, a school was able to contact CAMHS for advice around a child's self-harm and together developed a joint risk management plan. We saw CAMHS making continuing efforts to engage with children, including offering to visit the child in school, if the child felt more comfortable with this location.

We found the health board's perinatal service to be robust. The service actively engages collaboratively with various agencies, internal disciplines, and partner agency professionals such as Police, Probation and Social Care. The proactive approach to discussing complex cases during meetings highlights the service's commitment to comprehensive and inclusive care strategies.

Education

There are strong working practices between schools and other agencies such as health and children's services who work effectively in partnership to plan, implement, and review provision for vulnerable children in Powys. This is well supported through the termly Team Around the Cluster (TAC) meetings where multi-agency professionals attend a workshop style event to discuss common issues and agree interventions and support. These meetings are normally well-attended by education staff, CAMHS, school nursing service, Careers, Police, Youth Service.

Schools when invited, attend, and contribute fully to child protection conferences and reviews. Data on the child's attendance, punctuality and attainment are shared in school reports. Parents' contact with schools provides useful intelligence that supports the care and support planning for pupils well. Schools prioritise the importance of safeguarding their pupils and provide a range of purposeful support. For example, establishing a trusted adult for children to have access to, specific intervention programmes and facilitating rooms for social worker visits. Most schools keep appropriate school records, and information is shared when a child moves school suitably.

Dyfed Powys Police

Police personnel contribute effectively to child protection conferences and supply reports to help the multi-agency decision making. But police personnel are not trained in the Signs of Safety approach used by conferences in Powys.

Children's Services

Opportunities to work in partnership are positively led and taken up by children's services. We saw good working relationships between families and professionals. Parents told us they valued the support of children's services with some of their own vulnerabilities, including understanding how their own adverse experiences impact on their parenting capacity. We also heard of difficulties at times with communication and the adverse impact of changes of social workers.

Independent Reviewing Officers (IRO) have a critical role in overseeing the quality of practice and provide a valuable contribution in challenging delays where necessary. They prioritise visits to children prior to children looked after (CLA) reviews, building meaningful and consistent relationships with them. They consult parents in all cases prior to initial and review conferences.

We found in general effective partnerships are in place to commission and deliver good quality support to children and families in Powys despite the geographical challenges. Positive examples were shared of the good outcomes of this work. Third sector partners are clear and confident in their roles but feel their profile could be enhanced across early help.

What needs to improve

Powys Teaching Health Board

Owing to its geographical location, children in Powys frequently require access to healthcare services across borders. The different Information Management Systems in place can introduce risks associated with communicating safeguarding information. It is imperative for the health board to incorporate an acknowledgment of these risks, along with their corresponding mitigation strategies, into both the Safeguarding Maturity Matrix (SMM) improvement plan and the Risk Management Plan.

Dyfed Powys Police

Supervisors are not consistently recording reviews of investigations and giving clear direction on investigative and safeguarding priorities. They don't always act to escalate changes in risks in ongoing investigations. Review strategy meetings aren't always held in a timely way. It means that some investigations can take too long, and investigators don't always fully consider the long-term outcomes for children.

There is inconsistency in how investigators record information for the victim's codes of practice (VCOP) including a victim's needs assessment and informing the child of the outcome of the investigation.

We found some duplicate records of children and family members on the force's system. These need to be identified and reconciled to make sure the force has a clear understanding of the vulnerability and risk for these people.

Children's Services

Records of child protection meetings, such as conferences and core group minutes, are not consistently shared with parents and key partners. This means agencies may not receive key information to enable them to safeguard and support children and families.

Core groups provide regular updates to evaluate progress against children's plans, but there is inconsistency in this area. The link between risk and safety needs to be more explicit, with plans measuring progress rather than the delivery of services.

Signs of Safety is recognised and well used by practitioners and partner agencies, however, with the appointment of newly qualified social workers this could be an opportunity to ensure a model is embedded in practice.

2.4 Prevention

Partnership Arrangements

Strengths

For all agencies in the current context of increased demand, it is a challenge to prioritise the preventative agenda in a way which reduces the need for more formal care and support. Despite this, many children in Powys benefit from early help with plans evidencing a wide range of statutory, community and voluntary services which are child-focused and are used well to meet children's needs.

There are good relationships between children's services practitioners at the front door and their partners with regular interface as part of child protection procedures. We saw consideration given in general to identifying the needs of other children and adults at risk who may be affected, such as siblings and/or those children in contact with alleged abusers.

At times the availability of partners can be a challenge. Further work is required to ensure the expectations set out in the WSP are consistently adhered to, and the referrer is invited to participate in strategy discussions and/or meetings. Similarly, practitioners from education should always be invited to contribute to strategy discussions if they have worked, or are working, with the child.

What needs to improve

Despite a range of preventative services which are highly valued, we heard mixed accounts about their co-ordination. We consider arrangements for early help could be clearer, more streamlined, and consistent across Powys, but we understand there is a programme of work to expand this.

In some files we found gaps in analysis about specific and important areas for assessment. This included disguised compliance, parental motivation to change, the differing needs of siblings, and the impact of long-term and chronic harms. This resulted in cases where the individual needs of siblings were not considered in a timely way, and others where the risk of re-referral was not sufficiently managed.

As stated previously, we saw examples where children's plans were not reviewed nor updated in response to further incidents. This presents a missed opportunity to review the risks to children and to update the CASPP accordingly. For some children who have experienced long-term neglect, planning and interventions are ineffective across agencies, with insufficient focus on the safety and well-being of the child.

Strengths

Powys Teaching Health Board

Health board staff use the Signs of Safety approach to formulate conference reports and in safeguarding supervision sessions. They believed this supports holistic health assessments to identify both emotional and physical health needs, as well as wishes and feelings.

Pre-birth meetings occur between children's services and healthcare services in line with the regional pathway. To facilitate communication, a specialist pre-birth social worker and lead safeguarding midwife attend the meetings to provide additional oversight.

Where there are wider risks, there is evidence to support the efforts in risk management and preventative work. For example, Domestic Abuse, County Lines, and serious organised crime involvement.

Dyfed Powys Police

We found locally based personnel work effectively with other organisations to prevent crime and reduce risks to children and families. These personnel have extensive knowledge of their communities, and they know which local children are at risk. The force's 'Intact' initiative involves police and other organisations working jointly to prevent and disrupt crime and anti-social behaviour in communities.

Education

Pupils feel listened to in schools, they have a strong voice. Vulnerable pupils are well supported to play an active part in school life. They are encouraged to join clubs and are often named persons such as prefects or ambassadors. There is good use of a one-page profile to ensure that pupils have a voice in the design of their support. Where practice is most effective, pupils have trusted adults in school to whom they can turn for advice and support.

Nearly all schools use a good range of strategies to support pupils with anxiety or anger issues to meet their individual needs. Where practice is effective, schools have a well-planned curriculum which teaches pupils the importance of strong mental health and emotional well-being. This supports their school placement and can help to avoid exclusion.

There is evidence of strong support for families from schools, with many employing family liaison officers. Schools provide children and families with a wide range of beneficial interventions to help support pupils' social, emotional, and behavioural development. This includes practical help such as parenting classes, opportunities to develop skills and support to complete forms. There is evidence of parents being consulted appropriately on decisions that affect them and their children.

Innovative work is led by the Educational Psychology Team to support vulnerable pupils in schools including children with neuro diversity issues, pupils with adverse childhood experiences (ACEs), and trauma. In addition, the development of Emotional Literacy Support Assistant (ELSA) for non-verbal pupils is highly beneficial. Nearly all schools are provided with useful and timely advice from social services front door staff.

Children's Services

Children's services do not have waiting lists across teams and despite the context of increasing volume and complexity of referrals, staff express positivity about improvements made by the authority over the last couple of years. We heard about the support provided by well-being workers, who support social work practice with direct work to de-escalate need. On many occasions, parenting support, trauma informed practice, and crisis intervention were evident within care plans. Practitioners considered the individual needs of children and monitored complex family dynamics.

Despite the demands on the service, performance indicators in relation to statutory duties such as timely child protection conferences and visits are generally good. In the period March 2023 to August 2023, the performance in relation to the number of section 47 enquires complemented within statutory timescales has consistently improved from a dip in April 2023 at 46% to an upward trajectory of above 80% for

all other months. Whilst it is positive that this is an improving picture, the local authority must ensure that it consistently maintains the improvements made in relation to performance in this area.

What needs to improve

Dyfed Powys Police

We found inconsistency in force managers' knowledge about accessing and using child protection performance information. This is partly because the force information systems were recently changed. And the force is also introducing a new system of cloud-based record storage. It means that previous practices of accessing information no longer work. Not all personnel know how to access the force's information systems to support operational planning. For example, in understanding a child's vulnerability after repeated low level incidents and to plan multi-agency interventions to reduce this risk.

Children's Services

We heard there can be challenges around the progress of referrals which are rated a medium priority by the service as urgent contacts are prioritised. A prudent approach to resource allocation is required to ensure the right help is available at the right time. Senior managers should keep under review the resources within the front door/IAA service to ensure the team has sufficient capacity to consistently and effectively respond in a timely manner and to meet the levels of demand.

Next steps

On behalf of the partnership, the local authority should prepare a written statement of proposed action responding to the findings outlined in this report. This should be a multi-agency response involving Powys Teaching Health Board and Dyfed Powys Police. The response should set out the actions for the partnership and, where appropriate, individual agencies. The head of service for children's services should send the written statement of action to CIWLocalAuthority@gov.wales by (date to be confirmed as will be 6 weeks after report publication). This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

Methodology

Fieldwork

Most inspection evidence was gathered by reviewing the experiences of people through sampling agency records and file tracking children's care and support arrangements. We case sampled ten files and tracked six.

Tracking a child's record includes having conversations with the child where appropriate, their family or carers, key worker, the key worker's manager, and other professionals involved.

We held focus groups with staff and two professional groups focused on the working arrangements and outcomes for two of the tracked files.

We visited a small sample of primary, secondary, and special schools where we conducted meetings with the headteacher, the designated safeguarding lead and groups of children.

We interviewed a range of employees across different agencies.

We interviewed a range of partner organisations, representing both statutory and third sector.

We reviewed supporting documentation sent to the inspectorates for the purpose of the inspection.

We administered surveys to children's services staff, third sector organisations, schools and children and family members.

We observed child protection conferences, a child exploitation strategy meeting and practice as part of our inspection activity.

We evaluated samples of health and well-being schemes of work and looked at samples of pupils' work. This included holding a 'listening to learner' sessions in all schools visited.

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