Pembrokeshire County Council

Report of Joint Inspection of Child Protection Arrangements

June 2025

This document is also available in Welsh.

Mae'r ddogfen hon hefyd ar gael yn Cymraeg.

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Introduction

Between 17 and 21 March 2025, Care Inspectorate Wales (CIW), His Majesty's Inspectorate of Constabulary and Fire & Rescue Services (HMICFRS), Healthcare Inspectorate Wales (HIW) and His Majesty's Chief Inspector of Education and Training in Wales (Estyn) carried out a joint inspection of the multi-agency response to abuse and neglect of children in Pembrokeshire.

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

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
- the protection of 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:

Term or Phrase	Definition
AWARE	Capturing the Voice of the Child is required on every occasion a police officer investigates a child protection concern and staff are instructed to use their professional curiosity to consider the child's Appearance, Words, Activity and Behaviours, Relationships and Dynamics, and Environment (AWARE)
CAMHS	Child and Adolescent Mental Health Services
CASPP	Care and Support Protection Plan
CAT	Childcare Assessment Team
CID	Criminal Investigation Department
CLA	Children Looked After
CPR	Child Protection Register

CRU	Police Central Referral Unit for safeguarding concerns
CWMPAS	Collaborative Working & Maintaining Partnership in Adult Safeguarding
CYSUR	Child & Youth Safeguarding, Unifying the Region
DBS	The Disclosure and Barring Service helps employers make safer recruitment decisions by checking the criminal record of someone applying for a role.
DSP	Designated Safeguarding Person is a school or PRU's lead person on safeguarding and child protection
DTR	Refers to a professional's Duty to Report in respect of safeguarding concerns. This may also be referenced as a referral
EHE	Elective home education
ELSA	Emotional Literacy Support Assistant is a social and emotional intervention programme delivered by trained staff in primary, secondary schools and PRUs.
EWS/EWO	Education Welfare Service/Education Welfare Officer
FEO	Family Engagement Officers
Freebirth	Sometimes referred to as unassisted birth, is a practice where women intentionally give birth without healthcare professionals present
ICPC	Initial Child Protection Conference - The first child protection meeting consisting of family members, the child (where appropriate), and professionals involved with the child and family to make decisions about the child's future safety, health and development
ICMS	Information Case Management System
INTACT	Multi-agency partnership programme to tackle Serious Violence and Organised Crime in Carmarthenshire, Ceredigion, Pembrokeshire and Powys
LOG	Local Operational Group
MASH	Multi Agency Safeguarding Hub - A single point of contact for all new safeguarding concerns.
MWWSB	Mid and West Wales Safeguarding Board
NICHE	A police records management system used by several UK forces. It manages information in relation to the core policing entities of people, locations, vehicles, organisations (businesses or other groups), incidents (or occurrences) and property/evidence

Operation Encompass	A process which the police use to provide schools with information on domestic abuse incidents experienced by their pupils. Information on a domestic abuse incident affecting a child is provided by the police to a trained member of school staff the day after officers have attended a domestic abuse incident. Appropriate support can then be given, dependent upon the needs and wishes of the child
Part 6 CASP	Refers to the care and support plan for a Child Looked After
PIT	Multi-agency threshold forum, being piloted, named Partnership Integrated Triage
PPN	A PPN is an information sharing document that records safeguarding concerns about an adult or child. PPNs are shared with partner agencies to inform a multi-agency response.
PRU	A Pupil Referral Unit is a type of school established and maintained by a local authority to provide suitable education for children and young people who, by reason of illness, exclusion or otherwise, may not receive such education (section 19 of the Education Act 1996)
PRUDiC	Procedural Response to Unexpected Death in Childhood - sets out a minimum standard for the multi-agency response to the unexpected death of a child or young person. The aim of the PRUDiC is to ensure that this response is safe, consistent and sensitive to those concerned and that there is uniformity in the approach taken across Wales
RSB	Regional Safeguarding Board
Section 47 (s47)	Under s47 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
SMART	Specific, measurable, achievable, relevant, time-bound
SoS/Signs of Safety	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
TAPPAS	Meeting forum for agencies to ‘Team Around the Pupil Parent and School’
THRIVE	Threat, harm, risk, investigation, vulnerability and engagement model – a model used to assess the right initial police response to a call for service. It allows a judgement to be made of the relative risk posed by the call and places the individual needs of the victim at the centre of that decision.
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence

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

Summary

The safeguarding context in Pembrokeshire is one whereby increasing numbers of children need care, support, and protection. The number of children named on the Child Protection Register (CPR) has doubled in the last two years, from 58 children in March 2023 to 118 in February 2025. The complexity of referrals is also rising, and more children are needing to enter local authority care. In March 2023 there were 242 Children Looked After (CLA) by the local authority, which has risen to 312 as at February 2025.

Safeguarding and protecting people is everybody's responsibility, and all partners have experienced this rise in complexity and demand. Moreover, this is occurring at a time of significant budgetary pressures for all agencies. It is increasingly important partners work together to provide a joined up and efficient response to safeguarding issues.

Each of the four local authorities within the Mid and West Wales Safeguarding Board (MWWSB) area host Local Operational Groups (LOGs). LOGs monitor and analyse safeguarding practice locally, rather than regionally. This can promote improved coordination and collaboration across the partnership. We note key areas of current focus within the LOG include strengthening Duty to Report (DTR) submission quality, multi-agency collaboration, and addressing capacity challenges to improve standards.

Partner agencies mostly work well together to embed a positive culture in respect of safeguarding children. It is positive to note that education and the police have followed up on improvements required from previous inspections.

Inter-agency communication requires improvement in many practice areas, for example between school nurses and social workers. The absence of safeguarding records, including Care and Support Protection Plans (CASPP) and core group minutes, from health records is an indicator of disjointed communication. There can also be delays in health assessments being completed for children involved in the child protection process. Whilst the health board has identified improvements to address these concerns, ongoing delays mean protective actions to address risk can be adversely impacted.

The Signs of Safety (SoS) methodology is a relationship-grounded, safety-organised approach to child protection practice. It is used in Pembrokeshire and the method is mostly understood by partners. Some records and plans do not have sufficient focus on the strengths of the family and 'what matters' to them. The local authority and all partners should strengthen focus on the voice of individual children, the impact of harm, strengths, safety, protective factors, and outcomes. Local authority leaders plan to recruit two consultant social workers to address these improvements.

The impact of workforce pressures on morale and staff wellbeing remains a significant risk in child and family services, which is impacting some teams more than others. Staff across the whole service consistently reference workforce demands outstripping supply, having insufficient support for their wellbeing, and being unable to consistently deliver against their roles and responsibilities. Leaders and members should urgently work with staff to review workforce sufficiency and increase workforce wellbeing and resilience.

Professionals work well with local authority staff in the Childcare Assessment Team (CAT) and value their support. Nearly all Health Board and education staff told us they feel well-supported when they have a concern regarding a child's safety or wellbeing and need to make a referral. These positives must be strengthened further by improving the timeliness of CAT responses and confirming the outcome of referrals in writing to the individual or agency who is making the referral.

Most child protection enquiries are thorough and focus on the safeguarding needs of the child. Interventions would be improved further by having increased emphasis on partnership working at an earlier stage in the process. Nearly all strategy discussions are between social services and the police, and strategy meetings are not consistently convened before Initial Child Protection Conference (ICPC). This means practitioners are not consistently involved in a timely way, to share information and agree subsequent actions. Leaders should ensure practice aligns with the requirements of the Wales Safeguarding Procedures (WSP).

The conference process is a significant strength in Pembrokeshire. Attendance is good and partners make an important contribution to discussions about risk and need. Conference chairs provide good oversight and analysis of decision-making, which supports the development of clear outline plans to meet the care and support needs of children. Despite this strength, the local authority should ensure the ICPC is timely and takes place within 15 working days of the last strategy discussion/meeting.

Leaders across the education directorate make a valuable contribution to the safeguarding culture of the local authority. For example, educational psychologists, the educational welfare service, youth services, and improvement advisors work collaboratively and share information to provide effective support for children and

young people. All agencies benefit from the high-quality support they receive from these teams, which helps improve outcomes for vulnerable pupils.

There is variation in the quality of leadership across Hywel Dda University Health Board (HDUHB), ranging from proactive approaches to safeguarding practices to missed opportunities for professional challenge and the absence of supervision. Safeguarding training compliance is generally poor and requires a renewed focus and drive by managers to improve attendance.

Quality assurance can be inconsistent, capacity being a specific factor, notably for children's services and HDUHB. In the absence of clear quality assurance processes being implemented, leaders do not have sufficient line of sight on compliance or practice quality.

Overall, children in Pembrokeshire are protected and safeguarded from abuse, neglect, and other types of harm through an adequate multi-agency response. They experience reasonable involvement in their care and support and most people achieve sufficient outcomes. However, there can be inconsistencies in safeguarding arrangements, ranging from excellent contribution by agencies at child protection case conference to insufficient quality assurance and inadequate communication in other aspects of the inter-agency partnership. Improved local authority corporate support, including additional funding for children's services, provides opportunity to take forward required improvements.

Key findings and evidence

Well-being

Partnership Arrangements – Strengths

Partners generally have a shared understanding of their roles and responsibilities and there is a focus on effective inter-agency working.

There are examples of excellent collaboration between the police and social services when safeguarding children. This leads to prompt and effective decision-making during investigations.

Children Looked After (CLA) and children named on the CPR receive a collaborative response from professionals. Overall, there is good multi-agency attendance and contributions at core groups, child protection conferences, and CLA Reviews. This provides essential oversight of actions and outcomes linked to the Care and Support Protection Plan (CASPP) or Part 6 CASP. However, general practitioners and

midwifery services are not consistently invited to conference, and this should be addressed.

Leaders have implemented a rapid response process for learning following serious incidents where a child has been harmed. This takes place prior to the Child Practice review and the approach provides the local authority with opportunities to develop recommendations and improve practice in a timely way.

Leaders understand the benefits of multi-agency training. The police and local authority plan to jointly provide safeguarding training to 32 social workers and police officers; and the Health Board delivers multi-agency training on specialist topics such as Fabricated and Induced Illness and PRUDiC multi-agency training provides opportunity for strengthening safeguarding arrangements.

There is a wide range of useful local authority organised safeguarding training available for school and PRU staff and members of the management committee and governors. This includes generic child protection training and specific training, including on Prevent duties, safer recruitment, and Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV). Bespoke training is available if schools and the PRU request it. Training is evaluated following feedback, to support improvements.

Conference chairs facilitate inclusive child protection case conferences. They support the views of family and stakeholders to be shared; and practitioners constructively challenge when there is professional difference. Professional concerns are escalated through appropriate channels, when this is needed.

What needs to improve

ICPCs are frequently being delayed when social work and partner reports are not completed in a timely way. The WSP state a conference chair should be satisfied sufficient information is likely to be available, for the conference to make an informed judgement about continuing risk of harm to the child.

In exceptional circumstances the chair may wish to postpone the conference, but in doing so they must be satisfied the child is protected, and the conference is rearranged as soon as possible. All partners should strengthen efforts to complete reports in a timely way and the ICPC should take place within 15 working days of the last strategy discussion/meeting. Leaders should quality assure that this only happens in those circumstances outlined in the WSP.

Individual Agency - Strengths

Hywel Dda University Health Board

Robust governance structures and policies for safeguarding are in place. There is strong leadership in the management of CLA statutory processes with all health assessments being quality assured by the CLA Team and mostly completed within statutory timescales.

Learning from local and national reviews is widely shared across the Health Board and GP practices, and the Health Board acts swiftly to identify immediate learning as incidents occur. There are good well-being and support services in place for staff involved in traumatic safeguarding incidents.

A new safeguarding module in the Datix Cymru reporting system has enhanced scrutiny and oversight of safeguarding incidents. The recent pilot of having a safeguarding lead in one of the Health Board's Emergency Departments was instrumental in improving safeguarding training compliance and quality assurance processes and is a model that should be considered for future adoption.

Child and Adolescent Mental Health Services (CAMHS) waiting times for assessment and intervention have reduced significantly over the last year, with most children assessed within 28 days of referral and most interventions commencing within 28 days of assessment.

There is evidence of strong documentation in some areas, reflecting health service engagement in the child protection process. For example, some GP records demonstrate good safeguarding practice with clear documentation of domestic abuse incidents, safeguarding meetings, and reports for child protection conference.

There is an encouragement of professional curiosity and staff feel empowered to escalate safeguarding concerns.

Education

The Chief Executive Officer and elected members have established a clear vision for Pembrokeshire of *'working together to improve lives'*. Working closely with the Director of Education, they have established a strong safeguarding culture, and robust processes and systems at both corporate, school, and PRU levels.

As the lead corporate safeguarding officer for the local authority, the Director of Education articulates and secures a clear and well-considered vision for safeguarding. This is underpinned by a shared understanding that it is everyone's responsibility to ensure schools and the PRU are safe and supportive learning environments for the children and young people of Pembrokeshire. This vision is shared effectively across all local authority service areas.

Safeguarding is a high priority for all leaders across the education service. There is an appropriate corporate safeguarding policy, which covers all staff employed by the council. This is further strengthened by the role of safeguarding champions across the council, which includes elected members and senior leaders.

The education service provides a range of worthwhile safeguarding training. All elected members, school governors, management committee members, council employees, school and PRU staff complete the corporate safeguarding training upon appointment. Despite financial pressures, the local authority continues to renew Disclosure and Barring Service (DBS) checks every three years for all elected members, staff who are centrally employed, and those in schools and the PRU including school governors and management committee members.

Governors and members of the management committee have a good understanding of safeguarding procedures. They have developed their role as strategic leaders of safeguarding in their schools and the PRU. They understand their responsibilities to ensure policies and effective practices in respect of safeguarding. Safer recruitment practices are secure. There is highly effective support from the local authority for managing allegations against staff.

Leaders have an Information Case Management System (ICMS) which provides senior leaders with a wide range of purposeful and current safeguarding information. As a result, leaders accurately identify where a school or the PRU requires additional support, the support they need, and who will coordinate and lead the response. This provides effective management of resources and supports schools and the PRU to successfully improve their practice. The Safeguarding in Education manager receives alerts each time this happens.

There are highly effective systems to audit each school and the PRU's safeguarding practices on an annual basis. The Safeguarding in Education manager reviews each school and PRU's audit in detail to consider strengths and areas to improve. Each school and the PRU receive bespoke feedback when needed. This is a significant strength of the local authority.

The annual cycle of school and PRU visits ensures in-depth on-site reviews of safeguarding are undertaken. Prior to each visit, the Safeguarding in Education manager gathers a wide range of data about the school and PRU from different partners. This ensures the manager is well-prepared, leading to more informed and effective safeguarding decisions that ultimately enhance the safety and wellbeing of pupils. Schools and the PRU receive a written report that includes strengths and recommendations for improvement. Any recommendations are followed up by the Safeguarding in Education manager to evaluate progress.

Dyfed-Powys Police

The force has strong governance processes, which provides leaders with quantitative and qualitative child protection performance information.

The force recently reviewed its child abuse investigation arrangements and has introduced a joint investigation team of two detective sergeants and four detective constables. These officers work the same core hours as social services staff and they have received specialist training.

Officers and staff are highly motivated and committed to their work and understand the need to maintain their skills and knowledge. There is supportive working between the general Criminal Investigation Department (CID) and the specialist joint investigation team officers.

The force has strong oversight of its human resources. It plans to build resilience in its services which safeguard vulnerable people. It arranges specialist courses and uses performance information to decide which topics should be included, for continual professional development. For example, this year all frontline staff will receive training on neglect.

The force provides its workforce with well-being and psychological support. Supervisors can refer staff and officers or individuals can access these services directly.

A sequence of force risk management meetings support the coordination of police and partner agency activity, to disrupt offenders and protect children and their families. Force communication centre staff use the THRIVE risk assessment to decide the timing and type of response to child safeguarding incidents. This is effective and supervisors actively review open incidents to ensure the police response remains appropriate.

Children's Services

Children's services are experiencing increased complexity and demand, against a backdrop of significant financial pressures. In this context, it is positive to note the recent shift and improved focus of corporate leaders and members on social services. This includes increased funding for children's services and will provide opportunity to address acute need, whilst strengthening emphasis on early intervention and prevention.

Operational staff are highly dedicated and committed to promoting the safety and wellbeing of children. Staff are managing increasing complexity and demand, but their wellbeing is being significantly impacted. Senior managers are experienced and most staff describe them as being accessible and supportive. Leaders have

understandably focused on increasing capacity and reducing demand to support staff wellbeing.

The approach of conference chairs and Independent Reviewing Officers (IROs) is a notable positive, which provides reassurance about practice quality. Conferences are effectively chaired to ensure parents understand the process. Chairs explain each step clearly and provide opportunities for parents to ask questions, supporting their understanding and engagement. Conference chairs and IROs provide high-quality analysis and oversight of care planning.

Mid-point reviews are consistently held in a timely way to monitor the effectiveness of CASPP and part 6 Care and Support Plans. But the service is not immune from resource pressures and staff caseloads have risen significantly. This impacts service capacity to maintain standards and leaders should review whether increased capacity is needed.

Individual Agency - What needs to improve

Hywel Dda University Health Board

The quality of leadership varies significantly by service. In some areas, such as health visiting and school nursing, there is strong professional ownership and proactive approaches to safeguarding. However, the absence of supervision, professional challenge, and reflection is notable. Records frequently show repeated concerns without escalation, suggesting missed opportunities to lead safeguarding practice with vision and purpose.

The approach to risk is predominantly deficit-based, with a focus on presenting problems rather than potential strengths or protective factors. Although some cases mention interventions such as Care and Support Plans, FRAIT tools, or Early Help assessments, these are not consistently used to empower the individual or their family to understand risks and make informed decisions. The lack of follow-up or feedback loops also makes it difficult to determine whether the interventions improved well-being or merely met procedural requirements.

Training compliance is a concern, particularly for Level 3 safeguarding children training. Only 37% of medical and dental staff were compliant in December 2024. The provision of training is regularly available, but attendance levels are often low.

Consistent quality assurance and monitoring processes are required for the Health Board to assure itself that learning is embedded in practice. Whilst compliance data is reported via safeguarding governance meetings, actions to address deficits require strengthening.

Child protection supervision was not evident in the sample of files reviewed. There were inconsistencies in record keeping, with examples of minimal recordings and a lack of analysis.

Staffing capacity (in some teams) has impacted the Health Board's management of safeguarding, including in the areas of quality assurance, training and supervision compliance. Where staffing deficits have improved, there is evidence of a refreshed focus on these key areas of practice.

Safeguarding group supervision compliance is low due to poor attendance and the approach not being implemented for some relevant groups (such as CAMHS, Sexual Health Services and Allied Health Professionals). Similarly, attendance at monthly peer review sessions is inconsistent. Safeguarding supervision is an important element of reflection and learning which should be prioritised, alongside safeguarding training.

The Health Board's numerous IT systems do not support the timely collation and sharing of information, when safeguarding concerns arise. Leaders should identify opportunities to strengthen information sharing arrangements.

The reliance on child protection medicals being completed by acute paediatricians in an out-of-county hospital, due to the lack of a service in Pembrokeshire, presents a long-standing and unresolved challenge to all agencies involved. This has a significant impact on the timeliness and quality of child protection medicals; not least because people experience undue stress when they most need support. The Health Board should consider how best to resolve these issues to ensure a more timely and seamless service, both for agencies and for the children and families involved.

School Nurses follow the All Wales Framework for School Nursing. Whilst there is some evidence of school nurses being involved in the child protection process, this should be strengthened further. There is inconsistent communication between school nurses and social workers, to gather updates and share information. We found evidence of delays in health assessments being completed when children are subject to the child protection process. Such delays can impact the timely identification and management of health and safeguarding concerns.

There was variability in the completion and quality of safeguarding documentation across services. This includes missing or incomplete genograms, chronologies, and front sheets. This results in significant gaps in information sharing and an under-developed understanding of risks, which may lead to missed opportunities for intervention.

Education

Currently the Safeguarding in Education Manager is a sole role which would benefit from additional resources to build capacity and sustain the strong practice currently in place.

Dyfed-Powys Police

The force is continuing to improve its information systems, so its personnel can access more comprehensive information about risk and vulnerability. Leaders and managers review performance management data and operational teams use the information to prioritise their activity. However, there remains inconsistency in where information and records of incidents and child protection meetings are held on police systems.

This means that although the force holds information relevant to a child's risk and vulnerability, it is not always accessible to staff. In these circumstances, relevant information about the child's vulnerability and those who are a risk to them may not be fully taken into consideration when making safeguarding decisions. Accurate recording and the use of flags on Niche could improve the accessibility of this information for frontline officers and staff.

Children's Services

Corporate leaders and members have recently improved their understanding of the social care landscape and the needs of people in Pembrokeshire. Recent investment in the CAT and prevention services being a demonstration of this improvement and greater commitment to social care.

Despite this, operational staff express a significant gap between operational capacity and demand. This is negatively impacting the self-efficacy and morale of the workforce, with teams feeling unsafe in their practice. The local authority should ensure it retains priority focus on social care capacity and the needs of vulnerable children in Pembrokeshire.

With morale low, staff need to be included and heard. They want to overcome frustrations and support improvements. However, they are disconnected from corporate leaders and strategic plans. To support recruitment and retention, leaders should work with staff to co-produce plans for service development and communicate developments in a supportive and compassionate way.

Practitioners state their well-being needs are not met in a meaningful way and they do not experience sufficient support following critical events. Corporate leaders should renew focus on the wellbeing of staff to support workforce stability.

Practitioners and team managers across the service consistently describe caseloads as being too high. This was observed to undermine practice quality, with waiting lists for assessments and delays with s47 enquiries and ICPCs. Sufficient staffing resource must be in place to ensure children receive effective care and support. Specific attention must be given to current caseload expectations and whether these are realistic.

Whilst there are some good examples of records containing clear analysis of risks and actions, practice was variable and should be strengthened. Practitioners and managers must ensure the consistent recording of key decisions and SMART (specific, measurable, achievable, relevant, time-based) actions regarding child protection decision-making.

The local authority must maintain a consistent focus on identified risks and ensure actions to mitigate/eliminate them are sufficient. Specific improvement is required around responses to risks known about sexual offenders within a family context.

The Emergency Duty Team needs to respond to risk for all adults and children in Pembrokeshire. There are times when information sharing is inadequate, and we identified specific risks when matching children to placements out of hours. Leaders should review these arrangements to ensure safe practices are in place.

The local authority has moved to a new Information Case Management System (ICMS). Practitioners, managers, and leaders are not assured about the availability or reliability of data being received. The local authority must ensure timely improvements are made, so leaders can confidently monitor practitioner compliance with statutory standards and performance.

Child and family services have a quality assurance framework which is not fully being implemented. Leaders have diverted resource to the implementation of the new ICMS system. In the absence of reliable data or consistent quality assurance activities, leaders do not have sufficient line of sight on compliance or practice quality. Leaders should renew focus on quality assurance to ensure practice is consistently in line with agreed standards.

Staff do not consistently receive supervision which meets their needs. The quality of supervision is also variable. Specific improvements are required with support for staff well-being, the consistent use of SMART actions, and reflective practice. Leaders are aware of this issue and should ensure planned improvements are taken forward in a timely way.

Teams do not have systems or capacity to support reflective and strength-based practice. Leaders should explore opportunities to strengthen these arrangements and promote practice quality and workforce resilience.

People

Partnership Arrangements – Strengths

Overall, professionals effectively identify children in need of protection and promote their safety through the timely sharing of concerns.

Whilst the voice of the child is not consistently captured by all agencies, this is a strength for education and children's services. This is supported by trauma-informed approaches.

The Signs of Safety (SoS) methodology promotes a consistent approach to communication with families in child protection case conference. Conference chairs will not facilitate conferences unless professionals have shared their reports with parents. This supports parents to prepare for conference in a meaningful way.

What needs to improve

There is a tendency to lose focus on individual children if a sibling's situation is regarded as more urgent or complex. Assessments, plans, and meetings must maintain focus on the individual needs and outcomes of all children in sibling groups.

The recording of ethnicity and language on the Health Board and police records is not consistent. Leaders should ensure accurate and clear record keeping of important demographic information.

Individual Agency - Strengths

Hywel Dda University Health Board

Health Visitor assessments and recordings evidence the context of visits, observations of the child, a picture of the child's daily lived experience, and refers to contextual risks and parenting response.

There was evidence of professional curiosity in Health Visitor and Children's Community Nursing records.

The voice of the child was evident in the health assessments of Children Looked After and there are several initiatives to capture the voice of CLA.

Education

Members of the public can make anonymous referrals about the welfare of a child. Following a referral, the Education Welfare Service (EWS) do a home visit/welfare check. This makes an important contribution to keeping children and young people safe.

Increasing numbers of schools in Pembrokeshire employ Family Engagement Officers (FEOs). FEOs play a strong role in schools and the PRU, by building positive relationships with families and helping to support their needs. Through regular FEO network meetings, workers have the opportunity to share and improve their knowledge to strengthen their role and a deeper understanding of the work of other agencies.

The positive working relationships between school/PRU staff and parents/carers is a significant strength. Schools and the PRU develop trusting relationships with parents and carers, which positively supports a cohesive approach to supporting the needs of the child. Schools and the PRU know and understand the needs of their most vulnerable pupils and families exceptionally well. There are strong examples of the voice of the child and the family being listened to and included in plans and decisions. Schools and the PRU are a source of support for families and build trusting relationships for the benefit of the child.

The voice of the child is a significant strength. Where appropriate, pupils contribute to their plans and can make their needs and wishes known. They are confident to discuss these with trusted school staff. Children feel listened to, and their wellbeing is important to the adults around them. There are trusted adults for pupils to turn to for support.

Dyfed-Powys Police

No specific areas to record under this section.

Children's Services

The Welsh language Active Offer is made routinely by staff in CAT. This ensures people receive the Active Offer as soon as they contact the local authority.

Despite the pressures across social work teams, staff are dedicated and focused on improving the lives of children and families in Pembrokeshire. Staff focus on working positively with partners and families to keep children safe.

Practitioner capacity to record visits and meetings in a timely manner is impacted by demand pressures. However, most files have evidence of frequent contact between staff and families, and most visits and core groups are completed in a timely way.

Children are seen/seen alone where appropriate. Practitioners generally maintain focus on understanding the child's wishes and feelings. We found positive examples of direct work methods, including the use of toys and the SoS 'three houses' model to engage with children.

Practitioners consistently engage parents and promote their voice. CAT staff recognise the importance of parental consent and mostly take a strength-based approach. We found examples of well-documented attempts by practitioners to work through parental challenge, showing professional curiosity and perseverance in the process.

CASPP and conference minutes clearly explain concerns to children and families. Conference chairs nearly always write a summary of conference in the first person, directly to the child. This is positive practice and ensures practitioners and families retain focus on the child's lived experience.

There is evidence of CASPP and Part 6 CASP being completed to a high-standard and written effectively for children.

Individual Agency - What needs to improve

Hywel Dda University Health Board

There is little to no evidence that 'what matters' conversations are taking place in a structured or person-centred way. Individual views, wishes, or goals are rarely documented; and where professional concern is evident, it tends to dominate over the voice and perspective of the child or family. In particular, the absence of the child's voice is a recurring theme which limits opportunities for informed and collaborative planning.

When interactions are recorded, they are often brief, clinical, and lacking in plain language. There is little use of narrative to reflect the child or families' lived experience, or how their circumstances might impact their ability to stay safe, build resilience, or regain independence. This undermines the principle of acknowledging individuals as experts in their own lives and raises concerns about whether safeguarding approaches are genuinely collaborative and rights based.

There are some positive exceptions, such as school nurses and health visitors providing consistent input and showing attempts to engage meaningfully. However, these examples are not the norm and are not embedded consistently across services or professional roles. Leaders should maintain focus on strengthening the voice of the child in practice.

Education

No specific areas to record under this section.

Dyfed-Powys Police

There is inconsistency in how police personnel record the voice of the child. Senior officers closely monitor completion rates and the quality of the recordings on the voice of the child in PPNs. This action reinforces force policies and is increasing the quality of these reports. New officers are trained to use the 'AWARE' acronym and input through continual professional development supports existing staff to follow this guidance consistently. Leaders should maintain focus on strengthening the way officers capture and record the voice of the child in practice.

Children's Services

Practitioners across children's services state they are under-resourced and unable to meet demand in a timely way. This is impacting staff resilience and practice quality, with people experiencing inconsistent standards due to workforce pressures.

Children and families would benefit from greater focus on the role of extended family members in children's lives. Staff are able to refer to Family Group Conferencing and safety planning meetings could be convened using the SoS methodology. However, these approaches are not consistently used in practice.

In conference and CLA review meetings, parents and children are not always given the opportunity to speak with chairpersons to share their views. The Child Protection Conference and IRO Team need improved capacity to be able to consistently meet standards outlined in the WSP and IRO standards[1].

Core group minutes are often updates of the situation, rather than an evaluation of the effectiveness of the CASPP in reducing the risk of significant harm. The local authority must ensure core group minutes consistently review actions undertaken and reflect the extent to which they have contributed to improving the lived experience of the child and protected them from harm.

Children's services often use 'written agreements' with parents and carers as a means of promoting the child's safety. Whilst these may support the family to understand what has been agreed, consideration should be given as to whether written agreements provide false assurance to professionals about the safety of children. The local authority should review the effectiveness of such agreements and revisit more appropriate strength-based approaches.

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[1] Review and monitoring of a child or young person's care and support plan

The quality of statutory visit recordings is variable. The WSP outline that records must include reference to the child's wishes and feelings and changes in the child's life resulting from the implementation of the CASPP. Promoting the voice of younger children at conferences could also be strengthened. We observed frequent reference to the child being 'too young' to contribute, despite being above preschool age.

There is evidence of advocacy being offered to children. However, this practice is not consistent and there are examples of missed opportunities. The numbers of children referred for formal advocacy are low. This indicates the Active Offer of advocacy is not being consistently made. Leaders must ensure the Active Offer of advocacy is consistently made for CLA and children on the CPR.

Partnership & Integration

Partnership Arrangements – Strengths

Partnerships contribute to safeguarding decision-making and constructively challenging each other. Partner input at core groups and conferences supports effective decision-making and planning. We have seen elements of strengths-based practice and SoS used in these forums. This should be strengthened further to bring consistency to the experience of children and families.

Police personnel use the 'AWARE' acronym to help record relevant and detailed information about risk, vulnerability, and the voice of the child on public protection notices (PPNs). This means information about risk to children is generally communicated to multi-agency professionals.

An innovative pilot has recently run, named Partnership Integrated Triage (PIT), to consider all PPNs. Regular PIT attendees include the local authority, police, health, education, and youth justice. The meeting assesses and signposts information for multi-agency interventions. The forum provides opportunity to enhance approaches to threshold and information sharing. The partnership has received an evaluation and are considering implementation.

There are examples of excellent communication between schools and social services. Partners value the support of CAT staff and frequent 'team around the pupil, parent and school' (TAPPAS) meetings enable effective information sharing. Schools are invited to all child protection meetings. They feel that they are equal partners and their voices are heard.

The local authority organises useful network meetings where schools and the PRU Designated Safeguarding Persons (DSPs) meet to discuss concerns, share good practice, and receive targeted training and updates. Schools and the PRU staff value these opportunities very highly as they foster collaboration, enhance the skills and knowledge of the DSPs, and contribute to a safer and more supportive environment for pupils.

The Safeguarding in Education manager has a strong knowledge and understanding of all schools and the PRU. Advice to schools and the PRU is timely and useful. Schools and the PRU have regular safeguarding updates as part of the weekly education newsletters.

There are strong and effective communication systems in place between schools, the PRU, the Safeguarding in Education manager, and local authority services. These provide leaders and officers with effective means of sharing information and identifying potential risks and strengths in practice. Schools and the PRU value the highly effective and supportive role of the Safeguarding in Education manager when they identify concerns which they believe are not being acted upon in a timely manner.

Operation Encompass is used to provide schools with information about children who are at risk from domestic abuse. The partnership is extending this arrangement to include early years care providers. This positive step will improve the safety of vulnerable younger children and their parents.

A team of police officers are dedicated to local schools. These officers are trained to investigate and safeguard children at risk from digital online child abuse, such as sexting and child sexual abuse materials. The officers work closely with school communities to safeguard children and make sure they are not unnecessarily criminalised.

What needs to improve

Whilst there is evidence of effective sharing of information between partners, this should be strengthened in some areas.

Practitioners do not consistently follow-up on DTR referrals. If, having made the initial report in writing, the report-maker has not received an acknowledgement from social services within seven working days, they must contact social services again. The outcome of any discussion and the resulting decision must be recorded by the practitioner making the report.

In the absence of a multi-agency safeguarding hub or co-located safeguarding teams, initial strategy discussions are routinely held between children’s services and

police in the Central Referral Unit (CRU). Some records also highlight missed opportunities to convene a strategy meeting, when strategy discussions have progressed straight to s47 investigations and ICPC.

There are occasions when it would be beneficial to have wider multi-agency contributions to these meetings. For example, referrers and allocated social workers are rarely included in strategy discussions, as these meetings are convened by CAT and the police. Input from Corporate Safeguarding Leads in Health and Education would also be able to support information sharing and decision-making in the absence of involved practitioners.

At a minimum, appropriate practitioners, with responsibility for child protection in the police and social services, should be involved. The local authority should consider how urgent is the discussion, how many agencies need to be involved, and the seriousness of the risk. The more complex and high risk the concerns, the more valuable a face-to-face strategy meeting can be. What is important is to gather sufficient information to form an initial judgement. Partners should work together to develop effective systems for partners to consistently contribute to strategy discussions and meetings.

Ensuring systems are in place to support timely information sharing would also enhance safeguarding practice. For example, the outcome of and minutes of strategy meetings are not routinely shared with involved staff in a timely way. Any information shared, all decisions reached, and the basis for those decisions, must be clearly recorded and circulated within one working day to all parties relevant to the discussion.

ICPCs are routinely delayed when practitioners and partners do not complete and share reports, before conference. Involving professionals at an earlier stage in the child protection investigation would support improved timeliness of reporting. It would further ensure that practitioners' assigned tasks at the strategy discussion/meeting are clear about those tasks and can initiate ascribed actions without waiting to receive the record.

All outline CASPP should be shared with relevant partners in a timely manner. This practice is inconsistent. The outline plan should be implemented and developed by a core group of practitioners, in direct contact with the child and family. It requires partnership working between the core group and the child and family. However, the practice of sharing detailed plans and core group minutes is variable, and this may cause delays implementing actions to achieve safety and agreed outcomes.
The Local Authority must maintain and share the CASPP with the family and partner agencies.

Individual Agency - Strengths

Hywel Dda University Health Board

The Health Board is consistently represented at multi-agency meetings, including those of the Regional Safeguarding Board and its subgroups.

Records demonstrate that health staff are committed to working in partnership with other agencies, and there is evidence of attendance at child protection conferences and core groups.

CAMHS are represented on the Youth Justice Board and Corporate Parenting Group, they are involved in the schools 'In Reach' programme, and engage well with statutory processes, where they have information to share.

There are 10 residential children's homes in Pembrokeshire and the paediatrician and Children Looked After (CLA) nurse visits them on a regular basis to provide support, training, and health assessments.

There is evidence of good communication between multi-disciplinary teams and social care, with the child or unborn child being at the centre of their discussions. For example, there are frequent meetings between perinatal mental health teams and safeguarding leads, and multi-disciplinary teams for children with complex needs.

There is a structured handover process between midwives and health visitors and the use of a digital SharePoint system supports information sharing.

Education

Schools and the PRU are well represented at core group meetings and child protection conferences. They carry out their roles and responsibilities diligently to ensure their pupils' safety and wellbeing is of the highest priority.

All schools and the PRU have a named Education Welfare Officer (EWO). EWOs provide a high level of support to schools, the PRU, and their pupils. For example, they make regular welfare checks to pupils' homes, typically if children are missing from education or absent without reason. Their work has a positive impact on improving the attendance of many vulnerable pupils.

Dyfed-Powys Police

No specific areas to record under this section.

Children's Services

Improvements have been made to transition to not-for-profit models of care for children looked after and plans are in place to increase placement sufficiency. The local authority opened a new children's home in September 2024 and opportunities for further developments are being considered. This is a national challenge, and it is positive to hear members are supporting improvements in this area. The development of commissioning officers has also supported market shaping and the quality assurance of placements.

Individual Agency - What needs to improve

Hywel Dda University Health Board

The absence of the child's voice and lived experience was a theme in respect of some school aged children. Leaders should work with practitioners and the local authority to strengthen the voice of the child in records and ensure timely information sharing of important documents.

There were no CASPP or core group minutes in the health records seen, therefore it is difficult to evidence progress, and it would be difficult to challenge any drift or delay.

Safeguarding interventions are often designed for people, not in partnership with them. Plans are led by professionals, with little evidence that families or individuals have been involved in setting priorities, identifying solutions, or shaping what success looks like. Even where multi-agency meetings take place, the language used in documentation suggests a focus on professional accountability rather than shared responsibility.

Professionals do not consistently articulate their concerns in ways that would support a shared understanding or co-produced plans. Where worries are expressed, there is a lack of clear, accessible communication that invites the individual into a collaborative process. Partnerships with people should be strengthened. This requires a cultural shift from process-led safeguarding to person-centred practice that supports people to live safely and independently.

Education

No specific areas to record under this section.

Dyfed-Powys Police

No specific areas to record under this section.

Children's Services

Referrers are not consistently informed of the outcome of (DTR) referrals they have made and there is professional difference about the appropriateness of many referrals. The local authority should provide referrers with the outcome of referrals, as outlined in the WSP. By meeting this statutory duty, partners will also be able to collate information about trends and outcomes from referrals. The local authority is commissioning an independent review of thresholds and should include partners in this review. Leaders should use this information to develop an improved understanding of DTR thresholds.

Prevention

Partnership Arrangements – Strengths

The local authority sends a monthly update of all children named on the child protection register, to the police. The Force Communication Centre updates systems with this information, which informs front line officers who attend calls for service about the presence of vulnerable children. A similar arrangement is in place for registered sex offenders.

Police intelligence analysts regularly update profiles on community vulnerability and child criminal and sexual exploitation. This information supports multi-agency activity to disrupt offenders and prevent child victimisation.

The local authority approach to supporting the mental health and wellbeing of children and young people is a significant strength. A range of high-quality initiatives are well-established and embedded. This is enabling the local authority to see improvements in the wellbeing and outcomes of children and young people.

Well-established trauma informed approaches are embedded in schools' and the PRU's practice. These include daily check-ins with key staff, Emotional Literacy for Support Assistant (ELSA) sessions, emotionally available adults, and 1:1 therapeutic interventions. These approaches are underpinned by a professional development programme for staff, which maintains high levels of expertise in supporting the emotional wellbeing of pupils. This local authority led approach is positively impacting on the attendance of pupils, with a clear reduction in the levels of both fixed term and permanent exclusions across schools and the PRU.

The local authority has strengthened its support for pupils who are electively home educated (EHE). For example, improved funding to increase the number of officers has enabled the local authority to provide social events. Pupils who are EHE are carefully tracked to identify potential support. The local authority education service

offers advice and guidance for the families of EHE children. This supports building positive working relationships with families to safeguard the needs of pupils well.

What needs to improve

This inspection identified some specific trends and themes in respect of safeguarding arrangements, in Pembrokeshire. Leaders across partner agencies reported variable awareness of these themes.

There is an inconsistent approach to reporting children missing. The guidance to schools/PRU and staff in children's homes is not always understood and followed, before contacting the police to report children missing. This impacts police operational time and stigmatises some children, including those in local authority care.

Freebirth is a growing area of concern for the Health Board, which will require wider collaborative working. The local authority also identified an increasing trend of primary aged children being harmed through the ingestion of illicit substances, including crack cocaine. Partners should ensure timely information sharing about emerging safeguarding themes and work together to disrupt and reduce such risks within the population and for individual children.

Whilst there are strengths in the local authority and education response to EHE pupils, the police had not been sufficiently included in these discussions and would like to explore opportunities for improved information sharing.

The EHE community has more than doubled in Pembrokeshire since 2019. *WG elective home education guidance*[2] stipulates it is essential local authorities continuously work with partner agencies and have arrangements in place to identify children not known to the Local Authority. Support to families should be delivered as part of a co-ordinated multi-agency approach. The ability to work across and between agencies is essential to build a better understanding of the whole family's circumstances and their needs for care and support. Strong working relationships and a multi-agency approach can prevent needs escalating and identify when a child or family member is at risk.

Within legal parameters, partners should maximise opportunities to share information and make use of available resource to better identify and safeguard those EHE children who may be vulnerable to the risk of harm. The local authority should seek to develop an information sharing protocol which clarifies the circumstances under which information can and should be shared between agencies that support children.

[2] Elective home education guidance [HTML] | GOV.WALES

Individual Agency - Strengths

Hywel Dda University Health Board

We saw evidence of appropriate DTRs being completed, following the identification of safeguarding concerns during home visits and hospital attendances. When appropriate, the health visiting service identifies families requiring additional support and instigates a package of intense visiting.

Education

In schools and the PRU, there are well planned curriculum opportunities to teach pupils the importance of strong mental health, emotional wellbeing, and healthy relationships.

Schools and the PRU forge beneficial links with other agencies and organisations to support vulnerable pupils' needs. In addition, they provide valuable opportunities for parents and carers to benefit from the support of external organisations within their school day.

Dyfed-Powys Police

The force ensures that risk in domestic abuse incidents is accurately assessed. Specialist personnel review all domestic abuse incident reports and allocate investigations and safeguarding actions to support victims. This means children are recognised as victims themselves and are referred for help.

The police led INTACT program is designed to support children and young people assessed as at risk from becoming involved in criminality. Clear terms of reference make sure this targeted support is focused on children who are not receiving other statutory interventions.

Force communication centre managers check to see if call handlers record information on the system about the caller's vulnerability; and whether prompts to record the voice of the child and use body-worn cameras are given to responders.

There is a clear process for reports of missing children. All reports are recorded against a question set and then risk assessed by the force intelligence manager. The force has reappointed a missing persons coordinator, who makes sure all incidents are accurately recorded and shared with relevant partners. Positively, missing children are never recorded as low risk.

Children's Services

In the context of workforce pressures, it is positive that staff retain focus on prevention to support families to meet their needs, whilst reducing the risk of escalation and harm to the child.

An emphasis on prevention is evident to support families to address issues at an early stage. For example, the Family Support Team (FST) work closely with families to reduce risks and the Edge of Care Team aim to prevent children from entering the care system. However, practitioners express concern about the limited resources in these teams, and the impact this has on the timeliness of support and step-down arrangements.

Leaders are actively exploring opportunities to increase capacity across the service and initial investment focused on prevention. This includes thirteen additional posts provided to the CAT. It is envisaged this ensure people have their needs met in a timely way, whilst supporting qualified social workers to focus on statutory interventions.

The local authority is now exploring opportunities to strengthen workforce capacity by developing more preventative and statutory posts across children's services. This will include expansion of the Parent and Baby Early Intervention project, the Step-Up Step-Down Fostering project, and the local authority Edge of Care Team. Practitioners and families speak highly of these services. It is positive members are supporting with funding and part of the additional money is ring-fenced to fund more of these posts.

Children and families can be referred to the Pembrokeshire Families' Support Network (PFSN) for support with early help and prevention. This single point of access is well regarded, but practitioner awareness of available early help and prevention services is variable. This could be enhanced by leaders working together to ensure there is clearly communicated and consistent understanding of what is available and the pathways to preventative support.

Individual Agency - What needs to improve

Hywel Dda University Health Board

Health practitioners do not consistently follow-up on significant events such as domestic abuse incidents or following the receipt of DTRs. Records do not evidence any analysis of the incidents or plans to respond to them. Practitioners should work with children and their families to avoid situations arising that are likely to lead to the child experiencing abuse, neglect and harm. Effective safeguarding requires each practitioner and organisation to play their part, contribute to safeguarding, and promote the wellbeing of the child.

Education

No specific areas to identify under this section.

Dyfed-Powys Police

We found some variation in the completeness of police investigations. Generally, the focus on crime investigation was clear but, in some cases, we saw that officers and supervisors did not record comprehensive safety planning. This means that the impact of the incident and risks linked to behaviours of those around the child, was not fully assessed or addressed. A holistic approach to investigations would ensure the needs of all the children were considered and appropriate interventions considered.

Children's Services

Leaders report the increased resource in CAT is resulting in more assessments being completed by non-qualified staff, who subsequently assess the need for statutory interventions. Whilst it is positive that need is being identified, this means demand is continuing to outstrip resource and workforce resilience remains a concern.

CAT practitioners prioritise responding to immediate risks to ensure children are protected, but they cannot consistently meet demand in a timely way. Children's services should closely monitor and evaluate the level of demand in CAT and whether resources are sufficient for ensuring practice consistently aligns with statutory requirements.

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 Social Services, Education, Hywel Dda University 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 31 July 2025. 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 thirty 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 and secondary schools where we conducted meetings with the headteacher, the designated safeguarding lead and groups of pupils.

We met with representatives from a range of schools and the PRU including head teachers, DSPs and governors.

We interviewed a range of employees across different agencies.

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

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

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

We observed a strategy discussion and child protection conference as part of our inspection activity.

Acknowledgements

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