Denbighshire County Council, Betsi Cadwaladr University Health Board, North Wales Police

Report of Joint Inspection Review of Child Protection Arrangements

February 2023

Estyn

HMICFRS

Arolygiaeth Gofal lechyd Cymru
Healthcare Inspectorate Wales
aglc hiw

Arolygiaeth Gofal Cymru
Care Inspectorate Wales

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

 WG47561 Digital ISBN 978-1-83504-040-9

Introduction

Between 6 and 13 February 2023, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and Estyn carried out a joint inspection of the multi-agency response to abuse and neglect of children in Denbighshire.

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

Scope of the inspection

The Joint Inspectorate Review 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. There are a number of terms mentioned we describe here:

Term or Phrase	Definition
ACEs	Adverse Childhood Experiences
BCUHB	Betsi Cadwaladr University Health Board
CAMHS	Child and Adolescent Mental Health Service
Care Experienced	A child or young person who is either looked after or who has previously been looked after (for example an older young person who has 'left care' aged 18, a child who has returned to birth family, or an adopted child)
CHOS	Children's Services Head of Service
Children Looked After	A child or young person who is currently in the care of the local authority
CPR	Child Protection Register
CRU	Police Central Referral Unit
DCC or LA	Denbighshire County Council or Local Authority
DCS	Denbighshire Children's Services
DSL	Designated Safeguarding Lead Officer is the person appointed to take lead responsibility for child protection issues in schools.

DTR	The statutory *duty to report* to the local authority means a referral to social services who, alongside the police, have statutory powers to investigate suspected abuse or neglect.
ED	Emergency Department
FCR	Police Force Control Room
ForMi App	ForMi is a person-centred planning and outcome recording tool for employees or individuals receiving personalised support
IDVA	Independent Domestic Violence Advisers providing help and support to vitims of domestic violence
ISRO	Independent Safeguarding Reviewing Officers
MAP	Mulit-agency planning meetings aim to develop partnership arrangements in improving the educational achievement of the pupils requiring extra help
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
Mind of my Own App (Momo)	Inclusive app that empowers young people to participate in their lives and communicate their views to a trusted adult
MIU	Minor Injuries Unit
NWP	North Wales Police
PA	Personal assistants are employed directly by individuals to assist them with care and support
PRUDIC	Procedural Response to Unexpected Death in Childhood; sets a minimum standard for a multi-agency response to unexpected deaths in infancy and childhood
PVP	Protecting Vulnerable People (Police Designated Post)
RSB	Regional Safeguarding Board
Section 47	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.

TAF	Team around the family can offer advice and help to families requiring extra support
TAS	Team around the School (TAS) model aims to support schools to identify and support families earlier when the needs arise by collaboration with key partners
THRIVE	Police risk assessment tool used to assign a priority level to an incident
WSP	Wales Safeguarding Procedures detail the essential roles and responsibilities for practitioners to ensure they safeguard children and adults who are at risk of abuse and neglect

1 Summary

In common with many areas across Wales, the challenges in recruitment and retention of staff across key agencies in Denbighshire is impacting on safeguarding children's arrangements. This is exacerbated by high levels of demand and increasing complexity of children's needs. Deficits in the number of social workers and a competitive market, has resulted in an increasing reliance on newly qualified and agency social workers. Whilst agencies are addressing recruitment, the workforce position remains fragile. In the local authority, the situation has been categorised as a corporate high risk and in Betsi Cadwaladr University Health Board (BCUHB) service delivery of safeguarding is also categorised as a corporate high risk.

Despite this context, overall, systems and relationships are in place to facilitate effective partnership working where a child is at risk of abuse and neglect. Partners are working to a shared ethos of safeguarding children at different levels of vulnerability. Managers and leaders also provide a positive working together culture. The leaders of organisations clearly articulate a shared vision with a positive approach to regional safeguarding arrangements. This clear strategic commitment has resulted in the commissioning of a sufficient range of effective local services to support children and families (for example, community and voluntary services), including therapeutic help. Schools across Denbighshire work well with a wide range of services to support children's needs.

Overall, there is good multi-agency attendance and participation in relation to meetings convened under the Wales Safeguarding Procedures (WSP). This includes initial and review child protection case conference and core groups. Timely sharing of key reports such as child protection medical reports facilitate effective communication. Most significantly, multi-agency contribution is evident in addressing the child's safety through the care and support protection plan.

There are, however, areas of child protection practice that are very inconsistent and require urgent attention. Although professionals make appropriate referrals, including

to children's services, thereafter statutory functions in relation to promoting safety and well-being are not always being fulfilled. There are gaps involving all relevant agencies during the initial child protection strategy discussion period. Key partners are generally not invited to attend at the point of strategy discussion which are routinely held only between children's services and police. This means relevant information held by agencies who know children may not be made available to inform decision making.

In responding to information about risk and safety issues, the multi-agency response can be inconsistent and not proportionate. The response is not always able to prevent risk and harm escalating, nor conducted in a timely manner. Actions do not always happen within appropriate timescales and the help and protection provided to meet need and reduce risk can be delayed.

2 Key findings and evidence

2.1 Well-being

Strengths

Partnership Arrangements

The best examples of child protection practice in Denbighshire are when there is a shared understanding of the concerns regarding significant harm and agencies consider the impact this is having on the child. This was evident during observation of a child protection conference, which demonstrated a clear strengths-based approach whilst ensuring the care and support protection plan made an explicit link between risk and safety.

Child protection conferences are effective forums for timely information-sharing, planning and decision-making. These are attended by multi-agency groups. Conferences are well structured and facilitated through collaborative conversations with parents/carers whilst maintaining a focus on risk and safety.

The quality of referral information from partners to children's services generally provides clarity and relevant detail. This is significant as it enables prompt and accurate early decision-making.

The recently refreshed pre-birth protocol and accompanying training, in conjunction with the pre-birth liaison meetings has ensured timely planning in relation to unborn babies where there are safeguarding concerns.

Betsi Cadwaladr University Health Board

Referrals to children's services from health care professionals are appropriately made and articulate the professional's concerns. There is emphasis on the voice of the child and the intended outcomes to be achieved. There is emphasis on the voice of the child and outcomes the referral needs to achieve. Consent is obtained when reports are made, and parents are asked what support they want from children's services. There is appropriate consideration to signposting to early help

interventions. Good quality information presented in referrals means responses can be prompt, appropriate pathways followed and proportionate actions taken.

There are examples of good engagement between GPs and statutory safeguarding processes. This includes submitting written reports for child protection conferences and proactive following up in relation to missed appointments. In one GP file, records were flagged to indicate a safeguarding concern and 'think family' was evident (an entry was made in the child's record when father was referred to the mental health crisis team).

The Safeguarding Team have developed and implemented examples of exemplary and innovative practice across departments within the District General Hospital. This has included Safeguarding Ambassadors across the health board, Independent Domestic Violence Advisors (IDVAs) in hospitals (this role includes joint visits with social workers and attendance at key safeguarding meetings) and safeguarding meetings within Emergency Departments (ED) to undertake a peer review of the attendance of children under the age of 2 years who had recently attended the department. This is a recommendation from an external Child Practice Review. Security measures appear to be robust in areas where children are seen and examined. Where children attend the ED, key health professionals involved with the child are usually notified.

There are measures in place to ensure the health board identifies and investigates unexplained injuries. These include reviews of all incident reports by the safeguarding team, escalation discussions with multi-agency partners, peer review processes and plans in place to introduce an electronic system in Minor Injuries Units (MIUs).

Education

There is good education support and planning for care experienced children. Personal education plans (PEPs) are completed and reviewed regularly. Schools work well with children's services to support the well-being, progress and engagement of children looked after.

There are a range of effective interventions and approaches which have been introduced across the local authority to support the needs of pupils, including those at risk of harm and those subject to a care and support protection plans. The school-based counselling service provides a broad range of therapeutic interventions, including cognitive behavioural therapy. The trauma informed approach has been successfully rolled out across all schools. The impact of this and Adverse Childhood Experiences (ACEs) training indicates an improvement in staff understanding of the impact of trauma for a child. In addition, it allows for more effective selection of relevant interventions to support each pupils' needs.

Schools and other education providers also offer beneficial interventions such as Emotional Literacy Support Assistants (ELSA), resilience programmes and bespoke timetables which support vulnerable learners' engagement in education. Secondary schools generally provide a range of support and interventions during the school day for pupils at risk of harm, working in consultation with other agencies. These include

school employed family engagement officers, on-site local authority youth workers and access to the behaviour support service.

Transition planning for vulnerable pre-nursery and nursery children is a particular strength. Comprehensive and relevant information is shared between agencies and there is a strong child-centred focus. Record samples from secondary schools show there is suitable transition planning around vulnerable pupils who are moving to high school.

The local authority monitors school attendance closely including children subject to a care and support protection plan and children looked after. Attendance rates are lower than the time before the pandemic including those of specific groups of learners. This is in line with national rates and there are no areas of concern.

Discussions with year 7 pupils during the inspection week confirmed they feel safe in school, know where to go for support, feel they are listened to, and that their school provides positive learning experiences for them on well-being matters.

North Wales Police

The force has good systems to identify crimes in referrals and record these on their systems so they can be allocated for investigation. Where police officers are concerned for the welfare of children, they record this on the force systems. Central Referral Unit (CRU) staff check these reports and add other relevant information from the force systems before sending them to relevant children's services.

Call handlers in the Force Control Room (FCR) identify vulnerable children quickly and assess risk with THRIVE risk assessments. They assign immediate and priority responses to these incidents and their decisions are checked by supervisors. If there are delays in responses, supervisors review the risk and make sure incidents do not remain unassigned for too long.

The force systems give information about previous incidents linked to the callers and the addresses, so responders get supporting information to assess risk and deal with concerns.

Domestic abuse incidents are always assigned to officers for immediate responses. Call handlers remind officers to record children's vulnerability on force records. They do not, however, prompt officers to use body worn video or to record the voice of the child.

The force has access to specialist intelligence to support its responses to children at high risk, for example when they are missing or there are concerns about exploitation. A clear leadership structure is always in place to manage high-risk incidents.

Force leaders review serious incidents affecting children in daily tasking meetings. It means they can be certain that enough resources are allocated to help these children.

Children's Services

There are good opportunities to share information about risk within the service, for example the weekly meetings led by a service manager or children's services head of service (CHOS). This provides opportunity for focused conversations about specific children and families, as well as the balance of workloads and staffing issues.

When safeguarding concerns are identified through referrals received at the Gateway service, these are generally highlighted and passed to the Intake Team for further consideration in a timely manner.

Children and their families benefit from evidence-based approaches that help to reduce risks and meet their needs. Collaborative conversations are evident in the child protection conference process, with independent safeguarding reviewing officers (ISROs) prioritising contact with parents' pre-conference to enable improved communication and understanding. They also ensure plans are progressed, drift and delay are challenged and escalation is effective where required. They provide sufficient independent scrutiny and challenge to influence the progress of children's care and support protection plans.

There is imaginative and innovative use of support services working with some families, notably the therapeutic team. The ForMi app is being piloted as an active record system working with families, the aim of this is to give ownership to the child or parent as far as possible, helping motivation and engagement.

What needs to improve

Partnership Arrangements

There are missed opportunities to have multi agency input at the point of initial strategy discussion where health, education and other professionals would have a relevant role and valid contribution to make. There is minimal opportunity to attend multi-agency strategy meetings to review the conclusion of a Section 47 enquiry. Statutory agencies should be invited to attend, and these meetings should be convened. Better understanding of risk and safety would follow if all relevant practitioners working with a child attended such strategy meetings. This is a key area for improvement to address effective communication, sharing of information and better understanding of risks and barriers in delivering safety for children.

Feedback from children's services following a referral or duty to report (DTR) is not consistently shared with the referrer in a timely manner. This lapse in sharing of information means referrers may not be appraised about factors related to need and risk nor able to respond and work as effectively with families. Feedback to professionals can be also be inconsistent in other areas. For example, minutes of key meetings such as core groups are not consistently shared in a timely manner with other agencies. This is an area to develop to ensure compliance with the expectations in line with WSP.

Although inter-professional relationships are positive, opportunities for professional challenge in relation to practice would benefit improved outcomes for children. For

example, the standard approach to child protection enquiries is to undertake a single agency visit to families (often social workers visiting alone). This is not always appropriate and has remained unchallenged across agencies. Healthy and constructive challenge is essential to prevent complacency and promote continuous improvement.

Betsi Cadwaladr University Health Board

In maternity and health visiting services, although there is evidence of a joint antenatal visit where there are identified safeguarding concerns, there is no data available to determine compliance with the handover of cases between midwife and health visitor and health visitor and school nurse.

Assessments are not always completed in full, for example a holistic health visitor assessment omitted key safeguarding information such as domestic abuse. However, it is recognised routine enquiry for domestic abuse has to be completed in a safe environment and can be completed at a later date when safe to do so.

When a child in care was not brought to a hospital appointment, there was no evidence the policy pertaining to children not brought to appointment was followed. This means opportunity to seek assurance about children's safety and well-being could be missed, therefore improvement is required.

Education

Although the local authority generally monitors the attendance of vulnerable learners well, in a very few cases, officers can be slow to respond to incidents of poor attendance. This was highlighted in one of the files reviewed, where there was good multi-agency working but limited progress in reengagement of the child with education.

In a very few schools and non-maintained nurseries (where the local authority supports funded placements) there have been shortcomings in aspects of safeguarding processes. However, the local authority has been consistently clear and open about these shortcomings with link inspectors' pre-inspection. Officers have worked diligently and productively with schools and the inspectorate to minimise risks to children and have made swift and substantial improvements.

North Wales Police

All child protection referrals are reviewed by the CRU and all referrals are shared with children's services. Frontline officers assess their referrals as High, Medium and Standard priority. Many of these officers, however, are inexperienced and their assessments are not always accurate, nor are they routinely supervised. Incorrectly assessed referrals may cause delay in the system. CRU researchers work 7 days a week but there are backlogs leading to delay of up to 72 hours before information is shared.

The force uses flags and warning markers on their systems to alert officers about some risks to children. These flags prompt call handlers to get help to children, but there is inconsistency as flags for children subject to a care and support protection

plans are not routinely put on records. Their absence means frontline officers do not have the full information for an effective response and vulnerable children can remain at risk.

The force has data on its systems about crime and incidents where children are at risk, for example, missing children reports. This is used to allocate resources and understand demand management. The force, however, does not have much qualitative information to help it reduce risk to children. For example, PVP managers do not receive reports about repeat incidents with concerns for children to allow them to check the outcomes of previous interventions and if escalated activity is needed.

The force has information about serious and organised crime including criminally exploited children involved in county lines. There is not, however, a regularly updated problem profile for child sexual exploitation. These profiles are essential to let safeguarding partnerships plan and co-ordinate activity to reduce harm to children from sexual abuse.

Analysts complete strategic assessments and profiles containing data and assessments to help the force understand the extent of risk, threat and harm in priority areas, for example, criminal exploitation, but this approach is not used to drive an overall child protection strategy. It means the force is not prioritising the collection and assessment of the information it holds about children's vulnerability or those who are a risk to them. These information gaps are unknown. So an intelligence led approach to preventing child abuse is not in place.

When responding to families at risk from domestic abuse, officers don't always consider issuing offenders with domestic violence prevention notices (DVPN). These orders are a positive act to safeguard vulnerable families.

Police officers miss opportunities to secure evidence to support victims with evidence led investigations. Body worn video is not consistently used to record children's living environments, their demeanour and their accounts.

Children's Services

Children's services do not consistently meet statutory duties in line with the requirements of the WSP. There is inconsistent and insufficient evidence about how progress is occurring in Care and Support Protection Plans. At times children are not seen within the required statutory timescales. There can be deficiencies in the analysis, decision making and rationale in many files. In some areas of service, referrals are not being proportionately responded to nor escalated to child protection process in a timely way.

Improvement is required in recording the strengths and in particular the protective factors in children's lives. This is important because it is the basis of strengths around families that ultimately provides most effective protection. To achieve this concerns need to be more explicitly broken down, with improved analysis to ensure effective child protection plans can be implemented. These plans should have clear actions and outcomes, working with families to ensure there is an agreed understanding about risks.

There are examples of escalating domestic abuse and physical injury incidents and inadequate safeguarding plans to manage risk. We saw some incidents where repetitive allegations were made and opportunities to review recent file history were missed. Timeliness is also an issue and there are incidents where children are not being seen following an allegation. Single agency responses by children's services, especially with regards to allegations of physical injury and domestic abuse, requires urgent attention by children's services and police managers to ensure children's safety is not being compromised.

Recording is not always timely, which means key information is missing, this is not to say that work with families is not happening, but the lack of recording cannot evidence key statutory duties are being fulfilled.

There is variable management oversight of frontline practice, with some exceptional supervisory support evident, but also gaps in supervisor support to front line decision making. Managerial oversight in some service areas was often uncertain with rationale and oversight of decision making absent or unclear. Gateway team records needs to move away from recording 'NFA' to a clearer narrative about the rationale for decisions. There are examples of files being closed without sufficient analysis of the risk with appropriate safeguarding plans in place There needs to be a focus on improving challenge, managerial support and oversight of these arrangements.

We are concerned some Gateway workers are working in isolation. This is an area children's services should review to be reassured information is being captured appropriately and decision making has robust managerial support. We have acknowledged this area of service is subject to review and resources have recently been re-aligned to bolster the staff complement.

2.2 People

Strengths

Partnership arrangements

Leaders and managers understand the experiences of children and families that need help and protection and the prevalence of need and risk in their area. Overall, at an operational level, a child centred approach is evident. This is particularly clear when children are in school with schools support evident.

There is a positive approach to learning and development in relation to child protection across agencies. There is a programme of multi-agency face to face and virtual training covering a wide variety of safeguarding topics. This is delivered across the North Wales Safeguarding Board footprint in line with priorities identified by the board. Police, however, are not routinely accessing this training.

Joint Investigation training (JIT) is arranged through the Safeguarding Board. This is open to police and partners with a view to fostering better joint working and improved practices.

Betsi Cadwaladr University Health Board

The views of the child are sought by health care professionals, this is evident in paediatric consultations and in health visitor records. Where a health professional noted the presence of a relative at a child protection medical may have influenced the child's voice, this was noted in the child protection report to the social worker. This is particularly significant in maintaining a healthy scepticism when child protection concerns are being addressed.

Safeguarding professionals employed within BCUHB are approachable and proactive. There is a clear corporate safeguarding structure in place, which includes Adults, Children and Young People, Deprivation of Liberty Safeguards and the wider Harm agenda. The ability to utilise a variety of specialist roles ensures the Health Board have safeguarding leads, with several specialist functions. Safeguarding remains on the corporate risk register as the demand and complexity continues to challenge the service delivery.

The safeguarding team are fully engaged in all areas of multi-agency working, both at strategic and operational level. Senior safeguarding managers currently hold positions as Vice Chair of the North Wales Safeguarding Adult Board, and both Chair and Vice Chair of Local Delivery Groups. The Health Board completed the national, peer reviewed safeguarding self-assessment, known as the safeguarding Maturity Matrix (SMM) for 2021/22, scoring 25 out of 25.

Safeguarding supervision is accessible to all staff using a variety of models, with a supervision database in place to capture compliance with mandatory supervision. There is good communication between members of the health board's safeguarding team and staff working directly with children. Health professional Safeguarding Child at Risk reports are copied into the safeguarding team for information and therefore there is an element of quality assurance in the process.

The wellbeing of health board staff is a prime consideration and there are examples of services that are implemented by the Safeguarding Team that are accessible for staff to promote well-being, for example Trauma Risk Management (TRIM). This includes IDVAs who can provide support to staff members who are victims of domestic abuse.

Multi-agency training is readily available, well received and well publicised. Learning from reviews, such as child practice and domestic homicide reviews are delivered through training events, 7-minute briefings and learning bulletins. A programme of audits reflects areas of concern and determines whether lessons have been embedded in practice.

ED staff recently undertook a scoping exercise with children to consider the child's journey through the ED and how this could be improved. Feedback from the exercise highlighted staff felt more confident when assessing children, and the process gave children a stronger voice in shaping future practice in the ED.

Children in care can access their health assessments in a variety of settings, at times which suit them and by a health professional they know and trust. In most cases, the health assessments capture the child's wishes and feelings.

BCUHB is proactive in the Active Offer for communication and provision of services in Welsh. All staff who were interviewed confirmed patients and their families are actively offered communication in Welsh.

Education

The local authority understands strong supportive relationships between pupils and staff underpin good emotional development in pupils generally, but these relationships are key to vulnerable pupils. They work closely with Child and Adolescent Mental Health Service (CAMHS) In Reach Service to support staff well-being.

Schools have high levels of purposeful support from local authority officers which is valued, notably the work of the designated safeguarding lead (DSL) officer who provides strong and assured leadership. This is strengthened by the integrated working between education and children's services.

There is comprehensive and relevant support and guidance for schools. This includes clear policies on safeguarding. The local authority complies with statutory requirements for training of staff on safeguarding and child protection. There is relevant training provided to school safeguarding leads on a wide range of themes and there are regular opportunities to meet, discuss and share good practice.

The voice of the child is evident in schools work with children, with a range of effective approaches used to support the child to make their feelings known, for example the Personal Education Plan (PEP) one page profile.

North Wales Police

North Wales Police (NWP) has clear and structured governance for child protection. A monthly protecting vulnerable people (PVP) board is chaired by the Detective Superintendent and the bi-monthly force vulnerability board is chaired by Detective Chief Superintendent. The latter is attended by strategic leads from PVP, local policing, operational support and corporate services. Summary information from these boards is presented to the force's strategic management board (chief officer level) and the strategic executive board (including the Police and Crime Commissioner).

Managers use learning from local and national cases to improve the way its staff respond to vulnerable children. They are developing a prompt called VOICE to help frontline staff observe, engage with children, and record the voice of the child.

The vulnerability and knowledge practice programme (VKPP) is commissioned to give the force a peer review for its child protection responses. Detective inspectors are also required to audit their teams' cases in themed reviews.

The force responds to information about levels of demand and the need to maintain high quality decision making for child protection. It has increased the numbers of

detective sergeants in the force CRU. This allows specialist child protection supervisors to hold timely strategy meetings with the force's partners.

Children's Services

Denbighshire Children's Services (DCS) has a stable and supportive management group. This has been particularly important in recent months providing consistent support to staff, given the ongoing national workforce crisis. At the time of this inspection DCS had a 26 per cent vacancy rate across teams, this would be worse but for the support of agency staff.

Good managerial and peer support is routinely available to staff across the organisation. Staff well-being is a priority for managers, it is a routine agenda item at formal supervision. There is variable management oversight and opportunities for practitioners to reflect on practice, but practitioners routinely described managers as approachable, responsive and knowledgeable. This was evident across our wider inspection activity.

The young people who responded to a CIW survey said communication with social workers was good, they said they were listened to, and things were explained. Some families are being actively involved in decision making, with the local authority working hard to encourage parents' participation even when there is some reluctance. There are examples of professional support being adapted to help communication with parents and parents being supported through formal advocacy. This is significant as it means professionals are helping parents/carers to understand what the risks are and what is expected of them.

For the sample of records CIW reviewed in relation to complaints, when people make a complaint or raise a concern about children's services, responses are timely and follow appropriate lines of enquiry. This is positive as it reflects people's feedback is considered important and children's services are proactive in learning from what people have to say.

DCS has a Welsh language champion whom staff can approach if there are queries related to the Welsh language. The Gateway team provides the Welsh language active offer to callers through a telephone language selection message. With no current fluent Welsh language speakers in the team, the contingency is to utilise a Welsh speaker from the wider service list of Welsh Speakers. The Mind of my Own (Momo) App is bilingual, allowing Welsh speaking children to share their view in their language of first choice.

What needs to improve

Partnership arrangements

High turnover and increased vacancy rates have been an increasing challenge for many agencies. This can have detrimental effects on people receiving care and support through inconsistency and gaps in service. In social care and health in particular, it is acknowledged this a national challenge, and national health and social care recruitment drives need to continue. Recruitment and retention continue to be a priority across agencies in Denbighshire.

The voice of the child and knowledge of children's lived experience is inconsistent across some agencies. Agency records are not helping the focus on the child, although it is acknowledged this is more prominent in educational settings. In DCS there is positive use of the Momo App. We are aware there are plans to widen the use of Momo which will improve opportunities for children's voices to be heard.

Advocacy must be strengthened to improve opportunity for children's views to be represented. There must be enhanced promotion of the active offer of advocacy for children who are subject to care and support protection plans, working with the commissioned provider to achieve this. Where voice is prominent, this leads to improvements in the help and support to families.

The quality of records is variable and inconsistent. For some services this is a capacity related issue and it means agencies cannot be clear safeguarding roles and responsibilities are being fulfilled. IT Systems for social services records do not necessarily help the quality of recording. Across agencies, there are examples of inadequate recording of ethnicity and language. In general, record keeping across the health board is good, though some entries were not signed or dated and often the time of visits or phone calls was not recorded.

Many BCUHB staff use paper records and there are different records for different professionals. Therefore, staff may not always be aware if children or families are known to other healthcare services. The risks associated with paper records in relation to safeguarding were raised by several sources. We are informed measures are in place to determine how an electronic system can be introduced, however, as this is unlikely to be a quick resolution, the risk remains. In ED and the MIU, there is inconsistency in recordings, such as who attends with a child, the children looked after status of a child, and if the social worker was informed of an admission. There is not always a record to confirm a health child protection conference report has been shared with a parent/carer. Improvement is required with documentation and communication across teams.

There are areas to highlight under regional arrangements. The force Protecting Vulnerable People (PVP) detective superintendent meets with partners at the regional North Wales Children's Safeguarding Board (RSB), but attendance at chief officer level would be appropriate to reflect the strategic importance.

Whilst not a statutory requirement, there is no independent scrutineer role for the RSB. The partnership has not commissioned any independent scrutiny of the effectiveness of its arrangements to safeguard children.

A monthly heads of service meeting is held between the PVP superintendent and heads of children's services for the six local authorities in the force's area. This meeting allows senior managers to discuss operational activity so that it is efficient and effective. Police, however, have raised concerns about the quality and consistency of children's services return to home interviews for missing children. This issue has not been resolved and although this area was not the focus of this inspection, it requires urgent attention given the potential safety concerns associated.

Betsi Cadwaladr University Health Board

Recruitment and retention is a concern in some areas of the health board. For example, the lack of school nurses, and their competing tasks, can affect their involvement in working more intensely with school-aged children. Hence the opportunity to hear the child's voice and to understand their lived experiences is impacted.

There is a recognition children's rights are not fully embedded across all areas of the health board. There are examples of how this is being addressed and how it is being challenged at board level. The development of a Children's Charter is underway to underpin this.

The Safeguarding Team have robust governance arrangements, which are evident. However, the recent organisational restructure and the implementation of a new operating model has impacted upon the Central Integrated Health Community (IHC) Safeguarding Forum meetings where representatives from healthcare disciplines meet to ensure safeguarding practice is meeting health board standards and risks are being identified. It is evident the situation is now improving and risks were captured during this period of flux via the Safeguarding Team Senior Leads and escalated appropriately.

All new employees undertake a DBS check in accordance with their role. In addition, internal staff moving into a higher role that requires a DBS or a new role, where the DBS check is more than 3 years old, will have this repeated. Where safeguarding allegations or concerns are raised about a staff member in a position of trust, a further DBS will be requested.

Compliance with training is poor in some areas. This is acknowledged by BCUHB, and the safeguarding team are proactive in promoting improved compliance by offering bespoke training and supervision sessions for staff groups with low training records. Programmes of multi-agency and in-house training sessions are actively promoted via regular electronic safeguarding bulletins and information on the health board's intranet. There is currently no means to accurately determine compliance with Level 3 Safeguarding Children Training due to Level 2 and Level 3 training data being captured jointly via the electronic staff record (ESR). We are informed processes have begun to address this. Midwives undertake Level 3 training as part of an annual mandatory training day; therefore, this is accurately captured within the maternity services.

North Wales Police

There are challenges across the muti-agency workforce with new and temporary staff in post. In NWP the frequent changes of managers in key child protection roles does not allow the force and its partners opportunity to consolidate relationships and the relevant professional knowledge.

Officers are inconsistent in the way they record the voice of the child. The force knows it needs to improve and has added a section to its referral form for this, but

too often this section is left empty. Frontline officers responding to incidents do not always speak to children present. They also do not consistently record information about the child's demeanour, circumstances and wishes. Referrals to get help for children do not always contain the information needed to identify what services are required.

There is no current force wide vulnerability training. This results in an inconsistent approach to children's vulnerability. Multi-agency child protection training is not being accessed by many police staff. New police recruits do attend vulnerability training, including recording the voice of the child and how to make referrals. PVP staff get specialist child protection investigation training [SCAIDP]. The force also trains social workers alongside officers in evidential video interviewing children.

There is information about recognising and responding to vulnerability on the force intranet, however, the force does not monitor how many staff access this resource. It has reacted to training delays by introducing its own, college of policing approved course to train officers locally.

Children's Services

In children's services there is significant instability in the workforce which we know is a priority area for the local authority. There are examples where team managers have reduced capacity due to having caseloads themselves. An unstable workforce inhibits children's ability to form stable, trusting and significant relationships with a consistent worker. One carer described the departure of a social worker as a 'disaster' due to the impact on the child's ability to build a relationship with their worker.

In recognising the workforce situation as a corporate high risk, the children's services senior managers are concerned about the increased likelihood of risk due to insufficient resources. Actions to mitigate the workforce crisis are in place but there is a need to continue to move forward at pace through the on-going support of members and the senior leadership team, with a continuing focus on workforce sufficiency looking ahead.

As a consequence of vacancies and increased demand, workload is high, in some teams too high to enable quality practice and be assured of workers capacity to reflect on child protection responsibilities. This is evident where there were noticeable gaps in some records, but most significantly practitioners were not always taking opportunities to see children and build relationships with them. We cannot be confident opportunities are consistently taken to identify risks and listen to children about their experiences.

As described earlier, managers of front-line social workers as well as senior managers are accessible to practitioners for guidance and advice. Formal case management supervision records, however, were inconsistent in some service areas. This means there are insufficient opportunities for reflection and healthy challenges to ensure children's care and support remains focused and safety and well-being is continuously promoted.

2.3 Partnership and Integration

Strengths

Partnership Arrangements

There is good partnership attendance at the multi-agency risk assessment conference (MARAC) meeting. A dedicated agenda centred on parents with children means where children are at risk, there is a child focus. The meeting is well chaired by a detective inspector and all relevant staff groups submit written reports. Weekly meetings help the partnership to promptly respond to domestic abuse risk.

There are some established and developing links across services, with joint working clearly evident. The Bwthyn y Ddol development joint venture between Conwy and Denbighshire councils and BCUHB will provide a multi-disciplinary assessment service for children with complex needs when it opens. In the therapeutic team, there is positive support from CAMHS staff in providing clinical support to those social care staff who are facilitating Dialectic Behaviour therapy parent/carer support groups. The Local Integrated Family Team (LIFT) is a multi-agency team made up of staff from Conwy, Denbighshire and BCUHB. LIFT helps families at home in supporting parenting in difficult circumstances.

Schools have many positive partnership arrangements. For example, the school police liaison officers provide beneficial support to schools through the All-Wales Core Liaison Programme. They provide valuable learning experiences around important welfare and well-being matters. The programme is supported by the SchoolBeats.Cymru website, providing support for pupils, parents and teachers. Officers also support schools and pupils, investigating school-based offences and have excellent relationships with DSLs and headteachers.

There is a broad range of therapeutic interventions available to primary and secondary pupils through the education psychology service (EPS) and the school-based counselling service. Support for Denbighshire schools in implementing the Welsh Government Whole School Approach to Emotional and Mental Well-being Framework (WSA) is underway, primarily led by the EPS. This includes monitoring and evaluating emotional health and well-being data to identify trends and interventions to support the implementation of the WSA framework. The EPS also offers Emotionally Based School Avoidance (EBSA) training to schools, which has become more relevant following the COVID19 pandemic and the disruption caused to educational experiences.

The self-harm pathway was jointly created between the EPS and Denbighshire CAMHS to safely manage incidences of self-harm and suicidality in schools. As a consequence, CAMHS have dedicated staff to respond to staff in education settings. Between November 2021 and November 2022, 240 pupils were jointly supported through the Self Harm Pathway by education and CAMHS. Of these pupils, 10 were of primary age.

Betsi Cadwaladr University Health Board

CAMHS staff work in close partnership with multi-agency colleagues to safeguard and engage children. In one example, a representative from a school was able to access telephone advice in relation to a child self-harming, and therefore was able to develop a risk management plan. In another example, CAMHS staff made persistent efforts to engage a child, including offering to see the child in school, as it was felt the child might feel more comfortable there.

Collaborative multi-agency working was evident across health disciplines. For example, agencies work well together to manage the challenge posed when children with severe mental health problems are admitted to a paediatric ward as a place of safety, until a suitable care facility can be found.

Child protection information sharing arrangements are positive in BCUHB, for example during the antenatal period. Communication between health board staff and GPs in relation to safeguarding is generally robust.

Education

Education leaders foster a productive and collaborative relationship with children's services at all levels. There are suitable arrangements for joint working at both operational and strategic level. School and local authority staff state senior leaders in education services are approachable and supportive.

The multi-agency Inclusion Moderation Panel meets to discuss the interventions or provision for pupils with social, emotional or behavioural difficulties who may require additional support or a PRU placement following a request from schools. The Panel may also identify suitable Llwybrau support, in addition to other strategies for vulnerable learners and those hard to place.

Education Services and schools work effectively in partnership with teams within children's services to plan, implement and review provision for vulnerable children in Denbighshire. This is supported through regular Team Around the School (TAS) and Multi Agency Planning (MAP) meetings led by pastoral leads. MAPs are well established in secondary schools and are beginning to be introduced in primary schools according to need. This approach supports early identification and intervention.

Support for the education of children looked after is strong. There is effective collaboration between children's services and schools. Support for maintaining educational placements for children looked after who move care placements is also a strength. A notable feature is the number of children looked after that go on to higher education, further education and apprenticeships and are not NEET.

Children's Services

Generally, partners make regular use of the information, advice and assistance service provided by children's services Gateway Service. This helps partners make an informed decision about the suitability of a referral and to check if concerns meet the threshold for a referral. In the pre-inspection headteachers' questionnaire, in

nearly all areas, school heads were content with the service and support from and collaboration with children's services. There are also good links between headteachers and the head for education through weekly meetings which the children's services head of service also attends.

What needs to improve

Partnership Arrangements

There is no multi-agency threshold document in place. Children's services have developed a document, but not all children's services staff are aware of it nor is it used by partner agencies. The partnership should ensure such a document is developed and implemented collaboratively. This should provide guidance to all professionals about circumstances to refer children and families for support across levels of need.

North Wales Police

As referenced earlier in this report, there are inconsistencies in how the force gets information from local authority return home interviews with children. Sometimes these interviews are not held and other times there are long delays before the force receives any information. Operationally, this means officers do not always receive the quality of information they need to help find children quickly.

Children's Services

Child protection meeting records such as child protection conference and core group minutes and actions are not consistently being shared by children's services with key professionals. This means agencies may not understand the multi-agency approach to safeguard and support children and families.

2.4 Prevention

Strengths

Betsi Cadwaladr University Health Board

A new initiative to provide student nurses with a one-week placement in the Health Board's Safeguarding Team means students graduate with an improved practical understanding of staff safeguarding responsibilities and partnership working to protect children, young people and adults at risk.

The introduction of Safeguarding Ambassadors across the Health Board is an additional source of advice and support to staff in identifying safeguarding concerns.

Safeguarding supervision processes are well established, providing staff with a clear plan for the management of cases where there are safeguarding concerns. Reviews are underway to expand the staff groups required to undertake mandatory supervision.

The Safeguarding Team have introduced and manage the Trauma Risk Service for BCUHB staff service who have suffered trauma in the course of their work.

Examples included staff involvement in Procedural Response to Unexpected Deaths in Childhood (PRUDiCs), cases of new-born babies being removed from the care of their mothers and involvement with Child Practice Reviews.

The receipt of copies of Child at Risk reports into the Safeguarding Team enables the triangulation of organisational data, trends and a quality assurance process.

Education

Overall, preventative and reactive strategies are strong in most education providers across Denbighshire. It is positive to note in recent primary inspections, there were no recommendations related to safeguarding. There are suitable local authority risk assessment policy, process and proforma to support provision for pupils at risk, extremely vulnerable pupils and those presenting with violent and aggressive behaviours.

Education services place a strong focus on preventative measures and engaging children beyond the school day to improve its provision for well-being. For example, one special school runs a Saturday club to engage vulnerable learners and support their carers. There is also a holiday club for children with complex needs. The local authority play ranger service uses many school buildings across the authority, and especially in rural areas, to give children access to play outside normal school hours. These are also examples of joint service delivery, being led by children's services.

There are generally well-considered school plans for implementing the health and well-being aspect of the new curriculum in Wales. Many schools place a significant focus on well-being and welfare of the child through proactive and enriching experiences, such as holding 'Wellbeing Wednesdays' in primary schools where pupils have sessions on aspects of the 'Five Ways to Well-being'. Many secondary schools provide worthwhile opportunities for pupils to learn about safe and healthy relationships and a very few focus on the impact of pornography and negative attitudes towards the LGBTQ+ community.

Inspection outcomes for well-being and provision for care, support and guidance in Denbighshire schools, further education college and non-maintained nurseries is very strong since March 2021. This includes provision for the culture of safeguarding. Schools generally monitor attendance very well and, with the support of the Education Welfare Service, respond swiftly and effectively to concerns around attendance, particularly of vulnerable groups.

Children's Services

Many referrals being received into children' services, numerous reporting issues of neglect, are being appropriately reviewed and allocated for a proportionate 'What Matters' assessment. These assessments review the appropriateness of early and preventative services being accessed by families. Overall, these interventions helped to avoid escalation with good outcomes for the children and families identified.

Children's services do not have waiting lists across teams and despite the context of increasing volume and complexity, pathways between services in relation to early intervention and help for families, are fluent and families are receiving timely support. There are examples of prompt responses to presenting need and positive use of services such as Team Around the Family (TAF) and Supporting People providing appropriate and proportionate support to the needs of families.

Regular transfer meetings involve children's and early intervention services. This provides opportunity for shared oversight and professional discussion regarding children's circumstances and which services are best placed to work with families.

There is positive engagement between the local authority and third sector partners. This has helped in the commissioning of services and in this process the voice of children is evident, for example in relation to services for those young people leaving care.

The local authority has relatively stable numbers of children looked after. Senior managers and officers have a good understanding and knowledge of the profile of children looked after. They are strongly committed to the preventative agenda, and to the safe reduction of the number of children who are looked after.

What needs to improve

Betsi Cadwaladr University Health Board

Some areas within the Health Board are not compliant with mandatory safeguarding training. Although measures are being taken to address this, such as regular communications outlining available training dates and the availability of additional training sessions, ED staff in particular remain poorly compliant. This includes training in violence against women, domestic abuse and sexual violence.

North Wales Police

The remit of Operation Encompass is to inform schools about domestic abuse incidents that have occurred the night before, this should allow school representatives to engage with the family and support the child. However, there is delay in the notification process via the police which means opportunities to address safeguarding and well-being can be delayed.

There is an agreed process for frontline officers to make early help referrals directly to the local authority, but there is no area for officers to record the voice of the child in these referrals. There is also no requirement for police supervisors to check the content of early help referrals before they are sent. This means the force specialists don't know enough about these referrals or review either the quality of the information or appropriateness of these referrals.

Children's Services

For some circumstances there is a lack of focus on the needs of and support to carers in difficult caring situations. There should be an enhanced focus in supporting family members and foster carers as some examples of support and communication

with carers was limited and delayed. This means permanence and stability for children can be compromised.

3 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 the Betsi Cadwaladr University Health Board and North Wales 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 29 June 2023. This statement will inform the lines of enquiry at any future joint or single agency activity by the inspectorates.

4 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 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, healthcare and education staff, third sector organisations and children and family members.

Acknowledgements

The inspectorates would like to thank staff, partners and people who gave their time and contributed to this inspection.