Cwm Taf Morgannwg
Bwrdd Diogelu
Safeguarding Board




Annual Report
2025/2026

South Wales Police / Heddlu De Cymru

GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol
Cwm Taf Morgannwg
University Health Board

Cyngor Bwrdeistref Sirol Pen-y-bont ar Ogwr
BRIDGEND County Borough Council

Cyngor Bwrdeistref Sirol
MERTHYR TUDFUL
MERTHYR TYDFIL
County Borough Council

RHONDDA CYNON TAF

South Wales Fire and Rescue Service

BAVO

Gwasanaeth Prawf
Probation Service

InterLink
Rhondda Cynon Taf

VOLUNTARY ACTION
MERTHYR TYDFIL
GWEITHREDU GWIRFODDOL
MERTHYR TUDFUL

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0. Executive Summary

Purpose and scope. This Annual Report sets out how the Cwm Taf Morgannwg Safeguarding Board discharged its statutory responsibilities during 2025–26 to protect children and adults at risk, prevent abuse, neglect and other harm, and strengthen multi-agency safeguarding across Bridgend, Merthyr Tydfil and Rhondda Cynon Taf. It reports progress against the final year of the Board's 2023–26 Strategic Plan, provides assurance on governance and performance, and identifies priorities for continued improvement.

Key achievements in 2025–26

- **Regional exploitation response:** The Board launched its regional Exploitation Strategy and professional toolkit in September 2025, progressed Phase 1 for children and established strategic oversight, local implementation arrangements and communication activity. Phase 2 will extend the approach for adults at risk in 2026–27.
- **Stronger governance and accountability:** A revised Board and sub-group structure improved oversight of strategic priorities, risk, performance and the implementation of learning from Single Unified Safeguarding Reviews.
- **Learning from reviews:** Five safeguarding reviews were published, with continued partnership working to embed regional and national learning into policy, training, quality assurance and frontline practice.
- **Prevention and public awareness:** Activity included the conclusion of the NSPCC partnership campaign, Safeguarding Week activity focused on online harm, new adult safeguarding information resources, and strengthened emphasis on early help and prevention.
- **Multi-agency practice:** The two Multi-Agency Safeguarding Hubs continued to provide coordinated responses to safeguarding concerns. A revised Children's Services Threshold Guidance document was introduced in January 2026, alongside work to modernise operating, information-sharing and performance arrangements.
- **Workforce and participation:** Partners expanded safeguarding training, reflective learning and specialist practice, while developing ways for children, adults and families to influence services and improvement activity.

Performance and Assurance

Performance evidence presents a mixed but actively scrutinised picture. Children's contacts reduced in Rhondda Cynon Taf and Merthyr Tydfil but increased by 18% in Bridgend; across all three areas, fewer contacts progressed to assessment and child protection enquiries reduced compared with 2024–25. The number of children on the Child Protection Register fell by 3.96% in Rhondda Cynon Taf but rose by 20.6% in Bridgend and 9.9% in Merthyr Tydfil, with local assurance activity confirming that decisions remained proportionate and child focused.
Adult safeguarding reports increased in Rhondda Cynon Taf by 30% and Merthyr Tydfil by 44%, while Bridgend recorded a 10.8% decrease. The proportion progressing to Section 126 enquiries varied across the region, and completion within seven working days was 82% in Rhondda Cynon Taf, 75% in Merthyr Tydfil and 88% in Bridgend. Quality assurance, audit and reflective practice continue to test decision-making and identify opportunities for improvement.

Key challenges and priorities for 2026–27

- Implement Phase 2 of the Exploitation Strategy for adults at risk and develop meaningful performance indicators to evidence impact.
- Complete the review of MASH operating protocols, information-sharing arrangements and the regional performance framework, including preparations for the relocation of the Cwm Taf MASH.

- Strengthen regional data quality, intelligence and outcome measurement, including wider use of digital reporting and Power BI.
- Continue quality assurance of child protection conferences and Section 126 enquiries and review relevant protocols in light of practice learning and national guidance.
- Review regional self-neglect guidance when anticipated Welsh Government guidance is available, supporting greater consistency across the region.
- Maintain focus on workforce capacity and wellbeing in the context of sustained demand and increasing complexity, while deepening participation by children, adults, families and communities.

Overall Assurance. The Board can demonstrate sustained multi-agency commitment, improved governance and tangible progress in exploitation, prevention, learning and professional practice. The report also recognises uneven demand and performance across the three local authority areas. Continued scrutiny, evidence-led improvement and consistent regional practice will therefore remain central to achieving better safeguarding outcomes in 2026–27.

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

Welcome to the 2025-2026 Cwm Taf Morgannwg Safeguarding Board Annual Report.

In March 2023, the Board published a three-year Strategic Plan and each subsequent year during March it publishes its Annual Plan setting out its key priorities for the coming year. These priorities stem from the lessons that we have learnt over previous years and an analysis of the prevalent and emerging safeguarding issues affecting the CTM region. During 2025/26, we continued our strong focus on developing our strategical approach to exploitation both in relation to children and adults at risk, with the Board launching its regional Exploitation Strategy in September 2025. The regional Exploitation Strategy has supported agencies and those in our communities to better identify all forms of exploitation and support an increased understanding of how to report any concerns.

The Exploitation Toolkit for professionals supports effective risk assessment and helps identify effective interventions to reduce exploitation for those affected. The implementation of the Strategy is overseen by the Board's Exploitation Strategic Group which includes a comprehensive Communication Strategy to ensure that the profile of exploitation risk remains highly visible and well understood throughout the region. During 2025/26, Phase 1 of the Strategy for children has been progressed and moving into 2026/27, Phase 2 in respect of supporting adults at risk of exploitation will be implemented. The Board is also seeking to develop a range of exploitation key performance indicators which will help us measure the effectiveness of the Strategy as this embeds further within the region.

During this year, and in continued recognition of the need for early intervention and prevention to reduce and eradicate abuse and neglect, we have continued to work in partnership with a range of agencies in raising the profile of this. In particular, we finalised our partnership campaign with the NSPCC to better raise awareness of the need to report child safeguarding concerns within our communities and during Safeguarding Week, our chosen theme of "*Online Harm – Keeping Yourself and Others Safe"* was strongly supported by a range of partners including the provision of a face-to-face awareness raising event at the Merthyr Town Centre Hub.

The Board has continued this year to support further implementation of the Single Unified Safeguarding Review (SUSR) framework including close partnership working with the Welsh Government SUSR Group and other regional Safeguarding Boards to refine work process, information and learning methodology to further support practice improvements where harm to adults or children has occurred. The Board published five Safeguarding Reviews during 2025/26, and we continue to work with a range of key stakeholders including the WG Co-Ordination Hub. Wales Safeguarding Repository and the Home Office to support future learning at a regional and national level.

Finally, 2025/26 has been another year in which our key safeguarding partners have once again experienced significant levels of demand. As always, it is our staff who remain at the forefront of protecting our most vulnerable people and who work tirelessly to achieve this as effectively as possible despite the many challenges we currently face. Their wellbeing remains a priority for the Board, and we continue to seek assurances from our partners that staff are adequately supported.

If anyone is interested in finding out more about the Cwm Taf Morgannwg Safeguarding Board, or if you would like to get involved in informing our priorities, please contact our Business Unit by e-mailing: ctmsafeguarding@rctcbc.gov.uk

Lisa Curtis-Jones
Chair of the Cwm Taf Morgannwg Safeguarding Board

2. Safeguarding in Cwm Taf Morgannwg

The region of Cwm Taf Morgannwg covers the local authority areas of Bridgend, Merthyr Tydfil and Rhondda Cynon Taf with a combined population of approximately 427,000[1]

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

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

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

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

Safeguarding Children

Section130 (4) of the Social Services and Well-being (Wales) Act 2014 defines a child at risk as a child who:

a) Is experiencing or is at risk of abuse, neglect or other kinds of harm;

b) Has needs for care and support (whether or not the authority is meeting any of those needs).

What do we mean by Harm?

Harm is defined as:

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

Types of Harm

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

[1] Source: Office for National Statistics (Census 2021)

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

Safeguarding Adults

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

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

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

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

During this year, regional Adult Services and the Safeguarding Board collaborated to create enhanced information resources for use by Adults at Risk and their families and friends

Adult Safeguarding Booklets

Multi Agency Safeguarding Hubs

In the Cwm Taf Morgannwg region there are two Multi Agency Safeguarding Hubs (MASH) that report to the Board: **The Cwm Taf (Merthyr Tydfil and Rhondda Cynon Taf) Multi Agency Safeguarding Hub (MASH) and the Bridgend Multi Agency Safeguarding Hub (MASH).**

The purpose of the MASH is to act as the single point of contact for all professionals to report safeguarding concerns. MASH provides the opportunity for a higher standard of safeguarding by providing all professionals with more information on which to make better, more informed, and more timely decisions. This enables the

effective sharing of information between agencies, helping to protect children and adults from abuse and neglect.

Whilst the Bridgend MASH operates a fully co-located model with staff located at Bridgend County Borough's Civic Centre, in Cwm-Taf agencies operate a hybrid model based out of Pontypridd Police Station. During 2026/27, the Cwm Taf MASH will be re-sited at the new South Wales Police Divisional Headquarters at Ty Trevithick, Abercynon.

A full review of the MASH Operating Protocol, Information Sharing Protocol and a revised framework for MASH key

performance indicators has begun this year and will be completed during 2026/27. This will ensure that the CTM MASH arrangements accurately reflect evolved working practices which continue to support prompt information sharing and effective actions to safeguard people.

The collaboration of both Multi-Agency Safeguarding Hubs continues to be a key focus of the Board to streamline multi-agency safeguarding across the Cwm Taf Morgannwg region. Ongoing work this year has included:

- An ongoing multi-agency working group to support a consistent approach to modernised, operational MASH models utilising best practice and aiming to build on further, effective collaboration. The Terms of Reference and MASH Operating Protocols are subject to ongoing review this year to ensure the key aims of protecting children and adults effectively are being maximised.
- A revised Multi-Agency Children's Services Threshold Guidance document was introduced in January 2026 to support shared understanding of threshold decision making and eligibility support across the three local authority areas in Cwm Taf Morgannwg.
- Ongoing work to establish clear pathways for signposting and referrals for professionals (for both Children and Adults).
- Contributing to the National Independent Safeguarding Board's development of the National Multi-Agency Performance Framework. This will provide assurances to the Board on the efficacy of multi-agency safeguarding practice across the region.
- A Review of the existing "GOSS" information sharing system within MASH including a comprehensive service user consultation which is being further progressed into an enhanced information sharing platform due for implementation in 2026/27.

3. Members of the Safeguarding Board

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

The lead partner hosts the Board's Business Unit and holds the Board budget on behalf of the statutory partner agencies. **A list of Board members is attached as Appendix 1.**

4. What did the Board do in 2025-2026 to meet its Outcomes?

Governance

The Safeguarding Board implemented a revised governance structure during 2025/26 (*detailed at Appendix 2)* which created a new sub-structure to support the priorities of the Safeguarding Board. The new structure has increased the Board's ability to carry out its core functions to achieve positive outcomes for children and adults at risk in Cwm Taf Morgannwg and brought about enhanced scrutiny arrangements for how the Board is implementing learning and good practice generated by recommendations from Single Unified Safeguarding Reviews both regionally and nationally.

Challenge and Scrutiny

The Board holds partner agencies to account in relation to their safeguarding activities through effective monitoring and challenge via its Safeguarding Board and Sub-Group meetings, reviews, inspection reports and audit activity. The Board utilises its Risk Register to support the timely identification of any safeguarding risks and to ensure the efficacy of appropriate mitigating actions to address identified risk.

The Board encourages partner agencies to share individual inspections and reviews that relate to safeguarding and fosters a strong culture of learning and collaboration in respect of driving improvements in safeguarding activity both regionally and nationally. In 2025-2026, the Board received and reviewed the following reports, improvement plans and resource updates from agencies and key safeguarding partners:

- The Centre of Expertise on Child Sexual Abuse Self-Help Resource for adult survivors of sexual abuse and the disruption of exploitation
- Regional Response to the North Wales extended Child Practice Review "Our Bravery Brought Justice"
- National Child Protection Inspection Report – South Wales Police
- Cwm Taf Morgannwg Probation Delivery Unit Inspection Report – HM Prison & Probation Service in Wales
- Joint Rapid Review of Child Protection Arrangements – CIW, HIW & Estyn
- Multi- Agency Safeguarding Tracker Project (MAST) – West Glamorgan RSB

Performance

The Board has a performance framework in place to capture safeguarding data which is consistently scrutinised via its sub-groups. Work has been ongoing during 2025/26 with partners to ensure that we have a consistent, regional, multi-agency framework. The Board has also ensured representation at a range of national forums this year in respect of keeping abreast of developing workstreams, national guidance and good practice to support the delivery of effective safeguarding. This has included:

- Welsh Government - National Safeguarding Governance Review
- Welsh Government Steering Group for Missing Children
- Wales Procedures Project Board
- Single Unified Safeguarding Review Implementation Group
- SUSR Family Engagement & Training Groups
- Pan Wales Exploitation Group

- Centre of Expertise on Child Sexual Abuse

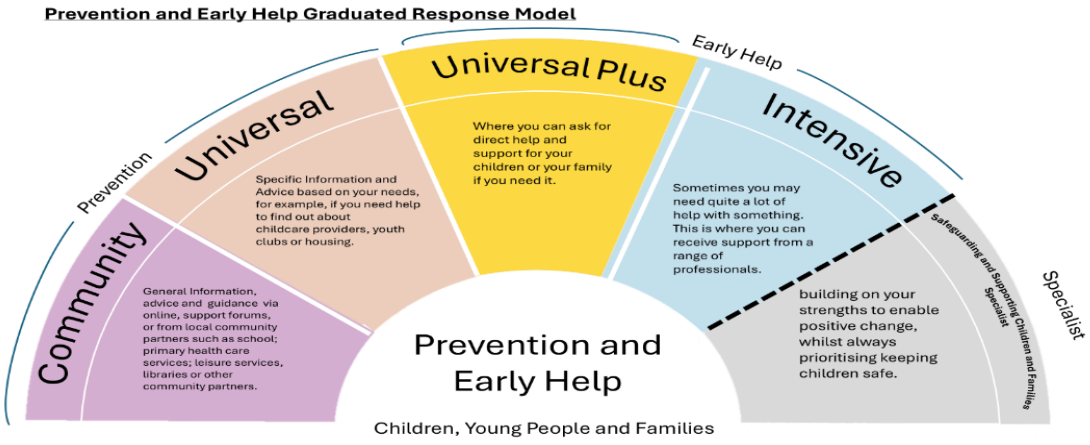
The Board has a Children's Quality Assurance and Performance Group (CQAP) and an Adult's Quality Assurance Group (AQAP) that receives and analyses multi-agency performance metrics, scrutinising, respectfully challenging data and reporting on key thematic sources of harm. This ensures that the triangulation of qualitative and quantitative data is analysed, focused on outcomes and the lived experience of the child and/or adult through the journey of their intervention. This year the Board has supported the development of the further use of Power BI to support an improvement in data recording for the Board's Children's Quality Assurance Panel to align with that already in place for its Adult Quality Assurance dataset.

Children's Safeguarding

In 2025-2026, whilst there has been an overall reduction in the number of contacts for RCT and Merthyr Tydfil, Bridgend experienced an 18% increase. However, all three areas experienced an overall reduction in cases progressing to assessment (*see Table at Page 10*).

In **Bridgend**, Children's Services launched the first phase of the regional exploitation strategy in September 2025. The Bridgend County Borough Council (BCBC) workstream has been established to bring together key partner agencies and drive the effective implementation of the strategy at a local level. The local board reports into the regional board on progress, with a clear priority over the coming year to strengthen data and intelligence capabilities. This will ensure a more comprehensive understanding of the needs, risks, and vulnerabilities of children and families across Bridgend and surrounding areas, enabling a more targeted and informed response.

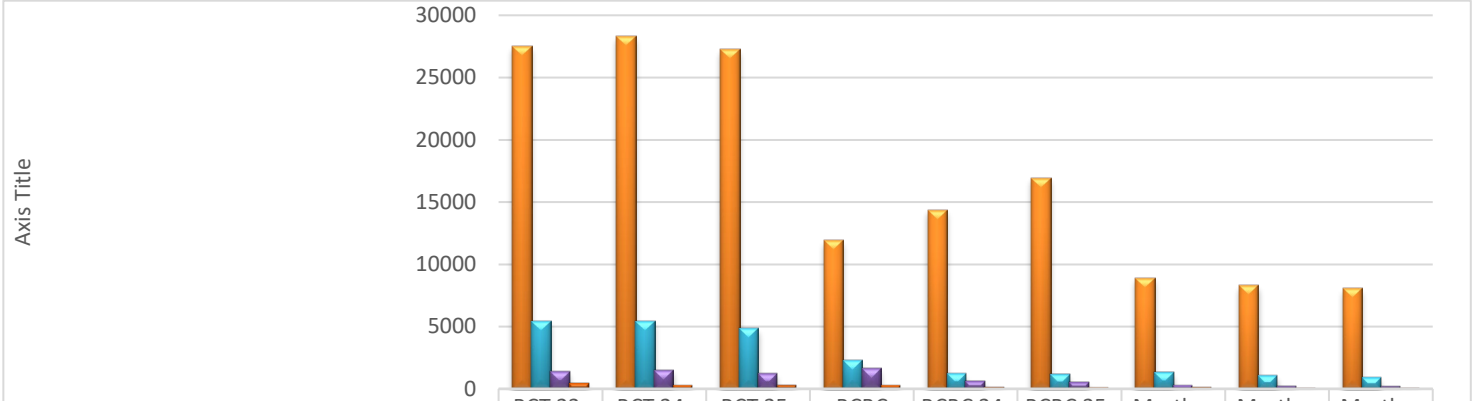
Rhondda Cynon Taf has undertaken a wider Early Intervention & Prevention Review to ensure a graduated response to need and a whole (multi-disciplinary) system response to ensure sustainable service delivery. The new model supports processes and systems that are accessible and easy for people to understand and navigate through. The ethos of the model crucially encourages self-reliance, promotes a fairer start by helping to tackle disadvantages, laying strong foundations for children's physical health, learning and emotional wellbeing, aiming to break cycles linked to deprivation and neglect. Taking action early and providing the right help at the right time can reduce the long-term impact of disadvantage, whilst improving health, educational attainment and social inclusion. Equipping parents and care givers with the right tools and support helps create stable, nurturing environments where all children can thrive.



In **Merthyr Tydfil** during 2025/26, a strategic approach to exploitation has been further developed for both children and adults at risk. Partner agencies have worked collectively to strengthen governance arrangements and implement agreed tools to support the identification and assessment of all forms of exploitation. This has improved the consistency and effectiveness of multi-agency responses.

Safeguarding has remained a key priority throughout the year, with managers and staff working collaboratively to ensure statutory duties are met while promoting the safety of both the public and the workforce. This aligns with the Council's Corporate Plan under the *Healthier Merthyr Tydfil* objective, which prioritises the provision of safeguarding advice and support to vulnerable groups through sustained multi-agency working and engagement with the Regional Safeguarding Board.

Children's Safeguarding Data

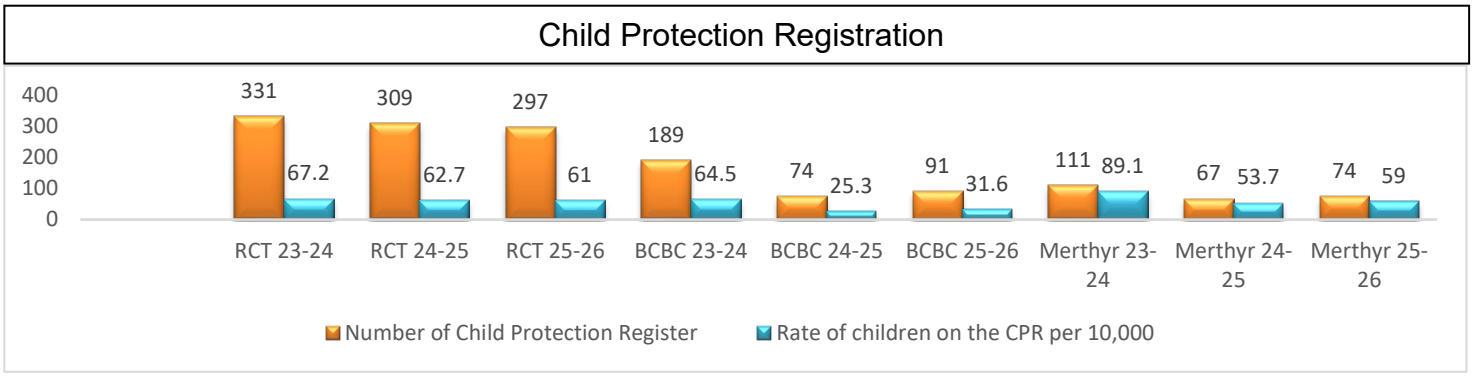


	RCT 23-24	RCT 24-25	RCT 25-26	BCBC 23-24	BCBC 24-25	BCBC 25-26	Merthyr 23-24	Merthyr 24-25	Merthyr 25-26
No of contacts	27534	28326	27266	11918	14356	16948	8905	8289	8065
Number of cases allocated for assessment	5446	5447	4851	2259	1237	1156	1313	1092	928
Number of child protection enquiries	1380	1501	1238	1622	640	539	312	227	187
Number of child protection enquiries that result in Initial Child Protection Conference	442	302	295	306	145	97	130	85	93

The number of contacts that proceed to assessment remains relatively low across the region with RCT progressing 18%, Bridgend 6.5% and Merthyr Tydfil 11%. RCT has remained stable when compared with 24-25 data with Merthyr experiencing a 4% reduction this year and Bridgend a 1.5% increase. During this year, a focus has continued across the region on the offer of prevention, early intervention and signposting with an enhanced focus being provided on a shared understanding of threshold decision making across the region supported by the publication of a Multi-Agency Children's Services Threshold Guidance document which was published by the Board in January 2026.

There has been continued development and implementation of social work models of practice across each local authority and whilst these models are localised, there are similarities, with a key focus on strengths, relationships, collaboration, trauma informed, whole family approaches. These developments are in line with the recommendations of the CIW/Estyn Rapid Review of Child Protection Arrangements.

Cases proceeding to child protection enquiries have continued to decrease across the whole of the region compared to 2024/25 as a continuation of local authority models of practice which support interventions with families based on what matters to them, proportionate decision making and earlier prevention and intervention have bedded in further to prevent escalation into child protection processes.



Whilst **RCT** experienced a 3.96% reduction in children on the Register this year, both **Bridgend** and **Merthyr** have seen an increase of 20.6% and 9.9% respectively. Merthyr's overall numbers of children on the Register are relatively small, however where there may be children from the same family being placed on the Register, this will contribute to a % increase which is attributed to our small increase this year.
For **Bridgend,** we have seen a targeted and sustained reduction in the number of children subject to Child Protection Registration (CPR) over recent years. Historically, the authority has had disproportionately high numbers of children on the CPR when compared with other local authorities. Through the implementation of a range of practice improvements, including the Signs of Safety practice model, we achieved a safe and steady reduction in CPR numbers during the previous reporting year. Whilst Bridgend experienced a continued reduction in the number of children subject to CPR throughout 2024/25, there has been a modest increase during the current reporting period, with registrations increasing from 74 to 91 children. This increase reflects a number of highly complex cases that have required statutory intervention and registration to ensure children are safeguarded appropriately.
In response to the increase in registrations, targeted audit activity has been undertaken whenever the number of children subject to CPR has exceeded 90. Findings from this audit work provide assurance that decision-making remains robust, proportionate, and child focused. Decisions made at Child Protection Conferences are consistently well-evidenced and are almost always reached unanimously by the multi-agency network.

In 2026-2027, we will continue to focus quality assurance work on child protection conferences embedding learning from practice reviews and national reviews and audits alongside relevant learning from internal comments and complaints which identify areas where, in line with the Wales Safeguarding Procedures we could improve. A thematic review of Conference complaints will be completed by the Board's Children's Quality Assurance Group in 2026/27 to support this and a review of the Board's CPR Enquiry Protocol and Child Protection Conference Protocol will also take place.

Model of Practice

Bridgend Children's Services

We have fully embedded Sign of Safety Child Protection Case Conferences and will be taking forward Care Experienced Reviews being conducted under the practice model.

Bridgend has continued to strengthen its response to child exploitation and adolescent safeguarding through the development of specialist services within Children and Family Support Services. The Safer Connections Team provides a targeted response to children and young people who are vulnerable to exploitation, missing episodes, harmful peer associations, offending behaviour, substance misuse and wider contextual safeguarding concerns. The team works closely with social care, education, police, health, youth justice and other partner agencies to identify risk, coordinate multi-agency planning, share intelligence and implement disruption activity. Through specialist consultation, direct work and risk mapping, the team helps strengthen protective networks around young people and ensures a coordinated response to emerging safeguarding concerns. Alongside this, the Adolescent

Crisis Team (ACT) has been established within the Edge of Care Service to provide intensive support for young people aged 10–18 who are experiencing significant crisis, placement instability, family breakdown or are at risk of entering care. ACT delivers a six-month intervention model combining intensive family support with therapeutic input to help stabilise situations, reduce risk and improve outcomes for young people. The service works closely with the Safer Connections Team where exploitation concerns are identified, ensuring that young people receive both specialist exploitation support and intensive crisis intervention where required. Together, these services provide an enhanced safeguarding response for adolescents across Bridgend, supporting earlier identification of risk, improved multi-agency coordination and more effective interventions for young people vulnerable to exploitation. Future developments include strengthening multi-agency exploitation panels, further embedding contextual safeguarding approaches, enhancing intelligence sharing and developing outcome measures to evidence the impact of interventions on reducing exploitation-related harm.

Reflective practice continues to be a key strength within Bridgend. Fortnightly multi-agency reflective learning sessions are held to review individual cases, identify learning, and consider opportunities to further strengthen practice and outcomes for children and families. In addition, Bridgend has recently implemented the Most Significant Change methodology to better understand families' experiences of child protection services and to inform service development. Although this work is at an early stage, the first story panel has now been successfully convened.

Further strengthening our commitment to participation and continuous improvement, the Independent Reviewing Service has introduced a feedback portal for children and families who attend Child Protection Conferences. This will support the service to gather meaningful feedback, understand lived experiences, and identify opportunities to enhance practice.

Overall, the implementation of the Signs of Safety practice model has supported a safe reduction in CPR numbers over recent years. Whilst there has been a small increase during this reporting period, assurance activity confirms that registration decisions remain appropriate and are driven by the needs and risks presented to children. Our reflective and learning culture remains strong, and we continue to place the voices of children and their families at the centre of our safeguarding practice.

Rhondda Cynon Taf Children's Services

RCT Children's Services continues to develop our model of practice in line with our vision. The new model will strengthen practice, leading to safe reduction of entries to care; provide timely and responsive intervention to families to keep them together, de-escalating need and risk, safeguarding children and safely reducing the number of children who become looked after. The three key pillars of our practice are Relationships, Collaboration and being Trauma Informed. We have rolled out collaborative communication training across the workforce as part of the continued development of the model of practice and remain committed to providing a strength-based model, working alongside children and families, building strengths to help them make the changes they need, whilst always prioritising our role in keeping children safe.

RCT Children's Service remains committed to hearing the voices of those with lived experience and although the loss of our Participation Officer has caused some challenges, we have continued to engage with children and young people, parents and families. Our Model of Practice (MOP) lead has engaged with Breaking Barriers Group (staffed by TGP Cymru), a group that enables parents with lived experience of the child protection system to come to gather and share their experiences of the system including what works well and what could be improved and the MOP lived experience sub group is dedicated to meaningfully taking the perspective of those with lived experience of our service to inform learning and shared understanding of service delivery and improvements (where required) .

RCT Children's Services have incorporated a strong emphasis on voice of child and lived experience into our reviewing processes.

RCT Children's Service Case Studies

- **RCT Children – Voice of the Child**
- **Case Study – RCT IFSS**
- **RCT Magu Case Study**
- **RCT Case Study – Lucy CSE**

Merthyr Tydfil Children's Services

MTCBC children's services utilise systemic model to support our practice. Performance data indicates sustained improvement across several key safeguarding measures. The timeliness of children's assessments has remained consistently high, exceeding targets throughout the year, with over 99% of assessments completed within statutory timescales.

There has been continued, effective management of safeguarding demand with the number of children looked after monitored throughout the year and reducing from 167 in April 2025 to 146 by the end of Quarter 4 this year. Similarly, the number of children on the Child Protection Register has remained stable, reflecting effective multi-agency intervention and review processes.

A key area of good practice was evidenced through the Care Inspectorate Wales (CIW) inspection of Plantation House (29 October 2025), a registered Children's Home within Merthyr Tydfil, which identified that safeguarding arrangements are robust, with staff trained to identify and respond to concerns and effective oversight in place. This provides assurance of a strong safeguarding culture within regulated services.

The case study below illustrates a positive transition journey for a young person with additional needs, where early planning from age 14, strong multi-agency working, and a focus on independence resulted in successful progression into Adult Services and further education.

- Case Study: Transitioning into Adulthood - The Journey of DW

Bridgend Youth Justice Service

BYJS has maintained a strong learning culture throughout 2025/26 with continuous review of practice, audit activity and learning from children, victims and partner agencies.

Examples include:

- Routine case audits and management oversight identifying learning themes and informing workforce development.
- Continued use of child-friendly reports and the "Getting to Know Me" approach ensuring children's voices directly influence assessment, planning and intervention.
- Learning from complex safeguarding cases has strengthened multi-agency pathways, particularly around exploitation, trauma, neurodiversity and speech and language needs. Continued development of restorative practice ensuring both children and victims receive appropriate information, support and opportunities for restorative engagement where suitable.
- Participation in regional learning events and safeguarding forums, sharing good practice and embedding learning from reviews.
- Strong communication between partner agencies through safeguarding meetings, EEYYP Panels and operational management arrangements ensuring safeguarding concerns are escalated appropriately.
- Despite increasing complexity of cases, the service has maintained high-quality practice through effective prioritisation, strong management oversight and collaborative working

Cwm Taf Youth Justice Service

Enhanced Case Management. (ECM).

ECM is a whole-system, psychologically informed framework that fundamentally reshapes how professionals across agencies understand, collaborate on and organise their support for children. At its heart, ECM centres each child's care around a shared, multi-agency formulation process. This brings together trauma history, attachment patterns, neurodevelopmental profile, emotional regulation capacity, family and systemic context and carefully balanced risk, resilience and protective factors.

A YJS Team and Practice Manager has delivered ECM awareness sessions to a number of partner agencies during 2026, including a presentation at a recent All Wales Youth Justice ECM Conference. Furthermore, the input of YJS in partnership with the Forensic Adolescent Consultant Service (FACS) received significant attention within the *'Psychology Matters'* publication, the details of which are embedded in the link below.

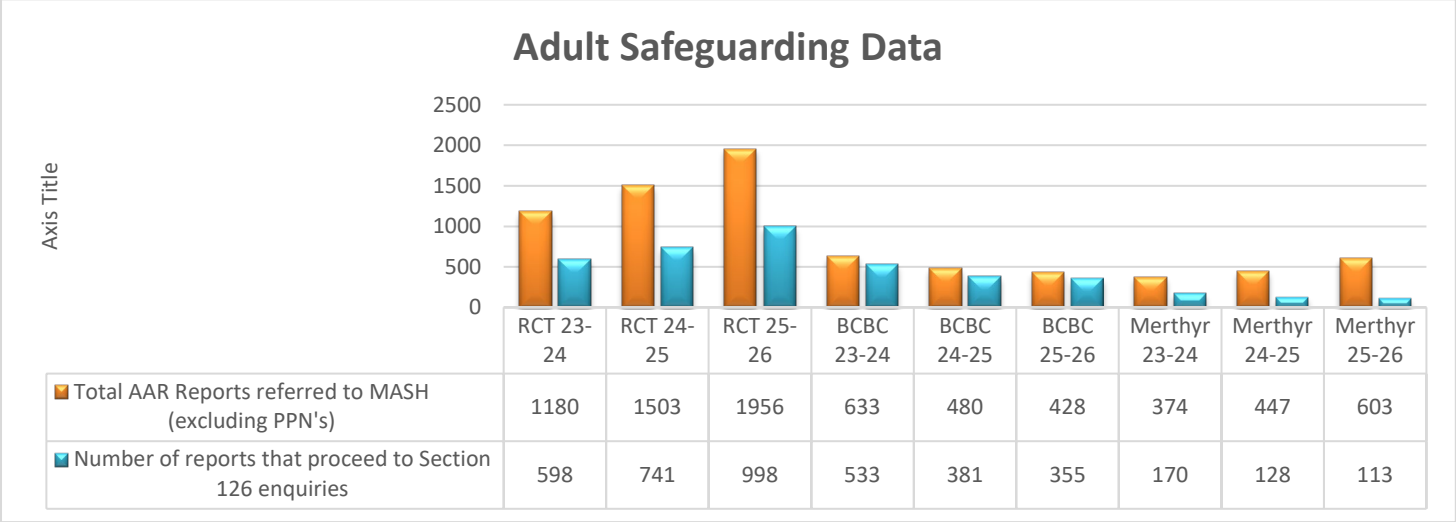
"A psychology-led model used to support some of the most vulnerable children in society – those in the youth justice system – reminds us that behind every offence lies a child's story." | BPS

Adult Safeguarding

Similarly to 2024/25, during 2025/26 there has been a further increase in reports for RCT (+30%) and Merthyr Tydfil (+44%) whilst Bridgend has experienced a decrease of 10.8%. The percentage of reports proceeding to S126 continues to differ between the three local authorities. The overall percentage for Bridgend was 82%, 3% higher than 24/25 (79%), whilst it was 19% for Merthyr Tydfil, 10% lower than 24/25, and RCT remained consistent with the past two years with approximately 51% of reports proceeding to S126. In Merthyr Tydfil, further analysis has been completed to explore the reduction in the number of AAR referrals not proceeding to S126 enquiries which established the following:

- Low level medication errors where a Care Provider has already taken appropriate action

- Client on client incidents whereby Police are already informed, and Care Home has already initiated an MDT approach to manage any risk
- A1 referrals from Health that have already been subject to the Health Board's Scrutiny Panel process where learning and required outcomes are already implemented
- Domestic Abuse cases already referred to the Cwm Taf MARAC for appropriate safeguarding measures



	RCT 23-24	RCT 24-25	RCT 25-26	BCBC 23-24	BCBC 24-25	BCBC 25-26	Merthyr 23-24	Merthyr 24-25	Merthyr 25-26
Total AAR Reports referred to MASH (excluding PPN's)	1180	1503	1956	633	480	428	374	447	603
Number of reports that proceed to Section 126 enquiries	598	741	998	533	381	355	170	128	113

S126 enquiries completed within 7 working days 25/26					
RCT	82%	**MTCBC**	75%	**BCBC**	88%

All 3 local authorities continue to be committed to improving on the national KPI regarding S126 enquiries being completed within 7 working days.

RCT Adult Services during 2025–26 have embedded a stronger learning culture through structured reflection on practice, including the dissemination of Safeguarding Practice Reviews (SUSRs, APRs and DHRs) and the use of forums such as the Champions groups for Self- neglect and Domestic Abuse to facilitate discussion and application to local practice. Seven-minute briefings and reports have been shared systematically with Team Managers and cascaded to staff, with evidence of active discussion in team meetings and practitioner forums, which has been identified by Service Managers in quarterly compliance checks.

Communication and engagement have been strengthened through these mechanisms, enabling practitioners to better understand themes such as barriers to engagement, the impact of coercion and control, and the importance of professional curiosity. This has informed our training needs analysis for the year. Reflective discussions have supported improvements in risk assessment and decision-making, particularly where individuals may be reluctant to engage with services.

- RCT Adults Case Study

In **Bridgend Adult Services** the Adult Safeguarding team have taken on different projects this year to meet our priorities which have seen increased awareness of safeguarding processes for those with a learning disability, the promotion of strength's-based working in the Team and the implementation of the Exploitation Strategy. The multi-agency Adult Exploitation Group has been developed following the implementation of and in line with the Exploitation Strategic Group. Its aim has been to develop partnership working and collaboration to foster a greater understanding of exploitation and violence, the impact it has on adults at risk, and the wider community, in order to improve the lives of those who are at risk.

A Safeguarding Focus Group was set up to explore the experiences of adults with learning disabilities and the adult safeguarding process. Workshops were set up to evaluate individuals understanding of 'What is Adult Safeguarding?' and capture individuals with LD lived experiences of adult safeguarding and how effectively the principles of voice, choice and control are considered throughout the process.

Partnership working: Most significantly we have seen improvements in the partnership working and relationships within HMP PARC. By spending time and through engagement they have developed an in depth understating of their statutory safeguarding responsibilities and they are taking great pride in ensuring that they meet these requirements. The social work team are fully integrated and have access to all areas of the prison. Prison staff have ease of access to ongoing advice and guidance provided by the social workers and prisoners are supported in achieving their outcomes.

Within the Safeguarding team, our fully embedded consultation process is now the norm and is allowing for timely advice and guidance without the need for unnecessary referrals. The is ensuring that advice and guidance is timely with safeguarding vulnerable adults remaining at the heart of what we do.

Merthyr Tydfil Adult Services have continued to see a rise in Adult at Risk referrals (A1's) by 61% over the past two years. Further quality assurance and audit work has taken place in respect of S126 which has provided reassurance that the number of AAR referrals that do not progress to S126 enquiries is correct. In Adult Services, performance in safeguarding enquiries has shown improvement over the year, supported by increased oversight and quality assurance processes, although timeliness remains an area for continued focus. Quality assurance framework is being implemented within Adult Social Care this will ensure that a centralised process reporting upon existing QA processes but also implementing learning across the service area. Audits are regularly undertaken in relation to safeguarding practice and reported to the QA subgroup of the board. Work has also been undertaken during the year to review and restructure safeguarding workstreams in preparation for 2026/27. This has streamlined governance arrangements, reduced duplication, and improved the efficiency and focus of partnership activity. MTCBC has continued to strengthen safeguarding practice through inspection outcomes, workforce development, quality assurance activity, and the use of case studies to inform learning and service improvement.

The case study below highlights the complexities of transition planning where risks escalate. It demonstrates the importance of flexibility, multi-agency coordination and maintaining engagement when circumstances change, particularly where placement stability and risk factors are evolving.

- Case Study – TS Adult Services

This case study provides a further example of transition planning for a young person with complex needs. It demonstrates the value of early planning, joint working between Children's and Adult Services, and a phased approach to transition to ensure continuity of care and reduce anxiety.

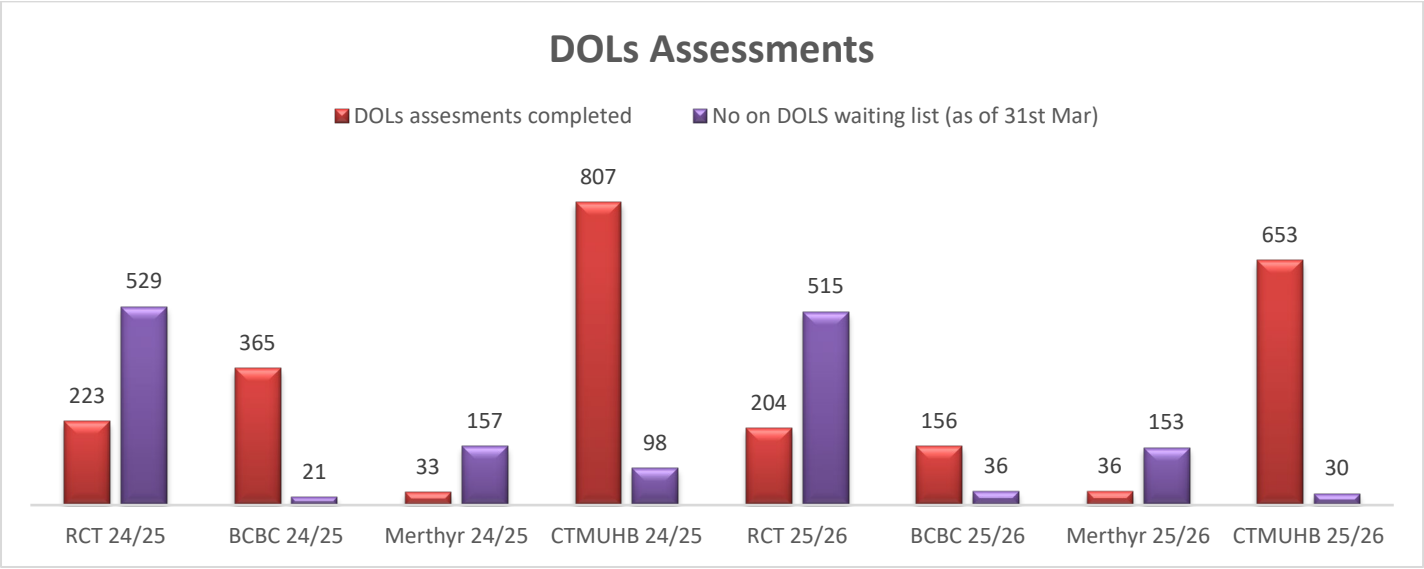
- Case Study - AM

Escalating Concerns

Reports from Local Authority Commissioning Departments were received each quarter in relation to service providers in escalating concerns. There were 5 in total during 2025/2026, a slight increase from 4 during 2024/25.

RCT	2	**MTCBC**	0	**BCBC**	3

Deprivation of Liberty Safeguards (DoLS)



The **Health Board** has experienced a 19% reduction in the number of DOLs assessments completed during 25/26 but also experienced a reduction of 69% to its Waiting List. which is attributable to the Health Board utilising Welsh Government funding to commission an outside DOLS service between January – March 2026. In respect of the overall decrease in the number of DOLS completed this year in comparison to 2024/25, this was impacted by unavoidable staff absences and recruitment changes in the Team.

For **Bridgend**, the reduction in DoLS referrals and assessments completed between 2024/25 and 2025/26 is likely to reflect a number of factors. BCBC has continued to adopt a proactive, preventative and strengths-based approach to supporting individuals, enabling more people to remain safely within their own homes and communities for longer and reducing reliance on residential care placements. Where individuals do enter residential care, they are often doing so at a later stage in life and with more complex health needs, resulting in shorter lengths of stay and consequently fewer renewal applications. In addition, the increased availability and use of community-based support, extra care housing and least restrictive approaches to care planning may have reduced the number of circumstances in which a DoLS authorisation is required. The data may also reflect wider changes in admission patterns, provider market factors and normal year-on-year fluctuations in demand for residential care and DoLS assessments. Overall, the reduction appears consistent with BCBC's strategic focus on prevention, independence and supporting people to remain in their own homes wherever possible.

Rhondda Cynon Taf and **Merthyr Tydfil** have remained relatively stable between 2024/25 and this year's 25/26 data.

Self-Neglect

In **RCT**, the RCT CBC Self-Neglect Panel was re-established in 2025. Referrals recommenced in August 2025, with the first Panel meeting taking place on 23 September 2025. The Panel has continued to operate throughout 2025/26, supporting multi-agency management of high-risk self-neglect cases. Since re-establishment, a significant number of referrals have been received; however, a high proportion have not met the agreed threshold for Panel consideration. Common themes include referrals being submitted before appropriate multi-agency discussions have taken place, cases where statutory services are already actively coordinating intervention, and referrals where alternative risk management options have not yet been exhausted. This has highlighted the need for ongoing practitioner guidance, awareness raising and training. Referrals are currently received through a

generic Self-Neglect inbox which is overseen by the Service Manager. A review of the current arrangements has identified a number of operational risks and limited resilience and oversight within the current process. Consequently, discussions are underway within RCT CBC to review these arrangements.

In **Merthyr Tydfil**, self-neglect cases have been managed under the Wales Safeguarding procedures and initiated S126 enquiries where appropriate and proceeded to strategy discussion if risk of harm is deemed serious. We have not held any SN cases via the previous panel process and find using the Safeguarding Procedures and 126 enquiry ensures a person-centred approach which is adopted in line with the SSWA 2014. Also, it allows us to address neglect issues with early intervention and sign posting where appropriate.

Bridgend maintained Self Neglect Partnership Panels during 25/26 but intend to adopt the same process as outlined above for Merthyr Tydfil from April 2026 onwards. A generic email address for referrals was put in place in 2024/25, and we will be reviewing current guidance to support our revised process from April 2026 onwards.

Adult Services throughout the region will continue to progress improvement work with the Safeguarding Board's Adult Quality Assurance Panel into 2026/27. All agencies recognise that the existing Cwm Taf Morgannwg Self-Neglect Guidance and Protocol requires review and update. However, it is considered important that this work aligns with the Welsh Government Non-Statutory Guidance relating to Adult Safeguarding and Self-Neglect expected during 2026/27. Once published, all areas of the region will support a review of the Guidance and Protocol to ensure consistency with national expectations and promote a more consistent approach within the region.

Professional Disagreements

The Board's Concerns Regarding Inter-Agency Safeguarding Practice (CRISP) Protocol supports practitioners in finding a resolution when they have a professional disagreement or concern in relation to another agency's safeguarding practice. Whilst a review of the current Protocol was scheduled for this year, it has been postponed to align with a full review of the Board's overall Complaints Policy and the anticipated updated guidance in respect of Section 5 WSP's (Safeguarding allegations / concerns about practitioners and those in positions of trust) expected early in 2026/27. This will enable a comprehensive overview of inter-related Board policies to be completed together ensuring cohesive alignment where appropriate. A priority will remain for, wherever possible all inter-agency differences to be resolved directly between agencies under good practice arrangements.
During 2025/26, there were no Stage 2 CRISPs referred to the Safeguarding Board.

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

The Board works to a Three-Year Strategic Plan (2023/2026) setting out its priorities for safeguarding children and adults at risk. The Board's Year 3 Plan can be found here: 2025-26 CTMSB Strategic Plan (Year 3)

In relation to the Board's Strategic Priorities, a summary of our work during 2025/26 is detailed below:

Strategic Priority 1: We will re-set and establish where we are and where we need to be.

During 2025/26, the Safeguarding Board established a revised sub-structure to provide an enhanced model to support its priority work-streams (please see Appendix 2). During 2025/26, the Board focused on establishing its new structure working with a range of key stakeholders to progress its key priorities. This has included a new Strategic Exploitation Group to oversee the implementation of our regional Exploitation Strategy and a new Improving Practice Delivery Group to oversee the completion of actions from Single Unified Safeguarding Reviews.

Each year in February or March, the Board supports an annual Development Day with its partners to set its priorities for the coming year. This then informs its Annual Plan as detailed above.

RCTCBC Education

RCT Education Services work with a range of partners to develop their safeguarding approach.

Annually all schools must review and evaluate their own safeguarding procedures and the Board's School Safeguarding Policy is also reviewed each year. We continue to work with a range of partners to develop our safeguarding approach. This year we have employed an Education Safeguarding Lead – this followed our self-evaluation where it was determined that we needed a stronger safeguarding interface with Children Services in particular and Part 5 WSP's. This has led to the development of relationships to share data on a routine basis so that, even in cases where no fault is found, there can still be learning opportunities identified and undertaken; common themes of practice can emerge which may lead to additional training opportunities; and targeted support to schools can take place where identified. Stronger working links have also been established this year with Coleg y Cymoedd who are now in routine discussions with our MASH staff, and this has developed into events where practice is being shared between schools and Coleg y Cymoedd to effectively support post-16 transitions.

Bridgend's EEYPP Directorate

BCBC maintains a strong Designated Safeguarding Professionals network facilitating consistent safeguarding practice across schools. We engage in effective multi-agency working leading to earlier intervention and improved outcomes for children and use our data to monitor vulnerability and trigger timely support.

During 2025/26, some of our key achievements included:

- Improved processes for Children Missing Education and tracking vulnerable learners.
- Increased safeguarding training attendance across education workforce.
- Strengthened collaboration between Education and Early Help services.

We have improved by ensuring enhanced quality assurance of safeguarding practices in schools, implementing a greater focus on contextual safeguarding risks affecting young people and supporting an increased awareness and response to mental health and wellbeing concerns.

Case Example (Generic):

A young person at risk of exclusion and disengagement was identified through attendance monitoring. Multi-agency support (*School, Education Engagement Team, Early Help*) resulted in re- engagement in education and reduced risk behaviours.

MTCBC Education

Education has continued to support the CTM exploitation strategy through awareness sessions and the development of an online training module for staff.

Further development includes an education conference on exploitation bringing together a range of partners to educate and share experiences amongst wider education staff.

Education continues to contribute to the local, regional and national stage on harm reduction work streams such as CSE and has developed an action plan alongside Children Services on how it will meet the recommendations that have come out of the North Wales Child Practice review.

Education representatives have, when requested, supported Single Unified Safeguarding Reviews and put any learning into practice, whilst also disseminating the information through various communication channels – emails, meetings and forums to schools and other educational settings.

With the implementation of group B Safeguarding training, Education in Merthyr Tydfil has worked closely with Workforce Development to develop a framework to ensure that all school staff attended and engaged in required training.

This has resulted in all education settings delivering the training through a consistent approach with mechanisms in place for those who missed the initial sessions. Initial concerns were raised in relation to the time requirements needed to complete the training, and how this would be possible in a school setting with limited opportunities. However, through the development of a framework and joint up approach, over 1000 staff have been trained at group B with those requiring group C identified.

RCTCBC Adult Services

RCT Adult Services have continued to strengthen their understanding of safeguarding demand and risk through routine performance monitoring, quality assurance activity, and engagement with multi-agency partners. Regular oversight of safeguarding referrals, strategy discussions and outcomes has supported improved identification of trends, including the prevalence of domestic abuse, self-neglect and complexity associated with co-occurring issues such as substance misuse and mental ill-health.

The establishment of practitioner-led Champions groups (Domestic Abuse and Self Neglect) has contributed to raising the profile of abuse and neglect across the workforce and supporting a more confident and consistent response to risk.

Bridgend Adult Services

This year BCBC has implemented a Learning Disability Focus Group whose work forms part of a wider programme that will support in evaluating current practice, identifying key learning and how we can improve the safeguarding process for adults with LD's and will continue into the next financial year. A Lead Co-ordinator was responsible for coordinating engagement, designing and delivering accessible workshops, developing questionnaires, and gathering and analysing feedback. A key objective of the focus group was to ensure meaningful participation in a way that supported consistent understanding of safeguarding and enabled individuals to express their views and experiences and to give service users with a learning disability the confidence to engage in the safeguarding process. The workshops to date have resulted in a demonstrable improvement in participants' understanding of the adult safeguarding process. Individuals were able to identify safeguarding concerns, articulate who to report concerns to, and describe what should happen following a disclosure. Importantly, one individual has demonstrated the benefit of these sessions and has subsequently felt sufficiently informed and confident to make a safeguarding disclosure to support staff, evidencing increased awareness, reduced barriers to disclosure, and improved confidence that safeguarding action would be taken. A further piece of work identified is to consider the voice of the participants and how we can capture this as part of the feedback process and our QA systems.

Suicide prevention has remained a further focus in our community work with the continuation of the Significant attempts of suicide and self-harm rapid response meetings.

Exploitation Strategy: The multi-agency Adult Exploitation Group has been developed following the implementation of and in line with the Exploitation Strategic Group. Its aim has been to develop partnership working and collaboration to foster a greater understanding of exploitation and violence, the impact it has on adults at risk, and the wider community, in order to improve the lives of those who are at risk. The BCBC, Adult Exploitation Protocol will act as an interim arrangement, whilst a regional response is developed. The Terms of Reference was agreed which is closely aligned to the contents and structure of the Cwm Taf Morgannwg, Terms of Reference for the Exploitation Strategic Group dated September 2024.

The purpose of the Adult Exploitation Group is also to ensure the effective delivery of national, regional, and local priorities for protecting and preventing exploitation. The protocol supports proactive partnership working where those at risk of exploitation are identified and safeguarded, and offenders disrupted and prosecuted using the 4'P' model. Prepare, Prevent, Protect. Pursue. The screening toolkit was designed to assist all practitioners to make

an initial judgement regarding the risk of adult exploitation. If concerns are identified the screening toolkit is submitted with an A1. An assessment toolkit was also implemented, and its purpose is to assist the multi-agency network to explore the protective factors, risks and vulnerabilities where exploitation has been identified as a concern. This can be utilised within preventative and/or statutory services. It is an aid to inform assessments and outcomes for adults and young people. Whilst taking some time to plan and to develop the pathway and supporting assessment, this has now been fully implemented and sits within the normal adult safeguarding referral process. The Lead Co-Ordinator's manage the process, any strategy meetings and are developing their confidence, knowledge and awareness in this area. Early indicators are that this has been well received by partners.

Within the Safeguarding Team the fully embedded consultation process is now business as usual and is allowing for timely advice and guidance without the need for unnecessary referrals. The is ensuring that advice and guidance is provided in a timely way with safeguarding vulnerable adults remaining at the heart of what we do.

Merthyr Tydfil Adult Services

Merthyr Tydfil Adult Services continue to work in partnership across the Cwm Taf Morgannwg Safeguarding Board structure, embedding learning from Single Unified Safeguarding Reviews (SUSRs) into practice and has progressed the development and implementation of a new Social Services database to strengthen data, oversight and service delivery. Corporate Communications continue to support safeguarding activity by attending monthly Service Management Board (SMB) meetings and assisting with the promotion of key campaigns and events, including Safeguarding Week. This has strengthened internal and external awareness of safeguarding responsibilities and key messages. Merthyr's Adult Services Lead Manager is Chair of the Board's Adults Quality Assurance Group which actively supports with other regional colleagues and agencies, improvements in adult practice, co-ordination of audit activities and supporting with SUSR implementation and learning.

RCTCBC Children's Services

RCT Children's Services have robust partnership working arrangements across Cwm Taf Morgannwg Safeguarding Board with a wide range of agencies including Contest, VAWDASV, CTM Violence Prevention Board as well as attendance across third sector partnerships e.g. Better Futures Partnership.

Children's Services are represented on workstreams of the Regional Neurodevelopmental Improvement Programme, which are tasked with ensuring that support services provided for families, children, young people and adults who are affected by neurodevelopmental conditions are well-defined, evidence based in approach, and deliver the outcomes that matter to people, and with developing a coordinated approach across partners to identifying neurodevelopmental concerns in the early years and providing pre-diagnosis support to individuals and families seeking assessment.

We are also represented on the CTM Emotional Health and Wellbeing Group of the Regional Children's Services Programme Board which aims to take a lead on emotional wellbeing and mental health services and developments across the region of Cwm Taf Morgannwg for children and young people, and in particular to address the findings from the development of the regional Area Plan and actions required to improve emotional health and wellbeing services for children and young people. In 2025/26 we continued to develop the whole collaborative system approach that coordinates support for children's emotional wellbeing through the development of CONNECT (Coordinated Network for Emotional Care of Children). We have appointed a Well-Being Coordinator who will collect complex referrals and ensure the multi-agency CONNECT Panel is provided with the information to determine the most appropriate pathway of support in line with the individual's well-being needs. This will ensure children and families are getting the right help, first time.

RCT Children's Services have continued to contribute significantly to the implementation of the Exploitation Strategy and continue to progress cases through the Exploitation Family meetings ensuring identified children are subject to multi agency community safety planning with a continued focus on disruption. The RCT Exploitation and Serious Violence Training was shared with Elected Members and Children's Services Staff during the 2025 Annual Safeguarding sessions. This was well attended by staff, and the training was later utilised by the CTMSB at Safeguarding Week in November 2025. This training raised awareness on the various contexts of harm, the methods of grooming, vulnerabilities and signs of harm, the impact on victims, victim blaming language and included the voice of a child and parent with lived experience. We have also continued to attend the Pan-Wales Exploitation network and contributed to the Thematic MoRile (the management of risk in law enforcement) CSE Partnership conducted by SWP.

RCT's Children's Services Right Help, Right Time, Right Place Strategy sets out our strategic direction for strengthening the local system's ability to deliver timely, proportionate and effective support for children, young people and families. It reflects a whole-system ambition to improve how need is identified, understood and responded to, with a stronger emphasis on prevention, consistent threshold application, effective front door arrangements and high-quality multi-agency decision-making. The strategy focusses on creating the conditions for sustainable improvement through clearer governance, stronger operational alignment, enhanced workforce confidence and better use of performance and assurance information. Taken together, the proposed actions are intended to reduce avoidable escalation, improve the consistency and quality of practice. The overarching aim is to deliver a more responsive, accountable and outcome-focused system that provides assurance of impact and improves safeguarding and wellbeing. In 2025/26 we started to develop a digitalised enquiry and referral pathway with Children's Services Front Door Scoping completed and an implementation plan in place. This will improve the accessibility of trusted and reliable information for children, young people and families and professionals by ensuring they get the right information, first time and supports families to help themselves.

Our data demonstrates continued high demand at our 'front door' although we did have a 3% decrease in overall contacts received compared to 2024/25 however a determination of 'no further action'(NFA) has exceeded 50% over the last 3 years with this year's NFA being 62%, 15% proceeded to a proportionate assessment, 3% proceeded to MASH for consideration of Child Protection thresholds and 9% were signposted to Resilient Families Service. Quality assurance work will commence to explore quality of decision making and outcomes to ensure these are timely and outcome focused. We are exploring the opportunities for outcome recording within the new and imminent system to change to MOSAIC to better report on IAA outcomes including advice and/or information provided as opposed to a blanket IAA – Info evaluated and no further assessment required. This will enable more robust analysis of the likely outcomes aligned to the IAA Teams role and responsibilities. Our data indicates we are responding to high levels of local need and increasing complexity in the families we work with and positively our data and quality assurance work evidences an improvement in performance with 98% of assessments having what matters conversations. Of these, 38% of cases ended in IAA with the provision of information and/or advice (largely consistent with previous year 36%), 37% identified preventative services were required (6% more than the previous year, aligned to our prevention and early help agenda), 19% required a more comprehensive assessment (6% less than previous year, aligned to our prevention and early help agenda) and 6% identified child protection concerns (largely consistent with previous year 7%), evidencing consistency in the application of thresholds at the 'front door' and a commitment to early, preventative help where appropriate.

The Strategy seeks a strong partnership ethos where agencies can access relevant and improved information sharing. As an example, RCT Children's Services have worked with our ICT department and Information Management Team to develop a Power Bi for Probation in order for them to access secure, proportionate and relevant information from WCCIS to complete their statutory information checks. Once implemented and evaluated this may provide scope for other agencies whilst alternative information sharing platforms are considered more widely by the CTMSB e.g. Multi Agency Safeguarding Tracker (MAST).

Bridgend Children's Services

During 2025/26, **Bridgend** Children's Services launched the first phase of the regional exploitation strategy in September 2025. The Bridgend County Borough Council (BCBC) workstream has been established to bring together key partner agencies and drive the effective implementation of the strategy at a local level. The local board reports into the regional board on progress, with a clear priority over the coming year to strengthen data and intelligence capabilities. This will ensure a more comprehensive understanding of the needs, risks, and vulnerabilities of children and families across Bridgend and surrounding areas, enabling a more targeted and informed response.

Bridgend has continued to strengthen its response to child exploitation and adolescent safeguarding through the development of specialist services within Children and Family Support Services. The Safer Connections Team provides a targeted response to children and young people who are vulnerable to exploitation, missing episodes, harmful peer associations, offending behaviour, substance misuse and wider contextual safeguarding concerns. The team works closely with social care, education, police, health, youth justice and other partner agencies to identify risk, coordinate multi-agency planning, share intelligence and implement disruption activity. Through specialist consultation, direct work and risk mapping, the team helps strengthen protective networks around young people and ensures a coordinated response to emerging safeguarding concerns. Alongside this, the Adolescent Crisis Team (ACT) has been established within the Edge of Care Service to provide intensive support for young people aged 10–18 who are experiencing significant crisis, placement instability, family breakdown or are at risk of entering care. ACT delivers a six-month intervention model combining intensive family support with therapeutic input to help stabilise situations, reduce risk and improve outcomes for young people. The service works closely with the Safer Connections Team where exploitation concerns are identified, ensuring that young people receive both specialist exploitation support and intensive crisis intervention where required. Together, these services provide an enhanced safeguarding response for adolescents across Bridgend, supporting earlier identification of risk, improved multi-agency coordination and more effective interventions for young people vulnerable to exploitation. Future developments include strengthening multi-agency exploitation panels, further embedding contextual safeguarding approaches, enhancing intelligence sharing and developing outcome measures to evidence the impact of interventions on reducing exploitation-related harm.

We have progressed work to develop a Children's Service Multi-Agency Thresholding Document to assist in the consistency of recognition of safeguarding risk and support a more consistent approach by agencies. We have fully embedded Sign of Safety Child Protection Case Conferences and will be taking forward Care Experienced Reviews being conducted under the practice model.

Merthyr Tydfil Children's Services

Merthyr Children's Service workforce stability has improved over the past year, resulting in safer caseloads, including within front door services. Whilst there continue to be challenges in recruiting experienced senior practitioners, succession planning and investment in newly qualified staff, including through "grow your own" schemes, is helping to build capacity and sustainability across the workforce. Across both Children's and Adult Services, a comprehensive induction programme is in place for all new staff. This provides a consistent and high-quality introduction to the local authority and includes a focus on key skills such as report writing and analysis. The programme has been developed as a rolling induction offer to support continuous workforce development.

Training opportunities are shared across services to support consistent safeguarding practice. Further work is ongoing to embed the child exploitation strategy and associated processes, ensuring that practitioners are confident in identifying and responding to exploitation risks. Work has also been undertaken to improve workforce understanding of child exploitation through regional collaboration. The planned introduction of a regional exploitation lead will further strengthen identification and response to exploitation risks.

Good practice relating to transition has also been identified within Good Practice and improvements for transition, where effective joint working with health partners supported a move away from a high-cost residential placement to a more appropriate supported living arrangement within the local community. This resulted in improved independence for the young person, better outcomes, and more efficient use of resources.

Good practice and improvements for transition

Cwm Taf Morgannwg University Health Board (CTMUHB)

The UHB Safeguarding Strategy is utilised to target bespoke training and communications in respect of protecting children and adults. This strategy is aligned with the Safeguarding Board priorities.

At the start of each reporting year, CTMUHB undertakes a structured assessment of safeguarding performance, risks, and priorities, informed by organisational intelligence, audit activity, and engagement with the Cwm Taf Morgannwg Safeguarding Board. This ensures that agreed priorities reflect both local need and regional strategic direction, with clear alignment to prevention, early intervention, and system-wide improvement.

CTMUHB adopts a triangulated approach to identifying and managing safeguarding risk, drawing on data, audits, practice reviews and frontline intelligence. This enables the organisation to identify emerging themes, monitor compliance, and ensure timely intervention for children and adults at risk of abuse or neglect.

Risk management is further strengthened through regional governance structures, enabling benchmarking, shared learning and oversight of safeguarding performance across partner agencies.

The Health Board actively promotes awareness of abuse and neglect through organisational culture, training, and public-facing initiatives. This includes supporting regional priorities such as early identification, prevention strategies, and implementation of programmes (e.g. VAWDASV and exploitation strategies).

CTMUHB also ensures that learning from reviews, incidents, and audits is widely disseminated to drive improvement and reinforce professional curiosity and reporting. CTMUHB works collaboratively with regional partners including local authorities, police, and third sector organisations through established structures such as MASH and Safeguarding Board sub-groups.

The Organisation actively contributes to regional priorities through joint policy development, multi-agency training, audits, and participation in strategic groups, ensuring a coordinated approach to safeguarding and improved outcomes for vulnerable populations.

CTMUHB prioritises the development of a competent and confident safeguarding workforce through structured training, supervision, and access to expert advice. Workforce capability is aligned to regional expectations, ensuring staff are equipped to recognise, respond to, and escalate safeguarding concerns effectively, with ongoing learning embedded through supervision, training programmes, and shared resources.

Welsh Ambulance Service Trust (WAST)

During 2025/26, the Welsh Ambulance Services University NHS Trust (WAST) Safeguarding Team has strengthened arrangements for the identification, assessment and management of safeguarding allegations, demonstrating a clear commitment to protecting patients, supporting staff and maintaining public confidence through consistent and transparent practice. In response to national priorities across Wales—including addressing sexual harassment, strengthening safer recruitment and promoting safer organisational cultures—a comprehensive review identified the need for clearer guidance to support staff in recognising safeguarding concerns, particularly in relation to professional conduct, sexual safety and substandard behaviours.

An enhanced safeguarding process has been developed and implemented, supported by a Safeguarding Risk Assessment Template and Safeguarding Allegations Checklist. These provide a structured framework to support identification of concerns, understanding of thresholds and consistent decision-making, translating statutory guidance, professional standards and the Wales Safeguarding Procedures into practical resources. This has strengthened frontline practice, organisational governance and risk management.

The revised approach supports earlier identification, more robust risk assessment and timely, evidence-based decision-making, reducing uncertainty, encouraging shared professional judgement and promoting a proactive safeguarding culture. Development was informed by national learning, internal activity and feedback from operational colleagues, ensuring alignment with best practice.

Early feedback indicates improved governance arrangements, with safeguarding allegations recorded, reviewed and escalated in a more structured and auditable way. Staff report increased confidence in identifying concerns, particularly in complex areas such as sexual harassment and domestic abuse, alongside greater clarity on safeguarding thresholds.

Probation Service

This year, the Probation Service has supported delivery of the Board's priorities through both national policy implementation and local partnership activity.

Strengthening Multi-Agency Safeguarding Practice

Probation has embedded a multi-agency approach to public protection, including consistent information sharing with police and social services in line with national agreements. Practitioners routinely attend child protection conferences, core groups and MARAC and safeguarding meetings ensuring safeguarding concerns are actively managed even where probation contact may be limited.

We have developed improved information sharing processes, including standardised police information request templates across Wales, enhancing the timeliness and quality of safeguarding intelligence.

Promoting a "Think Child" and Whole-Family Approach

The Service has formally embedded a "Think Child" approach across probation practice. This requires practitioners to consider the presence and impact on children in all cases, apply professional curiosity to identify hidden harm and challenge disguised compliance and minimisation

This approach ensures safeguarding is proactive, not solely reactive, and aligns closely with Board priorities around early identification and prevention.

Improving Safeguarding Awareness and Workforce Capability

The Service has supported the implementation of the updated HMPPS Safeguarding Adults Policy (2025), providing clarity on roles, responsibilities, and statutory definitions and introduced the HMPPS Adult Safeguarding Charter (2025), reinforcing expectations that all staff take responsibility for safeguarding, work collaboratively with partners and deliver person-centred and strengths-based practice. We support the ongoing delivery and monitoring of safeguarding training to ensure a competent and confident workforce.

Embedding Learning and Continuous Improvement

Learning from Safeguarding Adults Reviews (SARs), inspections and audits is embedded into policy development, practice guidance and training materials and further engagement with HM Inspectorate of Probation (HMIP) inspection activity, contributing to national and regional improvement actions.

South Wales Police (SWP)

SWP continues to support the Safeguarding Board by attendance at strategy meetings and at both the Adult and Child Quality Assurance and Performance panels (AQAP and CQAP), sharing any learning or trends within these groups and internally within SWP. SWP have now established a Harm Reduction Unit who identify opportunities for the use of preventative orders in robustly managing offenders and safeguarding victims. The Unit assists with the applications of Orders and allocation for ongoing management of these. Exploitation is an area that is covered by the Unit, from the review of NRM's to intelligence development and the SWP Exploitation Lead is Vice-Chair of the Board's Exploitation Strategic Group. The exploitation workstream is currently under review Force-wide to establish a comprehensive and consistent working model that will have partnership working at its heart and to ensure that there are no regional gaps.

South Wales Police are committed members of the SUSR process. We actively encourage staff to undertake panel and chair training provided by the Local Regional Safeguarding Boards. We are also active referrers in

the SUSR process, identifying opportunities for learning and review through daily monitoring of incidents and through participation of other reviews such as PRUDIC and Immediate Response Groups (IRG). SWP has two Statutory Review managers, who actively ensure that learning and actions from reviews are recorded,

actioned, and reviewed. They sit within our strategic command and can incorporate learning through policy and training reviews.

Strategic Priority 2: We will re-learn by reflecting on the past year and agreeing how what we learn as a Board can make a difference to safeguarding practice: -

RCTCBC Education Services

Learning Framework – A hybrid Group B Safeguarding module was developed to ensure schools are in compliance with the National Safeguarding Standards. The hybrid model has ensured that capacity to release staff from schools has not hindered access to safeguarding training.

Communication and Engagement – safeguarding was an element of the discussions held with parent/carer groups and pupil groups across 17 schools when formulating the new Education Strategic Plan. We are currently looking to further develop the ability of children to directly influence the work undertaken by Education and Inclusion Services. The annual plan for 26/27 will include a commitment for children to be part of the recruitment process for senior management, for example. We are also reinstating the annual Safeguarding Conference for Schools (not taken place since 2019) – this will be an opportunity to bring school leaders together with the focus of the 2026 conference being exploitation with the keynote speaker being Jan Pickles OBE, the Chair of the North Wales Safeguarding Board review that led to the 'Our Bravery Brought Justice' report.

Bridgend's EEYPP Directorate

Learning Framework:

BCBC has embedded learning from Single Unified Safeguarding Reviews and audits into practice through training sessions and DSP briefings. Internal audits have been undertaken in schools focusing on safeguarding procedures, record keeping, and response times. We have worked with the Board this year and other regional Education leads to resolve delivery issues with Group B training for schools, employing a cohesive partnership approach to support the effective delivery of this across our schools' base.

Communications and Engagement:

Clear communication channels established between Education, Early Help, and Social Care.
Safeguarding updates disseminated regularly via newsletters, meetings, and training sessions.
Engagement with children and young people through schools to raise awareness of how to seek help.

Bridgend Youth Justice Service

During 2025/26 BYJS continued to strengthen its safeguarding arrangements through robust governance, performance monitoring and effective partnership working. Following the service's HM Inspectorate of Probation inspection, which recognised BYJS as an Outstanding Youth Justice Service, safeguarding improvement has remained central to service development.

Key developments included:

Continued implementation of a trauma-informed, Child First approach across all areas of practice.

Further embedding of exploitation screening and assessment processes ensuring children at risk of exploitation, serious violence and contextual safeguarding concerns are identified at the earliest opportunity.

Active participation within the Wellbeing, Care, Support and Guidance (WCSG) Panel, bringing together Education, Children's Services, Health, Police and specialist services to identify vulnerable children earlier and coordinate multi-agency intervention.

Strengthened partnership working with South Wales Police, Children's Services, Education, the Local Authority Trauma Service, Youth Service Outreach Team and regional Youth Justice Services.

Continued development of information sharing arrangements through ChildView and wider directorate work to improve identification of vulnerable children.

Workforce development through regular safeguarding supervision, management oversight, reflective practice and quality assurance audits.

Continued delivery of trauma-informed practice training, exploitation awareness and safeguarding learning across the wider workforce through the Local Authority Trauma Service.

This collaborative approach has strengthened safeguarding arrangements, improved professional confidence and enabled earlier intervention for children presenting with complex vulnerabilities.

Cwm Taf Youth Justice Service

Cwm Taf YJS has made good progress during 2025/26 and produced a plan which has been subject to regular oversight by the YJS Management Board and Cabinet/Scrutiny meetings across Merthyr Tydfil and Rhondda Cynon Taf Local Authorities. Both the YJS Management Board and the Cwm Taf YJS have understood and responded positively to HMIP Inspection recommendations in 2024 and driven forward the necessary improvements in the delivery of services to children, families and victims of crime.

The positive strategic and operational improvements made against the Inspection recommendations ensured that the YJS was returned to Quadrant 2 of the National Oversight Framework in August 2025. A formal letter from the YJB recognised that the change of Quadrant was:

'In recognition of sustained and continued improvements across key indicators which is driven by significantly strengthened governance, strategic leadership and effective partnership working'.

RCTCBC Adult Services

During 2025-26, RCT Adult Services have established 'Champions' groups for practitioners around Domestic Abuse and Self Neglect. The Domestic Abuse group was set up in response to a number of DHRs in the region; the Self Neglect group followed the publication of the review of APRs in Wales, commissioned by the National Safeguarding Board. Both groups are facilitated by the Service Manager responsible for Safeguarding and are open to members of staff across Adult Services. Both groups enjoy good representation from a range of different teams. Members of staff have received relevant training; some of this has been specifically commissioned for them. Staff bring case examples from practice for discussion and external speakers are invited. For example, the Environmental Health lead has attended the Self Neglect group. The practitioners act as a source of information and consultation for other staff in their teams and are key to improving practice in adult services. Where relevant, reports and briefings from SUSRs are shared for discussion.

Merthyr Tydfil Adult Services

The Adult Services Lead Manager is the Chair of the Board's Quality Assurance Group supporting key priorities for the Local Authority and the Board in respect of improving responses to adult safeguarding practice. Merthyr Tydfil also secured a new Head of Adult Service during 2025/26. MTCBC continues to play an active role in regional safeguarding workstreams across the Cwm Taf Morgannwg Safeguarding Board, contributing to the development and delivery of priority areas including harm reduction, SUSR and quality assurance activity. Representation from the Council is embedded across key workstreams, including SUSR, Child and Adult Quality Assurance Panels (CQAP and AQAP), ensuring that local practice both informs and benefits from regional developments.

Significant progress has been made in strengthening the Single Unified Safeguarding Review (SUSR) process. Learning from SUSRs (previously Child and Adult Practice Reviews) is being embedded at both a local and regional level to drive improvements in safeguarding practice. MTCBC's Director of Social Services also contributes to the Welsh Government SUSR Steering Group, supporting the identification and dissemination of national learning and emerging themes.

MTCBC has actively contributed to the development of regional policies, supporting greater consistency in key areas such as safeguarding thresholds and responses to child exploitation. This has helped to promote a more aligned and coherent approach to safeguarding practice across partner agencies within the region.

RCTCBC Children's Services

We have a strong corporate safeguarding framework that ensures all employees, elected members, commissioned services, suppliers and contractors are aware of their safeguarding responsibilities. This includes a RCT Council Safeguarding Training Standards to ensure all staff and commissioned providers in RCT have consistent and good quality training that is relevant to their roles and responsibilities.

RCT Children's Services have representatives on all subgroups of the Board including a Chairing role of the SUSR (Review) Group. We have been fully committed to the new SUSR process and committed staff across the service directorate to attend the chair, reviewer and panel training. RCT Children's Services chair the SUSR Review group and supported the Improving Practice Delivery Group to ensure robust reviewing and monitoring process of recommendations and actions arising from learning to improve practice. We continue to engage in various roles in SUSR, child/adult practice reviews and domestic homicide reviews. Learning and good practice from reviews is valued and shared via management forums on a regular basis and cascaded throughout the organisation in a number of formats, including team meetings, inform and involve sessions, 7-minute briefings and newsletters. We also hold whole service annual summer safeguarding sessions to ensure key messages from reviews, audits and wider national work enabling space for practitioners to reflect on effective practice and learning. This year's session will include learning from the Gwynedd 'My Bravery Bought Justice' Review as well

as the national CSA Delivery Plan.

We continue to be committed to the contribution of the Engagement, Learning & Communication Group and the development, review and evaluation of the multi-agency training and assist in facilitating training. For example, RCT Children and Adult Services facilitate multi-agency training on Section 5, WSP, safeguarding allegations/concerns about practitioners and those in a position of trust across the CTM region and have contributed to the NSPCC 'Play your Part' campaign and supported the raising awareness of healthy relationships and coercive control in schools during 2025/26 and supported Safeguarding Week evidencing our continued commitment to raising awareness across RCT and the wider region on abuse, neglect and exploitation.

Merthyr Tydfil Children's Services

The Council has also strengthened its internal arrangements to support staff and promote a safe working environment. This includes a manager's guide on third-party abuse and harassment, alongside a Dignity at Work policy which enables staff to report concerns through established HR and safeguarding pathways. Reporting guidance is available via the intranet and ongoing work is in place to improve accessibility and awareness.

MTCBC follows the Health and Safety Executive (HSE) definition of work-related violence and has clear procedures in place for reporting and responding to incidents involving abuse, threats or harassment. This includes specific reporting mechanisms for incidents relating to protected characteristics, ensuring alignment with the Council's Dignity and Respect at Work Policy.

At a regional level, MTCBC has contributed to the development and implementation of an action plan in response to the CIW/HEIW inspection, in partnership with CAMHS and other agencies. This plan is regularly monitored and reviewed and is supporting continued improvement in multi-agency working and safeguarding practice.

These collective actions have strengthened multi-agency safeguarding arrangements, improved workforce confidence and consistency of practice, and enhanced the Council's ability to identify, assess and respond effectively to risk across children's and adults' services.

Wales Ambulance Service Trust (WAST)

The WAST Safeguarding Team has strengthened its approach to organisational learning through structured processes to identify, capture and embed learning across the Trust, drawing from sources including Single Unified Safeguarding Reviews (SUSRs), internal processes, safeguarding allegations and multi-agency feedback. Key themes are systematically reviewed, with actions recorded, tracked and overseen through the Safeguarding Strategic Group to ensure implementation and ongoing assurance.

Learning is further disseminated through enhanced communication and engagement, with the Safeguarding Hub providing a central access point to Regional Safeguarding Board reports, 7-minute briefings and wider resources, supported by infographics, organisational bulletins and targeted communications to ensure accessibility for staff across all roles.

Probation Service

The Probation Service has demonstrated a strong and sustained commitment to safeguarding within Cwm Taf Morgannwg during 2025/26. This is evidenced through active engagement with the Safeguarding Board, meaningful contribution to multi-agency work, and continued focus on improving safeguarding practice. Looking ahead, key priorities will include embedding consistency in safeguarding practice across all teams, continuing to enhance multi-agency collaboration and information sharing and building on a culture of learning and continuous improvement. Through this work, the Probation Service will continue to play a critical role in protecting the most vulnerable members of the community and supporting the shared objectives of the Cwm Taf Morgannwg Safeguarding Board.

South Wales Police (SWP)

The key achievement in 2025/26 has been the commitment to continue and develop the Cwm Taf MASH. The MASH in Bridgend is operating well and serves as the model to achieve for the Cwm Taf MASH. The closure of Pontypridd Police Station in 2026/27 and the required move for the MASH to a new location will allow a rebuild of the Cwm Taf MASH and an opportunity to refresh joint working protocols to strengthen future partnerships for MASH partners.

The Immediate Response Group (IRG) is an excellent partnership currently chaired by SWP, which comes together at short notice, and all participants make positive contributions. There is opportunity for further development moving forward, to share chairing responsibilities for example and to look at more efficient communication and information sharing tools eg. the use of Sharepoint. A review of the current Protocol was due to be completed this year but will now be finalised during 2026/27.

Strategic Priority 3: We will agree on how we can re-develop as a Board to maximise opportunities to improve how we safeguard people.

RCTCBC Education Services

SUSR – following the realignment of staff to various groups and sub-groups, there is now a consistent representation from Education in the Board's SUSR Group as well as representation within any relevant reviews themselves. RCT Education has been working closely with partners on a Domestic Abuse Related Death review this year into a completed adult suicide where there were school-aged children as part of the family.

RCT Education continues to work closely with Bridgend and Merthyr Education and the Safeguarding Board to support a consistency of approach in the region for safeguarding priorities wherever possible. During 2026/27, RCT and Merthyr Tydfil, in partnership with the Board will host an Education Conference targeted at School DSLs to improve their awareness of safeguarding themes and exploitation including national learning from the **"Our Bravery Brought Justice"** extended Child Practice Review.

Bridgend's EEYPP Directorate

Education in Bridgend has contributed to preventative approaches addressing exploitation, attendance issues, and youth vulnerability and targeted interventions for learners at risk of disengagement, including alternative provision and engagement programmes.

We are actively engaged with the regional SUSR process, including participation in reviews and the implementation of recommendations including this year, national learning from the *Our Bravery Brought Justice* extended Child Practice Review and share learning across education settings to strengthen practice and response.

We participate in regional networks including RCT and Merthyr Tydfil Education to ensure consistency in safeguarding responses across Cwm Taf Morgannwg.

Merthyr Tydfil Education Service

Continual engagement opportunities through forums and Headteacher meetings provide opportunity to communicate key safeguarding messages, learning and consultation.

Joint pieces of work such as C1 audits have led to greater understanding of the pressures faced by service areas and learning opportunities through the identification of themes.

The core Education team is small and therefore the capacity to attend all meetings or have a presence at multi agency arenas is sometimes difficult and not always possible. This includes MASH and weekly MARAC. There is a need to further develop more efficient information sharing tools so that there is an opportunity to input into these without always being present.

RCTCBC Adult Services

RCT Adult Services have strengthened the Safeguarding Duty function in response to increased demand and complexity, including the introduction of additional staffing resource and revised workflows to improve responsiveness. This has included the use of Safeguarding Lead Coordinator and SPA Senior support to manage screening, information gathering and early enquiries more effectively, enabling more timely and proportionate safeguarding decision-making.

These developments, alongside practitioner-led initiatives such as Champions groups and the systematic dissemination of learning from Practice Reviews, demonstrate a continued focus on strengthening safeguarding practice, improving multi-agency working and ensuring that adults at risk receive timely and proportionate support.

Merthyr Tydfil Children's & Adult Services

Partnership working remains central to how Merthyr Tydfil County Borough Council (MTCBC) manages demand and delivers effective safeguarding arrangements. Strong multi-agency collaboration continues across Education, Early Help and Prevention, Public Protection, Police, Youth Justice and Housing. This joined-up approach supports coordinated responses to safeguarding concerns, including community safety and youth behaviour, as well as longer-term planning such as accommodation and employability pathways. Key strategic partners also include neighbouring Local Authorities, the voluntary sector, Registered Social Landlords and Health.

MTCBC is committed to ensuring that all children, young people and adults at risk are protected from abuse and neglect and are supported to be safe, healthy and well. The Council fulfils its statutory safeguarding responsibilities across a broad range of individuals, including those with disabilities, older people, individuals experiencing domestic abuse, and those at risk of exploitation.

There continues to be strong partnership governance arrangements across the Cwm Taf Morgannwg region. MTCBC's Director of Social Services chairs the Regional Safeguarding Board and contributes to key strategic groups, including the Safeguarding Steering Group and the Suicide and Self-Harm Prevention Steering Group. This supports effective regional leadership, oversight and alignment of safeguarding priorities.

RCTCBC Children's Services

Workforce remains a key priority for RCT Children's Services with a workforce strategy underpinned by our values and model of practice, and regular steering group in place with a key focus on that staff wellbeing, staff development and retention.

Staff development and career opportunities remain an integral part of the workforce plan. Workforce stability has improved in several teams supported by initiatives such as the Apprenticeship Pathway Social Work Academy and Agency Pledge. Positively, Social work vacancies in Child & Family and Children Looked After teams have dramatically reduced, and the work of the social work academy means that we have only small numbers of vacancies with around 5-7 agency staff covering absence but not vacancies. Disabled Children's Team will also fully staffed by 9.7.26. The academy endeavors to bring together under one umbrella all training and development opportunities for our social work and residential practitioners the council provides.

Feedback from RCTCBC Apprentices:

"The apprenticeship scheme helped me in many ways. I couldn't afford to go back into education and RCT supported me to pursue my dream role. The council invested their time in me and helped me grow over the last 10 years. I would encourage anyone to do an apprenticeship, the support and training I received was phenomenal." (Qualified Social Worker)

"My apprenticeship was one of the best decisions I've made. It gave me valuable insight into working with families, supporting positive change, and understanding how safeguarding decisions are made. With the support of amazing colleagues, I learned quickly and grew into the role. The apprenticeship helped me build confidence, develop a wide range of skills, and secure full-time employment. I now support new workers, sharing my knowledge so they can feel as supported as I did. The apprenticeship pathway shaped the direction of my career and inspired me to stay in this line of work."
(Intervention Worker)

Bridgend Children's Services

Multi-agency reflective sessions have been developed within the Children's services. The purpose of the meeting is to develop a learning environment where practitioners and partners can reflect on cases with their managers and partner agencies to share good practice, to help us consider any learning we can take forward to develop our work with families. The meeting happens weekly and is progressed by a multi-agency workstream. The identified themes are considered through data analysis and aims to target areas that most impact families such as child protection activity over recent weeks including any initial strategy discussions or section 47's and reflect on decision making/threshold. Reviewing children who have been subject to Care and Support cases for a period longer than twelve months that are identified as drifting or stuck.

As good practice the Bridgend MASH now reconvenes any strategy meeting held outside of daytime hours by EDT in line with the Cwm Taf MASH, this supports fully multiagency working and information sharing principles.

Wales Ambulance Service Trust (WAST)

The WAST Safeguarding Team continues to work towards its vision of creating a safe and supportive environment where individuals are protected from harm and able to achieve positive outcomes. This is underpinned by a commitment to vigilance, compassion and continuous improvement in safeguarding practice across the Trust.

During 2025/2026, a Trust-wide survey was undertaken to better understand staff awareness, training needs, and experiences of reporting safeguarding concerns and engaging with the Safeguarding Team. The findings are being used to inform the 2026/2027 workplan, ensuring that key priorities reflect the views of colleagues and focus on improvements that will have the greatest impact on practice and confidence.

Whilst the WAST Assistant Director of Safeguarding remains a member of all Regional Safeguarding Boards across Wales, a revised approach to representation has been implemented during this reporting period. Through a Memorandum of Agreement between the six Regional Safeguarding Boards, WAST is represented by a designated representative from the National Safeguarding Service (NSS).

Probation Service

Whilst strong practice exists, inspections highlight that ongoing work is required to improve communication across Probation and Safeguarding teams and with consistency in the quality of information provided. The

Service will continue to work with its Safeguarding Board partners in order to foster further improvements and strengthen safeguarding practices within the region.

South Wales Police (SWP)

The use of Teams channels has been an important part of the communication pathway in the past year with safeguarding partners as a more efficient way of sharing information effectively. South Wales Police continue to engage with the Board, updating through the Business Unit when there are any concerns or changes to personnel and we continue to support the delivery of multi-agency safeguarding training for the region.

Other Board Priorities

Workforce and Wellbeing

All Safeguarding Board partners recognise ongoing challenges in staff recruitment and retention, and the wellbeing of staff remains a key priority. Partners report ever increasing demands and complexities in safeguarding services, so it is of critical importance that all staff working across our partner agencies feel valued and supported at all times. The Board has this year continued to support multi-agency training for its workforce members and the Board's Business Unit continues to provide a range of support to the Board's partners and professionals.

RCTCBC Children's Services

Workforce remains a key priority for RCT Children's Services with a workforce strategy underpinned by our values and model of practice, and a regular Steering Group in place with a key focus on staff wellbeing, staff development and retention.

We recognise the importance of an engaged, motivated and healthy workforce. Over the last three years, Children's Services has introduced a range of mechanisms through the introduction of a Communication Cycle to capture the voice of practitioners. The aim of the Communication Cycle is to improve communication and well-being across the service, and it is now firmly embedded.

Staff have access to a psychology led, reflective spaces forum, mental health self-service platforms as well as formal support through occupation health. RCT Children's Service have also piloted an enhanced flexible working pilot. This has enabled staff in the service areas where work demands have often restricted the ability to take flexi time back. Feedback from staff has indicated that the enhanced flexi scheme has been highly beneficial, enabling better planning and allowing them to take non-working days effectively and the system appears to be well supported by managers and accommodates staff needs and service deliveries.

RCTCBC Adult Services

RCT Adult Services have strengthened the Safeguarding Duty function in response to increased demand and complexity, including the introduction of additional staffing resources and revised workflows to improve responsiveness. This has included the use of a Safeguarding Lead Coordinator and SPA Senior support to manage screening, information gathering and early enquiries more effectively, enabling more timely and proportionate safeguarding decision-making.

These developments, alongside practitioner-led initiatives such as Champions groups and the systematic dissemination of learning from Practice Reviews, demonstrate a continued focus on supporting staff,

strengthening safeguarding practice, improving multi-agency working and ensuring that adults at risk receive timely and proportionate support.

Merthyr Tydfil CBC

Corporate Communications continue to support safeguarding activity by attendance at monthly Service Management Board (SMB) meetings and assisting with the promotion of key campaigns and events, including Safeguarding Week. This has strengthened internal and external awareness of safeguarding responsibilities and key messages.

Safeguarding training remains a mandatory requirement for all Merthyr Tydfil CBC staff and is delivered through the Council's training platform. Improvements to data systems within MTCBC have enhanced oversight of workforce development, enabling more effective monitoring of compliance across key areas including safeguarding, Prevent and VAWDASV training. This has supported a more structured and accountable approach to workforce learning and development. Across both Children's and Adult Services, a comprehensive induction programme is in place for all new staff. This provides a consistent and high-quality introduction to the local authority and includes a focus on key skills such as report writing and analysis. The programme has been developed as a rolling induction offer to support continuous workforce development.

These arrangements have strengthened the Council's learning culture, improved workforce confidence and oversight of training compliance, and supported more consistent and informed safeguarding practice across Children's and Adult Services.

Bridgend Council Children's & Adult Services

The Corporate Director of Social Services and Wellbeing for Bridgend is the senior lead officer who holds corporate responsibility for safeguarding. The Director and Heads of Service for Adults and Children's Social Care sit on the CTM Safeguarding Board alongside Heads of Service from education and housing. The Director operates as vice chair for the Board. The authority has seen a change in the leadership with a new Head and Deputy Head being appointed to BCBC Adult Services. There is a further change on a temporary basis to the Head and Deputy Head of Child and Family Services. These changes support a continued vision of continuous improvement in the services being delivered and in supporting staff to achieve the best outcomes for children and adults at risk.

Suicide Prevention

During 2025/26, partnership working between the Safeguarding Board and Public Health Wales has supported transitional arrangements to strengthen the Suicide and Self-Harm Prevention work-stream within the region. A review has been completed to agree revised governance arrangements and the Strategic Steering Group is now well established led by Public Health Wales. A further review of the terms of reference for the Suicide Review Group and the Immediate Response Protocol is due to be completed in 2026/27 to align workstream priorities with the Suicide prevention and self-harm: strategy and delivery plan | GOV.WALES.

The future focus of this workstream will look to strengthen preventative activity and provide a mechanism for cases where suicide is not completed and how to integrate more effectively the voices of those with lived experience to support a robust service and support response across agencies operating in the region.

Bridgend County Borough Council continues to operate an independent focus on suicide prevention and self-harm pending further progression of a wider, regional approach. They support community work with the continuation of the significant attempts of suicide and self-harm rapid response meetings. Front line professionals are reminded to ensure referrals are made as required to ensure that individuals at these times of crisis are provided with the right support. The void of specialist preventative suicide services within Bridgend has been identified as a future area to improve on but services such a "*4Tom*" can provide advice and guidance. There has been ongoing discussion with Public Health Wales regarding potential funding routes to create a service and should funding be made available, it is hoped that the *Jacob Abrahams Foundation* will extend its coverage into Bridgend.

CTMSB Protocols and Procedures

The Board has a Policy and Protocols Review Group (PPG) that has strong representation across the multi-agency partnership. During 2025/26, the Group was subject to a new Chair as part of the revised sub-structure arrangements. The PPG review and evaluate the Board's policies, procedures and guidance to ensure that these comply with legislative requirements and good practice developments. These are also key to providing additional support for partners and practitioners in respect of the delivery of effective safeguarding within the region. The work of the PPG also links closely with recommendations from the Board's practice reviews and national reviews and multi-agency audits with regard to the review and/or development of policy and practice guidance.

The following Board protocols and guidance documents were reviewed and updated during 2025/2026:

- CTM Multi-Agency Children's Services Threshold Guidance
- Guidance in relation to the Child Protection Register and Children Looked After
- School Safeguarding Policy

Partner Agency Achievements

In addition to the joint work that is undertaken as a multi-agency Board, individual partner agencies also share their achievements in relation to safeguarding.

Bridgend Council Children's & Adult Services - Bridgend are implementing the Most Significant Change model (MSC) to understand peoples lived experiences of working with us when they are subject to safeguarding concerns. Most Significant Change is a method of evaluating changes by using storytelling to collect data. It's qualitative, so it uses words not numbers. Bridgend Social Services are using the Most Significant Change method to evaluate what is working and what needs to improve in the services we deliver. The story is then shared with panel members that include Senior Leaders who can effect change within the system.

A consultation line has been developed in MASH / IAA which partners can access for advice and guidance on dealing with safeguarding matters.

Merthyr Tydfil CBC - A robust and maturing Quality Assurance Framework (QAF) is in place within Children's Services, supporting systematic auditing of practice, including the quality of referrals from partner agencies. Audit findings are routinely used to inform improvements and drive practice development. In addition, work is progressing with South Wales Police to strengthen the quality and consistency of Public Protection Notifications (PPNs).

Work has also been undertaken to improve workforce understanding of child exploitation through regional collaboration. The planned introduction of a regional exploitation lead will further strengthen identification and response to exploitation risks.

Rhondda Cynon Taf Children's Services - In 2016, RCTCBC established the Resilient Families Service (RFS) as a flagship early intervention and multi-agency family support service, supporting up to 1,000 families each year with complex needs. In 2025/26 Children's Services has undertaken a review of RFS to ensure it continues to deliver positive outcomes for children, young people and families, while remaining financially sustainable and strategically aligned. The review identified rising demand and increasing complexity of family need, exacerbated by the COVID-19 pandemic and the cost-of-living crisis. These pressures have contributed to greater economic hardship and changing patterns of engagement with services. Feedback from families consistently highlights improved communication, stronger family relationships, better child behaviour and emotional regulation, improved routines, and increased parental confidence and skills. However, some families reported that support was too short-term, that children would have benefited from more time to build trusting relationships with professionals, and that access to external services was delayed by waiting lists. In response, the review recommends reshaping the RFS operating model. This includes redesigning access pathways to distinguish early help targeted support and statutory intervention; introducing a Family Information and Support Hub to provide direct signposting and proportionate responses; streamlining assessment processes to reduce duplication and improve continuity; making intervention timescales more flexible and needs-led; clarifying practitioner roles to reduce the number of professionals involved with each family; strengthening transitions between services and links to community resources; and unifying IT systems to support more effective joint working and information sharing.

Rhondda Cynon Taf Adult's Services - RCT Adult Services have actively contributed to regional work streams aimed at strengthening safeguarding practice and consistency. The development of the Domestic Abuse and Self Neglect Champions groups has supported a harm reduction approach, enabling early discussion of high-risk cases, sharing of best practice, and improved practitioner confidence in managing complexity. These forums also provide a mechanism for testing new learning and embedding changes in practice at a local level.

CTM University Health Board - CTMUHB has demonstrated a number of areas of established good practice during 2025/2026:

- Embedding a whole-system safeguarding approach, ensuring staff are supported, confident, and able to fulfil their statutory responsibilities across services.
- Strengthened governance and quality assurance processes, including improved oversight of safeguarding activity and alignment to strategy priorities. This includes adoption of the Once for Wales Safeguarding module within Datix to support improved oversight of section 5 concerns.
- Use of digital solutions to enhance safeguarding practice, particularly in capturing the voice and lived experience of children and young people through survey tools and digital systems.
- Expansion of safeguarding supervision arrangements, including wider access across community services, supported by feedback tools to measure quality and impact.
- Development of formal safeguarding supervision policy and restorative approaches, with positive staff feedback indicating improved professional support.

These demonstrate a clear service improvement example linked to outcomes for vulnerable children.

Wales Ambulance Service Trust (WAST) - In March 2026, the Trust was proud to see a member of the Safeguarding Team recognised nationally, receiving the National Safeguarding Service 'Rising Star in Safeguarding' award. This achievement reflects the strength of safeguarding practice within WAST and the commitment of staff to driving improvement and innovation.

Probation Service -

Strengthened Public Protection and Risk Management
The Probation Service has improved processes for identifying and managing safeguarding risks, including completion of safeguarding checks at sentence commencement, timely safeguarding referrals and enquiries and integration of safeguarding considerations into all risk assessments with a clear focus on "keeping people safe", including proactive identification and management of risk to victims, children and vulnerable adults.

Improved Multi-Agency Collaboration
Our enhanced partnership work has led to more coordinated responses to safeguarding concerns, better information sharing and improved outcomes for individuals with complex needs. These include national examples of good practice including collaboration with health services to improve access to care and joint working arrangements to address mental health and substance misuse needs.

Person-Centred and Tailored Approaches
We support the delivery of tailored interventions based on individual need and vulnerability, including targeted approaches for specific cohorts (e.g. women, young adults) and an increased focus on engagement and desistance, with evidence that positive engagement improves outcomes for individuals under supervision.

Development of Safeguarding Infrastructure
The Probation Service has had active involvement during this year in the development of multi-agency performance frameworks and safeguarding dashboards and continues to support contributions to strengthening governance arrangements and oversight at Board level.

South Wales Police - A key achievement during 2025/26 has been the commitment to continue and develop the Cwm Taf MASH. SWP has also ensured we have adequate representation at the Board and regional safeguarding forums. Moving into 2026/27, SWP will strive to achieve force wide consistency so Safeguarding leads are able to further support and share good practice and learning.

6. Safeguarding Themes

Audit Activity

Achieving improvement in safeguarding policy, systems, and practice is a core function of the Board. Audit work is carried out via task and finish groups set up by the Quality and Performance Sub-Groups or from the Board's Single Unified Safeguarding Review group. Any recommendations made by case audits are monitored by these groups to identify how practice needs to adapt to reflect any learning. The key learning themes from audits completed this year are summarised below:

AUDIT & GOOD PRACTICE ACTIVITY	THEMES IDENTIFIED
Adults S126 enquiries exceeding 7-day statutory timescale	*Reason for Audit:* To identify common themes or trends in the region to facilitate measures that could be put in place to improve the overall percentage of S126 enquiries completed within 7 days.

To also identify areas of good practice that are already in place that can be shared across the regional Local Authorities.

Learning:

- A significant differential identified between staff operating the S126 process across local authorities. To be addressed by individual agency learning and supervision.
- The rationale as to why enquiries exceed 7 days was not routinely documented in some cases. New forms which now allow and prompt the Lead Co-ordinator to capture this information should effectively address this.
- Ongoing investigations conducted by Police or care providers delaying the conclusion of s.126 enquiries. Practice has since changed so when all appropriate safeguards have been recommended, enquiries are concluded.
- Some human errors when inputting completion dates.
- A delay in key partners sharing information within the identified time frame.

Areas of Effective Practice:

- All enquiries commenced promptly with immediate screening of concerns and liaison with key partners.
- All enquiries were robust, ensuring all key partners, agencies and practitioners were appropriately consulted regarding concerns.
- All cases provided a clear rationale for determination outcome which was formally shared with all individuals involved.
- For cases where the updated form was used, all records clearly outlined a rationale for cases exceeding the statutory timescales
- There is routine consideration of individuals views, wishes and feelings in each case. This is not compromised when working within statutory timescales and on occasions timescales were exceeded to ensure appropriate representation of the individuals voice and lived experience.

Areas for Development:

- Adult Safeguarding have introduced a ‘Request for Information’ response to key partners who have not responded to requests for information within 3 days.

	• Adult Safeguarding Teams now capture cases on a weekly basis, that are expected to exceed statutory timescales. This information is shared with the Service Manager for oversight.
Children Suspicious and Unexplained Injuries	**Reason for Audit: Following the "*Child T*" Child Practice Review, a recommendation was made** for the University Health Board (UHB) to commission an independent review into its practice and management of identifying and investigating non-accidental injuries in children and adolescents. The recommendation also requested that the UHB should develop systems for escalation and quality assurance which embed and include practice learning. In addition to, and because of, the above work, the RSB agreed on a course of action to begin a multi-agency professional forum (MAPF). The aim of which was to ensure that the multi-agency response to the identification and investigation of non-accidental injuries in children and adolescents was also reviewed. **Learning, Effective Practice & Improving Practice:** • **Importance of CPR Checks -** practitioners should utilise Child Protection Register (CPR) checks to gather relevant history for informed decision-making regarding child's welfare, although this should not delay making a referral when it is a clear child protection concern. • **Referral Clarity** - C1 referrals must include concise information about the presenting history, current concerns including any identified risk, and requested actions. It should also include details of birth parents (those with PR), adults suspected of causing harm (if known) as well as any specific needs of the child and/or adults e.g. language and/or communication/additional needs. Lack of clarity can hinder effective and timely responses. • **Position of Trust** - where parents are known to be in a position of trust through paid employment or voluntary work, a referral must be made to the relevant LA LADO for consideration of threshold under Section 5, Wales Safeguarding Procedures. • **Strategy Discussion & Decision Making** - strategy discussions should consider all children within the family and/or connected where there may be a transferable risk. If they are not considered the record should provide a clear reason. It should involve all relevant agencies to ensure a holistic understanding of the child's situation and risks. • Records should document the rational for not proceeding with joint enquires and should record the timescales and responsible person to feedback to SWP. • **Emergency Duty Teams** - robust pathways for strategy discussions out of hours need to be established to avoid any delay in facilitating the necessary information sharing and decision making in line with WSP's. Consideration should be given to demand on EDT and partner agencies when developing a pathway. • Reasons for a delay in facilitating the strategy discussion should be clearly recorded within the record of the strategy discussion including any actions and responsible persons.

- Consideration should be given to joint training between ED, EDT and SWP staff on managing the pathway outside of usual hours.
- **Child Sexual Abuse** - CTMSB should consider the recommendations of the CSPRP Review on CSA in the family environment alongside the imminent National CSA delivery plan to ensure the prevalence of CSA in all contexts are understood, children and their families are supported and staff across the partnership have the right, knowledge, skills and experience to respond to concerns of sexual abuse.
- **Professional Curiosity** - practitioners must demonstrate professional curiosity to explore concerns deeply, avoiding assumptions and seeking evidence to support their findings.
- **Whole Family Approach** - a comprehensive understanding of family dynamics and transferable risks is essential. This approach should include considerations for siblings and the impact of parental vulnerabilities.
- **Trauma Informed Approach (parents)** - a comprehensive understanding of parents lived experience and previous trauma is essential. This approach emphasizes the importance of understanding the parents' trauma and its effects on their ability to parent effectively. A comprehensive approach should be taken to address these issues and provide the necessary support.
- **History in Context** - multi agency chronologies are crucial in developing a holistic understanding of the child's lived experience, particularly in cases where there are repeat incidences of concern.
- Due consideration should be given to any themes arising from the case including parental motivation to change and indicators of disguised compliance.
- **Language, Communication and Additional Needs** - clear communication is key, especially when language barriers exist. Active offers for interpreters should be made to ensure accurate understanding. Advocacy should be offered for children and parents to assist in their understanding of process and ensuring their voice is heard.
- **Review Strategy Discussions & Decision Making** - Review Strategy Discussions should be utilised during complex enquiries and when new information is shared that requires discussion and corroboration to re-analyse the likelihood of significant risk of harm.
- **WSP Determinations at OSD -** OSD must always review the initial categories of harm and actions to ensure Sec 47 enquiries have robustly explored all identified concerns and give further consideration to transferable risk to siblings or other children.
- Whilst the WSP stipulate that the outcome of a Sec 47 enquiry is a determination made by SSD, where a OSD is held, it is important that relevant agencies are invited to contribute to the OSD, and agency views are recorded clearly including any dissenting views.
- The history should be fully considered in the context of the enquiry and when there is a 'Step Down' to ensure the issue of

consent is addressed and the likely impact on the child/ren if services are declined.

- This should be considered before an outcome is determined to ensure agencies are aware of their continued responsibilities to be vigilant to any identified vulnerabilities and the support that is required to reduce escalating concerns.
- Consideration should be given to training needs of practitioners on understanding the different thresholds/determinations of beyond reasonable doubt (criminal) and on balance of probabilities (social care) when making determinations in line with WSP.
- **Child Protection Medical -** Agencies to consider ways in which to gain meaningful parental feedback on the CP Medical Pathway to improve information sharing, parental understanding of pathway and service improvement/delivery whilst ensuring children's safety remains paramount. E.g. Leaflets (inc easy read), bitesize videos, glossary of language, support signposting, feedback (inc digital options)
- Wherever possible consistent language should be used within all reports referring to suspicious or unexplained injuries to avoid misinterpretation of conclusions. **We recommend a Language Glossary be used.**
- In line with RCPC Guidelines – Health should seek feedback from agencies as part of their quality assurance framework to inform service improvement
- **Child Centred Approach -** The pathway should be reviewed to ensure it remains child focussed.
- When reviewing the pathway, consideration should be given to the recommendations within the child safeguarding practice review panel finding on Bruising in non-mobile infants
- **Emotional Wellbeing & Support -** Further consideration of the impact and support needs of parents on their ongoing emotional wellbeing/mental health when children are separated, reunified and/or subsequently case closed due to 'No Further Action'.
- Whilst it is not the role of the auditors to determine whether one expert is right or wrong, consideration should be given to the impact of separation of newborns and their primary caregivers and the impact this has on secure attachments, development and mental health throughout and following the intervention.
- Further consideration is needed on how to reduce stigma of care, support and safe care needs within families to reduce marginalisation and isolation.

Recommendations:

- The Board's Protocol & Procedures Group to develop and publish Guidance and Pathway for the Management of Suspicious or Unexplained Injuries or Bruising, taking into account the learning arising from this audit and other relevant research. This should include a glossary of terms and clearly stipulate the CP Medical pathways for usual office hours and out of hours. An escalation pathway should also be contained within the guidance.

- When developing the Guidance and Pathway to be cognisant of the learning arising from this audit in relation to a child

centred approach and Parent-Child emotional wellbeing and support needs including appropriate resources.

- All agencies who support parents should be aware of all available information that parents/carers can access and may have been given as these can enable collaborative discussion on their understating of the pathway and their support needs.
- PPG to develop a CTM Dog Bite protocol. There should be specific reference to the Dog Bite Protocol within the Guidance and Pathway for the Management of Suspicious or Unexplained Injuries or Bruising. This is to ensure that in all cases (safeguarding or otherwise) where there is a dog bite it is referred to SWP in line with their existing protocol.
- To develop a mechanism for collating parental and child (where appropriate) feedback for future service development and improvement
- Health to ensure that practitioner feedback if routinely collated as part of their Quality assurance function in line with the RCPC guidelines.
- Learning from this review should be shared by all agencies and Board's Engagement, Learning & Communications sub-group should consider how it can be incorporated into existing multi-agency training and where there may a requirement for specific training.
- We recommend that when Recommendation 1, is complete and the out of hours pathway is agreed that joint training is undertaken, sharing the learning from this review and understanding the management of the pathway out of office hours, including roles, responsibilities and expectations including communication.
- Take forward recommendation from the recently published review in relation to CSA in the family environment, cognisant that the National Delivery Plan on CSA will be published in the autumn.
- All agencies to remined practitioners of their duties to report concerns about those in a position of trust to the DOS/LADO as prescribed in Section 5 WSP
- We recommend that another audit is scheduled within the CQAP audit planner to ensure the new guidance and pathway when implemented, is responsive and effective in the identification and response to suspicious/unexplained injuries and/or bruising and lessons from this and previous audits are improving practice and outcomes for children.

Adult Practice Reviews, Child Practice Reviews, Domestic Homicide Reviews and Single Unified Safeguarding Reviews

In 2025-2026, the Board published 1 Adult Practice Review, 3 Domestic Homicide Reviews and 1 Offensive Weapons Homicide Review (the OWHR as part of a pilot in partnership with the Home Office and Welsh Government). **Further information relating to the Reviews and how our partner agencies have applied learning from these is detailed below.**

The learning and recommendations from both regional and national Reviews are recorded in an Action Plan overseen by the Safeguarding Board and monitored via the Board's *Improving Practice Delivery* sub-group. Learning from reviews are shared with all key stakeholders including the use of 7 Minute Briefings and this also informs the Board's annual Training Plan which supports future learning opportunities for Board partners.

Review	Case Type	Brief Case Summary
Adult E 7-minute briefing	**Offensive Weapons Homicide Review (pilot)** **RCT**	**Date of incident: 17/12/23** Male - DR A 30-year-old male murdered at a house where he resided whilst studying at university. The fatal altercation involved a knife.

RCTCBC Adult Services - the report and & 7 Minute Briefing was circulated to Team Managers for discussion and dissemination to teams. It will inform our approach to the extension of the Exploitation Strategy, when this is extended to 18–25-year-olds. Our Service Managers for Mental Health, Learning Disability and Substance Misuse have been part of the group looking at an Information Sharing Protocol between the University of South Wales and partner agencies.

RCTCBC Children Services - RCT Children Services cascades Practice Review Learning via Children Service Manager Team meetings and Team Manager meetings. This is further disseminated and discussed in individual team meetings where practitioners reflect on the learning and practice.

RCTCBC Education - There was no direct involvement or outcomes for Education as the focus was on adults. However, the focus on a contextual safeguarding approach is an area Education is working with the Board and CSP on to ensure there is a multi-agency response to serious violence and exploitation.

Bridgend Adult & Children's Services - 7-minute briefings are available on the Corporate Safeguarding webpages for staff to access. Learning from local and national SUSR's is included in single and multi-agency safeguarding training.

BCBC Education - Learning has informed education staff awareness of the risks associated with knife crime and serious youth violence. The directorate has reinforced preventative education and safeguarding responses.

Merthyr Tydfil Adults & Children - Within MTCBC, learning from this review has been shared across Social Services through team meetings, supervision and safeguarding briefings. Key themes relating to risk escalation, managing conflict and multi-agency information sharing have been incorporated into local workforce learning and reflective practice discussions, helping practitioners consider how these issues may present within the Merthyr context. Managers have reinforced this learning through supervision and team-based discussion, supporting staff to apply the findings in day-to-day practice. The impact has strengthened

practitioner awareness of escalating risk within Merthyr, reinforced the importance of timely sharing, and supported more effective multi-agency responses to individuals at risk of harm.

CTMUHB - All reviews/SUSR are shared via email, through safeguarding operational and executive groups and with relevant care group structures. Reviews are also placed on the health board's safeguarding SharePoint pages.

Learning from this review was shared via email across services and targeted communication with colleagues within mental health and drug and alcohol services. CTMUHB have worked closely with USW to share resources and strengthen communication and referral pathways between the university and mental health services. In addition, exploration of collaboration with primary care services. Resources were shared with USW and partners in respect of the risks and links of cannabis misuse and poor mental health. The Health Board also contributes to university open day events.

South Wales Police – within the Vulnerability app designed by SWP there is a Special Measures video which can be shown to victims/ witnesses to help explain how special measures work and what may be applied for. Right 4 in the Victims Code of Practice provides the victims with the right to be referred to services and have such services and support tailored to their needs. In order to capture that assessment, officers and staff must complete the VU01 code on NICHE. This is a victim needs assessment for those who are intimidated and in fear. The VU code compliance is scrutinised through performance boards. SWP are currently undertaking a review of exploitation and missing children to ensure a consistent approach force wide. SWP will continue to support any CTMSB exploitation meetings and develop clear pathways for referral and support.

WAST - Whilst no WAST-specific recommendations were identified, the Safeguarding Team will continue to monitor for any published guidance within the Wales Safeguarding Procedures to inform practice in relation to adult exploitation.

BC YJS - Relevant learning was shared through management meetings, safeguarding discussions and team briefings. Particular emphasis was placed on:

- recognising escalating risk.
- effective professional curiosity.
- information sharing across agencies.
- understanding cumulative risk factors.
- timely safeguarding escalation.

These principles continue to inform safeguarding assessments and management oversight within BYJS.

Adult R 7-minute briefing	**Adult Practice Review** **Bridgend**	**Date of incident: 04/06/21** Female - JM An elderly woman, who was a former nurse, died from a suspected suicide.

RCTCBC Adult Services - the report and & 7-minute briefing was circulated to Team Managers for discussion and dissemination to teams and prompted consideration of assessment of suicide risk in older adults.

Bridgend Adult Services - 7-minute briefings are available on the Corporate Safeguarding webpages for staff to access. Learning from local and national SUSR's is included in single and multi-agency safeguarding training.

Merthyr Tydfil Adult Services - learning from this review has been shared across services through team meetings, supervision, and safeguarding briefings. Key themes relating to mental health, vulnerability, and the importance of early intervention have been incorporated into training and reflective practice discussions.

Managers have helped staff to explore how the findings relate to their engagement with individuals experiencing mental health challenges, with a focus on multi-agency work and professional curiosity. This has improved understanding of mental health risk and suicide prevention, strengthened early identification of vulnerability, and reinforced the importance of coordinated multi-agency support.

CTM UHB - Learning from this review has been shared repeatedly over the years since early learning was identified. A bespoke training session was delivered with mental health colleagues, supported by a Health IDVA and the Drive Perpetrators Programme. This session included learning from this review and other published SUSR's. The training was well evaluated, with colleagues recognising how learning could be reflected in practice. Emergency Department colleagues have received updates in respect of this review and are encouraged to attend suicide prevention training delivered both externally and online. Mental health services have explored how family and carers of those who are mentally unwell are better supported, through advice and resources.

South Wales Police - MARAC learning has been shared with all SWP MARAC chairs for their consideration and onward sharing with Coordinators/partners. Professional curiosity is encouraged in all investigative training and initial police learning and was featured as a standalone section in Operation Ammddifyn, the bespoke vulnerability training that was developed and delivered to South Wales Police officers and staff from the frontline to the Public Service Centre (PSC) and specialised departments such as Public Protection.

WAST - Whilst there were no WAST agency specific recommendations, the all-agency recommendation to encourage professional curiosity and embed it into practice has been actioned. Professional curiosity has been embedded within the Level 2 safeguarding induction training to ensure awareness amongst all new staff. This has been further supported through the dissemination of a 7-minute briefing on the topic.

Adult Y	**DHR** **Bridgend**	**Date of incident: 04/06/22** A 38-year-old female was struck by a train in Bridgend.

RCTCBC Adult Services - the report was circulated to Team Managers for discussion and dissemination to teams. It was also discussed in our Domestic Abuse Champions group.

RCTCBC Children Services - RCT Children Services cascades Practice Review Learning via Children Service Manager Team meetings and Team Manager meetings. This is further disseminated and discussed in individual team meetings where practitioners reflect on the learning and practice.

RCTCBC Education - There was a recommendation to the Home Office for statutory guidance on Operation Encompass. Operation Encompass was put into statute and there is guidance on how this should operate online. However, there are still considerable differences between how OE should work and the reality of how this works in practice and the variances between police forces/LA's. More work is needed in this area with South Wales Police as their systems feel underdeveloped at this time.

Bridgend Adult & Children Services - 7-minute briefings are available on the Corporate Safeguarding webpages for staff to access. Learning from local and national SUSR's is included in single and multi-agency safeguarding training.

BCBC Education - Domestic abuse awareness has been strengthened, with schools better equipped to identify and support affected children and families. Directorate staff have been supported to recognise escalating risk in domestic abuse cases and understand referral pathways more effectively.

Merthyr Tydfil Adult & Children Services - Within the Council, learning from this Domestic Homicide Review has been shared through team meetings, supervision, safeguarding briefings and relevant workforce development activity across Adult Services and partner forums. Key themes, including the identification of risk, the impact of domestic abuse, and the importance of timely information sharing, have been used to

support reflective practice discussions and to help staff consider how the findings apply within the Merthyr context. Managers have reinforced this learning through supervision and team-based discussion, supporting staff to apply the findings in day-to-day practice and decision-making. This has strengthened awareness of domestic abuse and associated risks within Merthyr, improved professional curiosity and information sharing, and supported more effective multi-agency safeguarding responses for individuals at risk.

CTM UHB - This review has been shared with all care groups. Specific work has been undertaken with health visiting and midwifery in respect of the Routine Enquiry audit, ensuring it aligns with all Wales Standards. Whilst the Health Board annually undertakes audits in respect of recording standards, there is ongoing work to ensure that current audit programme is sufficient to provide assurance in respect of record keeping in health visiting and midwifery. With the development of the Health IDVA team, learning from this review and others will be embedded into training packages. The Health Board has developed a training plan for 26/27 specifically for all groups of VAWDASV training, ensuring areas such as mental health, emergency departments and primary care are targeted with training. The Health IDVA across all three local authorities has close links with mental health services, ensuring there is effective communication in respect of identified victims and risk. CTMUHB safeguarding team are working with information governance, IT and primary care to establish a robust model of sharing information, including how alerts can be used within health systems.

South Wales Police - DVDS: Inputs have been provided to Domestic Abuse Unit staff by Statutory Review Managers to reiterate to staff that disclosures can be provided where parties have separated. Dip sampling of DVDS occurrences is undertaken by the Domestic Abuse Inspectors, whereby they review the occurrence from another Basic Command Unit (BCU). Safeguarding Officers from within the domestic abuse units are rostered to share the Operation Encompass reports each morning. The report is generated by Niche. This area of work is currently under review to look to increase those receiving the report and to see what further information can be obtained to enhance the report.

Adult Z Report Executive Summary	**DHR** **RCT**	**Date of incident: 15/06/2022** A 39-year-old male murdered by his partner.

RCTCBC Adult Services - the Report and & 7 Minute Briefing were circulated to Team Managers for discussion and dissemination to teams. These were also discussed in our Domestic Abuse Champions group, with a particular focus on the barriers to accessing support that are experienced by male victims of domestic abuse.

RCTCBC Children Services - RCT Children Services cascades Practice Review Learning via Children Service Manager Team meetings and Team Manager meetings. This is further disseminated and discussed in individual team meetings where practitioners reflect on the learning and practice.

Bridgend Adult & Children Services - 7-minute briefings are available on the Corporate Safeguarding webpages for staff to access. Learning from local and national SUSR's is included in single and multi-agency safeguarding training.

Merthyr Tydfil Adults & Children's Services - Within MTCBC, learning from this review has been shared through team meetings, supervision, safeguarding briefings and the use of 7-minute briefings across Adult Services and relevant partner forums. Key themes relating to domestic abuse, coercive control, risk assessment and inter-agency communication have been incorporated into local workforce development activity and reflective practice discussions, helping staff to consider how the findings apply within the Merthyr context. This has also been linked to wider regional work on substance misuse, which is being led across the region by RCTCBC, helping to strengthen shared learning and consistency of approach. Managers have

reinforced this learning through supervision and team-based discussion, ensuring that practice messages are understood and embedded in day-to-day work. We have strengthened awareness of domestic abuse and coercive control within Merthyr, improved risk assessment and information sharing between services and partners and contributed to more robust and consistent safeguarding practice across the Council.

CTM UHB - this review has been shared with the Mental Health care group to ensure colleagues within mental health and drug and alcohol services are sighted and consider how to action its recommendations. CTMUHB have undertaken a review of its contribution to MARAC and subsequently developed a Standard Operating Procedure to support staff in referring and managing high risk individuals. The Health IDVA team are consistently raising awareness of domestic violence within the Health Bard, with a specific focus on timely and quality interventions, including MARAC referrals.

South Wales Police - DVDS: Inputs have been provided to Domestic Abuse Unit staff by Statutory Review Managers to reiterate to staff that disclosures can be provided where parties have separated.
This Learning is placed on the intranet blog weekly for a 3-month period and details of case provided to Risk Assessor Sergeant for onward dissemination. Case study shared with PSC Lessons Learnt SPOC and PSC Clare's Law SPOC for dissemination within PSC. Dip sampling is undertaken to quality assure and monitor reasons for non-disclosure and targeted training is being undertaken to improve understanding of DVDS. Report placed on statutory reviews intranet page. MARAC volume - SWP are fully engaged in discussions with SWP PCC and stakeholders on the current challenges facing MARAC and necessity for refresh/reform.

Adult M Report 7-Minute Briefing	**DHR** **RCT**	**Date of incident: 07/05/2023** A 46-year-old female murdered by her partner.

RCTCBC Adult Services – the report was circulated to Team Managers for discussion and dissemination to teams. It was also discussed in our Domestic Abuse Champions group. We are considering the lessons for our practice in RCT, particularly around the expectation that individuals 'opt in' to services; for some, we recognise the barriers to achieving this are significant.

RCTCBC Children Service - RCT Children Services cascades Practice Review Learning via Children Service Manager Team meetings and Team Manager meetings. This is further disseminated and discussed in individual team meetings where practitioners reflect on the learning and practice.

Bridgend Adult & Children Services - 7-minute briefings are available on the Corporate Safeguarding webpages for staff to access. Learning from local and national SUSR's is included in single and multi-agency safeguarding training.

Merthyr Tydfil Adults & Children's Services - within MTCBC, learning from this review has been shared through team meetings, supervision, safeguarding briefings and the use of 7-minute briefings across Adult Services and relevant partner forums. Key themes relating to domestic abuse, risk management and inter-agency communication have been incorporated into local workforce development activity and reflective practice discussions, helping staff to consider how the findings apply within the Merthyr context. Managers have reinforced this learning through supervision and team-based discussion, ensuring that practice messages are understood and embedded in day-to-day work. We have looked to improve and strengthen our awareness of domestic abuse risk factors within Merthyr, supported more effective information sharing between services and partners, and contributed to more robust and consistent safeguarding practice across the Council.

CTM UHB - CTM UHB have developed a training plan for 26/27 that will include coercive control, this will ensure that professionals are trained to recognise and responds to domestic abuse and coercive control. This is likely to increase the identification of cases, leading to support for victims of domestic abuse. The new Health IDVA service is working closely with the Alcohol Liaison Team to improve cross communication and referrals. This will enable collaboration between services and outcomes identified through experience and outcome measures. Through dissemination of the Health Board's MARAC standard operation procedures, training and educational resources the Health Board aims to improve the quality of MARAC referrals. Understanding of the MARAC criteria and referral process will lead to cases of high risk being referred to MARAC in accordance with MARAC policy.

South Wales Police - a case study focused on police learning and specifically the importance of professional curiosity has been developed and is due to be used for force training days at the end of 2026. MARAC learning is shared with all SWP MARAC chairs for their consideration and onward sharing with Coordinators/partners. Report placed on statutory reviews intranet page.

WAST - Whilst there were no WAST-specific recommendations, the all-agency recommendation to ensure professionals are appropriately trained in relation to domestic abuse and coercive control remains embedded within expected practice. The Trust continues to demonstrate its commitment to the VAWDASV agenda through the implementation of a structured training programme. This includes Level 2 'Ask & Act' training, which incorporates coercive control and is delivered to all new clinical staff as part of their safeguarding induction. In addition, a bespoke digital Live Fear Free referral pathway is in place, enabling staff to refer individuals (with consent) directly to the helpline to access support tailored to their needs.

Complaints

The Board's Complaints Procedure provides families and individuals with the opportunity to make a complaint with regards to the multi-agency child protection conference process and procedures, the multi-agency adult protection meetings process and procedures and Section 5 Wales Safeguarding Procedures complaints in relation to practitioners. Where such complaints satisfy the requirements of the Board's Complaints Procedure, an Independent Panel will usually be convened to consider the complaint and provide a written outcome to any complainant.

CTM Safeguarding Complaints Procedure

During 2025/26, there were 2 complaints received in relation to the Child Protection Conference process and 1 in relation to Section 5 WSP Practitioner Concerns. Of the 3 complaints received, the following outcomes were made by the Board's Independent Complaints Panel:

- **2 Conference complaints were not upheld**
- **1 Section 5 complaint was not upheld**

Information and outcomes in respect of complaints are shared with the Board's Children or Adult Quality Assurance sub-groups with any learning or recommendations to inform improved practice. In 2026/27, a full review of the Complaints Procedure will be completed once the expected Section 5 WSP's updated guidance is published. This will include best practice guidance for services and partners in terms of ensuring a robust response to complaints at the first point of contact to minimise any escalation to the Board's Complaints Procedure.

7. Information Training and Learning

The Board's Engagement, Learning & Communications sub-group works with a range of partner agencies to review the training needs of practitioners in the region and support the delivery of multi-agency training

to improve practice. Relevant learning from serious case reviews are embedded into the Board's annual Training Plan.

Multi-Agency Safeguarding Training

The Local Authority Workforce Development teams (Cwm Taf and Bridgend) are the main source of reporting on safeguarding training, although all partner agencies must ensure that adequate safeguarding training is delivered to staff. The Board supports a range of training provision to support partners and professionals in safeguarding practice drawing on learning from audits and serious case reviews alongside feedback to inform an annual Training Needs Analysis outlining training area priorities.

During 2025/26, the Board continued to work in close partnership with Social Care Wales and our regional Social Care Workforce Development Teams to support training for our regional workforce and have committed to further, enhanced partnership working with Care Inspectorate Wales, the National Independent Safeguarding Board, the Centre of Expertise on Child Sexual Abuse and Welsh Government in respect of the learning from national reviews.

We supported the delivery of a range of training sessions aimed at improving safeguarding practice utilising its training grant allocation from Welsh Government. This included:

- **Safeguarding Group B Safeguarding – updated Group B training including supporting enhanced arrangements for school professionals**
- **Understanding Domestic Abuse & Coercive Control incorporating learning from CTM Serious Case Reviews**
- **Anti-Pathologising Trauma Informed Practice**
- **Professional Boundaries**
- **Transitional Safeguarding**
- **VAWDASV Ask & Act supported by VAWDASV regional funding also included a focus on coercive control and the abuse of older people.** Moving into 2026/27, having recognised the need to enhance further join-up between VAWDASV needs and the Safeguarding Board, increased collaboration will take place to ensure a more holistic approach to adults and children at risk of abuse is achieved.

We also collaborated with Stori Cymru to provide training to 114 professionals across the region during this year. Below is some of the feedback received from colleagues in attendance:

- ***Really good training for a sensitive subject***
- ***Really helpful, good resources***
- ***The trainer was very engaging and encouraging***
- ***I think it was a great reflection on my practice and where I can make improvements***
- ***Understanding the importance of asking someone "why"?***
- ***Gaining the ability to explore the reasons why someone is engaging in a particular way without causing offense***
- ***Useful to have new resources to update information and use with families***
- ***Thank you very much for the opportunity of this deep dive training. This is the first detailed training I have seen dedicated to Coercive Controlling Behaviour which is by far the biggest contributor to abuse and exploitation in all its forms.***

We continued to support training delivery in partnership with Welsh Government and Mid & West Wales RSB in respect of the Single Unified Safeguarding Review framework. Since SUSR implementation, 28 professionals across the region have completed the Welsh Government funded Chair & Reviewer training, enhancing our local capacity to lead and contribute to safeguarding reviews.

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

The table below outlines Cwm Taf Morgannwg's progress regarding the VAWDASV National Training Framework in 2025-2026:

Group	Numbers completed
1 e learning compliance	19,562 (in compliance)
2 Ask and act	324
3 Ask and act champions	30
4 Specialist provider training	6
5 Specialist managers	1
6 Senior leaders	11

Multi Agency Practitioner Events:

Transitional Safeguarding

During October 2025 in partnership with Social Care Wales, the Board hosted a regional, multi-agency Transitional Safeguarding event to raise the profile of TS and encourage multi-agency discussion and collaboration on how to progress any improvements in the region for this. During 2026/27, a further regional event is planned which

will inform a review and update of the Board's ***Principle and Approach to*** **Transition Protocol** and how the Board can further support future improvements in transitional safeguarding arrangements.

CTM Exploitation Strategy

The Board's regional Exploitation Strategy was launched in September 2025. Throughout 2025/26, a range of professional learning and awareness raising sessions were delivered throughout the region to support the implementation of this. A bespoke Communications Plan remains in place to support further awareness and promotion of the Strategy into 2026/27. To mark **Child Exploitation Awareness Day on the 18th of March 2026**, an online awareness session was arranged for foster carers and professionals working in residential settings for children and young people. 135 professionals signed up to join the online event, which focused on raising awareness of exploitation, recognising the signs and indicators of exploitation, understanding grooming and coercive control and increasing confidence in responding to safeguarding concerns.

Centre of Expertise on Child Sexual Abuse

During this year, a "*Signs & Indicators of Child Sexual Abuse*" webinar was delivered across the region to enhance professionals understanding, awareness and recognition of the indicators of child sexual abuse.

CTM VAWDASV Specialist Service Providers

During Safeguarding Week 2025, our regional specialist providers delivered a session on the risks of online harm in the context of Domestic Abuse. The session was aimed at helping professionals better understand the definition of Domestic Abuse and Coercive Control, increase knowledge of online abuse, the law as it relates to Coercive Control and online abuse, help understand the methods and technologies used in online abuse and the interventions available.

Barnardo's Better Futures

An online learning session was provided in respect of Children, Technology and Online Behaviour highlighting factors to consider when identifying, assessing, and intervening with children and young people who either harm or have come to harm online. It provided insight into the factors that increase risk of harm and vulnerability for children to be harmed in digital spaces, as well as what this means for recovery and intervention.

National Independent Safeguarding Board (NISB)

During Safeguarding Week, the NISB hosted their annual online National Safeguarding Conference "*Leading from Lived Experience in Safeguarding: Listening, Learning and Embedding in Practice*" in partnership with Manchester Met University. The session was attended by a range of CTM professionals.

Dissemination of Learning

As part of developing a positive culture of learning, the Board uses a range of methods to disseminate best practice and learning within the workforce, including Multi-Agency Practitioner Forums, information within the Board's e-bulletin, Safeguarding Updates, use of X (formerly Twitter), Facebook and the Safeguarding Board's website.

Safeguarding Updates

The Safeguarding Board's website continues to host 'Safeguarding Updates' and the Board's Business Unit and its Engagement & Communications Officer are responsible for disseminating a wide range of safeguarding updates and information to its key stakeholders. This includes:

- Policies and Protocols
- Single Unified Safeguarding Reviews
- Safeguarding Campaigns
- Good Practice Information

- New Legislation Updates
- Consultations and National Reports

Safeguarding Week 2025

Wales National Safeguarding Week campaign is an annual campaign that aims to raise awareness of and provide training on safeguarding issues. Safeguarding is about protecting vulnerable children and adults from abuse and neglect and ensuring their wellbeing. Making sure people are supported to live full and happy lives is also an important part of safeguarding. In 2025, the campaign took place between 10th and 14th November. The theme in Cwm Taf Morgannwg was *'Online Harm: Keeping Yourself and Others Safe'.*
The event brought together a wide range of partner agencies from across the statutory, voluntary and community sectors, demonstrating a strong multi-agency approach to safeguarding. Representatives attended from organisations including Age Connects Morgannwg, ASSIA, Barod, BAWSO, Compass, CTM Mind, Foster Wales, Merthyr Tydfil County Borough Council Adult Safeguarding, National Advisory and Liaison Service (NALS), New Pathways, NSPCC, South Wales Valleys Samaritans, Stori, South Wales Police, Voluntary Action Merthyr Tydfil (VAMT) and other local support services.

Some of the highlights of the week are listed below:

Online Harm in the Context of Domestic Abuse

Three sessions were delivered online by Assia, RCTCBC Oasis Centre, RCT Domestic Abuse Service and Safer Merthyr Tydfil. The sessions, delivered to 91 practitioners, provided an overview of domestic abuse, coercive control, and the growing impact of online abuse. The sessions aimed to increase understanding of how technology can be used to monitor, control, harass, or harm victims, explore the legal framework surrounding coercive control and online abuse, and help participants recognise the signs of digital abuse. The session also highlighted common methods and technologies used by perpetrators and outline practical interventions and support available to safeguard and assist victims.

Cybercrime – Digital Stalking and Harassment (including Violence Against Women and Girls)

62 delegates signed up to join this online session which was delivered by a member of the Economic and Cyber Crime Unit at South Wales Police. The session was extremely well received, with feedback highlighting how interesting and valuable the session was, with excellent delivery and lots of practical and useful advice.

Speaking to Children About Child Sexual Abuse

The CSA Centre also delivered a session on using the 'Communicating with Children Guide'. This explored the barriers that can prevent children from disclosing abuse and provides practical guidance on how professionals can support children to talk about their experiences. The training aimed to increase understanding of children's experiences, strengthen communication skills, and improve professionals' confidence in responding appropriately when a child discloses sexual abuse. It was delivered by an experienced safeguarding practitioner with expertise in child sexual abuse and multi-agency working.

8. How have we collaborated with others?

Working in partnership with others is integral to the work of the Board as safeguarding is an issue that crosscuts many different services, and which can have a significant impact on our communities. We work in partnership in a number of ways, with individuals, agencies, partnerships and organisations both within and external to Cwm Taf Morgannwg. Regional partnership working across Cwm Taf Morgannwg has remained strong, whether it involves planning workforce needs and training requirements, safeguarding services, integrating service provision or responding to region-wide challenges.

Public Service Board

The Public Services Board (PSB) acts as the principal strategic leadership forum for the planning, commissioning, and delivery of public services across organisational boundaries to achieve better outcomes for people. The RSB provides quarterly updates to the PSB and attends on an annual basis to present on the Board's safeguarding activities.

Community Safety Partnership

The Board works closely with the CTM Community Safety Partnerships on common areas of interest, such as domestic violence, substance misuse, anti-social behaviour, preventing serious violence and domestic homicide reviews. During 2025/26, a significant amount of partnership work has taken place to improve the oversight and monitoring of CSP Serious Case Review recommendations. An enhanced process has

been triangulated between the RSB and the CSP ensuring there is a robust process in place to support the delivery of relevant areas of learning. There are future opportunities for the Board and the CSP to collaborate further on cross-cutting themes that affect both partnerships, particularly in the context of serious and organised crime and the prevention of exploitation.

Public Health Wales

The Board continues to work positively in partnership with PHW in respect of the region's Suicide and Self-Harm work-stream. The Board also collaborates with PHW in respect of practice reviews, safeguarding referral pathways and good practice.

Wales Safeguarding Procedures Project Board

Members of the Board participate in the Wales Safeguarding Procedures (WSP) Project Board to ensure that the WSP for children and adults, along with the accompanying practice guides, remain fit for purpose and are adopted appropriately. The Board supports the Project Board in facilitating updates to Practice Guides.

Welsh Government

The Board works closely with the Safeguarding and Advocacy Division of the Welsh Government on matters including the Single Unified Safeguarding Reviews that include Adult and Child Practice Reviews, Domestic Homicide Reviews and Offensive Weapon Homicide Reviews and safeguarding-related legislation and policies and as part of wider networks across Wales. This includes other Welsh Safeguarding Boards.

National Independent Safeguarding Board (NISB)

A member of the NISB attends each Board meeting and provides advice and guidance in relation to safeguarding from a national, independent perspective.

Social Care Wales

The Board has contributed to the development of the National Training Framework, led by Social Care Wales and has continued to work pro-actively with SCW this year to support information dissemination in respect of Group B and Group C Safeguarding Training and in developing regional learning events.

Advocacy Providers
Advocacy providers sit on the Board's Adult Quality Assurance and Performance Sub-Group to ensure that the voices of adults at risk are heard and to support the delivery of best practice.

Third Sector
We continue to work with a range of third sector partners who bring added value and expertise to the Board and its work. We continually seek opportunities to work with the third sector to improve safeguarding approaches in the region.

NSPCC
Joint partner in respect of child safeguarding activities and awareness raising campaigns.

University of South Wales
Supporting Safeguarding Reviews and enhanced joint working arrangements including triangulation with the regional CSP.

Social Housing Providers & Community Housing Cymru
Working in partnership in relation to learning from Serious Case Reviews and supporting a pan-Wales Safeguarding Spotlight Event for providers in November 2026.

The Board was also pleased to be recognised this year for its positive partnership working arrangements as part of the pan ***Wales Safer Communities*** annual award nominations that took place in December 2026 for both its *Immediate Response Protocol* and its collaborative work with the NSPCC for its "*Chwarae Dy Ran (Play Your Part)"* campaign.

- "Chwarae Dy Ran (Play Your Part)" Award
- IRG Protocol Award

9. Participation and Involvement
Children, young people and adults who are affected by the exercise of the Safeguarding Board's functions should be given the opportunity to participate in the work of the Board. This is an area where we would like to extend the reach of the Board in collaborating more effectively with those with lived experience and welcome opportunities, particularly those with our third sector partners who can support enhancement of our work in this area. We will continue to strive to improve our participation opportunities as we move forward into 2026/27.

The information below highlights some of the work that has been carried out during 2025-2026:

NSPCC "It's Not Love" Campaign & Professional Learning Session

As part of the Board's ongoing collaboration with the NSPCC, the 'It's Not Love' campaign features a set of educational resources designed to help young people aged 11–14 understand healthy and unhealthy relationships. The materials explore themes such as domestic abuse, coercive control, and harmful sexual behaviours in peer and family contexts. These were initially delivered to secondary schools throughout the region in 2024/25 and during 2025/26, further promotion of the campaign materials took place with professionals to support increased awareness for continued signposting to the resource pack for those working with children and young people.

Safeguarding Week Community Event: Online Harm - Keeping Yourself and Others Safe

The 'Online Harm: Keeping Yourself and Others Safe' community event was held at the Merthyr Tydfil Town Centre Hub on 13th November 2025. The free drop-in event was organised to raise awareness of online harm and provide information, advice and support to members of the public on a range of safeguarding issues associated with digital technology and internet use. Topics covered included sextortion, trolling, identity theft, grooming, exploitation, stalking, radicalisation and online bullying.

The event brought together a wide range of partner agencies from across the statutory, voluntary and community sectors, demonstrating a strong multi-agency approach to safeguarding. Representatives attended from organisations including Age Connects Morgannwg, ASSIA, Barod, BAWSO, Compass, CTM Mind, Foster Wales,

Merthyr Tydfil County Borough Council Adult Safeguarding, National Advisory and Liaison Service (NALS), New Pathways, NSPCC, South Wales Valleys Samaritans, Stori, South Wales Police, Voluntary Action Merthyr Tydfil (VAMT) and other local support services.

The event provided an opportunity for residents to engage directly with professionals, access support services, and learn how to recognise and respond to online risk affecting both adults and children. This community engagement activity contributed to the Board's wider commitment to prevention, awareness raising and empowering people of all ages to protect themselves and others from harm.

Merthyr Tydfil Town Centre Hub Event:

Child Sexual Exploitation Awareness

An online, evening event was supported by the Lucy Faithfull Foundation - Preventing child sexual abuse in November 2025 for parents and carers. The session helped parents understand how and why child sexual exploitation happens and explores risk factors, signs and indicators. It also provided information on where to get help and how positive preventative action can help protect children and young people from exploitation.

10. Contributions of Board Members

Each Safeguarding Board partner has a responsibility to ensure that the Board is operating effectively. There are clearly defined Terms of Reference for the Board and each sub-group as well as role profiles for Board Members.

The Board continues to review the effectiveness of measures taken by partners and other bodies in relation to safeguarding via its quality assurance work, audits, and performance management. All the required statutory

partner agencies in Cwm Taf Morgannwg are represented on the Board and its sub-groups with positive attendance.

The Board's Development Day which took place on the 6th of March 2026 was well attended with partners contributing fully to the event. This set the priorities for the Board for 2026/27.

The Board provides induction information for new members which includes:

- The Board's Induction Pack
- 7 Minute Briefing
- Board Structure
- Terms of Reference for Board and its sub-groups

Our partner agencies are key to ensuring the Board operates effectively and partners support the Board in a number of different areas. Examples of these are summarised below.

Merthyr Tydfil County Borough Council (MTCBC)

MTCBC's Director of Social Services is the current Chair of the Safeguarding Board leading on our main Board meetings and supporting our work priorities. A range of Merthyr professionals and practitioners are members of the Board's sub-groups including the Adult Lead Service Manager who is Chair of the Board's Adult Quality Assurance Group. Professionals provide extensive support for the Board's Single Unified Safeguarding Reviews.

Bridgend County Borough Council (BCBC)

The Director and officers of the Council have continued to be active participants on the Board's sub-groups with representatives from both adults and children's services having both chairing and vice-chair responsibilities ensuring the priorities of the Board are being achieved.

Representatives from the Directorate have attended workshops, planning days and team meetings which have contributed to the setting up actions to meet the Board's priorities for its Annual Plan.

BCBC has also contributed fully to participating in SUSRs and the dissemination of learning from reviews. Following significant training there is now a wider cohort of staff who are able to participate as panel members, reviewers and chairs within the SUSR process.

Rhondda Cynon Taf County Borough Council (RCTCBC)

RCTCBC Children's Services continues to provide a high level of contribution to the work of the Board through regular attendance at and participation in the work of all of the Sub-groups to the Board.

During 2025-2026 RCTCBC Children's Services continued to host the CTMSB Business Unit and provided extensive support to the work of the Board and staff of the CTMSB Business Unit and supported the implementation of the CTMSB new substructure. We have consistently contributed as subgroup members to the Children's Quality Assurance Panel, providing regional analysis to the performance data highlighting themes, trends and risks to the CTMSB, attended Engagement, Learning & Communication Group, contributing to key events e.g. Safeguarding Week.

RCTCBC chairs the Exploitation Strategical Group, the SUSR Review Group and Improving Practice Delivery Group, bringing a renewed focus on consistent thresholding on new cases for consideration of SUSR and the previous actions plans from practice reviews to ensure an evidence base of improved practice across the region. We have also contributed to the delivery of multi-agency training by facilitating Section 5, Professional Concerns Training and attended and contributed to Immediate Response Groups and PRUDiC's.

RCTCBC have also been a representative on behalf of the CTMSB in relation to national work, e.g., National Performance Framework, Pan-Wales Exploitation Group and the National Single Agency Referral Form and the Welsh Government Missing Children from Home and Care Steering groups.

Cwm Taf Morgannwg University Health Board (CTMUHB)

Representatives of CTMUHB take part in the Board Development Day, reviewing the Risk Register and identifying priorities for the year. The Health Board's Executive Director of Nursing is Vice Chair of the Board.

As a key partner agency, the Health Board attends both the Single Unified Safeguarding Review Group and Improving Practice Delivery Group. CTMUHB have participated both as panel members and reviewers on a number of SUSRs.

CTMUHB Work collaboratively with care groups and partner agencies to establish how learning from reviews is implemented and embedded into practice. Through an annual audit programme revisiting recommendations to ensure they have been effectively embedded into practice.

CTMUHB actively works with the Regional Safeguarding Board and partner agencies to ensure consistency in safeguarding practice, policies and procedures across the region. The Health Board's Head of Safeguarding has actively contributed to the chairing arrangements of the Board's Policies and Procedures Group, supporting the development of Board's policies and procedures. This includes engagement in multi-agency audits, joint policy development and shared governance structures, supporting a standardised and equitable approach to safeguarding that reduces variation and improves outcomes for children and adults at risk.

Probation Service

The Probation Service has maintained a strong and consistent presence within Cwm Taf Morgannwg safeguarding structures and continued to strengthen its contribution to the CTMSB through active engagement, partnership working, and implementation of both national and local safeguarding priorities. We are an active participant in Board meetings and its sub-groups, ensuring probation is represented in multi-agency decision-making. We provide ongoing contribution to Safeguarding Intelligence Hub (SIH) activity, including data sharing, action tracking and performance improvement work. We have representation at multi-agency safeguarding auditing groups, contributing both case-level insight and system-level challenge and learning and support strong partnership working with police, social services, health and third sector agencies, reflecting the expectation that safeguarding is a shared responsibility across agencies.

We contribute to the Board's Task & Finish Groups, including work to strengthen processes around resolution of professional differences and fully participate in Board-led audits and assurance processes supporting transparency and continuous improvement.

Welsh Ambulance Service Trust (WAST)

The Welsh Ambulance Services University NHS Trust (WAST) is committed to supporting the work of Cwm Taf Morgannwg Safeguarding Board. The Assistant Director of Safeguarding provides a quarterly highlight report outlining key safeguarding activity and emerging issues, which is presented by the nominated NSS representative. The NSS representative also ensures that relevant learning is captured and shared with WAST accordingly.

South Wales Police (SWP)

South Wales Police continue to work effectively with the Board, contributing to multi-agency meetings and Board priority workstreams. SWP leads on the Board's Immediate Response Group Protocol chairing meetings and contributing to actions to support those affected by serious incidents within CTM communities.

We support SUSR's by contributing as both Panel Members and lead Reviewers and as a lead strategic partner for exploitation, serious violence and safeguarding.

11. Managing our Resources

The Cwm Taf Morgannwg Safeguarding Board uses the funding formula set out in the Social Services and Wellbeing (Wales) Act 2016 statutory guidance to support the functions of the Board's Business Unit. This allows us to assess and identify annual financial contributions from our statutory partner agencies. This is calculated as follows:

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

In 2025-2026 expenditure was as follows:

Staff	£485,972
Premises	£10,280
Other	£54,680

WG Grant Income (SUSR)	-£ 42,000
Total	£508,932

12. Other Board Activities

Adult Protection and Support Orders (APSOs)

Adult Protection and Support Orders have been available since the 2016 implementation of the Social Services and Well-Being (Wales) Act 2014 but have been used rarely. There were no APSO applications APSOs in 2025-2026.

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

The Board continues to work closely with Welsh Government and the National Safeguarding Board and responds promptly to requests for information or support. A good relationship has been established with both in terms of the work of the Safeguarding Board with the Chair of the Board and the CTMSB Business Manager contributing to national meetings as required. In addition, Board partners support various national work streams on behalf of the region. The Board has worked pro-actively with these as key stakeholders with other regional Safeguarding Boards to support the effective implementation of the All-Wales Single Unified Safeguarding Review framework.

Section 137 requests for information

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

In 2025-2026 the Board did not use its Section 137 powers to access information.

APPENDIX 1 - BOARD MEMBERSHIP

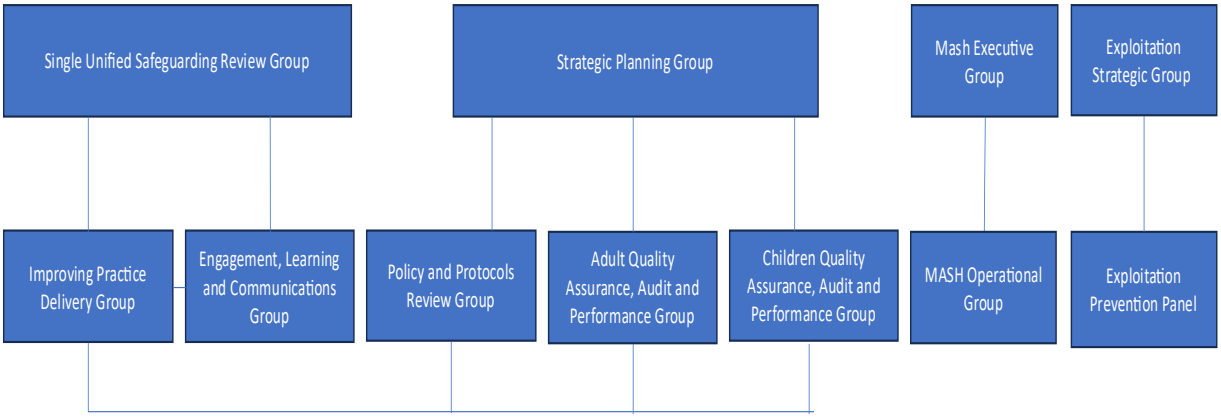
TITLE	AGENCY
Director of Social Services (Chair)	Merthyr Tydfil County Borough Council
Director of Social Services and Wellbeing	Bridgend County Borough Council
Director of Social Services	Rhondda Cynon Taf County Borough Council
Head of Safeguarding (Adults)	Rhondda Cynon Taf County Borough Council
Director Public Health	Rhondda Cynon Taf County Borough Council
Head of Safeguarding (Children)	Rhondda Cynon Taf County Borough Council
Director of Education and Inclusion Services	Rhondda Cynon Taf County Borough Council
Service Director, Children Services	Rhondda Cynon Taf County Borough Council
Head of Legal - Community Care and Children	Rhondda Cynon Taf County Borough Council
Prison Director	Parc Prison
Head of Safeguarding	Cwm Taf Morgannwg University Health Board
Named Doctor	Cwm Taf Morgannwg University Health Board
Executive Nurse Director (Vice Chair)	Cwm Taf Morgannwg University Health Board
Deputy Executive Nurse Director	Cwm Taf Morgannwg University Health Board
Head of Service	Cwm Taf Youth Justice Service
Head of Service	Youth Justice Service, Bridgend
Named Lead for Safeguarding	Public Health Wales
Designated Nurse (National Safeguarding Team)	Public Health Wales
Head of Probation	Probation Service
Director of Education	Merthyr Tydfil County Borough Council
Head of Public Protection	Merthyr Tydfil County Borough Council
Head of Adult Services	Merthyr Tydfil County Borough Council

Principal Safeguarding Manager	Merthyr Tydfil County Borough Council
Head of Children Services	Merthyr Tydfil County Borough Council
Head of Adult Social Care	Bridgend County Borough Council
Head of Children's Social Care	Bridgend County Borough Council
Head of Education and Family Services	Bridgend County Borough Council
Group Manager	Bridgend County Borough Council
Head of Public Protection	Bridgend County Borough Council
Head of Adult Safeguarding and Secure Estate	Bridgend County Borough Council
Superintendent	South Wales Police
Head of Protecting Vulnerable Persons	South Wales Police
Assistant Director Quality, Safety & Patient Experience	Welsh Ambulance Service Trust
NISB Member	National Independent Safeguarding Board
Safeguarding Lead Officer	South Wales Fire & Rescue Service

APPENDIX 2 – BOARD STRUCTURE 2025/2026

Cwm Taf Morgannwg Bwrdd Diogelu Safeguarding Board

CTMSB Sub-Group Structure 2025/2026



Glossary of Terms

Single Unified Safeguarding Review

Is a single review process incorporating all reviews in Wales which came into being on the 1st of October 2024. The Safeguarding Board must commission an SUSR where the following criteria are met:

- Adult Practice Review
- Child Practice Review
- Domestic Homicide Review
- Mental Health Homicide Review
- Offensive Weapons Homicide Review

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

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

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

Mental Health Homicide Review (MHHR)
MHHR's take place when a homicide is committed and the alleged perpetrator has been in contact with primary, secondary or tertiary mental health services within the last year.

Offensive Weapons Homicide Review (OWHR)
An OWHR takes place when the death of a person aged 18 or over occurs using an offensive weapon.

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

Children Looked After
A child is looked after by a local authority if a court has granted a care order to place a child in care, or a Council's Children's Services department has cared for the child for more than 24 hours.

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

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

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

Multi-Agency Risk Assessment Conference (MARAC)
A weekly risk management meeting where professionals share information in respect of high-risk cases of domestic violence and abuse and put in place a risk management plan.

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

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

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

Prevent
Prevent is about safeguarding and supporting those vulnerable to radicalisation or extremism.

Procedural Response to Unexpected Deaths in Childhood (PRUDiC)
This procedure sets a minimum standard for a response to unexpected deaths in infancy and childhood. It describes the process of communication, collaborative action and information sharing following the unexpected death of a child.

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

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

Social Services and Wellbeing (Wales) Act 2014
The Social Services and Well-being (Wales) Act is the law for improving the well-being of people who need care and support, and carers who need support.

Strategy Discussion / Meeting
A meeting for social workers and other professionals to discuss risks against an adult or child and to discuss how any risks will be addressed to protect someone from harm.

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

MOP – Model of Practice

Are You Concerned About Someone?

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

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

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

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

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

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

To contact **Children or Adults Services outside office hours, at weekends and bank holidays,** ring the Cwm Taf Morgannwg Emergency Duty Team on 01443 743665 or 01443 657225.

If you suspect that a child, young person or an adult is at immediate risk of harm call 999 and speak to the Police. Further information on how to report any concerns relating to a child or adult at risk is available here:

Rhondda Cynon Taf County Borough:
RCT Children: Reporting a concern about a Child | Rhondda Cynon Taf County Borough Council
RCT Adults: Report a concern about someone at risk | Rhondda Cynon Taf County Borough Council

Bridgend County Borough:
Bridgend Children: Child protection
Bridgend Adults: Safeguarding adults at risk

Merthyr Tydfil County Borough:
Merthyr Children: How to report a child/young person you believe is at risk of/experiencing abuse and neglect | Merthyr Tydfil County Borough Council
Merthyr Adults: Adults at Risk of Abuse or Neglect | Merthyr Tydfil County Borough Council

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

Remember - safeguarding is everybody's business! For more information and advice visit: About Us | Safeguarding, Cwm Taf Morgannwg