

Dear Chair

Thank you for your letter dated 22nd August 2024, inviting further views in respect of mandatory reporting, in the context of the Health and Social Care Bill currently before the Committee for stage 1 scrutiny.

As you noted in your letter, I covered this issue briefly within my stage 1 written evidence, reflecting a desire to hear more from the Government as to the work being done to “strengthen compliance with existing regulatory frameworks”.

I note the Government have since provided further information to the Committee in writing and in a further evidence session.

My office has always taken the approach of the existing duty being a personal duty, in the sense that an organisation cannot physically exercise a legislative duty; this has to be implemented via its personnel. Our organisation’s own safeguarding policy is therefore clear on the personal responsibility of any staff member who has concerns about a child or who receives an allegation or disclosure, to take this further, in discussion with the Designated Safeguarding Person for our organisation. We have induction and annual training on safeguarding for all of our staff to ensure that their duties are understood in line with this policy.

One key factor for an organisation-level duty to be successful must be **awareness raising**. It is important for policies to reflect the organisation’s responsibilities, but this on its own will not be sufficient to keep children safe. It is not enough to have a Designated Safeguarding Person and assume their work will cover this, as they can only report or advise on matters that have been brought to their attention. Rather, there is a need for regular and refresher training to ensure that new starters are made aware of their responsibilities and how to exercise these in practice, and that existing staff are reminded about this.

Case studies and anonymised examples can be a positive way to work through this with professionals. Perhaps this could be part of the new Single Unified Safeguarding Reviews team in Welsh Government’s approach to ensuring that learning from reviews is adopted across Wales.

I referred in my written evidence to the recent case relating to a headteacher in North Wales, where it appears from the information currently in the public domain that there may have been staff members who were aware of concerns but did nothing to pass these on. I do not wish to prejudice the findings of the current Child Practice Review (CPR) in that case, but this could be an example that could be used to argue for mandatory training for all staff in the relevant organisations.

Without staff members at all levels understanding the nature and extent of their responsibilities, there is essentially a break in the chain if they are the ones who



are aware of concerns but either do not fully understand or choose not to follow their responsibilities in relation to passing these concerns on.

Through my office's independent children's rights advice and assistance service, we are also frequently made aware of professionals in a range of statutory and frontline organisations who mistakenly believe or cite "GDPR" as a rationale for not passing on concerns. Whilst the ICO guidance is clear in this respect, it can also be seen from other CPR reports already undertaken that this remains a common misconception requiring to be addressed. Again I would see a potential role for the SUSR team in Welsh Government taking this forward, in conjunction with the ICO office perhaps.

The information shared by Welsh Government sets out why they don't wish to make changes to the current legislation, but doesn't set out the actions they are now taking on awareness raising for example. In order to accept their reasoning, I would respectfully suggest that more detail is required in that respect, to be assured that the current plans are sufficient to ensure children are being kept safe.

Yours sincerely,



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