Storfa Ddiogelu Cymru
Wales Safeguarding Repository

Capturing evidence on how the Wales Safeguarding Repository is impacting safeguarding review practice

Dr Bethan Davies
Professor Amanda Robinson
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Cardiff University

Impact project background and overview

Since 2018, a team of social scientists and computer scientists at Cardiff University have worked together to develop the Wales Safeguarding Repository (WSR) on behalf of, and with funding from, Welsh Government. Wales' new Single Unified Safeguarding Review (SUSR) process, in which the WSR is positioned as a central part, was launched on 1st October 2024.

The WSR is a digital repository that brings together reviews of the most serious safeguarding incidents in a single, searchable location, with the aim of supporting better learning to emerge from past cases. The repository will store all SUSRs going forward, alongside four types of historic reviews:

- Adult Practice Reviews
- Child Practice Reviews
- Domestic Homicide Reviews
- Mental Health Homicide Reviews

As explained in the Statutory Guidance, there is an expectation that the WSR should be used by practitioners throughout the SUSR process to inform their review and shape their identification of recommended practice improvements. As such, to coincide with the launch of the SUSR, we implemented a 'Closed Beta Testing' phase for the WSR, which allowed approved SUSR chairs and reviewers to access the information in the repository, while the website was still under development.

This brief report outlines findings from a Cardiff University funded IAA project exploring the early usage and impacts of the WSR. Through an online survey and 1-2-1 conversations with practitioners, the project has provided insight into how the repository has been used and demonstrated some of the impacts this has had on safeguarding practice to date.

Methodology

In June 2025, an online survey (Microsoft Form) was disseminated to practitioners across Wales who had used the WSR since October 2024 via a 'primary learning request' application.[i] The survey asked for basic descriptive information such as their roles, why they had used the WSR, what information they were seeking, whether they received what they were hoping for, what they did with the information, and how this differed from their existing ways of working. Six practitioners responded to the survey, providing a range of perspectives from their roles across National Government, Health Services and Safeguarding Boards.

Later, in July, practitioners who completed the survey (as well as others who had made WSR search requests) were invited to take part in 1-2-1 discussions about their use of the repository to date. The aim was to understand their experience in more detail, particularly to what extent their access to the WSR had impacted their practice. Six practitioners took part (five of whom had completed the survey), and the discussions lasted around 30 minutes each.

This 1-2-1 discussion aspect was brought in to replace the originally planned workshops. Due to unforeseen circumstances,[ii] fewer practitioners than anticipated had accessed the WSR website directly, meaning there were insufficient numbers to carry out multiple workshops across the country. Instead, the individual conversations allowed for more time to understand the perspectives of the different practitioners, providing a rich picture of the way the WSR had been used and changed practice to date, as shown by the four case studies presented later in this report.

Findings

Key findings from the Microsoft Form and conversations with practitioners are reported here, organised into four sections: (1) reasons for using the WSR; (2) benefits of the WSR; (3) what would have happened without the WSR (including illustrative case studies); and (4) 'tips' and insights to take forward.

1. Reasons for using the WSR

Practitioners indicated a number of different reasons for using the WSR, as summarised here:

- **SUSR decision to review.** Part of the SUSR process involves Case Review Groups deciding whether or not to carry out a review following a serious incident, depending on the potential learning from the case. One practitioner who was involved in this role used the WSR to explore previous cases and consider what 'new' learning might be achieved from conducting new reviews.

- **Learning about similar cases as part of an active review.** At the time, one of the SUSR review teams (chair and reviewers) from a local area had not yet had a panel meeting, but they had an idea of the key themes/issues from the Case Review Group. They wanted to see what other similar cases had been reviewed previously, and explore what was already known or not known in relation to the key issues.

- **Covid inquiry, Wales.** Concerns were emerging from the inquiry about the potential impacts of a lack of 'direct observation' on children during Covid-19 lockdowns, particularly those on the Child Protection Register. As such, a team of health policy experts wanted to understand what had happened over time in terms of non-accidental injuries in Child Practice Reviews.

- **Finding material to include in training.** A practitioner involved in safeguarding learning and development in a local authority requested examples of reviews involving child sexual exploitation, so they could be included in a training package. The local authority commissioned an English training provider, but felt it important to use Welsh examples, both to ensure relevance for staff, and to give the trainer some Wales-specific context.

- **'Grooming Gangs' inquiry announcement (UK).** After the UK Government launched the national 'Grooming Gangs' inquiry, there were questions about how many cases in Wales involved child sexual exploitation (including by 'gangs'/groups). A government policy team therefore requested this information, so they could have an understanding of the picture in Wales and could pass the information on to the relevant specialist team (Safeguarding and Advocacy).

- **Exploring an information sharing issue relating to SUSR policy/guidance.** From the SUSR consultation, information sharing was highlighted as a potential problem area during the course of reviews. Based on this consultation finding, and a need to better understand the extent of the problem to date, a policy manager requested reviews involving key agencies and information sharing/data protection issues.

2. Benefits of the WSR

All six practitioners who completed the Form said they received the information they were looking for, and five of them stated they were 'very likely' to use the WSR again in future. Conversations with practitioners revealed a series of perceived benefits to the WSR, which can be summarised as: getting a national view; timely results; comprehensive information; confidence in output; and tracking progress.

All practitioners referred to the value of the **national picture** that can be gained by using the repository. They emphasised the importance of learning from other areas of Wales, both in terms of good safeguarding practice examples and missed opportunities. With the SUSR process now in operation, they noted that chairs and reviewers are increasingly asking questions of other boards and regions, indicating the WSR is an important aid in this process. Reflecting on the value of access to reports and recommendations from other areas, one practitioner suggested this might inspire positive changes elsewhere, by virtue of being more visible; in other words, showing others what might be possible by indicating what a specific policy or practice change could look like.

Alongside this, the ability to get this insight in a **timely** manner was also emphasised by practitioners. In multiple examples, access to the WSR meant practitioners were able to fulfil queries linked to specific government inquiries, despite facing tight timeframes. The alternative way of gaining information – by manually contacting individual safeguarding boards and requesting information – would be a much slower process than a WSR search request.

Practitioners indicated that the information they received from their WSR searches was **comprehensive**, spanning multiple years and different review types. With such a breadth of information, one suggestion was that results could be used to evidence and drive policy change around the biggest questions in safeguarding. Linked to this, the comprehensiveness was also seen as having the potential to provide visibility to lesser-known issues, problems and trends. In contrast, without the WSR, another practitioner felt that insights from previous reviews would be 'lost in the past', despite the underpinning aim of a review being to learn from past incidents.

Flowing from the comprehensive information, practitioners indicated they had **confidence** in the output from the WSR. As one put it, this 'new tool in the toolkit' allows them to give assurances to policymakers

when needed, particularly in the context of submissions to inquiries, and to report findings to wider audiences. Another practitioner, reflecting on the new SUSR process as a whole, suggested the WSR could act as an extra 'crutch' for 'newbie' reviewers; they could search and explore previous reports – whether in similar or different circumstances to their case – and get an insight into structure, writing styles and narrative. Following a request made at the beginning of an active SUSR, the reviewer explained they felt more prepared having explored recommendations from similar cases.

Another perceived benefit of the repository was being able to **track progress** from previous reviews and recommendations. Linked to several of the benefits mentioned above, the access to all previous Welsh reviews supports greater policy oversight. As one practitioner explained, ensuring learning from past reviews is used supports robust safeguarding systems, and provides assurances to the public that when bad things happen, action is taken. In one specific example, following a WSR search, all recommendations relating to self-neglect from one safeguarding board's reviews were pulled together, and their progress then checked by a manager. As well as tracking progress on specific recommendations, this ultimately supports reviews to affect change, as the practitioner in this case explained:

> *"The fact that there have been a lot of recommendations in relation to self-neglect in the region we are working in is interesting and having sight of these means we can avoid making duplicate recommendations, and rather focus early-on on what has been done to implement the changes and what effect this has had, if any, in the region."*

3. What would have happened without the WSR?

Those who contributed to this project broadly agreed that without the ability to request information from the WSR, many of their questions would have gone unanswered, and their requests would either not have been possible to fulfil or would have been significantly delayed. Based on conversations with practitioners, the case studies below provide several illustrative alternative scenarios, indicating how practice now differs, and therefore the impact of having access to the WSR.

CASE STUDY: Reviews featuring self-neglect

The request for reviews involving an adult self-neglecting was submitted to gain general insight into how the issue had appeared in previous cases across Wales, in preparation for the upcoming first panel meeting.

Without the ability to look and think 'pan-Wales' via the repository, the knowledge and information available to a review would depend on who sits 'around the table'. For example, Welsh Ambulance Service NHS Trust has a national remit, and any representatives taking part in a review would therefore have a national picture, but they are not involved in every case. Instead, reviews often involve local authority representatives, who necessarily have a more localised view of issues.

In this specific case, without the WSR, previous reviews either would not have been considered, or the chair and reviewers might just have looked regionally (within the safeguarding board). It is possible a chair or reviewer might have had anecdotal knowledge of cases in other board regions, based on experience, but this would be lucky, and a national picture would not be possible.

CASE STUDY: Covid-19 inquiry

Information on non-accidental injury is not routinely collected by the NHS, meaning although practitioners and policymakers anecdotally know this happens, the information is not quantitatively or systematically available. This led to the WSR request for CPRs featuring non-accidental injury; although these would be the most serious cases, the information was still seen as important and useful to know.

In this instance, without the WSR, each Nursing Director and their safeguarding leads would have had to be contacted, and the information requested from them. This would have been time consuming, when there was only a limited window for the response. Without the information, there would have been a gap in understanding, making it harder to give oversight of harm to children.

CASE STUDY: Information sharing issues

With a need to better understand the way information sharing and data protection issues had featured in previous safeguarding reviews, the WSR was able to provide a comprehensive overview across different safeguarding boards, feeding into a significant piece of work.

Without the WSR, it would not have been possible to get the same richness of data or information. The alternative would have been to commission staff to undertake the work of contacting individual safeguarding boards, requesting their reports, reading them and pulling out relevant findings. This would have presented a significant barrier and would probably have meant the work was not done.

CASE STUDY: 'Grooming gang' inquiry

This request was important to Welsh policymakers, who wanted clear oversight of child sexual exploitation issues in Wales to date, particularly any cases involving 'group-based' abuse.

Before the WSR, this type of query would probably not have been made, because the information would simply have been widely spread across different agencies, making it difficult to access. It is possible the Safeguarding and Advocacy team would have undertaken the work of finding and linking the information, but this would have been a manual task and taken much longer.

4. 'Tips' and insights to take forward

Below are some key insights from practitioners, based on their experiences of using the WSR, about how to get the most out of the repository. These will be developed into 'top tips' learning materials to support WSR users in the next phase of testing.

Less is more when it comes to WSR searches – don't be afraid to narrow it down. Practitioners indicated that a broad search query can be useful at times, for example, if interested in exploring a new topic. However, this broad approach casts a wide net, bringing a lot of information back that might feel overwhelming. Instead, they said practitioners should not be afraid to narrow down their search. For

example, at the primary learning stage of a review, practitioners might want to focus on particular features or characteristics of interest to shape their search. For example, they might begin with APRs published only between 2021-2024, or they might focus on the theme of 'poor documentation and record keeping' for review subjects in contact with a specific agency. Then, if they are concerned they might be missing something, they can simply search again, using additional and/or broader search criteria. As one practitioner put it, this is about using the WSR as a tool to support reviews and safeguarding practice, rather than assuming it has all the answers.

Use various search terms for the keyword search. The keyword search is a useful way to explore specific issues/topics that have not previously been included as 'themes'. For example, although there is no theme for 'self-neglect', practitioners can still search for this term to find mentions in reports. However, it is important to use a mixture of keywords when searching for issues, because terminology has changed over time. For instance, 'self-neglect' has been spelled differently in some reports, as 'self neglect' or 'selfneglect'; searching for all three examples would ensure better search coverage. 'Contextual safeguarding' is an example of a more recent term that was not common some years ago, so practitioners should consider other ways this has been referred to previously in order to find results from older reviews. Simiarly, child sexual exploitation might be referred to as 'CSE' and may overlap with other terms such as 'grooming gang' or 'group-based CSE'.

Creative analysis and reporting of results. To date, practitioners have used and represented the results from the repository in some interesting and innovative ways. Using topic coding from a set of recommendations, one practitioner produced a graph to visually represent the most common themes, providing a useful snapshot. Microsoft Co-Pilot has also been used experimentally when a large amount of recommendation data was returned from a request. After entering the recommendations, the practitioner asked Co-Pilot to arrange them into theme/topic groupings to help identify and refine the next step of searching the repository data. In future, the outputs (for example, thematic reports or training programmes) from WSR-based research will be housed in the repository, further supporting the accessibility of these materials and avoiding duplication.

Conclusions

This project has explored early uses of the Wales Safeguarding Repository (WSR) and identified several clear impacts on practice to date. Based on responses to a short information capture form and conversations with practitioners who have made search requests since October 2024, this report has summarised some of the key uses and benefits of the repository, as well as improvements from previous practice. The key impact identified is that practitioners can gain an understanding of key safeguarding issues more efficiently, and comprehensively, than in previous years. The time savings from accessing the WSR cannot be easily quantified, but with limited resources a persistent feature of the safeguarding landscape, having access to the WSR means that 'primary learning' from past reviews is no longer a luxury that cannot be afforded. Instead, it is becoming a routine feature of the safeguarding review system in Wales.

With the WSR designed to support reviewers and chairs as they undertake safeguarding reviews, the WSR has been used as planned on a number of occasions, providing insights from previous reviews of similar cases. Among other reasons for using the WSR was also understanding the extent of information sharing issues, providing evidence and/or assurances to government policymakers and official inquiries, and finding local examples to include in training for practitioners. In each case, practitioners felt the benefits of the repository were its national scope, the timely results it could provide, the comprehensiveness of the data and the confidence this offered. The ability to identify recommendations on similar topics from

previous reviews is an especially valued feature that is expected to generate much needed improvements in the actionability, monitoring and implementation of recommendations across Wales.

In several cases, practitioners felt the searches they carried out would simply not have been possible without the WSR. Either the information would have been too difficult to access, requiring time and resources they did not have, or their knowledge have been limited to what they could find through their own networks at a local level. Instead, the WSR offered a faster, broader and more systematic search capacity yielding rich results. In cases where practitioners saw a huge amount of data returned from their broad and generic search queries, they recognised the benefits of narrowing their search criteria to focus on more specific issues/questions, in turn generating more relevant results.

Going forward, it is necessary to build upon these preliminary findings by accessing perspectives from a greater number of practitioners covering a broader range of agencies to identify additional ways that the WSR is impacting upon safeguarding practice. In addition, once SUSRs have been published and deposited into the WSR, this will provide the opportunity to evaluate the new SUSR report structure and how this compares to historic reviews in terms of the quality and completeness of the information provided. A follow-on project, once the WSR is fully implemented into the SUSR process and openly accessible to registered users across Wales and beyond, will undoubtedly provide much needed insights into the extent to which this first-of-kind national resource is producing its intended impacts.

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Endnotes

[i] Before the WSR website was directly accessible for practitioners, they were able to search for information contained within the repository through a 'primary learning request' route. In this process, practitioners were asked to complete a Microsoft Word form that detailed their questions and/or themes of interest. Once the form was submitted to the WSR team, the search request was completed and relevant data (and reports) returned to the practitioner via email.

[ii] The unforeseen circumstances were delays to the beginning of what would become the 'beta' testing phase for the WSR website. The intention had been that this IAA project would align with the WSR being opened up for chairs and reviewers to test remote access. However, technical delays affecting this roll out, coupled with the challenges of annual leave during the summer period of this project, led to fewer practitioners accessing the site directly than originally anticipated.