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**STRENGTHENING SAFEGUARDING
GOVERNANCE REVIEW IN WALES**
PHASE 1

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Foreword

I would like to extend my sincere gratitude to all those who contributed their time and expertise during the course of this Review. This Review has benefited greatly from the knowledge, information, and experience of professionals across Wales, including representatives from central and local government, health, policing, and the voluntary and community sectors, as well as faith-based and sporting organisations. In addition, I appreciate the independent contributions of many individuals. I also gained valuable insights from discussions with colleagues in Scotland and England, and from the Welsh Governments Research on safeguarding governance models from around the world.

Jan Pickles OBE March 2026

Strengthening Safeguarding Governance Review – Phase 1 Report

Purpose of the Review

It has been more than ten years since the current Safeguarding Governance arrangements in Wales were put in place following the Social Services and Well-being (Wales) Act 2014. Over the past decade, these governance structures have faced numerous challenges from both Brexit, which added pressure on the social care workforce, as well as the significant impact of the Covid pandemic. The legacy of these major events has impacted on the way we deliver services but also on our governance arrangements.

To place the people of Wales at the centre of Safeguarding Governance, Welsh Government must set clear policy and standards, ensuring that services deliver timely and appropriate interventions in partnership with service users.

This Review is the first phase of an in depth look at our safeguarding governance arrangements. The principles of good governance laid out in The International Framework: Good Governance in the Public Sector (2014)¹ suggests we ask ourselves these questions- they form the basis of Phase 1 of this Review. In terms of safeguarding governance:

1. What aspects do we already do well?
2. How do we get to the next level?
3. What practical next steps do we want to try?

It is proposed Phase 2 of this Review will refine the detail required and help answer the fourth question.

4. How will we know if we have been successful?

The Terms of Reference for Phase 1 of this Review are attached in full at Appendix 1 and the methodology is attached at Appendix 2.

Background and context of the development of safeguarding governance structures in the UK

Prior to devolution the governance of safeguarding was limited to child protection, with adult protection receiving little multi-agency scrutiny. In Wales, our approach aligned with the UK system of Area Child Protection Committees (ACPCs). This model concentrated on child protection specifically, excluding the broader concept of safeguarding and wellbeing. In contrast, adult protection was less understood or

¹ <https://www.publicgov.co.uk/2017/10/30/the-international-framework-a-great-structure-for-public-governance-reviews/>

developed and was typically addressed through individual agency interventions. Issues such as domestic abuse and violence were primarily managed in isolation by the third sector and the Police.

In England and Wales during the early 2000s, there was a transition from a traditional child protection approach to a more inclusive safeguarding model, with prevention and early intervention seen as integral parts of the state's response to abuse, neglect and other forms of harm. This evolution was shaped by the inaugural Joint Chief Inspectors' Report On Safeguarding Children² in 2002 and insights from the 2003 Victoria Climbié Inquiry³, alongside other tragedies. It must be noted that a similar widening of approach in Adult Protection did not happen for many years.

In Scotland the decision to retain the terminology of Child Protection remains until the present, the wider language of safeguarding has not been adopted. Despite much discussion of safeguarding across the 'life course', Scotland operates 31 Child Protection Committees (CPC) coordinated by a third sector organisation Celcis⁴. The Adult Support and Protection (Scotland) Act 2007 set up multi-agency Adult Protection Committees (APCs) in every council area. Adult safeguarding governance in Scotland was described to this Review as less developed. Celcis are funded by the Scottish Government and provides a what works approach and support to the CPC's, shaping the following with them:

1. What problem are we trying to solve?
2. What interventions are available and will be effective?
3. What organisational support is needed to implement and sustain effective practice?
4. What political, regulatory, financial, and partnership arrangements are needed?

The Five Nations joint workshops attended by Wales's National Independent Safeguarding Board (NISB) is seen as effective in sharing learning related to adult safeguarding across the UK and could be replicated for safeguarding children and young people.

In England, several institutional reforms were undertaken to improve safeguarding governance, including replacing ACPCs with Local Safeguarding Children Boards (LSCBs). Previously, ACPCs operated without statutory authority, which research indicated limited their effectiveness and consistency across regions. Identified shortcomings included an overemphasis on children's social care, disparities in representation and membership, variations in structure and practice, inadequate

² <https://lx.iriss.org.uk/sites/default/files/resources/097.%20Safeguarding%20Children%20-%20A%20Joint%20Chief%20Inspectors%20Report.pdf>

³ <https://www.gov.uk/government/publications/the-victoria-climbié-inquiry-report-of-an-inquiry-by-lord-laming>

⁴ <https://www.celcis.org/about-us>

leadership, and insufficient resources (Chief Inspector of Social Services et al., 2002⁵; Alan France, Emily R. Munro, Amanda Waring 2010⁶).

The major reform to safeguarding governance in England was in 2016 with Sir Alan Wood's Review of England's Multiagency Safeguarding arrangements. This led to the abolition of LSCBs and their replacement by the Statutory Safeguarding Partners based on the Local Authority footprint, represented by senior leaders from Health, the Local Authority and the Police who were to have decision making powers over budgets, people and policy. Implementation was delayed by Covid and service adjustments during lockdowns. Serious Case Reviews the precursor to the Welsh Child Practice Reviews were replaced in England with Local Child Safeguarding Practice Reviews (LCSPR)⁷ in 2018.

Wood's follow up review 'Sector expert review of new multi-agency safeguarding arrangements'⁸ in May 2021 found some early successes from the earlier adopters of the Safeguarding Partners model. However, Wood criticised many areas as offering little real change he described some areas as offering '*old wine in new bottles*'.

Overall, Wood felt the involvement of Education was limited and a noted weakness in the model. There are some areas in England who were resistant to the changes and have retained a wider partnership approach more similar to the Welsh Regional Safeguarding Boards (RSBs).

The next significant change in English safeguarding governance was the Children and Social Work Act 2017⁹ provided for the creation of the Independent Child Safeguarding Practice Review Panel¹⁰. The Panel was a step towards centralisation of governance arrangements as it commissions national reviews of child safeguarding both thematic and in individual high-profile cases. All Local Authorities notify the Panel of cases that meet the criteria for a local review and reach agreement of the added value the review can make to safeguarding learning.

The Social Services and Well-being (Wales) Act 2014, which came into effect in April 2016, marked a significant transformation for social services in Wales. The Act advanced independence and co-production, ensuring individuals have a more influential role in the services they receive. Now, a decade after this pivotal legislation, this Review has been commissioned to determine how governance of

⁵ <https://www.lgcplus.com/archive/government-welcomes-joint-inspectorates-report-on-childrens-safeguards-14-10-2002/>

⁶ France, Alan; Munro, Emily R.; Waring, Amanda (2010). The evaluation of arrangements for effective operation of the new Local Safeguarding Children Boards in England - Brief. Loughborough University. Report. <https://hdl.handle.net/2134/6448>

⁷ <https://www.legislation.gov.uk/ukdsi/2018/9780111167540/contents>

⁸ https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/987928/Wood_Review_of_multi-agency_safeguarding_arrangements_2021.pdf

⁹ <https://www.legislation.gov.uk/ukpga/2017/16/contents>

¹⁰ Chrome

extension://efaidnbmnnnibpcajpcglclefindmkaj/https://assets.publishing.service.gov.uk/media/67c97b1dd0fba2f1334cf300/Child_Safeguarding_Practice_Review_Panel_annual_report_2023_to_2024.pdf

multiagency safeguarding arrangements for children and adults at risk can be further strengthened.

IICSA recommendation 2022 -The establishment of a Child Protection Authority

In 2022, IICSA's seven-year inquiry into Child Sexual Abuse¹¹ recommended that a Child Protection Authority¹² (CPA) in England and Wales should be established. The three functions of the CPA are to:

- I. improve practice in child protection and provide advice
- II. make recommendations to government in relation to child protection policy
- III. have the power to inspect.

When the IICSA final report was released, both the UK Government and the Welsh Government accepted all of the recommendations directed to them fully or in principle. The Welsh Governments response¹³ pointed to the current roles and responsibilities of the Inspectorates, Children's Commissioner, Older People's Commissioner, and NISB as covering those functions. Stating the NISB already fulfilled parts (i) and (ii) of the IICSA recommendation,

In December 2025, the Department of Education in England (which does not have a similar body to NISB) announced the creation of a CPA, a new entity to enhance the child protection system and provide national oversight. Following a consultation on these proposals, which concluded in March 2026, its role, which is subject to review includes:

- Providing strong leadership to ensure good child protection practice is embedded consistently across local areas.
- Addressing systemic issues such as those highlighted by the Casey Audit into group-based child sexual exploitation and abuse.
- Ensuring agencies responsible for looking after children work together closely and share relevant information to prevent any child from falling through the cracks.
- Identifying emerging threats and holding services to account for protecting children.

The CPA announcement followed recent safeguarding events in England, such as the murder of Sara Sharif¹⁴ and findings from the Casey Audit¹⁵ on grooming gangs.

¹¹ <https://www.iicsa.org.uk/recommendations.html>

¹² <https://www.gov.uk/government/news/new-national-child-protection-authority-announced>

¹³ <https://www.gov.wales/written-statement-update-welsh-government-response-iicsa-final-report-recommendations>

¹⁴ <https://surreyscp.org.uk/wp-content/uploads/2025/11/SS-CSPR-SSCP-Report-for-publication-13.11.25.pdf>

¹⁵ https://assets.publishing.service.gov.uk/media/685559d05225e4ed0bf3ce54/National_Audit_on_Group-based_Child_Sexual_Exploitation_and_Abuse.pdf

The CPA will contribute to broader child protection reforms under the Children and Well-Being Schools Bill¹⁶, now in the final stages before the UK Parliament. A key function of the new body will be to ensure that lessons are learned from the reviews of serious cases and other information acted on consistently across the country.

The current safeguarding governance arrangements in Wales

Safeguarding in Wales operates within a multi layered national–regional governance framework, established through the Social Services and Wellbeing (Wales) Act 2014 and accompanying statutory guidance. Oversight involves Welsh Government, national advisory bodies, and regional multi agency boards.

The Welsh Government holds overall responsibility for the legislative and policy framework for safeguarding across Wales. It issues statutory guidance, commissions reviews, and ensures accountability for safeguarding arrangements.

The NISB is a national advisory body established under the Social Services and Wellbeing (Wales) Act 2014. Its duties are:

1. To provide support and advice to Safeguarding Boards with a view to ensuring that they are effective
2. To report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales
3. To make recommendations to the Welsh Ministers as to how those arrangements could be improved (S.132 (2)).

Wales has six Regional Safeguarding Boards, each covering a defined geographical footprint. Their statutory responsibilities are set out in the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. [legislation.gov.uk]

Core functions include:

- Multi agency safeguarding governance across partner agencies (e.g., local authorities, health boards, police, probation).
- Undertaking Child Practice Reviews, Adult Practice Reviews - from 2024, Single Unified Safeguarding Reviews (SUSRs) have replaced these (bringing together CPRs, APRs, DHRs, and mental health homicide reviews).
- Ensuring agencies collaborate effectively to protect adults and children at risk of abuse and neglect (and in the case of children, other forms of harm).
- Developing regional policies, quality assurance, and improvement mechanisms.

¹⁶ <https://bills.parliament.uk/bills/3909>

The RSBs are statutory bodies and central to coordinated safeguarding oversight at a local and regional level.

The Wales Safeguarding Procedures (2019) provide the procedural framework for frontline safeguarding practice across agencies. They were developed collaboratively by all six RSBs and endorsed nationally.

These procedures ensure consistency in:

- Reporting and responding to safeguarding concerns
- Multi-agency decision making
- Roles and responsibilities for practitioners and managers

They form an essential operational layer supporting the wider governance system.

Governance is underpinned by the Social Services and Well-being (Wales) Act 2014, particularly Part 7 (Safeguarding), which establishes:

- Duties on local authorities and relevant partners to protect adults and children at risk
- Statutory guidance Working Together to Safeguard People
- The mandate for establishing RSBs

This framework is supplemented by other relevant Welsh and UK legislation (e.g., Children Act 1989, Mental Capacity Act 2005, Violence against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015).

Summary of Governance Structure

Level	Body	Key Responsibilities
National	Welsh Government	Policy, legislation, oversight, commissioning reviews
National	National Independent Safeguarding Board (NISB)	Advises Ministers; improving consistency at national level
Regional	Regional Safeguarding Boards (6 RSBs)	Multi-agency governance; reviews; quality assurance; regional safeguarding strategy
Operational	Wales Safeguarding Procedures	Standardised practice guidance for all agencies

The RSBs are among several organisations dedicated to enhancing public safety and wellbeing, alongside bodies such as the Public Services Board (PSB), which is a

statutory entity established under the Well-being of Future Generations (Wales) Act 2015. The PSB aims to strengthen collaboration across various public service sectors. Additionally, there are Community Safety Partnerships, commonly known as Safer *name of area*, and the Violence Against Women, Domestic Abuse and Sexual Violence (VAWDASV) Boards.

We mainly learn from Reviews of extreme events where a death or serious harm has occurred. These reviews provide thorough insights but represent atypical cases. Therefore, the bulk of our learning comes from these outliers, leaving limited insight into the majority of cases.

RSBs do highlight examples of good practice in Annual Reports, and Boards may discuss cases at Development days, but multi-agency scrutiny is limited for cases resolved with positive outcomes.

Recent relevant developments in Wales - Single Unified Safeguarding Reviews and the Wales Safeguarding Repository

One of the key functions of RSBs is to undertake reviews of multi-agency safeguarding practice in which a child/adult at risk has died or been significantly harmed through abuse, neglect or other forms of harm like sexual abuse or exploitation. The purpose of these reviews is to learn and improve practice.

Since 2024 we have had Single Unified Safeguarding Review in Wales which has brought together several different types of safeguarding review:

- Child and Adult Practice Reviews
- Domestic Homicide Reviews
- Mental Health Homicide Reviews
- Offensive Weapons Reviews

The Wales Safeguarding Repository (WSR) was developed to support the roll-out of the SUSR and is an innovative use of machine learning and artificial intelligence which can facilitate rapid thematic learning from case reviews. This thematic learning can inform timely responses through the adoption of best practices or policy improvements. Created by the Cardiff University Security, Crime, and Intelligence Innovation Institute¹⁷, the WSR serves as a comprehensive digital repository consolidating safeguarding reviews conducted in Wales from 2008 into one searchable platform. This resource, initially designed for safeguarding professionals, policymakers, and researchers, became a 'live' resource in January 2026.

The potential for such a system is best demonstrated by an example. Before launching to safeguarding professionals, the WSR allowed researchers to assess good or best practices in previous reviews. 'What Do Previous Safeguarding

¹⁷ <https://www.cardiff.ac.uk/security-crime-intelligence-innovation-institute>

Reviews Tell Us About Best Practice'¹⁸ was published in October 2025. The report provides analysis of 183 reviews held in the WSR (as of July 2025), with publication dates ranging from 2008 to 2025. This is a significantly greater sample size than the thematic reviews previously conducted by Welsh Government or NISB.

Their analysis of the large number of reports held in the WSR has provided a clearer understanding of what has been considered 'best practice' in Welsh safeguarding reviews between 2008-2025, however does not illustrate wider best practice across sectors.

Executive Summary

What is working well in our current safeguarding governance model

- ✓ In the main, there are strong working relationships within RSBs and between RSBs, Welsh Government and other key stakeholders.
- ✓ The establishment of the SUSR process and Hub is seen as a positive step to ensuring the embedding of learning from reviews, though with the first reviews just coming through now, is still not fully formed.
- ✓ Wales has a solid legislative foundation through the *Social Services and Well-being (Wales) Act 2014*, backed by clear national safeguarding procedures accessible to all via the Wales Safeguarding app.
- ✓ RSBs have helped establish safeguarding as a shared, system-wide responsibility.
- ✓ The creation of NISB demonstrated strong national commitment to scrutiny of the governance arrangements.
- ✓ In relation to Adult Safeguarding, Wales appears in a stronger position than other nations, some of whom do not even have a definition of this in legislation.

What needs improvement in our current safeguarding governance model

- ✓ Consistency across the RSBs in terms of guidance and scrutiny.
- ✓ A system wide need to clarify the roles of Boards/ agencies within the governance structures and boost research capacity.
- ✓ RSBs require more national analysis, thematic reporting and strategic insight from Government - strengthening the connection between submitted data and its meaningful use.
- ✓ A consistent approach to Business Unit capacity
- ✓ Role of NISB requires clear clarity and purpose

¹⁸<https://orca.cardiff.ac.uk/id/eprint/182643/1/Best%20practice%20research%20report%20%282025%29.pdf>

- ✓ The third sector believe the guidance on 'and others' needs to be better defined to give them equal status as referrers.
- ✓ Sporting and faith organisations find responses to Position of Trust referrals inconsistent.
- ✓ Sports and faith groups who are working in communities find RSBs hard to engage with unless there has been a serious incident or they have a previous professional connection.

National Safeguarding Governance – System Feedback and Implications

Feedback from across the safeguarding system points to a landscape that is committed, experienced and motivated, but structurally complex and insufficiently aligned to the scale and nature of safeguarding challenges in Wales today.

Across RSBs, NISB, Business Units and Inspectorates, there is strong goodwill and local innovation, but also variation, duplication and gaps in accountability that limit the system's collective effectiveness.

There are clear strengths in joint working across agencies and with Welsh Government, but greater structural clarity and alignment would strengthen system leadership, accountability and impact.

Regional Safeguarding Boards – What we heard

RSBs are widely regarded as essential convening bodies, bringing together statutory partners and local expertise. However, feedback consistently highlights that membership arrangements are uneven. In some places, structures have grown faster than the system's ability to lead and oversee them.

Membership

- Membership of RSBs varies across regions with inconsistent representation, particularly from the education sector. There is no clear national position on whether Directors or Deputy Directors of Education best represent the whole education system. The result is variable influence and engagement across regions.
- The third sector and faith-based groups are not systematically embedded. Participation often depends on personal connections not clear governance routes. While some local authorities view them as trusted partners with valuable insights, their involvement is limited; in some cases, faith representatives are the only external participants in regional board training.
- The membership landscape is described as "complex", "cluttered" and "ever-expanding". Priorities have multiplied without matching clarity about what the Board should focus on and clarity on national priorities.

- RSBs feeling spread thinly across an increasing safeguarding agenda with limited growth supported through partnership agency funding arrangements.
- Through systems growth there is a lack of clarity about the roles and responsibilities of both RSBs and the NISB, and questions about whether regulators such as CIW should sit on RSBs and regularly meet with NISB.
- The level of seniority and expertise of RSB members is a concern, with suggestions that having senior leaders (for example, in health) may result in members without direct safeguarding experience but equally concerns were raised in relation to ensuring those who represent agencies can affect change.
- There is a need for further guidance at a national level about expectations for RSB members and Chairs include role profiles to ensure members fully understand their roles and are held accountable by wider Board members.
- Adult safeguarding remains less prioritised than children's safeguarding.
- Challenges facing RSBs members include unclear responsibilities, fragmented intelligence sharing and insufficient data or analytical capacity.

What needs to change

1. A nationally agreed membership model (including education), with clear expectations of attendance, authority and contribution.
2. Formal routes for third sector and faith engagement, moving beyond relationship-based inclusion.
3. A tighter national focus for RSB agendas, with core priorities set out and monitored.
4. A clear map of roles for RSBs, the NISB and the Inspectorates, including information flows and escalation.
5. Parity of focus for adult safeguarding in planning, scrutiny and assurance.
6. National analytical capacity so Boards can lead on risk, performance and learning.

Leadership of Regional Safeguarding Boards - What we heard.

RSBs were seen to benefit from skilled leaders who effectively handle multi-agency challenges. Independent Chairs were not favoured due to their lack of local ties and understanding. There were calls for a more consistent, competency-based approach to Board leadership, with clear processes for risk management, learning, and multi-agency collaboration, to ensure RSBs can deliver on their safeguarding responsibilities.

A number of RSBs have adopted a co-chair system; for instance, one board is overseen by two Directors of Children's Services, while another features three co-chairs, including a co-chair from a prominent children's charity. Other RSBs, however, continue to use the classic arrangement of a single chair with vice chairs.

Whatever the structure, the RSBs and their leadership consistently noted that dividing leadership duties is beneficial.

- Leadership arrangements vary widely across Wales. There is no standard competency framework for Chairs or a consistent national approach to risk, learning and escalation.
- The leadership landscape is complex, with Boards often feeling "spread thinly" due to an ever-expanding safeguarding agenda and a lack of clarity on core priorities.
- There is an ongoing call for clear more consistent guidance from Welsh Government and/or NISB on the roles, responsibilities, and expectations of RSB leadership. This includes the need for agreed competencies for chairs, engagement with the Inspectorates and the development of national processes for risk management, learning, and escalation.
- Effective RSB leadership is seen as empowering agencies to deliver safeguarding priorities, coordinating multi-agency work, and ensuring continuous learning and improvement. RSBs benefit from leadership that is informed by need, risk, and evidence, and that maintains a clear oversight of performance and outcomes.
- Leadership and RSB members are challenged by the lack of analytical capacity, inconsistent application of thresholds regarding MAPFs, and the need for more systematic approaches to training, information sharing, and evaluation.
- Whilst there is a clear focus in Wales on Adult safeguarding It receives less strategic attention than Children's Safeguarding, there is a call for leadership to elevate its importance.
- Leadership models are needed that foster proactive, rather than reactive, governance.
- Alignment with other structures Community Safety Partnerships (CSPs) and VAWDASV Boards should be streamlined and clarification of how Corporate Safeguarding interfaces with RSBs to avoid overlap. The lack of alignment between Regional Partnership Boards (RPB) and RSB boundaries causes operational complications. *(However, there was little evidence that Safeguarding features on the RPB's agendas.)*
- Assurance is over reliant on local authority intelligence, limiting a multi-agency view of risk and performance.

What needs to change

1. A national competency framework for RSB leadership (Chairs, Co-Chairs, Vice Chairs) with induction, support and appraisal.
2. Standard processes for risk management, learning and escalation, including the role of Inspectorates.
3. A balanced safeguarding mandate (adults and children) embedded in leadership objectives.

4. Streamlined alignment with Community Safety, VAWDASV and Corporate Safeguarding; boundary alignment or formal protocols with RPBs.
5. Multi agency assurance that draws on health, police, education and third sector data - not just local authority data returns.

Business Units – What we heard

Across Wales, Business units are consistently recognised as fundamental to the operation and effectiveness of RSBs. Rather than simply administrative bodies, Business units are seen as strategic drivers, coordinating core governance processes and supporting the delivery of Board priorities.

The RSB Business Units vary in size, which leads to different capacities for handling demanding workloads that can be easily affected by a prominent review or a surge in SUSRs (previously CPRs/APRs). One Board has a Business Unit with 7 full-time staff, while others have significantly less capacity. There is no nationally agreed partnership funding formula for this essential business support. The budget for RSBs to deliver and support SUSRs was seen as essential, with fears about how the SUSR model would be sustained without the key staff appointed using this funding.

Business Units vary in where they are situated: in one Board they are based in the 'Corporate Centre' within the Performance and Partnerships directorate and do not sit within the social services directorate, though they are managed by someone with considerable safeguarding experience and knowledge. This model was felt to allow for a more independent oversight of the delivery of the priorities and supports and strengthens messaging that safeguarding is everyone's responsibility. Another Board is situated in the Corporate Centre; however, line managed by a professional without safeguarding knowledge or experience which is said to cause issues in terms of understanding priorities and urgency. There was significant agreement that Business Units were:

- Pivotal in developing and maintaining core governance processes, such as risk management, self-assessment frameworks, audit and quality assurance, and learning and improvement frameworks.
- Essential for effective RSB oversight of priorities, performance and risks-- a Wales-wide approaches to these processes are required.
- Experience a significant variation in capacity across different regions, affecting their ability to operate effectively.
- Operating within a complex safeguarding landscape, highlighting the need for simplification to ensure greater clarity of roles and processes.
- Enable RSBs to move beyond reactive approaches and focus on proactive, evidence-informed practice.
- Impacted as RSBs and their member agencies are experiencing financial pressures, which pose challenges for Business Units budgets.

- A single, point of contact between Welsh Government and RSBs is required to streamline communications and reduce confusion for Business Units.

What needs to change

1. A baseline co-produced national specification for Business Units (functions, skills, minimum capacity) and support for a fair partnership funding approach.
2. Consistent national templates for risk, self-assessment, audit and learning (including MAPFs).
3. Placement and leadership of Units that protect analytical independence and whole system oversight.
4. A single Welsh Government interface for Business Units to reduce duplication and delay.

Detailed feedback on NISB

NISB called for enhanced powers, including the ability to require information and reports from inspectorates and to formally monitor the implementation of recommendations. Clarifying the Board's role in providing Ministerial assurance and relationship with other bodies, especially in light of the SUSR framework, is seen as necessary for credibility and effectiveness.

- NISB is widely recognised as a potentially valuable entity within Wales's safeguarding landscape, but stakeholders consistently report limitations in its current remit, resources, and influence.
- The relationship between NISB and RSBs is described as largely one-way, with the NISB not always providing added value, providing a clear support role or proactively co-producing plans with RSBs. Engagement with inspectorates is also seen as limited, and there is a call for more routine collaboration and intelligence sharing.
- The NISB's remit and impact are not always clear to RSBs with engagement being member led as opposed to a clear role.
- The NISB needs to be more visible with a robust communications strategy.
- The NISB needs to be more proactive, collaborative, and intelligence led.
- Faith based groups welcomed their limited contact with NISB as a route into the safeguarding governance arrangements.
- Since the development of the SUSR, the need for national annual thematic review in its current style, risks duplication.
- There is a desire for NISB to have more systematic engagement with RSBs, moving beyond a reactive or periodic approach.
- A limited view was that NISB should have powers to hold agencies and RSBs to account as well as clearer oversight of the implementation of review recommendations. (*This view was expressed by ex-police colleagues who were more keen than other participants on a command and control structure*)

- Many participants felt that the development of NISB could have the potential to support coordination of an improved strategic approach across Wales.

What needs to change

1. A clear, public statement of role, including how NISB relates to Welsh Government, RSBs, SUSR/WSR and Inspectorates.
2. Planned, routine engagement with RSBs and Inspectorates
3. A clear annual plan that informs its annual report to promote the role and value of NISB.

The Inspectorates – What we heard

The inspectorates are widely regarded as critical to effective safeguarding governance, there is a strong appetite for more integrated, visible, and collaborative working across the landscape. Reference was made to regular, direct engagement with NISB and RSBs, shared analytical capacity, and a greater role in fostering a culture of learning and accountability across Wales.

- Engagement is often with individual authorities, not Boards, leading to fragmented intelligence and missed opportunities to align improvement.
- Inspectorates should routinely present their inspection findings directly to RSBs.
- Joint inspections by the Inspectorates were seen as superior to single inspections.
- Inspectorates are recognised as important for providing external challenge and assurance but too distant from day-to-day safeguarding practice - joint training, and intelligence sharing would drive up standards across agencies.
- Clarity was required on how inspectorates are assured that their methodologies are robust.
- More formal, structured annual meetings between inspectorates and RSBs but not a seat on the RSBs, as this could blur the lines between scrutiny, support, and governance.
- There is a recognised need for transparent and robust mechanisms to hold inspectorates to account, especially given their influential role in monitoring and evaluating safeguarding practice across agencies.
- There was limited support for the inspectorates to align their inspection and assurance activities with emerging national safeguarding frameworks, such as the “Five Key Domains of Safeguarding Effectiveness” developed by the NISB.

What needs to change

1. Direct, routine presentation of inspection findings to RSBs, with clear follow up and tracking.

2. Pooled intelligence across Inspectorates, RSBs and partners; shared analytics to support system learning – central analytical function.
3. Structured annual engagement between Inspectorates and Boards; no routine inspectorate seats on Boards (to avoid blurring scrutiny and governance).
4. Clarity on who does what post SUSR: inspection, assurance, escalation and national learning.

What needs to improve- How do we get to the next level?

- The current “complex, cluttered and ever-expanding” governance landscape must be rationalised.
- The limited capacity for social care research within central government needs to be addressed.
- Clarity of roles, responsibilities, powers, expectations and relationships of Welsh Government, NISB, RSBs and Inspectorates as the governance system.
- Adult safeguarding must be elevated to an equal priority as children and young people’s safeguarding, both in RSB membership and agenda setting.
- National guidance is needed to define core priorities and focus areas for RSBs, preventing them from being spread too thinly and enabling a more strategic safeguarding agenda - A national strategic safeguarding plan should be considered.
- Analytical and evaluation capacity within the system is required.
- A national approach to evaluation of interventions to inform a ‘What Works’ menu to enable RSBs access to evidence led interventions.
- Learning from the full spectrum of case reviews and experiences should inform our planning. Shifting our focus from extreme examples to what works for successful outcomes for individuals and families in Wales.

Conclusion and recommendations

As services evolve, it is crucial that governance frameworks keep pace with these changes. The remit of the RSBs is consistently under pressure to adapt and include emerging issues.

As part of this Review, the Welsh Government’s Research Team examined safeguarding governance arrangements across parts of the world. The research revealed significant variation in the extent to which safeguarding governance is managed at either a central or regional level.

In most nations, governance arrangements for children and young people are distinct from those for adults, with adult safeguarding generally subject to less scrutiny. In contrast to Wales where the Social Services and Well-being (Wales) Act 2014 adopted a comprehensive, life-course approach, recognising that everyone in Wales may have care and support needs at different points in their lives.

Strengthening our Safeguarding Governance for the next decade

All organisations and individuals who contributed to this Review acknowledged the current strengths within Wales's safeguarding governance arrangements. These strengths were seen as essential foundations on which to build for the future. However, participants also identified the need to streamline existing governance processes to ensure the system evolved to tackle contemporary challenges and emerging threats. Alongside calls for a simpler governance structure was recognition of the importance of clearer roles and responsibilities for all elements of our current safeguarding governance system the Inspectorates, RSBs and NISB.

The present composition of the RSBs, as well as the NISB and Inspectorates was described as supporting good working relationships. There is a high degree of trust between partners, both within the RSBs and across the wider safeguarding governance framework. Agencies consistently report that these robust partnerships allow for constructive challenge. It is vital to maintain and further strengthen these foundations.

These recommendations align with the principles set out in the SSWB (Wales) Act 2014 by incorporating co-production and collaboration throughout the safeguarding governance system. This approach helps to maintain consistency and supports the development of a rich learning culture.

The aim of Phase 1 was to explore the following:

- The roles and responsibilities of the National Independent Safeguarding Board and Regional Safeguarding Boards;
- The interface between these bodies and the Inspectorates;
- The overall effectiveness of these arrangements in protecting people from harm;
- Recommendations to further strengthen safeguarding governance in Wales.

This Review of Wales's safeguarding governance has established there is an appetite for improvement across the existing safeguarding governance system. Ten years into the current arrangements we can see what works well and where improvements can be made. This review provides a compelling argument from system enhancement to transformational change.

In England, the proposed establishment of a Child Protection Authority—recommended by the Independent Inquiry into Child Sexual Abuse (IICSA) in 2022 for both England and Wales—is currently under consultation. Its main aims are to enhance system leadership, improve information sharing, address risks such as those highlighted in the Casey Report on grooming gangs, and ensure accountability among local safeguarding partners. This Review did not receive any submissions calling for a similar authority in Wales; instead, it was suggested that building upon

existing entities such as the NISB and the Ministerial Board could deliver the necessary leadership and oversight. There is broad recognition that should the NISB's remit evolve, resourcing this evolution would be required.

For a simplified governance structure to be effective we must share a clear plan, one which allows for the regional variations necessary to reflect the needs of our diverse communities in Wales. While independence is important within any governance structure, accountability and ownership must also be clearly established. Each RSB understands their communities, and we must build on this to deliver safeguarding oversight, tailoring services to suit their local communities while interpreting national guidance appropriately.

This approach recognises the diversity of Welsh communities and is seen as a strength. However, the Review also found that such variation can pose challenges for all-Wales organisations, such as Her Majesty's Prison and Probation Service (HMPPS), and for national third sector, sport, and faith-based organisations. Although these organisations are identified as essential safeguarding partners in Part 7 of the SSWB (Wales) Act 2014, they reported difficulties engaging consistently with the RSBs.

Increasing collaboration - a shared approach

Throughout the consultation meetings, it was broadly acknowledged that improved collaboration between RSBs, NISB, and the Inspectorates requires a clearer understanding of each entity's roles and responsibilities. These issues are further obscured by the considerable workload faced by the RSBs and the supporting Business Units.

Creating an intelligence led system

The prototype Welsh Government data safeguarding dashboard supported by the National Office has been well received, as it enables LAs and RSBs to scrutinise and benchmark against neighbouring authorities and across Wales. Whilst this work is welcomed, pace and expansion of this work is required.

Every agency collects data, however there is not a clear system for routine sharing to a central point across all agencies to support whole-system oversight. The Inspectorates have analysts and useful insight, but this intelligence is not consistently pooled or presented where multi-agency accountability sits.

A comprehensive picture of risk and practice is available if we bring together: MAPFs, child death reviews with safeguarding components, RSB quality assurance findings, coroner advice, Youth Justice and Serious Further Offence reviews, lessons from Multi-Agency Public Protection Arrangements 3, and inspectorate products.

What is missing is a settled home for the analytical function and a single, robust intelligence framework. Stakeholders were clear: a coherent, shared intelligence

model would improve planning, prioritisation and assurance, and move the system from compliance reporting to intelligence-led safeguarding.

Recommendation 1 - Establish a Ministerial Safeguarding Oversight Board

The current strengths of the SUSR Ministerial Board demonstrate the power of this scrutiny and oversight but this must be widened to include all sources of information and intelligence available in the sector. Such a Board would provide the rigour to ensure our governance arrangements are working effectively whilst providing the Minister and Government with a transparent overview of safeguarding in Wales.

Recommendation 2 - A Central Intelligence Hub

1. Designate the location of the core analytical function and resource it to support the pan Wales landscape
2. Issue a standard analysis cycle.
3. Adopt common templates for risk, learning and performance so Boards can compare and act.

Whilst there are areas that require further data, this is not about more data. It is about using what we already have – together - so leaders can see risk sooner and act faster.

An intelligence-driven system



Recommendation 3 - A National Safeguarding Plan

The system should evolve as learning emerges. At present, however, multiple sources issue recommendations and timelines in isolation, with limited regard to system-wide demand, capacity or prioritisation. This produces effort without focus.

The remedy is one national plan that everyone works to. A National Safeguarding Plan, co-produced with RSBs, NISB and the Inspectorates, would set clear, shared priorities and a single improvement timetable, while allowing local tailoring within agreed national parameters to reflect the diversity of communities across Wales.

The Plan should be intelligence-led (drawing on SUSR/WSR, inspectorate findings and multi-agency QA) and scrutinised giving a clear line of sight. The Plan with an attached National Safeguarding Risk Register, would provide Ministers with a continuous line of sight on system risks, progress and any emerging threats.

What needs to happen now - National Safeguarding Plan

1. A single National Safeguarding Plan should be produced, setting out six to eight national priorities and outcomes.
2. An attached National Safeguarding Risk Register should be developed alongside the Plan.
3. The Plan should be co-produced with RSBs, NISB and the Inspectorates, then agreed by a Ministerial Board.
4. Existing improvement activity should be aligned to the Plan, with unaligned asks paused or re-sequenced.
5. A single national reporting template should be issued for risk, learning, performance and impact.
6. RSBs should report quarterly against the Plan.
7. The Plan and Risk Register should be refreshed annually, informed by emerging intelligence and learning.

Recommendation 4 - An enhanced role for NISB

Review discussions were clear that, if further responsibility is placed on the NISB, its current capacity would be insufficient to discharge those duties effectively.

Consideration should be given to arrangements akin to an NHS Trust Board, providing increased capacity required for sustained oversight, scrutiny and system leadership.

Under a strengthened model, the practical role of the NISB would expand to include:

- Supporting the National Safeguarding Plan co-production
- Overseeing the Plan's Risk Register
- Facilitating peer review between RSBs
- Produce an annual NISB plan which is signed off by Ministers, subject to a remit letter to ensure clear roles and remits across the safeguarding landscape.

What needs to happen now

1. NISB's future remit should be clearly defined, setting out its role in, assurance and system leadership in a single, concise statement.

2. Resources should be explicitly aligned to that agreed remit.

A clear annual cycle should be established, with a Ministerial remit letter issued each year and a NISB Business Plan produced in response, providing transparency, accountability and assurance to Ministers.

Recommendation 5 - Learning from all cases

For learning from reviews to be comprehensive, it is essential that they encompass a broad range of cases, including those where services have successfully collaborated with individuals and families to achieve stable and safe outcomes. Effective learning also depends on deriving insights from 'average cases'. These typical scenarios are fundamental in evaluating successful outcomes, as they represent the majority of safeguarding referrals and cases where individuals and their families receive, or should receive, appropriate support in a timely and structured manner with clearly defined outcomes understood and agreed upon by both practitioners and those involved. Across the UK, there has been a tendency to focus on cases involving extreme harm, often overlooking these average cases. However, such instances are exceptions rather than the rule.

Recommendation 6 - Agreement on a partnership pan Wales funding formula for the Business Units

The Chairs of the RSBs maintain regular engagement with both the NISB and Welsh Government; however, it is the Business Units that provide essential operational expertise. Within the current framework, Business Units facilitate the exchange of ideas, best practices, insights from reviews, and emerging trends among RSBs. Acting as the 'engine room' for RSB business. Although their workload is significant, capacity levels differ regionally due to legacy partnership funding arrangements. To address these disparities and enhance overall effectiveness, the implementation of a nationally agreed partnership funding formula for Business Units appears essential to ensure all partners are supporting the role of RSBs.

Recommendation 7 - (Phase 2) Clarify leadership roles and responsibilities within the safeguarding governance framework.

Over the past ten years, safeguarding has evolved considerably, creating a strong demand to further define the responsibilities of chairs and members of RSBs and NISB. This clarification aims to ensure their effectiveness over the next decade. Welsh Government should publish a roles and responsibilities document to ensure clarity on the current roles. This is attributed to Phase 2, as Phase 1 actions will require consideration to inform the document.

Recommendation 8 - (Phase 2) Improve mechanisms for sports, faith and belief organisations engage with RSBs.

There are significant professional social work and advocacy teams within safeguarding in sporting, faith and belief organisations in Wales. These are a rich source of information and intelligence, and the safeguarding governance system must engage with them systematically. The benefits of this are twofold as it will increase the reach of safeguarding into less known communities whilst raising the status of safeguarding within their organisation's governance structures. Already this work has started with sporting organisations now having a planned meeting cycle with the Safeguarding and Advocacy team in Welsh Government.

Appendix 1: Terms of Reference of this Review

1. Purpose

1.1. The purpose of this review is to evaluate the accountability and governance arrangements for safeguarding in Wales, with a particular focus on the core structures: the National Independent Safeguarding Board (NISB), Regional Safeguarding Boards (RSBs), and the Inspectorates.

1.2. This review reflects Welsh Government's continued commitment to ensuring safeguarding in Wales is robust, responsive, and focused on protecting those most at risk. Safeguarding people from abuse, neglect, and other forms of harm is a continually evolving area of practice. To ensure our systems remain effective and fit for purpose, they must be subject to regular review. In line with this commitment, Welsh Government is undertaking a review of the current accountability and governance arrangements for safeguarding in Wales.

1.3. The review will assess the effectiveness of current safeguarding governance systems and identify opportunities to strengthen clarity, leadership, and assurance. It will consider the reflections made by Baroness Casey in her national audit of group-based sexual exploitation, which highlighted challenges arising from fragmented responsibilities and the need for decisive leadership and effective partnership working.

2. Aims and Objectives

This review will seek to:

2.1. Evaluate the roles and functions of the NISB and RSBs, including their effectiveness in assuring the delivery of safeguarding duties.

2.2. Consider the interface between inspectorates and safeguarding governance systems, particularly in relation to assurance of service quality and safety.

2.3. Identify opportunities to strengthen governance arrangements and enhance system clarity and accountability.

2.4. Provide a cohesive reflection on current arrangements and make recommendations for improvement, including potential structural or procedural changes.

2.5. Identify target areas for further work where additional scrutiny or development may be beneficial.

2.6. Consider how current systems support the embedding of learning from safeguarding practice, reviews, and inspections including how this informs and is informed by research.

3. Context

3.1. The Social Services and Well-being (Wales) Act 2014 established the NISB and introduced new safeguarding duties for local authorities and key partners. Over the past decade, RSBs have evolved from local authority-specific boards into regional partnerships, often merging adult and children's boards.

3.2. Baroness Casey's audit of group-based child sexual exploitation (May 2025) raised concerns about the complexity of safeguarding governance, noting that "the multitude of organisations and splits in responsibilities do present challenges for clear, decisive leadership, effective partnership working and sharing of information."

3.3. This review responds to those concerns and aims to ensure that Wales's safeguarding systems remain effective, responsive, and focused on achieving the best outcomes for children and adults at risk.

4. Scope

4.1. The review will consider:

4.2 The statutory roles, responsibilities, and effectiveness of NISB and RSBs.

4.3 The relationship and assurance mechanisms between inspectorates and safeguarding boards.

4.4 The governance structures supporting multi-agency safeguarding arrangements.

4.5 Opportunities for reform or enhancement to improve clarity, accountability, and impact.

5. Methodology

5.1. The review will be led by Jan Pickles OBE, a highly respected safeguarding expert with extensive experience across public services in Wales. She will act independently and engage with key stakeholders to gather insights on current effectiveness and areas for improvement.

5.2. Central engagement will be undertaken with the following stakeholders:

- Chair, Vice Chair, and members of the National Independent Safeguarding Board (NISB)

- Chairs, Vice Chairs, and constituent members of Regional Safeguarding Boards (RSBs)
- Business Managers of RSBs
- Senior leaders and leadership teams within the Inspectorates
- Children's Commissioner and Older People's Commissioner

5.3. Jan Pickles will also work with wider agencies as she deems appropriate. Engagement will mature and evolve throughout the course of the review, allowing for deeper exploration of emerging themes and perspectives.

5.4. The review team will also consider relevant data, previous audits, and comparative models from other UK nations where appropriate.

6. Governance

6.1. The review will be led by Jan Pickles OBE, who will act independently throughout the process.

6.2. Jan Pickles will deliver her final report to the Minister for Children and Social Care, who is the commissioner of this work.

6.3. She will draw on sources of expertise as she sees fit during the review. This may include (but is not limited to) academic experts, civil servants, and sector specialists.

7. Timings and Reporting

7.1. The review will run from October 2025 until Spring 2026.

7.2. A final report will be submitted to the Minister for Children and Social Care in Spring 2026. The report will detail findings and recommendations and will be made publicly available.

Appendix 2: The methodology used in this Review

The Terms of Reference were distributed at the outset of the review process, with amendments encouraged and incorporated.

The following information was reviewed to inform this report:

- The Welsh Government Research Unit provided information on how other countries across the world manage the governance of their safeguarding functions (see further information in Appendix IV).
- Research on the effectiveness of multi-agency safeguarding governance structures in the UK.
- Research evidence on what make good governance
- Significant papers/reviews etc

In the consultation meetings the Review asked participants:

- What is the interface between the National Independent Safeguarding Board, Regional Safeguarding Boards and inspectorates?
- What works well in Wales?
- What needs to be strengthened?
- Are there other areas that require a more in-depth review?
- How would you see a model of accountability for safeguarding working in the future?
- What is the interface between the National Independent Safeguarding Board, Regional Safeguarding Boards and inspectorates?
- What works well in Wales?
- What needs to be strengthened?
- Are there other areas that require a more in-depth review?
- How would you see a model of accountability for safeguarding working in the future?

During the course of this Review 69 organisations and individuals were consulted with from December 2025 to March 2026 they are listed in Appendix III

The Review questions were raised and comments received at the following conferences across Wales

1. North Wales Headteachers Conference - Conwy 06.02.26
2. Rape and Sexual Abuse Conference -Conwy 02.02.26
3. Public Health Wales Safeguarding Conference - Cardiff 24.03.26

The role of the NISB is set out in Section 132 of the Social Services and Wellbeing (Wales) Act 2014 as follows:

Appendix 3: Key information

The National Independent Safeguarding Board

(1) There is to be a board called the National Independent Safeguarding Board (referred to in this Part as “the National Board”).

(2) The National Board's duties are— (a) to provide support and advice to Safeguarding Boards with a view to ensuring that they are effective, (b) to report on the adequacy and effectiveness of arrangements to safeguard children and adults in Wales, and (c) to make recommendations to the Welsh Ministers as to how those arrangements could be improved. (3) The National Board— (a) must make an annual report to the Welsh Ministers, (b) must make such other reports to the Welsh Ministers as they require, and (c) may make such other reports as it thinks fit.

Regional Safeguarding Boards

Safeguarding Children Boards were established in each local authority area by the Children Act 2004. The SSWBA 2014 stipulated that ‘Safeguarding Board areas’ would align with the health footprint in Wales, creating 6 Regional Safeguarding Boards.

The functions of the Boards are set out in ‘The Safeguarding Boards (General) (Wales) Regulations 2015’ and ‘Working Together to Safeguard People Volume I – Introduction and Overview’.

The functions of the Boards are:

- a) contribute to ensuring national policies and procedures remain fit for purpose, and contribute to developing policies and procedures to co-ordinate what is done by partners on the Board;
- b) raise awareness of the Board’s objectives, and provide information about how this might be achieved;
- c) review the efficacy of measures taken by those Safeguarding Board partners either individually or collectively, to implement the objectives of the Board and make whatever recommendations it sees fit;
- d) undertake child practice reviews and adult practice reviews, in accordance with regulation 4 – **this has been superseded by the Single Unified Safeguarding Review (SUSR).**
- e) to undertake audits, reviews and investigations;
- f) to monitor the extent to which any recommendations made under paragraph (c) or (d) are being or have been met;
- g) to review the performance of the Board and its partners in carrying out its objectives.
- h) to disseminate information about best practice and learning arising from reviews under paragraph (d) or (e);
- i) to facilitate research into protection from, and prevention of, abuse and neglect of children and adults at risk of harm;

- j) to review the safeguarding training needs of practitioners and provide/commission multi-agency safeguarding training.

There are 6 RSBs in Wales that have responsibility for safeguarding adults and children in their regions.

Care Inspectorate Wales

Funded by and working independently of Welsh Government to inspect and regulate social care, play and childcare services to

- Carry out functions on behalf of Welsh Ministers to provide assurance on the quality and safety of services
- Decide who can provide services
- Inspect and drive improvement of regulated services and local authority social services
- Undertake national reviews of social care services
- Take action to ensure services meet legislative and regulatory requirements
- Respond to concerns raised about social care and childcare services

Healthcare Inspectorate Wales

Funded by and working independently of Welsh Government to inspect healthcare services to ensure they are provided in a way which maximises the health and wellbeing of people.

- Focus on the quality of healthcare provided to people and communities as they access, use and move between services.
- Adapt approaches to ensure they are responsive to emerging risks to patient safety
- Work collaboratively to drive system and service improvement within healthcare
- Support and develop the workforce to enable them, and the organisation, to deliver priorities.

Estyn

Funded by and working independently of Welsh Government to inspect education and training in Wales directed by a range of legislation and regulation as well as an annual programme of work from Welsh Government.

Estyn's vision is to improve the quality of education and training and outcomes for all learners in Wales and its mission is to support education and training providers to develop a self-improving and learning culture through advice, inspection and capacity building.

Appendix 4: Glossary of acronyms and links

Acronym	Explanation and where possible website link
ACPCs	Area Child Protection Committees -the previous governance structure for children
APC	Adult Protection Committees – Scotland https://www.gov.scot/policies/social-care/adult-support-and-protection/#adult%20protection%20committees
APR	Adult Practice Reviews- Wales precursor to Single Unified Safeguarding Review
CIW	Care Inspectorate Wales https://www.careinspectorate.wales/
CPA	Child Protection Authority https://www.gov.uk/government/news/new-national-child-protection-authority-announced
CPC	Child Protection Committees Scotland https://www.celcis.org/our-work/key-areas
CPR	Child Practice Reviews -Wales - precursor to Single Unified Safeguarding Review
CPC	Child Protection Committees Scotland https://www.celcis.org/our-work/key-areas
CSP	Community Safety Partnerships https://www.gov.uk/government/publications/community-safety-partnerships/community-safety-partnerships
Estyn	The education and training inspectorate for Wales https://estyn.gov.wales/
HIW	Healthcare Inspectorate Wales https://www.hiw.org.uk/
HMPPS	His Majesty's Prison and Probation Service https://www.gov.uk/government/organisations/hm-prison-and-probation-service

The Inspectorates	This refers to Care Inspectorate Wales, Healthcare Inspectorate Wales and Estyn
LCSPR	Local Child Safeguarding Practice Reviews -England
LSCB	Local Safeguarding Children Boards- England
NISB	The National Independent Safeguarding Board https://safeguardingboard.wales/about-the-board/
MAPF	Multi Agency Professional Forums -Wales
MAST	Multi Agency Safeguarding Tracker https://www.local.gov.uk/case-studies/multi-agency-safeguarding-tracker
RPB	Regional Partnership Boards- 7 in Wales https://www.gov.wales/regional-partnership-boards-rpbs
RSB	Regional Safeguarding Boards https://www.northwalessafeguardingboard.wales/ North Wales https://www.gwentsafeguarding.org.uk/ Gwent https://cysur.wales/home/ Mid and West Wales www.wgsb.wales Neath Port Talbot & City of Swansea www.cardiffandvalersb.co.uk Cardiff & Vale www.cwmmtafmorgannwgsafeguardingboard.co.uk Merthyr Tydfil, RCT & Bridgend
SUSR	Single Unified Safeguarding Review
SUSR (DA)	Single Unified Safeguarding Review with domestic abuse element
SUSR(MH)	Single Unified Safeguarding Review with a mental health element
SUSR(OW)	Single Unified Safeguarding Review with an Offensive Weapons element
VAWDASV	Violence Against Women, Domestic Abuse and Sexual Violence

WSR	Wales Safeguarding Repository https://www.cardiff.ac.uk/security-crime-intelligence-innovation-institute/research/projects/wales-safeguarding-repository
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Appendix 5: List of organisations and individuals consulted

1. Regional SG Board Chairs and NISB – 2 meetings
2. NISB Chair and Vice Chair
3. NISB – 2 meetings
4. Ex chair of NISB
5. Chief Executive of a Local Authority
6. Public Health Wales - National Safeguarding Service
7. Heads of Public Protection Units
8. Mid and West Wales Cysur Regional Safeguarding Board
9. Cwm Taf Morgannwg Regional Safeguarding Board
10. Gwent Regional Safeguarding Board
11. North Wales Regional Safeguarding Board
12. Cardiff and Vale Regional Safeguarding Board
13. West Glamorgan Regional Safeguarding Board
14. Individual Business Managers x 6
15. Regional Safeguarding Business Managers – 2 meetings
16. HIW Senior Leadership Team
17. Estyn Senior Leadership Team
18. HIW Chief Inspector
19. CIW Chief Inspector
20. CIW Senior Leadership
21. NSPCC
22. Welsh Women's Aid
23. Children's Charities leadership group
24. SUSR Hub Team - 2 meetings
25. Youth Justice Service
26. Cascade Director
27. Care Director
28. National Adviser to tackle violence against women
29. Children's Commissioner
30. Older Peoples Commissioner
31. Minister for Children and Social Care
32. HMPPS Assistant Chief
33. North Wales Chief Constable
34. Church in Wales Safeguarding Lead
35. The Methodist Church in Wales Safeguarding Lead
36. Caldey Island Safeguarding Lead
37. Roman Catholics Safeguarding Lead Archdiocese of Cardiff
38. Safeguarding Lead Interdenominational Group
39. Sport Wales
40. Kyniska - Athlete led sports advocacy service
41. Welsh Government Safeguarding & Advocacy Team and the Single Unified Safeguarding Review Hub Team

42. Audit Wales
43. WCVA Safeguarding Manager
44. Chair of the National Mental Capacity Forum
45. Chief Executive Centre for Expertise on Child Sexual Abuse
46. Ex-Chair of England's National Panel
47. Trustee - The Association of Safeguarding Partnerships England
48. Business Manager -The Association of Safeguarding Partnerships England
49. Trustee and Business Manager The Association of Safeguarding Partners
England
50. Celcis - Child Protection Committee Coordinator Scotland
51. Chair of Scotland Child Practice Committees
52. Independent member of Home Office Quality Assurance Board for Domestic
Abuse Related Dearth Reviews
53. Chief Statistician Welsh Government
54. SUSR reviewers and chairs x7
55. Ex -Chair of an ACPC in Wales
56. Welsh Government Chief Statistician