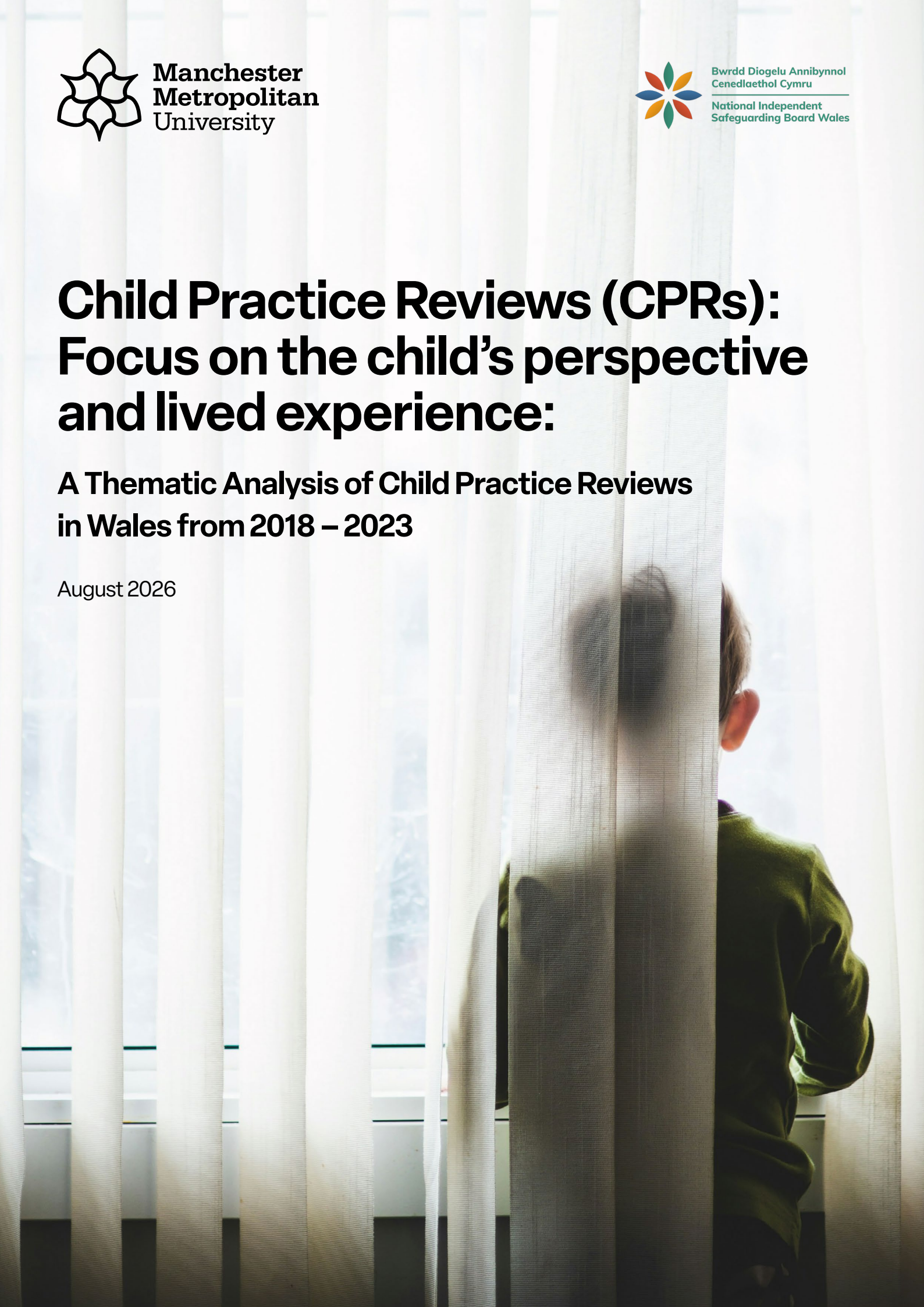
Manchester Metropolitan University

Bwrdd Diogelu Annibynnol Cenedlaethol Cymru
National Independent Safeguarding Board Wales

Child Practice Reviews (CPRs): Focus on the child's perspective and lived experience:

A Thematic Analysis of Child Practice Reviews in Wales from 2018 – 2023

August 2026



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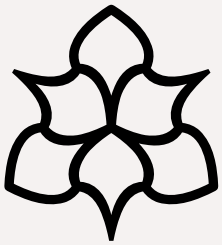

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Preface

The authors of this thematic review recognise that the circumstances which led to these Child Practice Reviews (CPRs) are deeply distressing. They involve children who have experienced serious harm or whose lives have been lost and the impact of these events extends to their families, friends, practitioners, and the professionals involved in reviewing these cases. We are grateful to all those who have contributed to the review process and to the learning that arises from it.

It is important to acknowledge that CPRs represent a small proportion of safeguarding activity; specifically, those cases where harm has escalated to the extent that a statutory review is required. As such, the findings of this report should not be interpreted as representative of safeguarding practice more broadly. Rather, they provide insight into the most complex and challenging situations, where multi-agency safeguarding responses have not operated as effectively as intended, often within highly demanding and resource-constrained environments.

This report builds on previous national analysis of CPRs in Wales and continues to reflect the significant pressures within the safeguarding system. Practitioners and leaders operate within a context of increasing demand, workforce challenges and the complexity of working with children and families experiencing multiple and overlapping adversities. The authors wish to recognise the commitment, professionalism and dedication of those working across safeguarding services, many of whom continue to go above and beyond in their efforts to support children and families.

The purpose of this thematic analysis is to support reflection, learning and improvement. It is not intended to attribute blame to individuals, agencies, or local areas. Instead, it seeks to identify recurring themes, challenges and examples of effective practice in order to strengthen safeguarding systems and responses across Wales.

A key focus of this review is the extent to which the child's lived experience is understood, represented and used within CPRs. While previous analyses have highlighted the importance of hearing the child's voice, this report places greater emphasis on how that voice is evidenced, how children's day-to-day experiences are understood within their wider context and how this understanding informs professional decision-making and action.

Undertaking this analysis requires careful and, at times, uncomfortable reflection on situations where safeguarding responses did not achieve the outcomes intended. However, such reflection is essential if learning is to be meaningful and sustained. Alongside identifying areas for improvement, this report also recognises examples of effective and thoughtful practice, which can inform future approaches. Ultimately, the aim of this report is to contribute to the ongoing development of safeguarding practice by strengthening how systems recognise, understand and respond to the lived experiences of children. By doing so, it seeks to support more effective, consistent and child-centred safeguarding across Wales.

Executive Summary

This briefing report presents the findings from a thematic analysis of 24 Child Practice Reviews (CPRs) undertaken across the six Regional Safeguarding Boards (RSBs) in Wales. The reviews relate to children who experienced serious harm or whose lives were lost and provide a critical opportunity to reflect on safeguarding practice, multi-agency working, and how learning can be strengthened to improve future responses. The incidents examined occurred between 2018 and 2023, a period that includes the COVID-19 pandemic, which is likely to have influenced service delivery, workforce capacity, and safeguarding practice.

This review builds on the 2023 national thematic analysis of CPRs but takes a distinct and more focused approach. Rather than examining safeguarding systems solely through patterns of risk and response, this analysis centres on how the child's lived experience is understood, represented, and used within CPRs. In doing so, it highlights a critical distinction between recording the safeguarding activity that has taken place, understanding that activity from the child's perspective and demonstrating how this understanding informs decision-making and outcomes.

Across the CPRs analysed, most children and families were known to multiple agencies, often over extended periods of time. However, this awareness did not consistently translate into coordinated action, shared ownership of risk, or effective escalation. Harm was rarely associated with a single incident; instead, it reflected cumulative and overlapping concerns, including neglect, domestic abuse, parental mental health and substance misuse. While these risks were often recognised, they were frequently assessed in isolation, limiting professionals' ability to identify patterns of escalating harm over time.

A key finding throughout the analysis is the continued tension between procedural activity and a meaningful understanding of the child's lived experience. While agencies were often involved and actions were recorded, the child's day-to-day reality was not always clearly articulated or evidenced to play a central role in decision-making. Children were sometimes spoken to, but this was not always consistent, not always undertaken in a way that enabled them to speak freely and not always revisited over time. In some cases, parental or carer perspectives were prioritised, or children's views were accepted without sufficient exploration of context or influence. This reflects an ongoing challenge in moving from gathering information about a child to developing a deeper understanding of their lived experience.

This pattern is further reinforced by the descriptive findings. While all CPRs included some form of indirect reference to the child's lived experience, fewer than half provided a clear and explicit account of the child's voice. More significantly, only one review demonstrated how the child's views were considered to directly influence safeguarding decisions. This is a critical finding, suggesting that even where children's voices are present, their perspectives are not consistently shown to shape professional thinking, assessment, or action.

A similar gap is evident in relation to family and carer involvement. Although the majority of CPRs recorded that families were consulted, fewer than half made these contributions clearly visible within the review. In many cases, consultation was recorded as a procedural requirement, without demonstrating what was shared or how it informed learning. Qualitative findings reinforce this, with families emphasising the importance of being listened to, receiving clear communication, and being meaningfully involved in decision-making. Together, this suggests a risk of consultation becoming procedural rather than purposeful.

The role of advocacy and the presence of individuals championing the child's perspective was also inconsistent. While some CPRs referred to advocates, champions, or trusted adults, their role was rarely clearly defined within safeguarding processes. In extended CPRs, where independent advocacy should routinely be offered, only a third made any reference to this and very few demonstrated how advocacy contributed to decision-making. The qualitative findings further highlight uncertainty regarding who is responsible for ensuring the child's perspective is consistently represented, particularly in complex multi-agency contexts.

Workforce instability was identified in just under a third of CPRs, with references to changes in social workers, capacity pressures and a lack of continuity in relationships. The qualitative analysis highlights the importance of relational practice, demonstrating how trust, consistency and sustained engagement are central to understanding a child's lived experience. Where relationships were disrupted, opportunities to build meaningful understanding and support were reduced.

Across both the quantitative and qualitative findings, a consistent theme emerges: the difference between recording that something has happened, understanding it from the child's perspective and demonstrating how this perspective has been considered and played a role in decision-making and outcomes. This is reflected in how the child's voice may be captured but not always acted upon, how consultation can be recorded but not clearly integrated into analysis, and how recommendations are made without always being visibly grounded in the lived experience of the child.

Overall, the findings suggest that safeguarding systems are often effective at identifying and recording risk, but less consistent in integrating the child's lived experience into decision-making and learning. The implications for practice are clear. There is a need to move beyond procedural compliance towards a more consistently child-centred approach, where children's experiences are central, visible, and actively inform safeguarding responses. Strengthening the visibility and impact of the child's voice, improving the quality and transparency of family engagement, clarifying the role of advocacy, and ensuring that learning is consistently evidenced and applied will be critical to enhancing both the effectiveness of CPRs and the wider safeguarding system.

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Introduction

Where children experience significant harm or where their lives are lost, Child Practice Reviews (CPRs) provide a critical opportunity to understand what happened and to improve professional and organisational safeguarding practice (Child Safeguarding Toolkit, 2026). CPRs are multi-agency reviews that examine the detail and context of agencies' involvement with the child and their family. They bring together practitioners, managers and senior leaders to reflect on practice, systems and decision-making. Each review relates to deeply distressing circumstances for children, families and practitioners. The purpose of CPRs is to support learning and improvement rather than to apportion blame (Welsh Government, 2019).

In 2023, a national thematic review of CPRs in Wales (McManus et al., 2023) examined patterns of risk, multi-agency safeguarding responses, and the quality and consistency of CPR processes. That review identified a number of recurring and systemic challenges, including the accumulation of risk over time, the role of professional curiosity, barriers to effective information sharing, threshold uncertainty, and the practical difficulties of working with families where concerns are longstanding but do not consistently meet the threshold for statutory intervention. A central message from this work was the importance of understanding the child's experience within the wider family and system context, and the extent to which this understanding informs professional judgement and decision-making.

Since the publication of the 2023 review, safeguarding review arrangements in Wales have continued to evolve. CPRs are now being brought within the wider Single Unified Safeguarding Review (SUSR) model (Welsh Government, 2023). This model aims to integrate different types of reviews into a single, more coherent process. Its intention is to reduce duplication, strengthen multi-agency learning, and place greater emphasis on how systems operate collectively, rather than considering incidents in isolation. This represents an important shift in the safeguarding landscape, with increased expectation that learning from reviews is clearly evidenced, consistently articulated, and effectively translated into practice.

While the CPRs analysed within this report were completed under the previous review arrangements, they provide an important baseline for understanding both enduring challenges and future opportunities within the SUSR model. As such, this report is likely to represent one of the final national thematic analyses of CPRs under the previous framework. As such, the findings provide not only insight into safeguarding practice, but also an important evidence base for shaping how learning is captured, analysed and translated into improvement within the emerging SUSR framework. It offers a critical point of reflection during the transition to SUSR-led review processes and provides an opportunity to consider how learning from CPRs can inform the future development of the SUSR model. It therefore provides a unique opportunity to take stock of recurring themes, assess the extent to which previous learning has been embedded and consider how this learning can be carried forward and strengthened within the evolving safeguarding landscape.

As with previous analyses, the CPRs included in this study represent a minority of safeguarding cases and should not be interpreted as representative of safeguarding practice more broadly (McManus et al., 2023; Rees et al., 2019; 2021). However, they remain a critical source of insight. These reviews provide detailed accounts of situations where harm escalated despite professional involvement. They therefore offer a unique opportunity to examine whether learning from previous reviews has been embedded, sustained and translated into practice across safeguarding systems.

This briefing report builds directly on the 2023 thematic review and forms part of an ongoing programme of national analysis. However, rather than repeating earlier findings, this review takes a more focused and in-depth approach to examining the child's voice and perspective and lived experience within safeguarding. This includes consideration of what daily life was like for the child, how their experiences, behaviours, and perspectives were understood by professionals and the extent to which this understanding played a role in safeguarding responses.

This focus reflects a persistent and well-documented challenge within safeguarding practice. While reviews frequently emphasise the importance of hearing the child's voice and adopting a whole-family approach, these lived experiences are not always consistently or clearly articulated across agencies or over time. Where information is fragmented, procedural activity can become more visible than the child's day-to-day reality. This can limit professionals' ability to recognise patterns of cumulative or escalating harm (McManus et al., 2023; Rees et al., 2019; 2021).

This review, therefore, seeks to examine not only whether children's voices are present within CPRs, but how their lived experiences are represented, understood and considered within safeguarding analysis, decision-making and learning. In doing so, it aims to contribute to a deeper understanding of how child-centred practice is evidenced within CPRs and how this can be strengthened within evolving safeguarding systems.

As with the 2023 review, this report is intended to be constructive rather than critical. Its purpose is to support reflection, learning and improvement, with the overall aim of strengthening how safeguarding systems recognise, record and respond to the lived experiences of children across Wales.

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Methodology

This study used a desk based mixed methods approach, combining qualitative thematic analysis with descriptive and exploratory quantitative analysis. The methodology builds on the approach adopted in the 2023 thematic review of CPRs in Wales (McManus et al., 2023), while placing greater focus on how the child's lived experience is captured and understood within safeguarding reviews.

The analysis included 24 CPRs conducted across the Regional Safeguarding Boards (RSBs) in Wales. Both concise and extended CPRs were included and analysed in full. The reviews relate to children who experienced significant harm or whose lives were lost and were examined using the published reports provided for the purposes of this study. No direct engagement with children, families, or practitioners formed part of the research.

A qualitative thematic analysis was undertaken to explore how children's daily lives, relationships, environments and experiences were described within the CPRs. Particular attention was paid to how children's voices, behaviours and lived experiences were recorded and interpreted within the review narratives. Themes were identified through an iterative process using Braun and Clarke's (2006) approach to thematic analysis, drawing on learning from the 2023 review while also allowing new themes to emerge inductively from the data.

To support consistency in coding, an inter-rater reliability check was undertaken using Cohen's Kappa. Ten percent of CPRs were independently coded by a second reviewer and agreement between coders was assessed. The resulting score ($\kappa = .835$, $p < .001$) indicates a very strong level of agreement in how themes were interpreted and applied. While inter-rater reliability is not always a feature of qualitative research, it was employed here to strengthen confidence in the consistency of coding. This was considered particularly important given the practice-focused nature of the analysis and its potential implications for safeguarding learning and improvement, especially in relation to key variables such as the visibility and interpretation of the child's voice.

In addition to the qualitative analysis, descriptive statistical analysis was conducted to summarise key characteristics across the cohort, including child and family factors, types of harm and patterns of agency involvement. These descriptive findings were used to identify common trends and areas of variation across the reviews.

Further exploratory statistical analysis was undertaken to examine relationships between selected variables, particularly those relating to the child's voice and lived experience. Given the small sample size ($n = 24$), this analysis is exploratory in nature and is intended to complement the qualitative findings by supporting a more detailed understanding of patterns within the data, rather than to establish causality.

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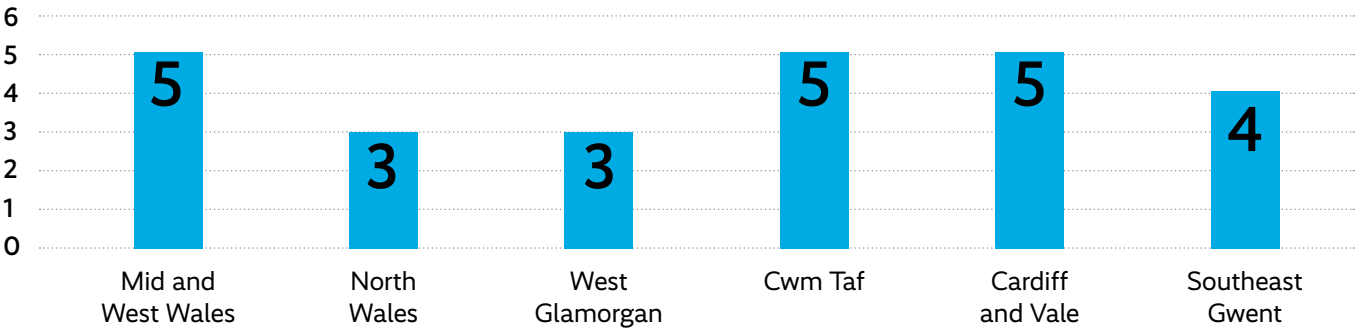
Descriptive analysis

24 CPRs were included in this report drawn from the six RSBs in Wales. The distribution of CPRs across RSBs remained broadly consistent with previous thematic reporting in 2023, with the number of CPRs per board ranging from 3 to 5. The highest number of CPRs were recorded in Mid and West Wales, Cwm Taf, and Cardiff and Vale (n = 5 each). Gwent contributed n = 4 CPRs, while North Wales and West Glamorgan each contributed n = 3 CPRs during this period.

Figure 1. Number of CPRs across RSBs



Half of the CPRs were conducted as Extended (n = 12; 50%) and half as Concise (n = 12; 50%). This equal split suggests that a relatively high proportion of cases in this small sample were children who were already subject to statutory involvement (e.g., already on the child protection register and/or given a looked after status) in the six months preceding the index incident (as per the criteria for Extended CPRs).

The incidents captured within the CPRs occurred between 2018 and 2023, reflecting both more recent incidents and reviews completed over a longer period. As with previous thematic reviews, variation in review completion times and publication points should be considered when interpreting these trends.

3.1. Risk factors: Index child and family characteristics

3.1.1. Severity and Type of Harm

Across the 24 CPRs, 15 cases involved the death of a child (62.5%), and 9 cases related to non-fatal significant harm (37.5%). This finding continues to demonstrate that CPRs largely reflect the most serious outcomes for children and therefore provide an important (though not representative) window into situations where harm escalated despite professional involvement.

Table 1. Outcome severity recorded

Outcome	Frequency (n)	Percent (%)
Child death	15	62.5
Non-fatal significant harm	9	37.5
Total	**24**	**100**

When examining the type of harm recorded within CPRs, physical abuse (fatal and non-fatal combined) and health-related harm[1] were the most frequent categories, each accounting for five cases (20.8%).

Suicide was the next most recorded incident, appearing in four CPRs (16.7%). These cases primarily involved adolescents, though one case involved a younger child (aged 9), reflecting an increasing visibility of poor mental health within CPRs. Interestingly, when compared to the 2023 thematic review, where suicide represented the highest single category of harm, the current cohort presents a more evenly distributed profile of risk. While no direct comparisons can be made given the small sample size of reviews (n = 24) findings consistently show that chronic neglect, physical harm and health related vulnerabilities remain a prominent concern within safeguarding reviews.

Sexual abuse was identified as the primary harm in three CPRs (12.5%), including abuse occurring both within the family home (n = 1) and in care contexts (n = 2). A further two CPRs (8.3%) involved exploitation related harm (child sexual exploitation and/or criminal exploitation).

Drowning incidents accounted for two CPRs (8.3%), both occurring within a supervision/neglect context. In addition, one CPR (4.2%) related to a Sudden Unexpected Death in Infancy (SUDI) associated with unsafe sleep practices following parental intoxication. Finally, two CPRs (8.3%) focused on chronic neglect and cumulative harm resulting in significant impairment but not death.

Table 2. Dominant Type of Harm Recorded

Dominant harm detected*	Frequency (n)	Percent (%)
Physical abuse (fatal and non-fatal)	5	20.8
Health-related harm	5	20.8
Suicide	4	16.7
Sexual abuse	3	12.5
Exploitation-related harm (CSE/CCE)	2	8.3
Drowning (supervision context)	2	8.3
Chronic neglect / cumulative harm (non-fatal)	2	8.3
SUDI / unsafe sleep	1	4.2
Total	**24**	**100**

**Note: categories reflect the dominant harm theme recorded; some CPRs included multiple harms and therefore the most prominent/dominant harm that led to the review was chosen.*

3.1.2. Age and Gender

The age of children ranged from 5 weeks to 17 years. Infants under 1 year accounted for 16.7% (n = 4) of CPRs, while children aged 1 - 4 years represented 12.5% (n = 3) of cases. Children aged 5 - 12 years accounted for 25% (n = 6). The largest proportion of CPRs involved adolescents aged 13 - 17 years, who represented 45.8% (n = 11).

Cases involving infants and younger children were more commonly associated with physical abuse, health-related harm, drowning, unsafe sleep, and chronic neglect within the home environment. Whereas cases involving adolescents reflected aspects of the nature of suicide, exploitation, placement instability, and complex emotional and behavioural vulnerabilities.

Table 3. Age of Child Recorded

Age Category	Frequency (n)	Percent (%)
Under 1 year	4	16.7
1 – 4 years	3	12.5
5 – 12 years	6	25.0
13 – 17 years	11	45.8
Total	**24**	**100**

[1] Health-related harm: a proportion of CPRs reviewed, cited medical conditions or needs that may have had relevance to the outcome, sometimes in combination with other exacerbating factors, however, these varied in nature and it was not possible to weigh/ascertain their significance for the likelihood of harms suffered.

Regarding the gender of children, just over half of CPRs involved female children (54.1%, n = 13), while 37.5% (n = 9) involved male children. One CPR (4.2%) involved more than one child of mixed gender, and in one case (4.2%) the gender of the child was not clearly specified within the published report. When compared to the 2023 review, where gender distribution was broadly even among cases where this information was recorded, the current set of CPRs shows a slight over representation of female children.

Table 4. Gender of Child Recorded

Gender	Frequency (n)	Percent (%)
Female	13	54.1
Male	9	37.5
Mixed (M/F)	1	4.2
Unknown	1	4.2
Total	**24**	**100**

3.1.3. Siblings and household

Looking at household settings, almost all CPRs recorded at least one sibling present (91.6%, n = 22). The majority of CPRs involved children living in larger households, with 19 reviews (79.2%) recording three or more children in the home. Mixed or non-biological sibling relationships (including half siblings) were identified in six CPRs (16.7%). In one review (4.2%), the household setting was unclear.

Table 5. Recorded Sibling and Household Composition

Household/Sibling Indicator	Frequency (n)	Percent (%)*
More than one child	22	91.6
3 + child	19	79.2
Non-biological / mixed sibling relationship	6	25
Unclear in review	1	4.2

Note: These categories are not mutually exclusive. Several CPRs met more than one of these criteria, and therefore percentages should not be interpreted as cumulative here.*

3.1.4. Parental/Caregiver Vulnerabilities Recorded

Poor mental health was the most frequently documented vulnerability, present in 16 CPRs (66.7%). This included diagnosed conditions, ongoing treatment, emotional instability, trauma histories, and untreated/ fluctuating mental health difficulties.

Domestic abuse was recorded in 15 CPRs (62.5%), either as current intimate partner violence, coercive control, historical abuse patterns, or children's exposure to abusive relationships. Substance misuse was identified in 11 CPRs (45.8%), most commonly involving alcohol and/or cannabis use.

Neglectful home conditions were also evident in 14 CPRs (58.3%), often linked to chronic disorganisation, unsafe living environments, hygiene concerns, missed health appointments, or inconsistent caregiving. In many cases, these environmental concerns co-occurred with poor mental health and domestic abuse, reinforcing patterns of cumulative harm rather than singular safeguarding incidents.

Figure 2. Recorded Parental / Caregiver Vulnerability Indicators

3.2. Agency awareness and involvement

Agency awareness prior to the incident was high. Half of CPRs (n = 12; 50%) involved children who were either on the child protection register or given a looked after status (reflecting the Extended review criteria). Most children/families were already known to children's services at some point prior to the incident (n = 22; 91.7%). Only 2 CPRs described the child/family as unknown to statutory safeguarding agencies.

Nearly half of CPRs (n = 11; 45.8%) recorded at least one referral to children's services that did not meet the threshold for statutory intervention. This echo's themes identified in 2023 relating to the risk of cumulative harm being missed when incidents are assessed in isolation.

Table 6. Children's Services History and Referral Threshold

Indicator	Frequency (n)	Percent (%)*
Child on CP register and/or Looked After (at/near incident)	12	50.0
Known to Children's Services at some point	22	91.7
Unknown to statutory safeguarding agencies	2	8.3
Referral recorded as below threshold	11	45.8

Note: These categories are not mutually exclusive. Several CPRs met more than one of these criteria, and therefore percentages should not be interpreted as cumulative here.*

Also, multiple agencies were typically involved with each family prior to the incident. Health services were involved in 22 of the 24 CPRs (91.7%), Police in 21 (87.5%) and Education in 18 (75%). However, consistent with the previous thematic review, the presence of multiple agencies did not necessarily translate into coordinated risk ownership.

Table 7. Recorded Agencies/Organisations That Have Engaged with Child/Family Prior to Incident

Agency	Frequency (n)	Percent (%)*
Health	22	91.7
Police	21	87.5
Education	18	75.0

Note: These categories are not mutually exclusive. Several CPRs met more than one of these criteria, and therefore percentages should not be interpreted as cumulative here.*

3.3. Visibility of child

Further descriptive analysis was also undertaken across all 24 CPRs to examine how clearly the child's lived experience was represented within the review and recommendations. Each variable was coded as 'present' or 'absent' based on explicit evidence within the published report.

3.3.1. Visibility of the Child's Voice

Across the CPRs, direct reference to the child's wishes, feelings, or perspectives of their lived experience was limited. Fewer than half of reviews (n = 11, 45.8%) made clear/ explicit reference to the child's voice within the narrative. Even more strikingly, only one review (4.2%) provided explicit evidence that the child or young person's views directly played a role in influencing safeguarding decisions.

It is acknowledged that what constitutes as "explicit" reference to the child's voice may be interpreted differently across reviewers. In this review, "explicit" was defined amongst reviewers as clear and identifiable evidence within the CPRs where the child's wishes, feelings, or lived experience were directly presented rather than inferred through professional interpretation. While all CPRs (n = 24) included some form of indirect reference to the child's lived experience, this analysis focused on where the child's voice was clearly and directly visible.

Table 8. Visibility of Childs Voice in CPRs

Indicator of Childs Voice	Frequency (n)	Percent (%) *
Visible/explicit reference to child's voice	11	45.8
Visible/explicit evidence that the child's view played a role in influencing safeguarding decision	1	4.2

Note: Categories are not mutually exclusive and do not sum to the total number of CPRs (n = 24), as not all reviews contained visible evidence of the child's voice.

3.3.2. Recommendations Relating to the Child's Lived Experience

Half of the CPRs (n = 12; 50%) included a clearly identifiable recommendations emphasising the importance of hearing and recognising the child's lived experience and hearing and acknowledging their perspectives. However, this was not always reflected in the main body of the reports. In several cases, recommendations about improving the child's voice were made despite limited evidence within the main body that the child's perspective had been clearly captured and/or considered.

However, it is important to note that CPRs are not consistently structured and not all reviews include a formally labelled 'recommendations' section. Some reviews present learning within "learning points" or "areas of improvement" rather than a formal recommendation section. When both recommendations and learning points are considered together, the number of CPRs referencing the importance of the child's voice increases to 15 out of the 24 CPRs (62.5%).

Table 9. Recommendations and Learning Points Related to the Child's Voice

Indicator of Learning/Recommendation Related to Child's Voice	Frequency (n)	Percent (%) *
Recommendations related to child's voice	12	50.0
Recommendations or learning point related to child's voice	15	62.5

Note: CPRs are not consistently structured. Some reviews present learning within "learning points" rather than a formal recommendation section. Percentage is based on the total number of CPRs (n = 24). Categories are not mutually exclusive.

3.3.3. Advocacy and Championing the Child

Across the 24 CPRs, a quarter of reviews (25%) referred to the presence of an advocate, champion, or trusted adult in the child's life. However, these roles were rarely described as being actively involved in safeguarding decision making processes or clearly embedded within multi-agency planning. In most cases, advocacy was mentioned briefly within the narrative rather than being positioned as an active component of safeguarding responses.

Extended CPRs relate to cases where the child was either on the child protection register or a looked after child within the six months prior to the incident, meaning that independent advocacy should ordinarily be offered as part of statutory safeguarding arrangements as part of the active offer[2]. However, out of the extended CPRs reviewed (n = 12) only 4 reviews (33.3%) made any reference to advocacy support. In most of these cases the reference was brief and did not clearly describe the advocate's role within contributing to safeguarding discussions or decisions. Only 1 CPR provided clear evidence that an advocate was actively involved in supporting the young person such as deciding to remain in placement, as well as supporting them to contribute to their review meetings.

One review also referenced the involvement of a Children and Family Court Advisory and Support Service (CAFCASS) guardian within proceedings. In the remaining 8 extended CPRs (66.7%) there was no explicit reference to advocacy or to whether advocacy had been offered or taken up. This finding does not necessarily indicate that advocacy was absent, but rather, it highlights that offer, uptake and transparency of advocacy is not consistently visible within CPRs.

Table 10. Advocacy and Championing the Child in CPRs

Indicator of Advocacy/Championing	Frequency (n)	Percent (%) *
Advocacy and championing referenced **(Across all CPRs)**	6	25.0
Advocacy referenced **(Extended CPRs only, n = 12)**	4	33.0
Clear evidence of advocate involvement in decision making **(Extended CPRs only, n = 12)**	1	8.3
CAFCASS guardian referenced explicitly **(Extended CPRs only, n = 12)**	1	8.3
No advocacy referenced **(Extended CPRs only, n = 12)**	8	66.7

Note: Categories are not mutually exclusive. Percentages for Extended CPRs are calculated from n = 12, while overall figures are based on n = 24.

3.3.4. Workforce Instability

Workforce instability was identified in 7 of the 24 CPRs (29.2%) as a contributing factor impacting safeguarding practice, although workforce factors were not routinely documented across the majority of reviews. In these cases, reviews referred to multiple changes of social worker, lack of continuity in lead professionals, capacity pressures, or staffing turnover affecting working relations, assessment quality, or escalation of concerns. This can impact upon relational practice and continuity to build trusted relationships.

3.3.5. The Consultation Process: Family and Carer Involvement

The majority (91.7%) of CPRs stated that parents, carers and/or family members had been consulted as part of the review process. This was typically recorded within the CPR review process section, often using standardised wording confirming that family members had been informed, their views sought, and feedback provided. However, while consultation was widely reported, the clarity and visibility of that engagement formatted within the CPR, varied.

Only 10 CPRs (41.7%) included clearly identifiable summaries of what parents or young people said, or demonstrated how their reflections were considered within the analysis. In these reports, the reader could clearly see how family perspectives contributed to learning. There was variation in how this information was presented. For example, some CPRs included a section highlighting the lived experience perspective alongside different learning points. In others, the lived experience contribution was more concise and general and featured in one section of the CPR.

In contrast, 12 CPRs (50%) recorded that consultation had taken place but did not make the content of that consultation visible within the report. Engagement was noted procedurally, but without clear explanation of what was contributed or how it shaped the findings. A further 4 CPRs (16.7%) recorded that consultation was offered but declined, and 2 CPRs (8.3%) made no reference to consultation at all.

[2] Written Statement: National Approach to Statutory Advocacy for Children and Young People (15 July 2022) | GOV.WALES

Table 11. Family and Carer Consultation within CPRs

Indicator of Consultation	Frequency (n)	Percent (%) *
Consultation recorded (any form)	22	91.7
Family views clearly visible within CPR	10	41.7
Consultation recorded but not visible in report	12	50.0
Consultation offered but declined	4	16.7
No reference to consultation	2	8.3

Note: Categories are not mutually exclusive. Some CPRs recorded consultation but did not make the content of that consultation visible within the report.

3.4. Further exploratory analysis

In addition to descriptive analysis, exploratory statistical testing was also undertaken to examine whether there were meaningful associations between key variables relating to child voice and advocacy within the CPRs. Given the small sample size (n = 24), Fisher's Exact Test was used as it is appropriate for small datasets. Variables included in the analysis were coded as binary indicators (present/absent) based on explicit evidence within the CPRs (e.g., whether the child's voice was clearly visible within the narrative, and whether a champion or advocate was identified). However, findings should be interpreted with extreme caution given the small sample size that was available to the research team. Further research should aim to provide bigger datasets to validate these findings.

3.4.1. Association Between Child Voice in CPRs and Recommendations of Childs Voice

Analysis firstly looked at whether there was a relationship between how clearly the child's voice was presented within the body of the CPR and whether the review made recommendations about strengthening child centred practice. Fisher's Exact Test identified a statistically significant association (p = .012), with a large effect size (Phi = .585). In practical terms, rather than demonstrating a disconnect, this pattern actually suggests there may be a clustering of child centred practice.

CPRs that visibly implemented the child's wishes, feelings, or lived experience within the narrative were significantly more likely to include recommendations reinforcing the importance of hearing and responding to the child's voice too. Conversely, this also meant that where the child's voice was less visible within the CPR, it was also less likely to feature within the identified learning.

3.4.2. Association Between Champion Present in CPRs and Childs Voice Present

Further analysis also explored whether there was a relationship between the presence of a champion or advocate within the CPR and how clearly the child's voice was reflected in the CPR. A statistically significant association was identified (p = .014), with a large effect size (Phi = .577). The pattern here is notable.

In every CPR where a champion was recorded as present, the child's voice was visibly integrated into the CPR (100%). By comparison, where no champion was identified, the child's voice was visible in only one third of reviews (33.3%).

While this does not mean that the presence of a champion directly causes stronger child voice representation, it does suggest that where a child has an identified advocate or trusted adult recognised within the review process, their lived experience is more likely to be clearly reflected in CPRs.

3.5. Summary of Descriptive Analysis

Across the CPRs analysed, a consistent picture emerges of children and families experiencing multiple, overlapping vulnerabilities over time. Risk was rarely associated with a single incident. Instead, harm more often reflected cumulative patterns, including chronic neglect, domestic abuse, parental mental ill health and substance misuse. These factors frequently co-occurred, creating complex and evolving contexts in which risk escalated gradually rather than triggering immediate intervention. While this pattern was particularly evident in cases involving younger children, the data also highlights a significant proportion of adolescents, with increasing visibility of mental health concerns, self-harm and exploitation.

Agency awareness prior to the index incident was high. Most children and families were known to services, often over extended periods and across multiple agencies, including health, police, and education. However, this awareness did not consistently translate into coordinated action or shared ownership of risk. A notable proportion of cases involved referrals that did not meet statutory thresholds, reinforcing ongoing challenges in recognising and responding to cumulative harm when concerns are assessed in isolation.

Analysis of the visibility of the child's voice highlights a significant gap between recording and potential to influence. While some reference to the child's lived experience was present across all reviews, fewer than half made this explicit and only one CPR demonstrated clear evidence that the child's perspective had a role in directly influenced safeguarding decisions. A similar pattern is evident in relation to family consultation, where engagement was frequently recorded but not consistently visible or clearly linked to analysis and learning. The role of advocacy was also inconsistently documented, with limited clarity regarding whether advocacy was offered, taken up, or how it contributed to safeguarding processes. This reflects a wider issue across CPRs: the difference between recording that something has happened and demonstrating how it has played a role influencing analysis, decision-making and learning. This is particularly evident in the disconnect between recommendations and narrative evidence, where strengthening the child's voice is frequently identified as a priority, but not consistently modelled within the review itself.

Exploratory analysis reinforces these findings. CPRs that more clearly articulated the child's voice were significantly more likely to include recommendations relating to child-centred practice, suggesting a clustering of stronger practice rather than a consistent baseline. In addition, the presence of a champion or advocate was strongly associated with increased visibility of the child's voice within the review, indicating the potential importance of relational and representational roles in strengthening child-centred safeguarding.

In summary, these findings highlight a central challenge within safeguarding systems: the gap between information being known and that information being meaningfully integrated into understanding, decision-making and action. While agencies are often effective at identifying and recording risk, there is less consistency in how children's lived experiences are understood, connected over time and used to inform safeguarding responses. Strengthening this connection between knowledge, interpretation and action remains critical to improving outcomes for children.

04

Qualitative Key Findings: The Lived Experience of the Child

Thematic qualitative analysis was undertaken to identify key themes from the data. This explored how the child's perspectives and lived experience were understood and represented in the CPRs.

Table 12. Qualitative Themes and Subthemes

4.1. Safeguarding Practice within CPRs	4.1.1 Representation of child's lived experience in CPRs	Direct communication with child or parent perspective
		Impact of home life, health, environmental factors and historical information
	4.1.2 Integrating and centralising child's perspective into decision-making and support	Relational practice
		Champion of child's iewpoint
		Continually acknowledging and validating child's experiences
		Balancing a safeguarding response with wishes and feelings
4.2. Inclusion of Child, Family and Carers within CPR process	4.2.1 Key issues from feedback family, young people, carers views	
	4.2.2 Learning points and recommendations related to child voice and experience	

The thematic analysis identified two key themes with subsequent areas of focus. Firstly, safeguarding practice within CPRs, which looks at how the child's perspective and lived experience was described and represented within the CPRs from a practice lens. Secondly, the analysis looked at the format of the CPRs themselves and how the perspectives and experiences of the child, parents and carers were included in the CPR process and embedded within the CPRs themselves.

4.1. Safeguarding Practice within CPRs

4.1.1 Representation of child's lived experience in CPRs

This theme focused on how children's perspectives and lived experiences within safeguarding practice were represented in CPRs. Given the diversity of the children included in the reviews, direct communication between professionals and children was not always straightforward. For example, some children were babies, while others had communication difficulties that affected their ability to express their perspectives.

As a result, the analysis considered not only direct communication with the child, but also how a chronology of the child's life, including family context and environmental factors, could provide insight into their lived experience. This included examining how these factors were understood and whether their impact was considered from the child's perspective.

Direct communication with child or parent perspective

Direct communication, or the absence of communication between the child and professionals, was not always clearly evidenced within the CPRs. In several cases, engagement with parents regarding the child's perspective was prioritised over direct contact with the child. For example, one CPR noted that "although numerous references are made to [the child's] thoughts and feelings during these calls, and it was positive that this was addressed, there are only two recordings where it was explicit that [the child] was spoken to directly" (CPR 10). Similarly, another review described how parents' views were ascertained, and a safety plan was developed, however, the child "was not spoken to and mother's declining of this was not challenged as a concern" (CPR 20). This reflected a reliance on parental accounts of risk and safety, with an implicit assumption that these aligned with the child's perspective.

Where CPRs did evidence that children's wishes and feelings had been ascertained, this was often presented positively. However, there was limited exploration of the underlying reasons for those views or the factors influencing them. For example, one CPR noted that "significant weight was given to [the child's] wishes and feelings about whom he lived with, without sufficient exploration of what was motivating him" (CPR 13). In this case, the child's mother was described as 'villainised', with her views dismissed and the father's perspective prioritised.

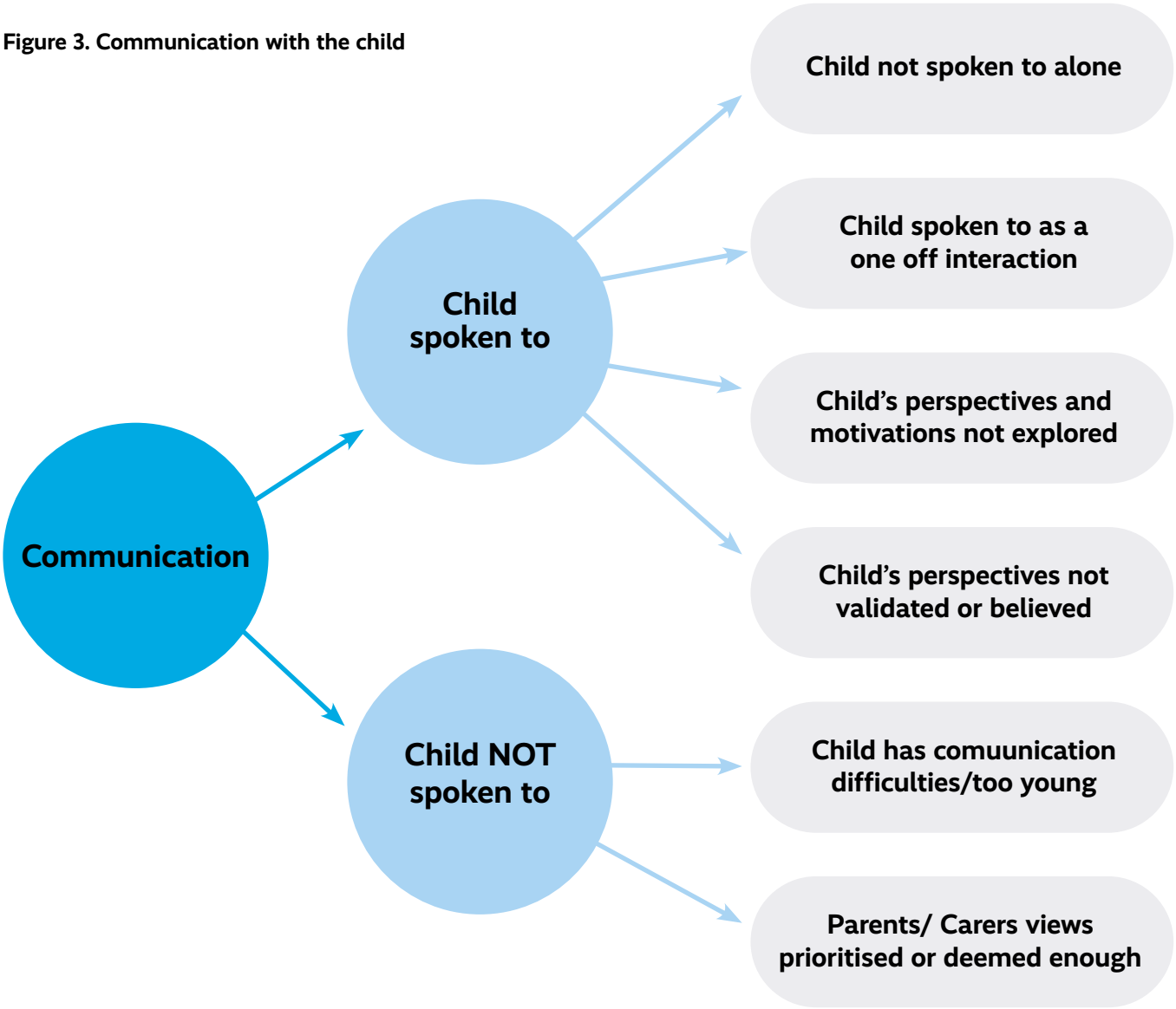
In addition, while some CPRs reported that children were spoken to in relation to safeguarding concerns, consideration of how and where these conversations took place was not consistently documented. One review highlighted that the absence of a safe or private environment may have limited the child's ability to speak openly, recommending that children should be seen alone where appropriate (CPR 19). More broadly, whether children were seen alone, whether this was considered appropriate, and how professionals planned to communicate effectively with the child were not consistently addressed within CPRs.

Whilst it was positive that CPRs reported children were spoken to regarding safeguarding concerns, consideration as to providing safe environment was

not always noted. CPR 19 observed this could be a factor which may impact the ability for child to speak openly; therefore, the child should be seen alone where appropriate. The child being seen alone or the consideration of whether this was appropriate, and indeed a plan on how best to communicate with the child to understand their perspectives, was not always something which was addressed within CPRs.

These findings indicate that direct communication was often limited, one-off, or insufficiently explored. This aligns with Figure 3, which illustrates the variability in direct communication, including instances where children were not spoken to, were spoken to only once, or where their perspectives were not fully explored or validated.

Figure 3. Communication with the child



Good Practice: CPR 10: where a child had not attended multiple medical appointments, an initial decision not to offer further appointments was revisited and the child was subsequently seen virtually during the COVID-19 period. CPR 22: where numerous visits were undertaken by a child protection social worker, supporting more consistent engagement with the child.

Impact of home life, health, environmental factors and historical information

In addition to identifying the presenting safeguarding concern, understanding a child's lived experience required consideration of their history, their family's history and their daily environment. The impact of where a child lived was particularly relevant, especially for children with complex health needs. For example, living in a rural or hilly area, or having limited access to appropriate equipment, affected how a child's needs could be met. One CPR documented how a mother experienced "extreme stress caused by inadequate

and inappropriate housing and the constant threat of eviction" (CPR 15). While these external factors contributed to building a picture of the child's circumstances, their impact on the child was not always fully explored from the child's perspective.

CPRs also identified cases involving children with complex medical conditions and health needs, alongside organisational challenges in coordinating care. This included a lack of clarity around accountability and difficulties at transitional points between services. As a result, there were challenges in supporting parents effectively and in understanding patterns such as missed appointments. This limited understanding of how health needs interacted with safeguarding concerns. CPRs also highlighted uncertainty regarding the point at which missed health appointments should be considered a safeguarding concern.

Understanding life within the home, including who the child lived with and who the key adults were, provided important insight into their daily lived experience. This also extended to understanding the experiences, perspectives and needs of siblings and parents. However, CPRs indicated that this broader family context was not always integrated with current safeguarding concerns. For example, in CPR 11, both parents had experienced adverse childhood experiences (ACEs), and the review emphasised the need for professional curiosity in understanding "the history of their parenting in all its aspects to understand fully the risks to their children" (CPR 11).

In other cases, concerns about the home environment were recognised, including exposure to domestic incidents (therefore a victim in their own right), anti-social behaviour and poor living conditions. However, the impact of these experiences on the child was not always explored. One CPR noted that there was "no apparent consideration to the impact on the child's emotional wellbeing" (CPR 17). This suggests that, although information was known, its implications for the child's lived experience were not consistently understood or applied with a safeguarding lends.

Overall, these findings reinforce the need for a more holistic approach, where children's needs and risks are understood within the context of their environment and history. Without this, there is a risk that the cumulative impact of these factors is not fully recognised, limiting the ability to escalate concerns and respond appropriately.

Good Practice: CPR 3 – a health visitor observed a mark on a baby that could have been a finger mark and referred the child to a GP. Although the GP assessed the injury as accidental friction, the health visitor, drawing on previous concerns, made a safeguarding referral to children's services.

4.1.2 Integrating and centralising child's perspective into decision-making and support

The second focus of this theme examined how CPRs described practitioners' understanding of children's perspectives and experiences and how this understanding was centralised within decision-making and subsequent action. This included the role of relational practice, the extent to which children's wishes and feelings were validated and revisited over time, and how these perspectives were balanced alongside those of parents and carers. It also explored whether there was a clear champion of the child's viewpoint, advocating for their perspectives within safeguarding processes.

Relational practice

Relational practice has been described as "harnessing the relational within caring, supportive, educational, or carceral settings as a systems response" (Lamph et al. 2023, p1). The notion of relational practice was observed as a key theme in understanding and acknowledging a child's perspectives and experiences across the system. CPR 4 observed that relationships with the child and professionals were not established and that no one person had a consistent trusted relationship with the child. This could make it challenging to talk to a child so that they want to open up and share their perspectives of their lived experiences.

There were examples of good relationships between families and practitioners amongst the CPRs, such as the child protection social worker (CPR 14) but also examples whereby relationships had broken down. For example, a parent within CPR 18 stated that their social worker would make negative observations in conferences and meetings, which had not been communicated to him previously, resulting in him feeling ambushed.

Other examples highlighted challenges when there was a lack of continuity among key workers and the potential distress this caused. For example, a mother from CPR 24 stated that it was important to develop a trusted relationship with practitioners to be able to open up and share her thoughts, and that "every time there was a change of worker, she had to repeat her story advising that each time this impacted her mental health and caused her to relive this trauma".

This highlights how important the development of these trusted relationships is in understanding a child or family lived experience and for them to feel comfortable sharing their perspective. It also requires the safeguarding process to acknowledge who is best placed to have this relationship and how they should be included within the safeguarding process.

Good Practice: CPR 2: The school were noted to be very active in providing support and care for the young person and the young person responded positively to the relationships formed with staff. CPR 15: Ongoing support from health visitor provided consistency. CPR 23: Student social worker consistently supported child building a trusting relationship, alongside a child sexual exploitation social worker. CPR 6: The involvement of the youth worker attached to the school appeared to have a positive input.

Champion of child's viewpoint

In addition to practitioners working relationally, a key factor identified within the analysis was understanding who was championing the child's viewpoint across the safeguarding process. Regarding the extended CPRs, it should be noted that every child in Wales who is looked after by the care of the local authority, or involved in child protection processes, has the right to advocacy from a statutory Independent Professional Advocate (IPA) (Welsh Government, 2025). However, take up of this offer varied.

In addition, those children in the concise reviews may not have been entitled to an active offer of an IPA, yet understanding their views and advocating on behalf of their wishes and feelings is equally essential. In addition to formal advocacy roles, a named trusted adult who has a relationship with the child can ensure that the child's perspectives are known, shared and included within decision-making forums. However, it was not always clear within the CPRs if such a person existed for the child, who this person was, or how they were included within the safeguarding process.

In some of the CPRs there were examples whereby social workers played this role or parents acted as advocates for their child's wishes and feelings, particularly when a child had complex health conditions and the parents advocated for their child's desire for a 'normal life' (CPRs 10, 16). However, parents often had their own viewpoints which may have differed from those of their children's and experienced their own challenges. CPR 18 noted that whilst children can be entitled to independent advocates, some children were seen as too young to qualify or benefit from their use and reviewers recommended that "each organisation considers advocacy through a broader lens such as non-instructed advocacy which may have been of benefit had the services been approved". This aligns to observations in CPR 1, whereby reviewers stated:

"Whilst it is positive that due regard was given to [the child's] stated wishes and feelings and to the views of the Independent Advocate and Children's Guardian, a more rigorous and longer-term approach may have afforded a more fully informed balancing exercise between [the child's] stated wishes and feelings and his longer-term well-being and welfare" (CPR 1)

Ensuring relevant people can be included within the safeguarding process and decision-making can be a challenge. In CPR 14 it was noted that the child had communication difficulties and had a domiciliary care worker assigned to her, who had very regular and intensive contact, and would have held a rich source of information. However, this person was never invited to a safeguarding conference, possibly due to lack of information sharing protocols. This highlights that there can be key adults who have a trusted relationship with the child, who could and should be considered within the safeguarding processes to advocate for the child's perspectives or provide valuable information to represent the child's best interests.

Good Practice: CPR 1: The allocation of an independent advocate for the child demonstrated good practice; a CAFCASS children's guardian was appointed for child during the care proceedings conducted during the timeline period. CPR 12: A children's guardian was appointed and remained the guardian throughout. CPR 13: A children's guardian engaged with them regularly to discuss their wishes and feelings, introduced them to their solicitor and the Judge. CPR 2: Young person continued to actively engage with the Crisis Intensive Intervention Team (CIIT) worker. CPR 10: Child received frequent support from a school-based Youth Intervention Service (YIS) worker. Although the child found it difficult to articulate her feelings, the YIS worker gained some insights and recorded concerns about their emotional well-being.

Continually acknowledging and validating child's experiences

As children's lives are evolving with dynamic circumstances, it stands to reason that their perspectives would also have the potential to change over time. CPRs often spoke about understanding a child's wishes, feelings and hearing their voice, but this was not always revisited, validated or explored. In CPR 1, it was noted that the accounts from the foster carer were prioritised over the child:

The weight given to the accounts of the foster carer himself at times overshadowed a consideration of the children's own experiences in placement. It is possible, therefore, that the established status of [the carer] as a good and trustworthy foster carer preceded him and made it difficult for professionals to identify and escalate areas of concern" (CPR 1)

The child in this CPR fed back to reviewers the importance of continuing to ask a child what they think and to listen to their response.

"a one-off interview not instigated by the young person is unlikely to lead to the sharing of such sensitive information, particularly if the young person has not been believed in respect of previous concerns" (CPR 1)

Similarly, CPR 19 noted that after a child's father died, they were offered bereavement support and counselling but at this time the chid did not want to engage and this offer was not revisited despite the child "regularly vocalising the significance of his father's death". This highlights the need to revisit attempts to understand the child's perspective and needs.

CPR 13 showed that the child's voice was listened to, but the reviewers highlighted that the views of the father were prioritised over those of the mother and he was present for the child protection medical, thus missing an opportunity to speak to the child alone. The consequence of this was that "significant weight was given to child's wishes and feelings about whom he lived with, without sufficient exploration of what was motivating him".

Good Practice: CPR 1: There was evidence of practitioners sensitively considering matters affecting the child as they sought to meet his care and support needs, with positive use of advocacy and the child's voice and wishes and feelings being central. CPR 10: Child engaged in that discussion voicing concerns about their limited career opportunities. The careers service attended the call to help assist the child with follow-up activities.

Balancing a safeguarding response with wishes and feelings

There was variety in how a safeguarding response was provided when a child or parent expressed their perspective. Examples included a lack of escalation in concerns for example, when a child expressed self-harm and suicidal thoughts. This was particularly prominent when there was a move between areas and the child felt that there were problems with the continued provision of support at the required level.

In other examples, when a child was witnessing domestic abuse between parents, there is no record as to the offer of any therapeutic intervention, nor was there any recording of whether therapy was offered as part of a safeguarding response when the child disclosed sexual activity aged 10. Another review showed that when a child did express their concerns, such as when the child reported being threatened with a knife, these concerns did not result in vulnerability being recognised and safeguarding referrals were not made by police or health on these occasions.

In CPR 1, case notes showed that there was a recording of the child's perspective in the form of an allegation in relation to their foster carer, however, there was no evidence that the child was asked about what happened on that occasion or his time in placement in relation to this until an exit interview almost three years later. This shows that when a child has expressed their concerns, an appropriate safeguarding response which includes the child, does not always follow in a timely way, depending on other information being considered.

Good Practice: CPR 1: There was evidence of positive use of advocacy with a child's voice and wishes and feelings being central and contributing to influencing a safeguarding response such as their Pathway Plan in partnership.

4.2. Inclusion of Child, Family and Carers within CPR process

This theme focusses on how the child, family and carers are included within the CPR process. The first focus of this theme explores the feedback of the child, family or carers into the CPR. It summarises key issues raised such as challenges, as well as suggestions for future practice.

4.2.1 Key issues from feedback family, young people, carers views

Summarised below are some of the key areas of focus where children, families and carers fed back to reviewers as part of the CPR process. Whilst some feedback featured in the narrative of the CPR and within 'Learning Points', not all of these observations were featured within the Recommendations section. This raises the question as to whether such feedback should be included within recommendations, where future action can often stem from.

Challenges and suggestions

- **To listen and provide opportunities to share their perspectives:**
  - Hear what children families want and address what is important to them
  - Listen and believe children
  - Be curious about their behaviour, continually ask
  - Should be a process rather than a one-off meeting and that 'follow ups' and information about support
  - Use child focused apps to have safe directed access to trusted adults when they want to
  - Offer 'walk and talk' out of the home with professionals
- **Provide clear communication:**
  - Improve timeliness of health information
  - Better communication between agencies
  - Explain process and why it is happening, who to contact
  - Be honest and transparent, don't say different things in meetings to home visits
- **Access to appropriate support:**
  - Needs more holistic in assessment and joined up in offering support, for example, addressing domestic abuse and mental health
  - Specific support for looking after children as a victim of domestic abuse
- **Reflect and challenge:**
  - Professionals should have challenged more on remaining in a relationship and expressed their concerns about this.
- **Involvement fathers:**
  - Do not overlook the role and background of the biological father and its potential significance in the care and interventions provided.
  - Contact father to inform them of children's services of involvement
- **Inclusion of wider family including grandparents**:
  - Grandmother in one case was significantly involved in caring, need to listen to their views and perspectives also.
- **Training for practitioners:**
  - Get specific training for practitioners from an independent agency with specialist expertise, for example, in working with care experienced children
- **Continuity in relationships:**
  - Recognise impact of multiple workers and impact upon the distress of reliving trauma
  - Transitional handovers of support and intervention across areas

Positive Feedback:

- **Feeling listened to and supported (Health Visitor and GP)**
- **Police officer who supported child described as 'amazing'**
- **Positive support provided to prepare for court**
- **Targeted support services put in place**
- **Local Authority continued to keep siblings placed together.**
- **School monitored child's welfare, supported and advocated for them**
- **Children's social workers were child focused**
- **Children's social workers provided a good service foster carers**

4.2.2 Learning points and recommendations related to child voice and experience

The second focus of this theme relates to the recommendations and key learning points within CPRs with regards to understanding and acting upon the child's voice and their lived experience. There were ten categories identified which featured understanding the child's perspective as a point of learning or recommendation to take action forward. These are summarised below:

1. Understand **impact of trauma** on lived experience
2. **Time to build relationships** with child to understand lived experiences
3. Ensuring **child seen alone** to understand lived experiences
4. Explore what is **motivating the child's** perspective
5. **Advocacy** to understand a child's perspective
6. **Continually understand** child's perspectives at **all stages**
7. Child's perspective **recorded consistently**
8. Child's perspectives **included within assessments** and **safeguarding plans**
9. **Practice Guidance** on understanding child perspectives and lived experience
10. **Training** regarding understanding child's loved experiences

The examples include varying levels of detail of what is specifically required to strengthen our inclusion of children's voices and experiences, to guide our safeguarding practice. For example, one recommendation highlighted that "children's wishes and feelings should consistently be documented whenever possible" (CPR 16). In this example, there was no further detail regarding addressing any barriers as to why this was not the case or how their wishes and feelings can be acted upon, for example, to be considered in making safeguarding decisions. Some examples were more specific and potentially clearer to implement and had consideration of what was required to facilitate understanding a child's voice. For example:

> **"Fostering teams to ensure mechanisms are in place to facilitate children and young persons looked after's voices and views being captured as part of placement supervision and annual reviews, including channels through which they can communicate with trusted professionals, and to seek opportunities to strengthen this"**
>
> (CPR 1)

There were also examples within one RSB, whereby the same recommendation was featured in three separate CPRs over a 14-month period, with additional wording in one to include a specific reference to disabled children. This particular recommendation asked for consideration of developing practice guidance on lived experience to ensure the child is actively heard. Whilst it is understandable to have repeated recommendations due to the time needed to implement, an 'action taken to date' would be beneficial when recommendations are repeated in subsequent CPRs to highlight progress and ensure action is taken.

05

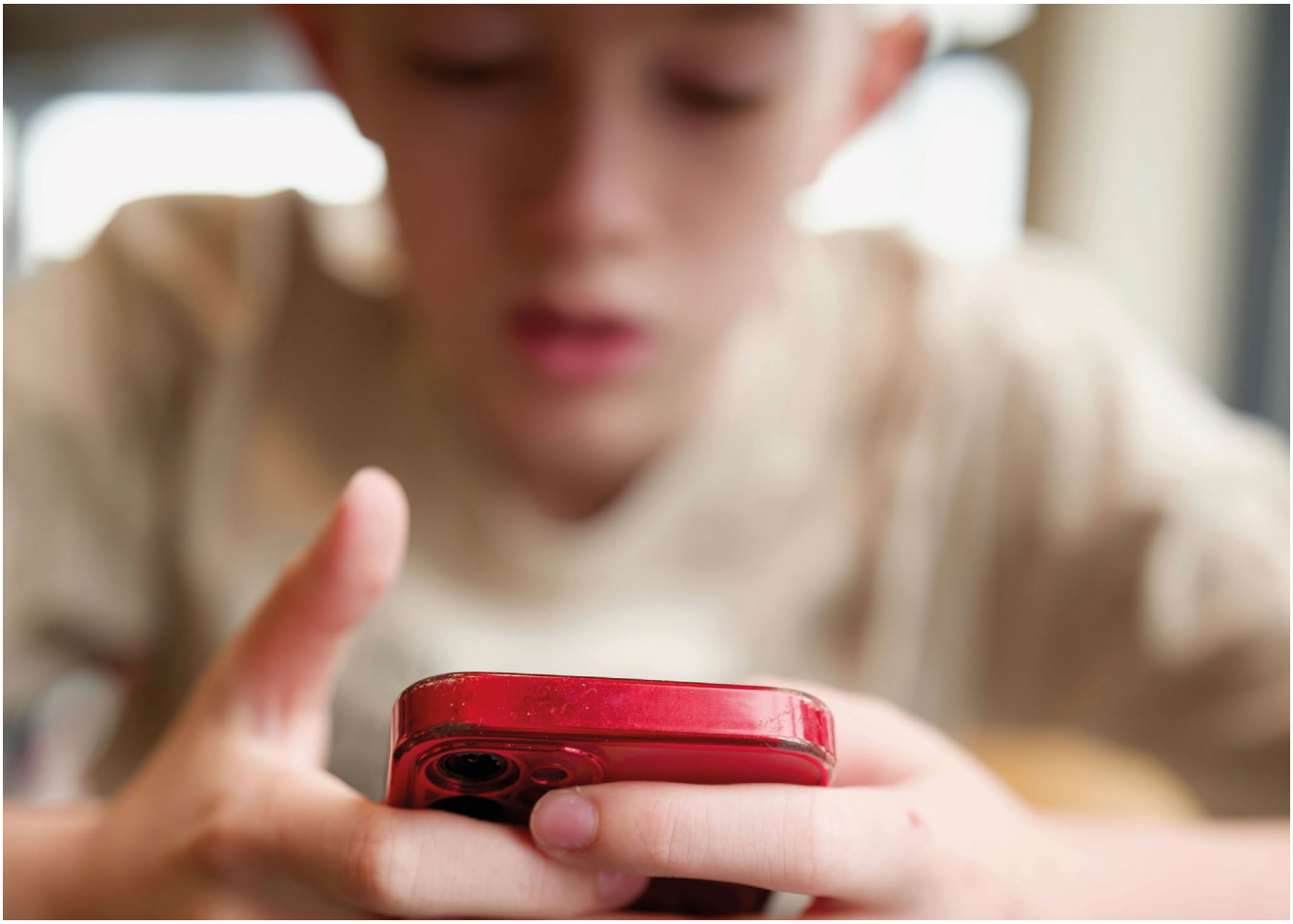
Concluding Thoughts

Whilst there were varying degrees to which the child's wishes and feelings were understood, recorded and utilised within safeguarding decisions, there were inconsistencies in understanding and validating the child's perspective and how this played a role in influencing safeguarding decisions and intervention.

Safeguarding children is embedded within a very complex system and governed by various legislation, guidance, national and local policies and procedures. Practitioners are operating within a pressured environment of high demand and finite resources, all of which could be argued to potentially contribute to a systems-led approach rather than a child-led approach. A key question to be raised is how well the safeguarding system can consistently encourage and enable practitioners to curiously identify, be led by, and appropriately respond to the child's perspective? The table below highlights some potential differences to reflect on how a systems-led process could look like and how this could differ to a child-led perspective.

Table 13. System-led or Child-led

Safeguarding Journey	System-Process Perspective	Child Experience Perspective
Identification	What issues have been identified as potential safeguarding concerns?	What is going on for the child right now and what are the biggest worries they have?
Exploration	Assessment of unmet need, potential harm and risks, as well as protective factors, for child, family and environment.	What is day to day life like for the child and their family, who is around and when?
Action	What is the most appropriate safeguarding support/ intervention for the child and family?	What is matters most to the child? What would they like to happen? What could make life better for the child and their family?
Evaluation	What actions have been complete and what is the outcome? What changes have arisen and what is the plan going forwards?	Has anything changed, gotten better or gotten worse? What matters to the child most right now? Are they confused about anything? What would they like to happen next?



Together, the findings in this thematic analysis show that there were inconsistencies and challenges in how a child's perspective and their lived experiences were sought, acknowledged, and then acted upon. Almost two thirds of the CPRs stated that within recommendations or learning points, more learning must be undertaken to better understand the child's perspectives and lived experience and hear their voice. These are reoccurring themes which have been found across CPRs, APRs and in England for Child Safeguarding Practice Reviews. This would suggest a review of what issues recommendations are advocating for and how they are being implemented, exploring any progress made within subsequent operational and strategic responsibilities.

Within the CPRs themselves, there was significant variation in how the child's perspective was understood and consideration within safeguarding interventions. A statutory responsibility of ensuring all children who are looked after, or subject to child protection processes have an 'active offer' for independent professional advocacy. However, take up can be inconsistent and more broadly, in 2023-2024, the total number of "active offers" of advocacy for children was 3051 and there were 1345 "active offers" where an independent professional advocate was provided, implying that 1706 offers were not taken up. The status of this offer is not always acknowledged within CPRs and without it, the question remains as to how assured practitioners, managers and indeed reviewers are, in terms of their understanding and acting upon the child's perceptions, of what is occurring for them in their daily lives and what they feel would help. Ensuring that when young people do express their views, that this is acknowledged, they are validated and this is acted upon is key to ensuring that any safeguarding practice is child-focused.

Understanding the views and perceptions of children, families and carers is a unique perspective and can provide valuable information as to how safeguarding support is received and wider context. This information was represented very differently within CPRs and not always visible or clearly linked to any areas of ongoing learning. If children and families are to be at the heart of the safeguarding process, then their perspectives and experiences should be clearly visible throughout the safeguarding process, with transparency of how such perspectives have been acknowledged within decision-making and subsequent action.

This analysis highlights key points to reflect on, in relation to our understanding of children's and families' perspectives, their lived experiences and how we act upon this information. If their perspective is to be at the heart of all safeguarding activity, then these understandings must continually be the foundation of not only our practice but also any learning which comes from reviews.

06

Key learning points and opportunities for development

6.1 Evidencing children's perspectives and understanding their lived experiences throughout the safeguarding process.

Context: While all CPRs included some form of indirect reference to the child's lived experience, this was often reported to be missing and only 1 CPR demonstrated that this played a role in directly influencing safeguarding decisions. CPRs identified that the impact of co-occurring risks and cumulative harms were not always viewed through a child's perspective. This meant that that 'lower-level' concerns were not always collectively addressed, as there was less understanding of the impact of how such concerns affected a child's daily lived experience.

Practitioners and managers must ensure that children's perspectives have been sought appropriately by providing opportunities and mechanisms which are safe and child friendly, to be able to share their true wishes and feelings. This should include seeing the child alone and where this is not possible, documenting reasons why. These perspectives must be clearly recorded to evidence that the child has been heard, understood and validated. Crucially, it should be demonstrated and recorded how children feel about the concerns agencies have, including 'lower level' and cumulative harms and the impact of such harms on their daily lived experience.

Consideration of the MAST (Multi Agency Safeguarding Tracker) to support this capturing of accumulated risk and harm is suggested.[3] The child's wishes and feelings should demonstratively play a role in escalating concerns and contribute to safeguarding decisions, detailing the subsequent action and outcomes.

Thought should be given to understanding who is appropriate to champion the child's viewpoints at all levels within the process, including wider family members and a broader consideration of practitioners who have a relationship with the child. Notably, the child's perspectives are not static and therefore should be continually reviewed with their motivations explored.

Regarding those who are not able to communicate directly, including those babies or those with communication difficulties, consideration should be given to understanding how their lived experience can be best understood.

Reviewers should continue to reflect on whether the child's perspectives and lived experiences are understood and if there is evidence of this impacting safeguarding decisions.

NISB/Welsh Government to consider commissioning research to specifically explore the perspectives of children, families and young people to understand what they view are challenges in practitioners understanding their lived experiences and what they feel would strengthen this practice.

6.2 Embedding the child's perspective throughout the review

Context: Across the CPRs, direct reference to the child's wishes, feelings, or lived experience was inconsistent with nearly half (45.8%) CPRs showing clear/explicit reference to the child's voice within the narrative with only one review out of 24 providing explicit evidence that the child or young person's views played a role in directly influencing safeguarding decisions. Findings show that where the child's voice is visible in the narrative, it is also more likely to appear in recommendations.

Reviewers should seek to understand from their analysis, who is championing the child's perspectives and ensuring that these are understood at each stage of the safeguarding process. Reviewers should seek to understand children's views across the safeguarding journey, how those views were considered and acted upon and the role children played in safeguarding decisions affecting them and subsequent outcomes.

[3] https://policyinpractice.co.uk/case-study/partners-south-wales-use-mast-to-transform-safeguarding-by-connecting-data/

6.3 Use of Independent Professional Advocacy

Context: Effective advocacy is crucial if we are to safeguard children and young people and protect them from abuse and support practice[4]. Children and young people are entitled to an active offer of advocacy from a statutory Independent Professional Advocate (IPA) when they become looked after or become subject of child protection enquiries leading to an Initial Child Protection Conference[5] which would meet the criteria for an Extended CPR. Only 33.3% of extended reviews made any reference to advocacy support. In most of these cases the reference was brief and did not clearly describe the advocate's role within safeguarding discussions or decisions. In 66.7% there was no explicit reference to advocacy or to whether advocacy had been offered and taken up or declined, or was this revisited with the child. Given the importance of understanding and including the child's perspective across the safeguarding process, reviewers need to be assured they have this understanding.

Practitioners and managers should ensure that any offers of advocacy are considered at the earliest possibility and that these offers are recorded, alongside recording of whether this has been accepted or declined. Where a child has declined an advocate, this decision should be revisited where appropriate. There should be consideration as to how an advocate is involved in the safeguarding process.

Reviewers should seek to ascertain an understanding of whether a child has been offered an IPA, if they accepted, what their role was within the safeguarding process and CPR contribution, if the child declined an advocate, were the reasons recorded and was this decision revisited?

Welsh Government/RSBs should seek to review and consult to clearly define the role of an advocate in the safeguarding context, explore what specific training exists and consider whether more training should be provided to key professionals such as conference chairs.

Regarding those children who have challenges communicating directly, including infants or those with communication difficulties with consideration given to understanding how their lived experience can be best understood.

Reviewers should continue to reflect on whether the child's perspectives and lived experiences are understood and if there is evidence of this impacting safeguarding decisions.

NISB/Welsh Government to consider commissioning research to specifically explore the perspectives of children, families and young people to understand what they view are challenges for practitioners in understanding their lived experiences and what they feel would strengthen this practice.

[4] National-advocacy-standards-Nov-02.pdf
[5] Independent Professional Advocacy cover english

6.4 Continuity of trusted relationships and relational practice

Context: Workforce instability was identified in 29.2% of CPRs, but its impact was not consistently explored. Continuity within professionals working with children and families can help support relational practice and develop trusted relationship. Changes in continuity can arise from workforce challenges or fragmentation in service delivery from different agencies. Additionally, not all agencies are included within the safeguarding process, even if they have key role in the child's life, such as a domiciliary worker or advocate.

Practitioners and managers should consider the importance of wider practitioners, who may play a significant role in a child's life and can help to share their lived experiences and perspectives and consider how these relationships can be continued or transitioned to practitioners.

Reviewers need to clearly highlight where workforce challenges have been an issue in ensuring that relational practice is established and sustained. This should include resource challenges, transferring between agencies and any other barriers which can impact upon a child developing a trusted relationship to disclose their perspectives and provide a clear understanding of their lived experience. CPRs should now be looking to routinely consider how changes in social workers, staffing pressures, or lack of professional continuity may have affected assessment, escalation and engagement.

NISB/SUSR team to consider further research to understand the impact of workforce challenges as a key theme identified within CPRs (and wider reviews).

6.5 Transparency of feedback from children, families and carers within CPRs

Context: There was variability in the clarity of feedback from family, friends and children within the CPR report. 41.7% included clearly identifiable summaries of what parents or young people said or demonstrated how their reflections were considered within the analysis. In contrast, 50% recorded that consultation had taken place, but this content was not easily visible within the report.

Reviewers and **RSBs** should aim to be transparent in deciding how visible this feedback is within the review and identify how it can best inform learning going forwards, including if any elements of this feature within recommendations and demonstrating where any changes have been acted upon. This should be led from SUSR guidance which notes that the child and family's involvement should beat the 'heart' of the review[6].

SUSR team should consider providing clearer audit data on compliance of inclusion on whether a child, family or carer has been consulted and invited to contribute to the CPR and whether they accepted or declined and that this is stated within the CPR. Whilst clear guidance exists on the inclusion of this within reports, this report has highlighted continuous challenges in this being actively represented within CPRs.

6.6 Monitoring of implementation of recommendations and learning points from CPRs

Context: In 62.5% of CPRs there was a recommendation or learning point which related to understanding the child's perspectives or lived experience, this suggests that this is a reoccurring significant issue. The thematic analysis showed ten categories of the types of recommendations relating to this issue, suggesting that there are different types of challenges and to ensure learning is being applied, an update on progression of these recommendations and learning points would likely be beneficial.

RSBs should explore how recommendations and learning points can be taken forward from the CPRs and SUSRs they have commissioned, relating to understanding the child's voice, perspectives and lived experiences and evaluate the progress of implementing these recommendations. The Recommendation iFramework (Ball, McManus & Monaghan, 2025) may be of benefit to assist as supporting guidance. The introduction of the SUSR process aims to improve the quality of reviews and any recommendations should be linked with the SUSR co-ordination hub, to aid consistency of implementation of learning into practice.

6.7 Further Use of CPR Data at a National Level (SUSR Learning)

Context: The exploratory analysis identified meaningful associations between key variables, including the relationship between child voice, advocacy and learning. However, these were based on a small sample size.

These findings highlight the potential value of further analysis at scale.

Due to the creation of the Wales Safeguarding Repository within the **SUSR team**, there needs to be consideration as to how the national data held within this system is routinely analysed and shared in order to better understand what supports strong child centred safeguarding practice and how this can be embedded consistently.

[6] Single Unified Safeguarding Review: statutory guidance

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