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WHAT DO PREVIOUS SAFEGUARDING REVIEWS TELL US ABOUT 'BEST PRACTICE' ACROSS WALES?

Storfa Ddiogelu Cymru
Wales Safeguarding Repository

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EXECUTIVE SUMMARY

- The Wales Safeguarding Repository is a digital repository that brings different types of safeguarding reviews together in a single, searchable location.
- The repository currently includes Domestic Homicide Reviews (DHRs), Mental Health Homicide Reviews (MHHRs), Adult Practice Reviews (APRs), Child Practice Reviews (CPRs) and Single Unified Safeguarding Reviews (SUSRs).
- These reviews contain details of actions taken by practitioners and agencies in order to safeguard review subjects; despite the tragic circumstances usually discussed in reviews, reviewers do still identify approaches that are seen as 'best practice' in many cases.
- 'Best practice' can be defined as: positive working practices and approaches, implemented by individuals or organisations, that adhere to safeguarding policy in Wales.
- The report provides a descriptive analysis of 'best practice' examples, as identified by reviewers, from reports held within the WSR (N=183), including DHRs, MHHRs, APRs, CPRs and SUSRs.
- Five broad themes were identified as Care and Support; Communication; Risk and Escalation; Policy, Procedures and Reporting; and Learning and Reflections.
- 'Best practice' in care and support includes practitioners being consistent and persistent (when needed) in offering care and support and developing positive working relationships with those they safeguard. Another element of this theme is ensuring practitioners themselves are adequately trained and supported to fulfil their role.
- Communication 'best practice' includes effectively, consistently and, when needed, persistently communicating with review subjects (and families or carers who support them). This also extends to communication between practitioners, particularly in the context of multi-agency working.
- Risk and escalation 'best practice' centres on practitioners' assessment of and responses to risk, including escalating to other practitioners or agencies where appropriate, to ensure risk can be managed effectively.
- 'Best practice' in policy, procedures and reporting is based on following all procedures as expected, making necessary referrals within set timeframes, and keeping clear, detailed records on all safeguarding cases.
- Learning and reflections 'best practice' is slightly different to the four themes above, in that it is about learning from past cases and reviews. This analysis found a number of examples where reviewers made suggestions around what would have been 'best practice' in certain cases, recommending that this is taken forward into future safeguarding.
- Based on these thematic findings, a set of 10 'implications for practice' have been drawn together and are presented in the final section of this report.

SECTION 1: INTRODUCTION

This report presents key findings from an analysis of 'best practice' as documented in safeguarding reviews across Wales since 2008. Safeguarding reviews are conducted following the most serious incidents, and therefore typically examine tragic circumstances that have led to significant harm or death, though they do sometimes find examples of 'best practice'. Occasionally referred to as 'good' or 'effective', the meaning of 'best practice' is not always explicitly defined within reviews. However, for the purposes of this report, we take this term to mean: **positive working practices and approaches that adhere to safeguarding policy in Wales.** Applied to safeguarding practice, this includes aspects such as provision of care, risk assessment, communication, information sharing, record keeping and referrals.

As part of their case analysis, reviews often highlight where practices in these areas had a positive impact on the safety and wellbeing of individuals. However, because reviews are designed as an opportunity to learn from previous harms and missed opportunities, the more positive practice examples documented within them have often been overlooked. The aim of this report is therefore to draw out these 'best practice' examples and explore the key themes cutting across different kinds of safeguarding reviews in Wales. The analysis is based on 183 reviews published between 2008-2025 and held in the Wales Safeguarding Repository.

What is the Wales Safeguarding Repository?

The Wales Safeguarding Repository (WSR) is a multi-disciplinary project funded by Welsh Government to bring together different types of safeguarding reviews into one central repository. The WSR is closely aligned to the Single Unified Safeguarding Review process in Wales, which aims to identify learning following the most serious incidents of harm. The WSR is designed to support this process by drawing on social science and computer science methodologies.

The repository currently includes five different types of review:

- Adult Practice Reviews (APRs)
- Child Practice Reviews (CPRs)
- Domestic Homicide Reviews (DHRs)
- Mental Health Homicide Reviews (MHHRs)
- Single Unified Safeguarding Reviews (SUSRs)

Until 2025 in Wales, both APRs and CPRs were conducted, with the same methodological practice, when there was known or suspected abuse or neglect with the intention of identifying ways to improve current practices. DHRs were conducted when someone died from suspected domestic abuse; going forward, DHRs will be referred to as Domestic Abuse Related Death Reviews (DADRs), better recognising deaths from domestic abuse related suicide. MHHRs were conducted when an individual known to mental health services committed a homicide. As of 2025, SUSRs are now carried out when a safeguarding incident in Wales meets any of the criteria above, as part of a single, unified review process.

The reviews contain details of actions that are taken by practitioners and agencies in order to safeguard the review subject, as well identifying which of these are seen as ‘best practice’. This reveals areas in which actions taken (such as offering care and support, effective communication, supporting practitioners and recording and reporting practice) have been positive aspects of safeguarding for a review subject. Despite the benefits of identifying and highlighting good working practices, which can be used to inform future practice guidelines, no other study has thematically analysed ‘best practice’ examples within Welsh safeguarding reviews. This report therefore provides an important analysis of a wide range of ‘best practice’ examples across five different types of reviews undertaken in the Welsh context.

Within this report, the term ‘review subject’ will typically be used in place of ‘victim’ or ‘perpetrator’, in line with SUSR guidance (Welsh Government, 2024). However, ‘victim’ and ‘perpetrator’ are terms that may be present in examples taken from previous reviews.

METHODS

Aims and objectives

The overall aim of this report is to identify 'best practice' examples from reviews that are currently held in the Wales Safeguarding Repository (WSR). Thematically analysing the examples within these reviews allows us to understand what practitioners are thought to have done well in the past, and what actions were considered positive or beneficial in supporting review subjects. The aim is to identify findings that can inform future practice, and produce examples to be shared with a wide range of practitioners.

The report provides analysis of 183 reviews held in the WSR (as of July 2025). With publication dates ranging from 2008 and 2025, they include:

- 45 Adult Practice Reviews (APRs);
- 87 Child Practice Reviews (CPRs);
- 34 Domestic Homicide Reviews (DHRs);
- 14 Mental Health Homicide Reviews (MHHRs); and,
- 3 Single Unified Safeguarding Reviews (SUSRs).

Every review included in this analysis is from Wales, published by Welsh Safeguarding Boards, Community Safety Partnerships, or Healthcare Inspectorate Wales. In rare instances, where a review subject moved to Wales from another part of the UK (or abroad), reviews may reference services outside Wales; but in every case, the final incident - and the lead up to it - took place in Wales. Of those included in our analysis, only one review, an APR, did not mention 'best practice', nor did it identify any actions that were seen to follow 'best practice'.

Developing the coding framework

Each review was added to NVivo, a qualitative coding software that allows researchers to store data, identify and code recurring themes, and run complex search queries. Multiple text searches and queries were carried out using a variety of search terms (a full list of terms can be found in Appendix 1). The search process was iterative, starting with the terms 'best practice', 'good practice' and 'effective practice', before adding additional terms as other phrases used by reviewers to describe 'best practice' were identified (for example 'positive practice' and 'consistent'). Carrying out multiple searches using different combinations of the search terms ensured as many examples as possible were identified to inform the qualitative analysis that followed.

Following Braun and Clarke's (2006) thematic coding approach, and after searching and reading through examples of 'best practice', an initial coding framework was developed. This consisted of many sub-codes within three primary codes: "Care and Support", "Communication" and "Reports". After some refinement and re-coding, five main themes were identified and are included in this report. For each theme below, the number (N) of coded extracts is noted in brackets; as is often the case in qualitative coding, some extracts were coded to more than one theme:

- Care and Support (N=483; section 2.1)
- Communication (N=450; section 2.2)
- Risk and Escalation (N=127; section 2.3)
- Policy, Procedures and Reporting (N=363; section 2.4)
- Learning and Reflections (N=93; section 2.5)

Limitations

A potential limitation of this project is that one researcher carried out the analysis. Although this ensures consistency across the coding framework itself, other researchers conducting the same analysis might have developed a different set of codes and themes. However, this was managed by regular discussions between the researcher and supervisor throughout the process of coding and refinement.

SECTION 2: FINDINGS

This section reports key findings from the analysis of 'best practice', organised by themes and sub-themes. Examples of 'best practice', as identified by reviewers (report authors), are provided throughout. The value of identifying 'best practice' can be summarised as ensuring that:

> *[effective] practice is disseminated and built upon by relevant managers and staff currently delivering the services in question. –* ***DHR2022-W01***

What is 'best practice'?

'Best practice' – sometimes referred to as 'good', 'effective', 'positive' or 'expected' practice – is specified in several reports, typically in relation to a specific action by a practitioner or agency. For instance:

Good practice is to consult with all relevant professionals involved in the patient's care and treatment prior to such decisions being made. *– APR2019-W01*	***Best practice recommends children are seen on their own by practitioners, away from parents and carers, in an environment where they feel safe, so that the child can speak about the impact that the circumstances which have prompted safeguarding concerns.*** *– CPR2023-W01*

As such, for the purposes of this report, we **define 'best practice' as**:

Positive working practices and approaches, implemented by individuals or organisations, that adhere to safeguarding policy in Wales.

2.1 CARE AND SUPPORT

As might be expected, the most common theme across reviews was 'Care and Support', with many reports discussing positive examples of provision of care to review subjects and their families. As well as many generic references to supporting and engaging with individuals, 'best practice' in this area can largely be divided into four sub-themes: Consistent Care and Support; Persistency in Care and Support; Positive Working Relationships; and Support and Training for Practitioners.

2.1.1 Consistent Care and Support

Across many reviews, consistency in care and support was identified as essential for all practitioners working with a vulnerable person. Consistent offerings of support to review subjects was also seen to encourage a feeling of safety, as well as an understanding that help was available. In one example relating to an adult living with complex vulnerabilities, a personal adviser was praised for working closely with both the adult and other practitioners, ensuring consistent care and support was provided:

> *The personal adviser worked closely with Adult V, his WIR carer and college to provide consistent and valuable support, often exceeding expectations.* – ***APR2024-W02***

It is notable that the personal adviser was seen to have exceeded expectations as part of their role in this case, clearly making an important contribution to the vulnerable adult's welfare.

While consistency in care and support is considered beneficial for all vulnerable individuals, reviews point to this being particularly valuable in relation to children and young people. For example, the presence of the same Independent Reviewing Officer (IRO) for a group of siblings supported a more complete safeguarding picture:

> *Child Y had a stable and consistent IRO for two and a half years. The same IRO was responsible for Child Y's siblings, which ensured an overview and enhanced understanding of the individual and group care and support needs.* – ***CPR2024-W11***

As well as advancing their understanding of the overall case, the consistency in the IRO may also have benefitted the rapport and relationship between the practitioner and Child Y (and their siblings). For another child included in this same review, Child X, an Independent Advocate was recognised for regularly ensuring the child's voice was taken into account during reviews of their case:

> *Child X attended the majority of his Child Looked After Reviews, and his wishes and feelings were ascertained and supported at reviews by an Independent Advocate.* – ***CPR2024-W11***

As this shows, both consistency in the individual practitioners (where possible) and their approach to working with vulnerable people is positioned as beneficial in safeguarding reviews.

Furthermore, across reviews, importance was placed not only on offering consistent care and support to vulnerable people, but also to those around them who may benefit from additional help. In one example, both the review subject and their parent were offered care and support in terms of transportation, due to the child not being brought to appointments previously:

> *There is ample evidence provided by SSD and Health to demonstrate the practical support provided to the child and parent to facilitate attending health appointments especially during covid restrictions.* – ***CPR2024-W12***

In this case, providing support to the parent in the form of practical transport was considered beneficial to the child, ensuring they were able to attend their medical appointments. This suggests that 'best practice' may, at times, involve care and support being extended beyond specific appointments and individuals, as part of a more 'holistic' approach to safeguarding.

2.1.2 Persistency in Care and Support

Persistency in offering care and support was not seen as a necessity in every safeguarding case, because if subjects were willing to engage, being persistent was not needed. In a number of reviews, however, where practitioners faced particular barriers in their delivery of care but remained determined in their approach, this was commended. For example, in the case of Adult A, who had specific health needs and struggled to engage with practitioners, the District Nurses were faced with resistance when they tried to provide necessary support. Their persistency was commended by the reviewers:

> *The District Nurses, whilst navigating the challenges and limitations presented, demonstrated positive practice working with Adult A's resistance to engage in care and support.* – ***APR2025-W03***

In this example, without the persistence of the District Nurses, it is likely Adult A would have gone without the care and support they needed.

In another example, a child needed important medical care but had missed a key appointment. The paediatrician was, however, persistent in their provision of care, ensuring an alternative time was made available, therefore supporting Child C's parent/carer to bring them to the appointment:

> *Although Child C missed the appointment, the paediatrician did not discharge her from the service and offered a further appointment.* – ***CPR2021-W06***

A similar example of persistency in the medical context can be seen below, where a Substance Misuse Midwife was struggling to engage with an expectant mother, and therefore attended a different medical appointment to ensure contact:

The urine sample would have been provided and tested earlier had mother engaged with appointments. The Substance Misuse Midwife was only able to obtain a urine sample through attending another appointment to engage the mother. The SMS Midwife and Community Psychiatric Nurse took the opportunity to attend an antenatal clinic to gain access to the mother to obtain the urine sample. This is considered good practice. – ***CPR2021-W04***

Likewise, other examples include persistent engagement around substance misuse issues and 'missing' episodes:

The good relationship that Substance Misuse Services and the YJPS managed to develop with the young person through persistence despite them at times not wishing to engage to address their problems. – ***CPR2019-W02***

Police Officers continued to search and make enquiries to find the young person, when they had been reported as missing. For some Officers this was outside of their working hours and when they were considered to be off duty. – ***CPR2022-W03***

Notably in the second example, the persistency shown by police in trying to find them and support them in returning home was seen as going beyond expectations. In all of these cases, the persistency of practitioners was considered an important part of ensuring review subjects received the care and support they needed, and this was consistently deemed 'best practice' by reviewers within safeguarding.

2.1.3 Positive Working Relationships

Developing positive working relationships with review subjects is another aspect of practitioners' activity that has been identified as 'best practice' in safeguarding cases over time, and is linked to the delivery of care and support. Reviews suggest that having this professional relationship could allow the review subject to build trust with the practitioner, resulting in better engagement with services. The example below, where the subject had been involved in a serious incident involving drugs and a knife, relates to a charity building a positive working relationship. This enabled the provision of specialist services and support over an extended period:

Redthread national charity provided support and counselling services following a serious incident. They are based at the hospital and engage with individuals involved in serious violence incidents. They were able to develop a relationship and engage over a 6-month period. – ***SUSR2024-06/CTM***

In another case, this time relating to a child and their sibling, support was required in relation to an adoption following significant harm. Professionals offered support during their transition between different foster carers, and the review explicitly noted the 'relationship-based practice':

> *The best practice was evidenced by the relationship-based practice experienced between Child A and their sibling and professionals, and between practitioners. That practice included being child focused and completing joint visits. –* ***CPR2024-W08***

As noted here, the focus on the children's needs and views was key to developing the relationship that reviewers saw positively in this case. Other reviews echo this sentiment, and link positive and trusting relationships with practitioners to review subjects' ability to access support. In the final example below, relating to a large and complex family, the sibling of a review subject reflected on her positive relationship with practitioners:

> *One family member described how the 16 plus service had made a difference to her, and whilst this service was not available to her older sibling, having somebody you can trust and talk to like a normal person was greatly valued as a quality that enabled her to access support from this service. –* ***APR2016-W04***

2.1.4 Support and Training for Practitioners

Although 'best practice' in care and support largely centred around review subjects, examples of support were also identified in relation to practitioners. Unsurprisingly given the complex and sensitive nature of safeguarding work, the provision of appropriate support and training by organisations to practitioners was viewed positively by reviewers. As recognised elsewhere, access to support allows practitioners to explore challenges they face in their roles, in turn supporting them to deliver care of the highest quality (Health and Care Professions Council, 2021). One example of 'best practice' in this context was support offered to care home staff following the homicide of someone they cared for, with reviewers explicitly recognising the shock practitioners experienced and the difficulty of processing such news:

> *Staff from the Care Home stated that they were offered support which is good practice. –* ***APR2018-W02***

In addition to references to 'general' support such as this, other reviews referred to more structured wellbeing support for practitioners. In one case relating to a review subject who had been arrested and later passed away, those who worked with him required significant support, to which their organisation facilitated access:

> *Some positive examples shared with the review team included senior management speaking to staff and offering support, the opportunity for private counselling and access to psychological therapies. –* ***MHHR2016-W01***

While there are intrinsic difficulties and sensitivities for all practitioners working in the safeguarding arena, this example points to a need for additional specialist support to be offered in some circumstances, constituting a different yet equally valued form of care.

Similarly, training for practitioners was seen to facilitate better knowledge and understanding among practitioners of the issues they must deal with, as well as developing (or enhancing) the necessary skills for working with vulnerable people. In one case, where a review subject was struggling with substance misuse and receiving threats from others, a youth worker's unique set of skills were identified as particularly beneficial:

The importance of the role of Youth Worker must not be underestimated, they are specifically trained and skilled to work with young people. – ***CPR2024-W01***

This example demonstrates the value of practitioners equipped with specialist skillsets. For organisations, this underscores the importance of training and developing their practitioners, in turn supporting practitioners to implement 'best practice' in their work with vulnerable people.

2.2 COMMUNICATION

A second recurring theme in safeguarding reviews is 'Communication'. The analysis shows this is positioned as fundamental in safeguarding practice, with clear and consistent engagement framed as key to ensuring vulnerable people receive the support they need. Sub-themes were: Effective Communication; Consistent and Persistent Communication; and Multi-Agency Working.

2.2.1 Effective Communication

Across reviews, effective communication is widely positioned as vital in keeping individuals safe, with a number of 'best practice' examples emerging in the analysis. This includes communication between practitioners, and communication by practitioners with review subjects, as well as their wider families. For example, in one case where the review subject had complex vulnerabilities, the communication between practitioners and carers was identified as key to the safeguarding process:

> *The review saw evidence of best practice in the commitment demonstrated by multiple practitioners and foster carers to safeguard and support Adult V. Excellent working practices and good communication between practitioners and foster carers ensured Adult V had developmental opportunities within the scope of his complex vulnerabilities. –* ***APR2024-W02***

Notably, this example goes beyond safeguarding and support, recognising the value of ensuring Adult V had access to developmental opportunities, with the effective communication being positioned as an important part of this.

In another example, communication by a PPN (Public Protection Notice) Coordinator with a victim was praised. In this particular case, the victim had been subjected to a serious assault, and the Coordinator's approach to engaging them was recognised as adhering to 'best practice':

> *Establishing contact with victims at the earliest opportunity is extremely important; this case identified that the PPN Coordinator successfully established contact with Helena at the earliest opportunity which is in line with best practice guidance. –* ***DHR2021-W05***

Beyond communication between practitioners and individual victims or review subjects, the analysis also found that effective communication sometimes extended to families and/or carers. As well as sharing important updates, communicating with those around a vulnerable person was seen as useful in helping them understand safeguarding issues, and how to best support the person's wellbeing. In one example, meetings with family members were not only an opportunity to provide updates, but also to gain new and broader information that could inform patient care:

During John's inpatient stay, there were meetings with the family which were documented as opportunities to obtain collateral information. This is good practice and allows clinical teams to broaden their awareness of the clinical picture, therefore supporting understanding of the presenting problem as well as associated clinical management. – ***SUSR2022-02/CTM***

Although, as the review documents, communication with John's family was not entirely effective, the reviewers were clear that engaging with families and carers is a positive practice, supporting them to care for their loved one, and that ensuring services have a complete picture to inform their care planning.

2.2.2 Consistent and Persistent Communication

Reviews point to the importance of consistent (and where needed, persistent) communication in ensuring vulnerable people have regular and sustained contact with those who can offer help. It also supports practitioners to have better awareness of the issues at hand, and therefore a more complete understanding of the case. There was explicit acknowledgement in one review of the consistent communication between practitioners and the review subject, where the subject was struggling to engage with agencies:

Practitioners planned to meet with Mr X together to enable structured, consistent contact whilst maintaining safe practices, and not overwhelming Mr X with multiple appointments. Where face to face contact could not be facilitated, telephone contact was regular and consistent. – ***APR2025-W02***

This 'best practice' approach, including the alternative use of telephone calls where necessary, was seen by reviewers as key to maintaining communication and supporting Mr X to continually access practitioners, while also recognising his needs and overcoming the potential barriers.

As noted earlier (section 2.1.2) being persistent is not necessary in every case. However, when presented with resistance or challenges that may prevent communication with a vulnerable person, reviewers identified persistency as 'best practice'. One example demonstrated how services, along with family members, persistently tried to contact a review subject in relation to a mental health appointment. In this particular review, where there was a history of not attending appointments, as well as deterioration in the review subject's mental state and psychosis symptoms, this continued perseverance was valued:

John did not attend his planned appointment with mental health services on the 29th July 2021 and health board records shared with panel indicate multiple attempts to contact him and his family by telephone were not successful. – ***SUSR2022-02/CTM***

Although John did not attend this and other appointments, the numerous attempts to contact him, both in the lead up to and following the appointments, were viewed positively by reviewers. This persistency is in contrast to the concerning examples highlighted by Robinson et al. (2019), that saw patients discharged from services after not engaging.

Below are two further examples of persistence in contact and engagement, the first centring on police efforts to maintain contact with a vulnerable adult who was in an abusive relationship, and the second in relation to children's services repeatedly visiting a family in an effort to engage with them:

The MARAC process worked well in identifying risk factors and developing a safety plan for this couple. Following these meetings, police were persistent in trying to engage Adult R, through phone calls and joint visits. It is acknowledged that this effective practice should be encouraged through all agencies. – ***APR2022-W05***

It was shared during the learning event that Children's Services were persistent in attempting to engage the family and during the Care and Support Plan being in place eleven visits were attempted although many of these were unsuccessful, and only one visit where the children were spoken to individually. – ***CPR2022-W02***

As this suggests, across different safeguarding contexts and needs, consistent and persistent communication with review subjects is considered 'best practice'. The final example below usefully summarises the value of this approach in the specific case of a vulnerable elderly person, Adult X. Here, the practitioner's persistency yielded trust, opportunities to provide assistance, and important wellbeing checks:

The approach the social workers took with Adult X and Adult W was persistent in trying to develop a relationship with them built on trust and confidence. The social worker identified that grocery shopping was an issue and found innovative ways to arrange delivery of food and for its payment via a locally based grocery shop. The social worker was assertive and gained entry on several occasions to check on the wellbeing of Adult W, even though Adult X was often reluctant to allow entry. – ***APR2024-W01***

2.2.3 Multi-Agency Working

Communication is positioned as an integral part of effective multi-agency working within safeguarding reviews, helping to ensure that a vulnerable person is being provided with the help they need, and that agencies are working together sufficiently to support them. It is also seen to enable them to bring together their professional knowledge to strengthen the care they provide, as demonstrated by the example below:

There was joined up thinking and effective inter-agency working between the community drug and alcohol team and housing team, and there was a significant amount of contact with Male B by professionals (within these teams) in an attempt to encourage and persuade him to attend appointments and take up offers of support. – ***CPR2024-W04***

Another example of effective multi-agency working was identified in a case of self-neglect by a vulnerable adult. As they often tended to disengage from support services, the multi-agency contact approach adopted while the adult was in hospital was seen as 'best practice':

> *Within the hospital setting and whilst Adult A was an in-patient there appears to be a great deal of activity and communication from various agencies and a fair understanding by all of what was happening. –* ***APR2015-W01***

This indicates a positive view of the joint working of agencies, pointing to shared knowledge and a united effort to provide support to Adult A.

Inter-agency communication in the safeguarding arena is common, sometimes taking place within formal multi-agency meetings, where practitioners are expected to communicate relevant information held by their agency with others. In the case of a review subject suffering poor mental health, agencies were recognised by reviewers for sharing relevant information to shape the support offered to the individual:

> *The MARAC [Multi-Agency Risk Assessment Conference] had good representation from all statutory agencies on both occasions, with representation from mental health services, including Adult R's care coordinator. This ensured effective communication and information sharing between agencies, resulting in a personalised approach. –* ***APR2022-W05***

As this example notes, the MARAC was well-attended by the agencies in contact with Adult R. This attendance is positioned as important in facilitating the communication that followed, which ultimately led to the tailored care plan; this not only underlines the need to communicate important information, but also the value of having representation from all relevant agencies at such meetings.

2.3 RISK AND ESCALATION

'Risk and Escalation' was another 'best practice' theme identified from the analysis of reviews, an aspect positioned as crucial in safeguarding frameworks and keeping vulnerable people safe. This theme can be divided into two key areas: Risk Assessment; and Escalating Concerns.

2.3.1 Risk Assessment

Unsurprisingly, the consideration and assessment of risk was positioned as key in safeguarding vulnerable individuals from harm to themselves and others. Reviewers recognise the complexity and challenge often posed when assessing 'risk' in practice, and this regularly features as cause for concern across reviews. However, some positive examples have been identified by this analysis. Several reports make general references to 'correct' assessments of risk in the course of a safeguarding case, but the examples below are more specific.

One review points to the actions of a health practitioner contributing to saving a newborn baby's life, after they recognised the risk of 'overwrapping' based on the baby's clothing. In this case, the baby was seen in his pushchair with a hat pulled down over his face and multiple covers over the pram. Other practitioners had observed similar instances in the weeks previous, but unlike the Hearing Screener in this example, they had missed the risks. As a result, the review notes:

> *It has been suggested that by making the safeguarding referral when she did, the Newborn Hearing Screener may have saved Child A's life. –* ***CPR2019-W04***

In another example, foster carers were recognised for their efforts to mitigate the risk posed to children in their care by another young person. In this complex case, the young adult had a known risk of harmful sexual behaviours towards children, and so:

> *Mindful of the potential risk presented by the young adult, foster carers R did not leave the children unattended during the day. –* ***CPR2024-W08***

Recognising and considering this risk indicates an effort to safeguard the children, which reviewers viewed positively under these circumstances.

2.3.2 Escalating Concerns

Practitioners' escalation of their concerns to others who are better positioned to provide specific care and support for a vulnerable person is widely recognised as 'best practice' in reviews. In one example, an adult required support from agencies, but this was being hindered by a family member. Their social worker was seen to have gone beyond expectations in their efforts to provide care, and ultimately escalated the case appropriately to others:

The social worker went the 'extra mile,' undertaking numerous cold calls, drive bys, phone calls to the home and monitored the food deliveries through regular contact with the local shop. Also checking signs of movement in the property and liaison with neighbours. It is evident that the social worker had concerns regarding this case and escalated the case to their line manager and safeguarding and sought to involve other agencies in the management of this case. – ***APR2024-W01***

Reviews such as this clearly identify the importance of escalation within the safeguarding process. In this context, 'best practice' is characterised as a recognition from practitioners of both escalating risks and concerns, as well as the limits of their position in responding, leading to the escalation of the case to other agencies and practitioners who can offer support.

Another example of concerns being escalated to other practitioners stems from the case of an individual who was self-neglecting and required additional support for their care needs. The District Nurses who were visiting this individual to assist with wound care felt her presentation had begun to deteriorate, and had concerns around mental health, alcohol use, and mobility. They therefore made a report to the Local Authority's Safeguarding Team and requested an escalation to the GP for an assessment of mental capacity. This was deemed to be positive practice by the District Nurses:

The review found there was positive practice in the escalation of concerns to the GP and the report to Adult Safeguarding in response to the presentation of self-neglect behaviours. – ***APR2025-W03***

Similarly, another review notes the children's charity Barnardo's recognising and responding to escalating risks of harm for a young person. In this case, the child had experienced sexual abuse, exploitation, and domestic abuse, and a number of agencies were involved in attempts to safeguard her. Barnardo's efforts to escalate concerns to other agencies and practitioners were explicitly recognised as 'effective' by reviewers:

The child made a number of disclosures to the Barnardo's SERAF service that were immediately shared with the social worker and police. Barnardo's repeatedly escalated concerns and requested strategy meetings to respond to these increased risks. – ***CPR2019-W10***

2.4 POLICY, PROCEDURES AND RECORDING

The analysis also identified 'Policies, Procedures and Recording' as a recurring theme across safeguarding reviews in Wales, indicating that this is essential to effective safeguarding practices. Two sub-themes were identified: Adhering to Policy and Procedure; and Record Keeping.

2.4.1 Adhering to Policy and Procedure

Following key policies and procedures has frequently been highlighted as 'best practice' across safeguarding reviews. In some ways, this might reasonably be considered 'expected' rather than 'best' practice. However, the numerous references to this in reviews suggests a recognition (by reviewers) of the issues encountered by practitioners, such as time pressures and the complexity of cases, which might present challenges to procedures in practice. As such, reviewers recognise the importance of policies/procedures in guiding practitioners on the necessary actions to take when they are presented with various issues and scenarios, and several reviews explicitly attribute positive safeguarding outcomes to compliance with procedure, for instance:

Child protection procedures were followed and all four children were safeguarded. – ***CPR2014-W12***

The following examples of adherence to policies, both of which relate to cases of high-risk concerns in child safeguarding, were highlighted by reviewers as good practice:

Child maltreatment was considered and a second paediatric opinion was requested consistent with LSCB policy, which was explained to the parents. – ***CPR2015-W10***

All agencies responded and followed correct practices once safeguarding issues had been identified. Good evidence of prompt and effective communication between Police, Children's Services and Health. Safeguarding procedures were followed in a timely way. – ***CPR2014-W06***

As indicated specifically in the second example (CPR2014-W06), the timeliness of practitioners' actions is deemed key in safeguarding; adherence to policies and procedures alone is not considered sufficient without timely intervention. Other reviews also point to the importance of prompt action, specifically in response to key information being shared:

At the point where the information in the safeguarding referral became known, agencies acted effectively and promptly to safeguard the child. – ***CPR2020-W02***

In this particular case, concerns centred around neglect and demanded swift safeguarding measures. More broadly, information sharing was also considered beneficial for shaping intervention design, as shown by the following example relating to a mental health crisis:

This review has demonstrated Steven effectively engaged with a variety of support at USW who worked cohesively, sharing information appropriately to offer the best interventions. – ***SUSR2024-06/CTM***

Policy and procedure, and the importance of timeliness, also extends into the period following a serious incident. This is alluded to in the example below, which centres on police making a referral following a domestic homicide incident. While the worst outcome had been realised, reviewers commended the police's quick referral for the DHR to be conducted, with the aim of learning from the tragic circumstances that had unfolded:

> *This was a timely notification and demonstrated a good understanding by the police of the need for a referral at the earliest opportunity. –* ***DHR2021-W04***

2.4.2 Record Keeping

Good record keeping and documentation is recognised as important across reviews, supporting practitioners and agencies in all aspects of case management and assessment. For example, in a case of accidental drowning of an infant, the record keeping was described as 'excellent':

> *Practitioners worked very well together and there is evidence of excellent communication and record keeping. –* ***CPR2021-W04***

The records included details of previous welfare checks, living conditions, the parent's substance misuse and lifestyle, and the level of engagement with practitioners following the child's birth. This provided a clearer picture of the events that led to the child's tragic death and ensured their siblings could be safeguarded. Reviews such as this point to the importance of good record keeping for providing an accurate picture of past and present circumstances, to better inform risk assessments and safeguarding measures, and to be shared with other agencies where necessary.

In another review, there is explicit praise for the detail and frequency of records that documented safeguarding concerns from a school:

> *It is also recognised that the breadth of recording (detail and frequency) of concerns by the school was of notable good practice. –* ***CPR2016-W06***

In this specific case, reviewers praised the inclusion of the children's voices and their experiences of family life. There were concerns, however, that the records were not shared effectively with other agencies; the reviewers indicate that the information would have provided a 'fuller picture' about the parents' capacity to care for the children, and would have been useful to the assessments taking place.

Linked to the theme of policy and procedure above, ensuring clear and detailed records are completed is largely expected safeguarding practice, as identified in the examples below. The first concerns a young adult who had previously been in the care of the Local Authority, while the second relates to a group of siblings on the Child Protection Register:

There was good record keeping which evidenced that relevant policies and procedures had been complied with, including the All Wales Child Protection Procedures 2008 and the Protocol for Young Persons at Risk [of] Exploitation. – ***APR2016-W03***

It is clear from the case records that the Public Law Outline processes were followed by Children's Services in accordance with the prescribed procedures with the appropriate meetings and documentation being completed. – ***CPR2016-W06***

In these cases, the thorough records were useful when it came to undertaking the practice reviews and informing the resulting recommendations, as they evidenced to what extent the relevant guidance and processes had been followed.

2.5 LEARNING AND REFLECTIONS

The final theme identified in this analysis is Learning and Reflections. This includes the points of learning and suggestions relating to 'best' or 'good' or 'effective practice' that have been highlighted by reviewers in their analysis of safeguarding incidents. They provide further insight into what 'best practice' looks like, and can be grouped as: Learning from Past Reviews; and Suggested Good Practice.

2.5.1 Learning from Past Reviews

A fundamental aim of safeguarding reviews is to ensure important learning from the past is taken into consideration in future cases. As such, when previous safeguarding actions have not been suitable or not had the intended impacts, identifying this learning has important implications for subsequent practice. Some reviews suggest that past learning and recommendations have indeed informed safeguarding practice in later cases, which reviewers have identified as 'best practice'. One example pointed to police contacting a university for information about a review subject, a practice that had resulted from a previous DHR:

> *The contact with the University was good practice and the panel were informed that this had been identified as an area of learning within a previous DHR and that work had been undertaken since this time to create working relationships and information sharing processes. –* ***DHR2021-W05***

Such examples point to the positive impacts of the safeguarding review process. Similarly, in relation to disclosures of abuse from children, learning from previous reviews was seen to have shaped the positive practice that emerged in a later safeguarding case:

> *Previous reviews have highlighted the need for children to meet on their own with practitioners, away from parents and carers in an environment where they feel safe, so that the children can speak about their concerns. In this case, when that good practice was followed, the children were able to share information which led to them being accommodated. –* ***CPR2015-W09***

As these examples illustrate, drawing on learning from the past to inform future practice is viewed favourably by reviewers. Furthermore, acknowledging and implementing recommendations from safeguarding reviews provides a promising indication that reviews are being used by safeguarding agencies and practitioners, and are improving practice and policy as a result.

2.5.2 Suggested Good Practice

In some cases, the safeguarding reviews held within the WSR did not identify any actions deemed 'best practice'. It is unclear whether this is because no positive or effective actions were seen across the case history, or whether they simply were not recorded by reviewers. However, some of these reviews did make suggestions about what would have constituted 'best practice' in particular cases, which may be helpful in guiding future practice; a few examples are summarised here.

Suggestions include those centred on information sharing with other agencies, as in the example below, relating to the discharge of a vulnerable individual from hospital:

> *Following Mr. A's discharge from acute Mental Health Ward 1 on the 13th December, the police representative on the Panel stated that it would have been good practice for the ward staff to have informed the police of his discharge for consideration of safeguarding options. –* ***APR2015–W02***

In this particular case, where a number of issues centred around care planning following discharge, and reviewers felt that better information sharing would have enabled more effective safeguarding planning. In another example relating to information sharing and mental health, reviewers felt that Community Mental Health Teams should have been in contact to better support an individual who moved between areas. Noting a long history of relapse and self-harm, the reviewers suggest:

> *Given the severity, complexity and chronic nature of Mr G's problems we would consider it good practice to have made a referral directly to the South Pembrokeshire CMHT. –* ***MHHR2011-W01***

Suggestions for 'best practice' also included those related to support for families and carers. For example, in the case of an individual who had suffered poor and fluctuating mental health throughout his life, the review noted that the family's needs were not taken into consideration, despite them providing care to the individual. It was therefore suggested that:

> *In line with best practice guidelines, support for carers should be provided around diagnosis and how to identify and manage signs of relapse/illness. –* ***SUSR2022-02/CTM***

In this case, reviewers felt the family could have been much more informed about the condition, and how and when they could intervene, ensuring they could have better cared for their loved one as well as themselves. In another explicit reference to 'best practice', this time in a case where there were both mental health and homelessness concerns, reviewers were critical of the overall assessment approach. According to the review, too much emphasis was placed on finding permanent accommodation away from a homeless hostel (Tresillian House), with too little attention given to the patient's mental health needs. Reviewers felt key concerns could have been better responded to:

> *Best practice would have provided a more responsive approach to concerns raised by staff at Tresillian House. –* ***MHHR2008-W01***

The final example below aptly summarises the importance of learning from past reviews and identifying – or 'scoping out' – examples of good practice from other areas and agencies:

The panel reflected that in addition to the staff training, learning regularly from DHRs, or alike as part of good practice, would assist in understanding and appreciating the joined-up nature of work and appreciate how significant recording is when all agencies add their notes together. […] scoping out good practice examples from other areas could support local community initiatives to improve practice and knowledge. – ***DHR2023-W01***

SECTION 3: CONCLUSIONS

This report has presented findings from an analysis of 'best practice' from safeguarding reviews stored in the Wales Safeguarding Repository. While these safeguarding reviews, with their focus on incidents of serious harm and homicide in Wales, unavoidably yield tragic outcomes in most cases, there are many references to the positive and effective practices used by practitioners who have come into contract with vulnerable people. These 'best practice' examples, drawn from 183 reviews, were the focus of this report.

Our 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 between 2008-2025, with five thematic areas emerging from 1,516 coded extracts: Care and Support; Communication; Risk and Escalation; Policy, Procedures and Reporting; and Learning and Reflections.

Implications for practice

Understanding what is considered 'best practice' is useful for many audiences, including policymakers, practitioners and academics, and can be used to inform further research and/or recommendations. From the analysis, we can conclude the following are considered characteristics of 'best practice' in safeguarding in Wales:

1. **Care and support** that is **consistent**, and practitioners who are **persistent** in their approach to supporting vulnerable people, ensuring needs are met.
2. Practitioners developing **positive relationships** with individuals they work with, facilitating trust and engagement.
3. **Organisations providing sufficient support and training** to practitioners, enabling them to perform effectively, with particular care for their wellbeing following difficult incidents.
4. Practitioners ensuring that **communication** with vulnerable people (and their families and/or carers) is **effective, consistent,** and where necessary, **persistent.**
5. Agencies and practitioners **working together**, communicating and sharing relevant information, to provide the best standard of care to a vulnerable person.
6. Practitioners **recognising risk** and conducting the relevant **assessments** to provide the appropriate response to safeguarding issues and protect individuals from harm.
7. Where concerns about a known individual have grown, practitioners **escalating** cases to the relevant supervisor or agency, ensuring the appropriate skills and care are in place to mitigate risk or harm.
8. **Policies and procedures** across all aspects of safeguarding being adhered to in every case, with required referrals made in a **timely** manner.
9. Practitioners keeping **clear and detailed records**, documenting key pieces of information and decisions about cases, and **sharing this information** with other practitioners and agencies where necessary.
10. Agencies and their practitioners **drawing on learning from past reviews** and taking this into consideration to inform future safeguarding practices.

Directions for future research

This project is the first of its kind to analyse 'best practice' examples held within safeguarding reviews in the Welsh context, responding to a previous gap in our understanding. To develop this further, one avenue for future research would be to draw comparisons between past recommendations and recent 'best practice' examples. This would provide useful insight into whether, or to what extent, recommendations have been actioned over time, helping to trace the impacts of previous safeguarding reviews, even where definitive implementation information was not previously available.

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APPENDIX 1: SEARCH TERMS

Initial search terms:

- Best practice
- Expected practice
- Good practice

Additional search terms:

- Attempting
- Commended
- Consistent
- Co-operation
- Cooperation
- Detailed reports
- Effective
- Effective communication
- Effective practice
- Good communication
- Good continuity
- Good relationship
- Good response
- Kept on trying
- Maintained involvement
- Mindful
- Multiple attempts
- Positive practice
- Responsive
- Thorough
- Thoughtful
- Timely
- Underestimated

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