NATIONAL SAFEGUARDING WEEK 2026
WALES

Understanding Lived Experience

Drawing on Practice Reviews and Research to Strengthen Safeguarding Practice

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Lived experience is safeguarding evidence

Aims

- **Learn from practice reviews —** explore key themes from Child and Adult Practice Reviews.
- **Understand lived experience —** how experience shows in words, behaviour and silence.
- **See the whole person —** look beyond diagnosis, disability or presenting issues.
- **Work alongside people and families —** build shared understanding with individuals, families and professionals.
- **Develop a shared picture —** use analysis and supervision to spot patterns and cumulative risk.
- **Use research to strengthen practice —** turn learning into more informed practice.

“What is life like for this person today?”

This question runs through every theme.

Voices should shape how we understand risk, respond to harm and improve practice.

Keep the person in view.
Keep testing the picture.

Practice focus: Understanding the person’s world • Meaningful lived experience • Embedding Professional Curiosity and reflective practice

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What is recent research telling us?
Recurring themes

- **NISB Wales 2026 (24 reviews):** children's experiences must be central to decisions, practice and learning. The opportunities named are to strengthen advocacy, family engagement and professional practice.
- **NISB Wales 2023 (33 reviews):** over half had a referral judged below the intervention threshold. The child's lived experience and accumulating risk weren't always understood.
- **NSPCC Learning 2024:** children were not seen often enough or asked their views, and barriers to seeing them went unchallenged. The learning is to understand how children communicate and to build trusted relationships.
- **NISB Wales 2025 – Adult Practice Reviews (25 reviews):** adults' wishes were recorded but not always acted on. Advocacy was delayed or unused, professional curiosity was inconsistent, and multi-agency working was fragmented.
- **England 2024 (652 reviews):** personalised practice fell short in half of 229 reviews analysed.

RECURRING THEMES

Voice recorded but not acted on • Advocacy and professional curiosity lacking • Children not seen or heard • Fragmented multi-agency working

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Child Practice Reviews (CPRs): Focus on the child's perspective and lived experience, 2026: found the child's voice is recorded, but rarely shapes decisions

The child's voice: visible, but rarely acted on

Explicit reference to the child's voice in 11 of 24 reviews (45.8%).

Only 1 review showed the child's views influenced decisions (4.2%).

Advocacy and champions make the difference

Only a third of extended reviews mentioned independent advocacy.

With a champion, the child's voice was visible in every review (33% without).

Relationships and families

Workforce instability in just under a third of reviews disrupted trusted relationships.

Family consultation was often recorded but not shown to inform learning.

Risk is recorded well; the child's experience must shape decisions.

Source: Ball, Monaghan & McManus (2026), NISB Wales / Manchester Met. 24 CPRs, 2018–2023.

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Risk, Response and Review (2023): Multi-Agency setting
The thematic analysis of CPRs

The child's voice: captured, but not always understood or used

Voice was absent at referral, assessment and intervention stages.

Home visits took place but there was "little understanding of the children's lived experiences".

Professional curiosity: accounts need testing

Over-reliance on families' self-reporting; greater awareness of disguised compliance (families engaging "just enough") needed. Reviews urge checking information with other agencies and all available sources.

Analysis and supervision: keeping cases on track

Over half recorded a referral judged below the intervention threshold.

Good supervision avoids case drift and keeps focus on outcomes.

NSPCC Learning (2024): case reviews 2019–2023 show the same pattern

Children not seen often enough or asked their views; barriers unchallenged.

Learning: understand how children communicate; build trusted relationships.

Seeing a child is not the same as understanding their daily lived experience.

Sources: McManus, Ball & Almond (2023), NISB Wales (33 CPRs, 2013–2021); NSPCC Learning (2024), The voice of the child. Full references in notes.

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Adult Practice Reviews (2025): The Thematic Review of 25 APRs in Wales

The whole person: wishes recorded, but not always acted on

Wishes and interests were not always evident in support plans or notes.

Focus on equipment and process, not what mattered to the adult (APR 19).

Professional curiosity and advocacy: missed opportunities

Curiosity and escalation of concerns were inconsistent across agencies.

Delayed or unused advocacy left adults unrepresented in key decisions.

Multi-agency working and workforce: a fragmented picture

Unclear accountability and no unified database to share concerns.

High caseloads and staff retention were major concerns (APRs 2, 6, 19).

Recording what matters to the adult is the first step; acting on it follows.

Source: McManus, Ball & Monaghan (2025), Thematic Review of APRs Wales, NISB Wales. 25 APRs, 2016–2022. Full reference in notes.

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Adult reviews: lived experience and voice

NISB Wales thematic review of 25 Adult Practice Reviews (incidents 2016–2022).

WHAT THE REVIEWS FOUND

Adults' voices and wishes were not always visible.

- Adults' perspectives and lived experiences were often not fully visible in decisions.
- Many reviews lacked clear records of what mattered to the person.
- Advocacy was limited and mental capacity inconsistently considered.

WHAT GOOD PRACTICE LOOKED LIKE

The person's voice was put on the record.

- Voices built into the person's own care planning, with timely, repeated offers of advocacy.
- "This is Me" documentation (APR 15).
- Services acting on an adult's wishes and feelings (APR 10).

The person's own voice belongs in the record — and must shape what we do.

Sources: McManus, Ball & Monaghan (2025), Thematic Review of Adult Practice Reviews Wales, NISB Wales. Closing line is a teaching prompt.

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England (2024): the second national analysis of Safeguarding Adult Reviews

The whole person: life and wishes not always understood

Personalised approaches fell short in 50% of the 229 reviews analysed in depth.

Some practice failed to understand the person's life experience or trauma.

Curiosity and capacity: assumptions went unchallenged

No professional curiosity in 44%; mental capacity poorly considered in 58%.

"Lifestyle choice" assumptions fed a "culture of resignation".

What good looked like — and what reviews asked for

Person-centred practice and Making Safeguarding Personal were seen in 29%.

Recommendations most often sought better direct practice (93% of SARs).

Wales and England: understand the person's life, not only the risk.

Source: Preston-Shoot, Braye, Doherty & Stacey (2024), Second national analysis of SARs, LGA/ADASS. 652 SARs, 2019–2023.

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Practice reviews are changing

New learning now comes through the Single Unified Safeguarding Review (SUSR).



WHAT CHANGED

- Statutory guidance issued October 2024.
- Replaces Working Together volumes 2 (child) and 3 (adult).
- Brings four review types into one: adult, child, domestic homicide and mental health homicide.
- Reviews beginning after October 2024 are SUSRs.

WHY IT MATTERS

- Families take part in one review, not several.
- Learning is identified and acted on sooner.
- Core principle: learn from the experiences of those connected to the incident.
- Published reviews go into the Wales Safeguarding Repository.

ONE REVIEW • FAMILY VOICE • FASTER LEARNING

The practice reviews in this presentation predate the SUSR — but learning from lived experience carries forward.

Sources: Welsh Government, SUSR statutory guidance (October 2024); Cysur, SUSR; Gwent Safeguarding Board.

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Getting it right: whose values are we using?

Most practitioners work with great compassion and kindness — so why is this still a theme?



OUR OWN VALUES

Our values shape what we notice — and what we dismiss.

- Our own life experience, bias, values and those of colleagues, agencies and wider societal values shape how we judge and make decisions.
- When we judge, we can stop really listening.
- Our values are always in the room. Awareness helps us notice them and manage their influence.

PROFESSIONAL VALUES

Shared standards, applied consistently to everyone.

- Social Care Wales Code of Professional Practice (from 1 July 2026) puts more focus on anti-discrimination.
- Voice and control is a founding principle of the Social Services and Well-being (Wales) Act 2014.
- Culture, race, faith and health shape lived experience. The Anti-racist Wales Action Plan makes “valuing lived experience” a core principle.

“What matters to this person — and what does our standard require?”
Then look at the whole person and their lived experience.

Sources: Social Care Wales, Code of Professional Practice for Social Care Workers; Welsh Government, SSWB (Wales) Act 2014 and Anti-racist Wales Action Plan. Bottom line is a teaching application.

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See the whole child — look beyond the label

Disability, placement status and behaviour must prompt questions — not close them down.



CHILD REVIEW · DONCASTER

Doncaster residential settings review

- Widespread abuse and neglect of disabled children in three residential special schools.
- Distress and communication should prompt curiosity about harm, not be put down to disability.
- “Specialist” or long-established provision must never be assumed safe.

CHILD REVIEW · POWYS

Child A — CYSUR 3/2021

- Child A, 16, had spina bifida and died at home in 2020 after chronic neglect.
- Many professionals involved, but no one held the whole picture.
- Weekly school calls went to her mother; only two are recorded as speaking to Child A herself.
- Missed health appointments were not followed up.

CHILD REVIEW · GWYNEDD

Our Bravery Brought Justice (2025)

- The headteacher in North Wales used his position of trust to abuse children at his school.
- Children did speak up, “he was too physically close”. This was “dismissed as ‘not inappropriate’”.
- “Staff were not encouraged to believe children”; he named children as “particularly untrustworthy”.
- Parents who raised concerns “were given short shrift”.

Children told us. The question is who listened and who acted.

Be professionally curious, listen to children who raise concerns, and be prepared to “think the unthinkable”.

Sources: Child Safeguarding Practice Review Panel (2022–23); CYSUR 3/2021 (published March 2024); North Wales Safeguarding Board, Our Bravery Brought Justice (2025).

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See the whole adult — look beyond the label

Behaviour, silence, missed contact and self-neglect are information — not explanations



ADULT REVIEW · NORFOLK

Joanna, Jon and Ben — Norfolk SAR (2021)

- Three adults with learning disabilities died in a specialist hospital, Cawston Park.
- “Challenging behaviour” did not explain the person’s experience or health needs.
- Day-to-day records, advocacy and family knowledge were essential evidence.

ADULT REVIEW · SAR “PAUL”

Paul — Safeguarding Adults Review

- Paul had a reputation as “challenging” and “reluctant to accept services”.
- The review’s view: “this was not a man who totally refused to engage; this was a man who was anxious and scared.”
- No one assembled the complete picture, so cumulative risk was missed.

ADULT REVIEW · NORTH WALES

Whose voice was heard? — NWSAB/2/2024

- A man in his early 50s died in 2024; another man at the address was convicted of his murder.
- Calls went through the other man’s phone, often on loudspeaker; visits were rarely private.
- Two earlier concerns about financial abuse did not lead to protective action.

Speaking to someone isn’t the same as hearing them.

Look past the label, hear the person’s own voice, and put the whole picture together.

Sources: Norfolk SAB, Joanna, Jon and Ben (2021); Cornwall and Isles of Scilly SAB, SAR “Paul”; North Wales SAB, Concise Adult Practice Review NWSAB/2/2024 (published Feb 2026).

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What stops us?

Be honest — what gets in the way of hearing someone's lived experience?

THE QUESTION

What are the barriers and obstacles that prevent you from truly including the lived experience of the adult, child, families or carers?

YOUR TURN

Tell us what stops you really hearing or understanding the lived experience of the person/child.



Name it plainly: a word or short phrase is enough.

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What gets in the way?

Research suggests these are some of the recurring themes that stop us hearing the person. Name them honestly: they are barriers to manage together, not personal failings.

TIME & WORKLOAD

- Overwhelming caseloads
- Workload, resources and training
- A mind on the next visit, not the person in front of us.

BUREAUCRACY

- Managerial efficiency drives
- Munro (2011): a system “over bureaucratised and concerned with compliance”.

WHOSE ACCOUNT?

- Parent/carer narrative outweighs the person’s (halo effect)
- Gatekeeping by parents or carers
- Paternalistic protectionism

VALUES & CONFIDENCE

- Being led by our own values
- Lack of confidence
- Difficult to challenge those in positions of power (other professionals or agencies)
- Normalising behaviour; desensitisation/over-optimism.

HARD QUESTIONS

- Fear of “getting it wrong” (race, ethnicity, culture)
- Unsure what to say if someone discloses
- Over-reliance on verbal communication
- Intimidating, hostile settings.

Pressure is real. The question is what the person loses when we are under it.

Sources: Race & Frost (2022), Child Abuse Review; NSPCC Learning (2025), Disguised compliance; Friel, Symonds & Cartwright (2025); Munro Review (2011); NSPCC (2019); NWSAB Professional Curiosity Guidance (2022).

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The person/child can disappear from the case

Thematic reviews of child and adult practice identify the same underlying risk.

CHILDREN

Voice and perspective were not always central to practice.

- Some knowledge was privileged, creating tunnel vision.
- Assessment sometimes focused on individuals and missed the wider family or domestic context.
- Separate contacts did not always reveal the child's daily reality.

ADULTS

The "whole person" and lived experience were missed.

- Agencies often held different parts of the person's story.
- Presenting issues could obscure identity, history, strengths and wishes.
- Escalation and cumulative risk were missed when information stayed separate.

Shared practice needs to shift from
"Which service issue is this?" to "What is this person's life telling us?"

Sources: NISB Wales, thematic analysis of Child Practice Reviews (2020); McManus, Ball & Monaghan, APR Wales (2025).

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Contextual risk: how the child/adult becomes invisible



In a cycle of escalating risk, this creates contextual risks, where conscious and unconscious pressures on everyone cause them to deviate from clear analysis or procedure and engage in defensive practice, fuelled by anxieties of “fear, blame and mistrust”.



Within this, the child/adult can become invisible.
“Seen but not seen”

Source: Safeguarding Network, 2021/22.

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In their words

Make room, allow people to speak first, then ask what they would want us to do differently.



LIVED EXPERIENCE

Adults who went through a safeguarding enquiry

- “I put my views across, but I got one-word answers. I didn’t feel listened to. I felt like I was the problem and thus was disregarded.”
- “It was a 2-minute conversation then he left. I wasn’t involved in it. No-one asked me what I wanted.”

WHAT THEY ARE TELLING US

What would this person want us to do differently?

- What did they need from us that they didn’t get?
- Was it about time, tone, honesty or follow-through?
- Which of our own assumptions does it challenge?
- If we asked them what we could do better, what would they say?

Their words are evidence: use them to test our picture, not to decorate it.

Quotes: Healthwatch Together (2023), Safeguarding Voices: Blackburn with Darwen section 42 enquiries (England). Anonymised, published report.

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“Was Not Heard”
The voice of the child/young person

- When you find new ways to hear, you hear new things
- I have the right to be listened to, and taken seriously
- Tell me what your decision will be before you go ahead with it
- Explain how it affects my life
- Tell me how things I’ve shared helped you make this decision.

Seen isn’t the same as heard — and unseen means unheard

- Lola James (2024): assessment “lacking in detail and analysis”; concerns not pulled together.
- Logan Mwangi (2022): 31 injuries explained by his mother with him present.

Sources: ‘Was Not Heard’ (2020), LLR Safeguarding Children Partnerships; Lola James CPR (2024); Logan Mwangi CPR (2022); Dylan Seabridge CPR (2016). Quotes from the film’s published descriptions. Word cloud: Independent Inquiry into Child Sexual Abuse (2022), Executive Summary. https://www.iicsa.org.uk/index.html

Why Truth Project participants did not disclose child sexual abuse at the time



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Meet each person with fresh eyes

We don’t know their story yet. Begin from respectful uncertainty, not assumption.



WHAT PRE-JUDGING LOOKS LIKE

- “We know this family” — the file is read before the person is met.
- A diagnosis or label becomes the whole explanation.
- The first explanation becomes the only one, and we then look for evidence to back it.
- A plausible carer narrative overshadows the person’s own experience.
- The “rule of optimism”: risk is explained away rather than tested.

WHAT FRESH EYES LOOKS LIKE

- Meet with an open mind – beware of assumptions you might have made based on others’ views and case files and compare these with what you see.
- Ask what you don’t know, and who could tell you.
- Hold alternative explanations open until tested.
- Check whether the account fits other sources.
- Take your doubts to supervision or reflect with colleagues or managers.

BE ALERT • QUESTION • REFLECT • REFER

Look beyond the presenting issues: every person arrives with a story we haven’t yet heard.

Sources: Cysur (MAWWSB) Professional Curiosity guidance; NWSAB Professional Curiosity Guidance (2022); PHW Professional Curiosity training pack (2026).

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Make space to really listen

Put people at ease, be authentic, and let them know that we care, that we have time and that we will take it.



WHEN WE'RE RUSHED

The important information stays hidden.

- If we arrive late, stressed or distracted, the person notices.
- Someone with baseline anxiety may need longer, not a faster question.
- Missing information is often about the relationship, not the person.

WHAT HELPS

Show you care. Take your time.

- Show you care and help them open up — be authentic.
- Take your time and slow down.
- Show you understand, sum up what you've heard in your own words and check you've got it right.

Listening with full attention is a safeguarding skill — and it starts with humanity.

Sources: NSPCC Learning (2019), Let children know you're listening. Left-hand points are teaching applications.

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Think family, with the child at the centre
Think community, with the adult at the centre

Explore family history, relationships and wider circumstances.

- Seek different perspectives. Test professional, family and carer assumptions.
- Consider culture, communication and access to support.
- Show how the child's/adult's daily experience changes the way we see something and any assumptions we may have made.



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Voice is more than words

Babies, non-speaking children and adults with communication needs still have a voice — our methods must adapt.



LOOK

Meet the person. Notice presentation, environment, relationships and change over time.

LISTEN

Attend to words, behaviour, body language, silence, distress and attendance patterns.

ASK

Ask directly. Use play, accessible communication, interpreters, advocacy and trusted people.

CHECK OUT

Separate observation from interpretation. Triangulate meaning, check in with others involved and show how it changed action. Reflect.

Not speaking does not mean no voice.
Notice carefully, interpret cautiously, reflect, verify and act.

Sources: MAWWSB Professional Curiosity resource pack (Look, Listen, Ask, Check out); Wales Safeguarding Procedures.

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Communication and Courage

Three themes recur across decades of case reviews.



ASSESSMENTS

- Thin information-gathering and analysis at the front door
- Reluctance to revise in light of new information (Arthur Labinjo-Hughes and Star Hobson review)
- Racial and cultural heritage overlooked: English language, knowledge of services, impact of racism, cultural and religious practice.

INTER-AGENCY WORKING

- Information sharing breaks down between and within agencies
- Information is exchanged, but not always shared, questioned or understood



KNOWING THE PERSON

- Understanding their lived experience and being curious about their daily lives, and making this central to decisions, multi-agency practice and learning
- Children show distress through behaviour more than words (Cossar et al., 2019)
- Adults' wishes and lived experience are often missing from plans and decisions, with protected characteristics, bias and racism often given too little consideration.

Curiosity and challenge need communication and courage.

Sources: Sinclair & Bullock (2002: 19); CSPR Panel (2022a); Cossar et al. (2019); Dickens et al. (2023); CTM Safeguarding Board (2026); McManus, Ball & Monaghan (2025); Preston-Shoot et al. (2024).

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Be honest — and willing to ask the difficult question

Honesty builds trust, false reassurance spends it — and avoiding the question is the risk.

AVOID

- Saying everything will be alright or over promising.
- Making promises that aren't ours to make.
- Rushing to reassure before we have understood.
- Dodging the difficult question: fear of being intrusive, of the answer, or of losing rapport with a parent/carer.

GOOD PRACTICE LOOKS LIKE

- Explain what you will do next and who you will tell.
- Say plainly what you can and can't do — and follow through.
- Ask what matters most to this person right now, then wait for the answer.
- Ways in: "What is a normal day like for you?" "What's going well, and what worries you?"

ASK • WAIT • REFLECT • BE HONEST • FOLLOW THROUGH

Discomfort signals that curiosity is needed. Honesty and follow-through build trust.

Sources: NSPCC Learning, Responding to a disclosure; NSPCC (2019), Let children know you're listening; Welsh Government, SSWB (Wales) Act 2014; PHW Professional Curiosity training pack (2026); Cysur guidance. Prompts are suggestions, not quotations.

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When resistance and fear take over

What gets in the way of curiosity, and what should drive decisions.



GIVING UP

- We can give up in the face of resistance
- Rational-sounding explanations taken at face value, especially if they fit our own values
- Curiosity narrows; chances to safeguard are missed.

FEELING UNSAFE

- Professionals may feel overwhelmed, intimidated or even afraid
- Fear can lead to withdrawal and hard questions going unasked.
- Use reflection with colleagues, teams and supervisors to explore and get support and guidance.

THE CHILD'S/ADULT'S VOICE

- "Children's/adults' own voices, experiences, wishes and feelings should be the drivers to decision making."
- "Where access to those children/adults is being (however subtly) controlled, concerns should be heightened."

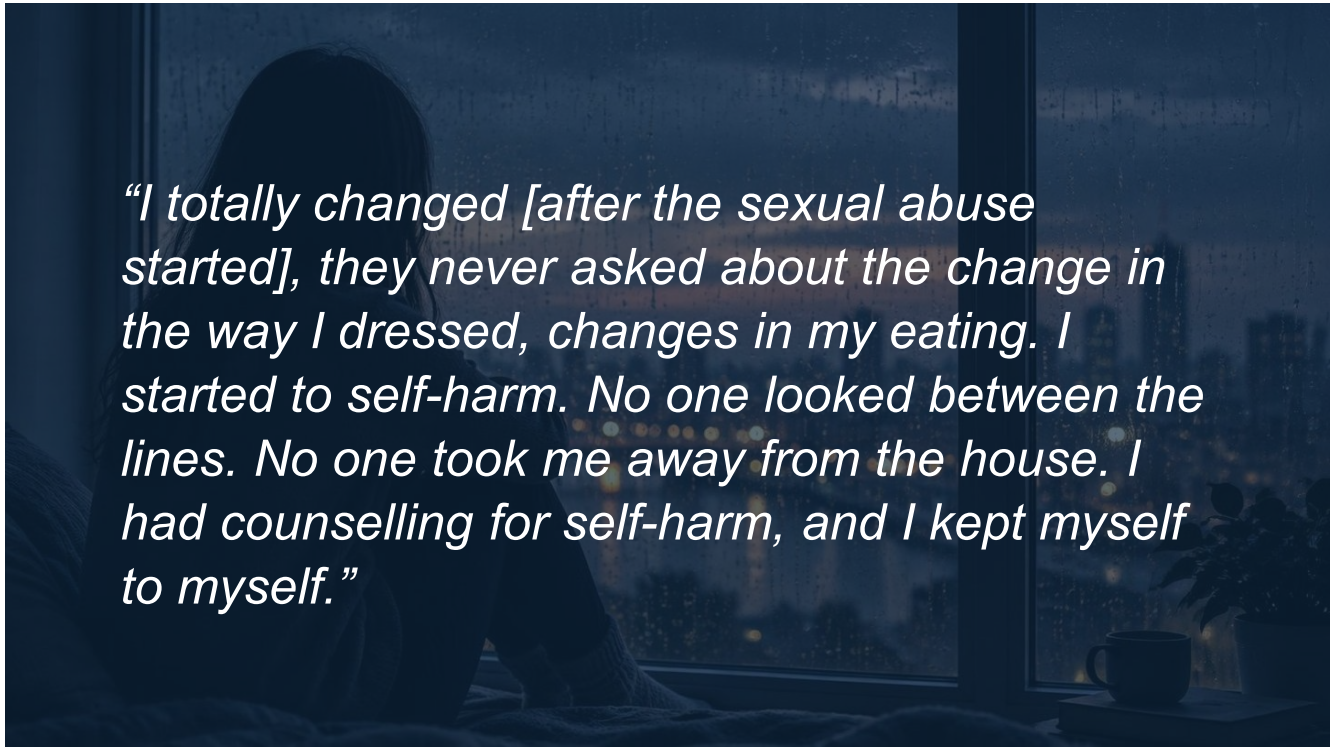
Don't give up, don't go it alone — let the person's voice lead.

Source: Dickens et al. (2023), drawing on 2017–19 serious case reviews.

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“No one looked between the lines”

A young person’s account from a 2017–19 serious case review.



WHAT THE REVIEW FOUND

- Professionals must be alert to behavioural signs; in many reviews this did not happen
- Curiosity was lacking in all the agencies involved
- Professionals must take responsibility for their own practice
- But critical reflection and rigorous supervision were limited.

Limited reflection and supervision undermine curiosity.

Sources: Dickens et al. (2023), quoting a 2017–19 serious case review; Burton & Revell (2018), British Journal of Social Work 48(6).

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Supervision should interrupt assumptions

Reflective supervision creates a fresh pair of eyes — and turns curiosity into accountable action.



SUPERVISOR QUESTIONS

- Where is the child or adult in this account?
- What do we know directly, what are we inferring, and what is missing?
- What pattern or escalation challenges the first explanation?
- Could diagnosis, disability, age, culture or a service label be shaping our view?
- Whose voice is absent — and how will we enable it?

PRACTITIONER LEAVES WITH

- Alternative hypothesis to test — including an alternative explanation.
- Another source to cross-check.
- Ideas on accessible contact or advocacy action.
- A clear decision if there is escalation.
- A record of how lived experience changed the plan.

LOOK • LISTEN • ASK • CHECK OUT • REFLECT

Evidence is strongest when research, records, professional judgement and lived expertise are examined together.

Sources: MAWWSB Professional Curiosity Resource Pack; Munro Review (2011).

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What helps us?

Sharing good practice — how do we get over the barriers and hear the person?

THE QUESTION

What helps you get round the obstacles we have discussed, so the lived experience of the person is heard and included?

YOUR TURN

Share a few words or a brief example of what works: what helps you really listen, ask the difficult question, or get the view of someone who can't use their voice.



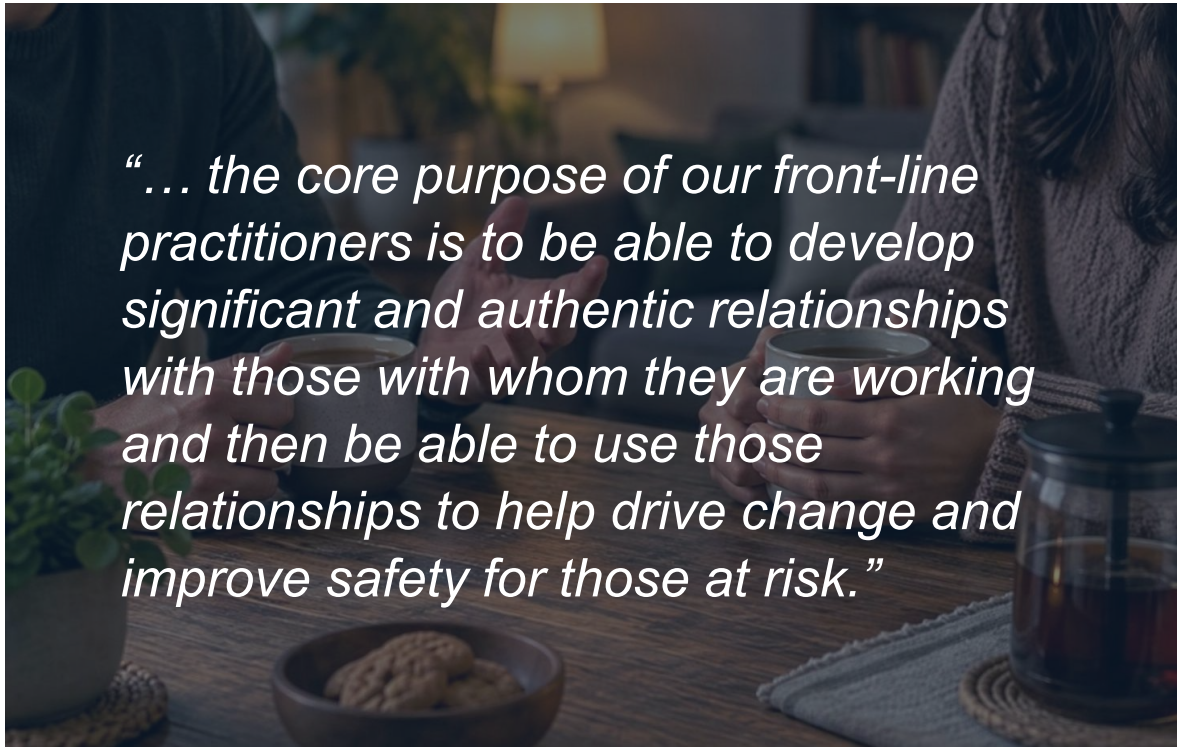
Sharing good practice and experience help all of us.

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Relationships drive change

Good communication is far more than information sharing.





EXPECTED OF ALL PRACTITIONERS

- Listen and observe
- Ask in ways people can understand and answer
- Reflect and analyse
- Explain clearly; use different settings and methods
- Give reasons, even when the answer is no
- Be curious: ask the second question

Information exchange is not the same as effective communication.

Source: a serious case review quoted in Dickens et al. (2023), Children and Youth Services Review 152, 107081.

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Recording and multi-agency planning

What the research says helps when many agencies each hold part of the picture.



RECORD

Chronologies often have gaps, or list dates with no meaning. Record what happened, what it meant and what was done — or why nothing was.

SHARE

Share safeguarding concerns promptly; confidentiality shouldn't delay it. Say what you know, why it matters and what happens next.

COLLABORATE

Plan with partner agencies and take joint responsibility. Know each agency's role, make joint decisions where you can, and agree who does what by when.

ONE PICTURE

Combine each agency's chronology into one multi-agency picture, then follow up — coordination and follow-up are still inconsistent.

Record it • Share it • Collaborate • Check it happened

Sources: NSPCC Learning (2024, 2025), multi-agency working and information sharing; Safeguarding Wales, pointers on chronologies; NISB Wales, Research Insights 1 (2025).

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What can we do?

Being listened to is critical for children and adults, and no one ‘good worker’ fits everyone — so ask each person.

ASK THEM

Tell a recent contact twice: as you’d record it, then as they would.
“What would you say if I asked you how it went?”

PEER SUPPORT

Talk through hard conversations, pressure and uncertainty with colleagues — “thinking the unthinkable” needs support.

SUPERVISION

Bring the person’s voice — not only a safeguarding scale: what they said, what you observed, and what it meant to them.

ONE THING

Choose one thing to notice, ask, record, challenge or do differently. Keep an open mind and question assumptions.

Think family. Think community.
Keep the person in view.

Sources: Stabler, Wilkins & Carro (2020), Child & Family Social Work; Friel, Symonds & Cartwright (2025), Child & Family Social Work.

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What helps us challenge with confidence

Research-based practice builds confidence; openness and support turn curiosity into action.



Challenge is not conflict — it is how we keep the person at the centre.

WHAT HELPS PRACTITIONERS

- **Confidence to challenge:** practitioners need the confidence, time and capacity to question and check what they're told. Organisational barriers can undermine curiosity.
- **Openness to being challenged:** moving away from defensive practice and valuing reflection as a practice tool.
- **Behaviour changes:** a change in a child's or adult's behaviour should prompt practitioners to explore their daily life.
- **Grey areas:** when concerns sit below the threshold, practitioners should still explore, seek advice and refer. Knowing each agency's role and respecting everyone's view leads to quicker, better outcomes.
- **Work together:** differences in professional opinion indicate that no one agency has fully understood the child's/adult's situation, so step back, consider a new approach and develop new ways of working collaboratively.
- **Embedding curiosity:** curiosity should be supported, reviewed and monitored by the whole organisation, so it never rests on individual practitioners alone.

Question • Reflect • Seek support when needed • Work together

Source: "Work together" point – Nottingham City Council

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Any questions?

Thank you very much

Diolch yn fawr

Keep the person in view.



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References

Sources cited across the slides. Where a web link is not shown here, it is in the slide's speaker notes.

WELSH REVIEWS AND SYSTEM

Ball, E., Monaghan, P. and McManus, M. (2026) Child Practice Reviews (CPRs): Focus on the child's perspective and lived experience. NISB Wales / Manchester Metropolitan University (August 2026).

Cwm Taf Morgannwg Safeguarding Board (2026) A Thematic Analysis of Child Practice Reviews in Wales from 2018–2023 (summary).

Cysur, Single Unified Safeguarding Review (SUSR); Gwent Safeguarding Board, What is a Single Unified Safeguarding Review.

McManus, M., Ball, E. and Almond, L. (2023) Risk, Response and Review: Multi-Agency Safeguarding. A thematic analysis of Child Practice Reviews in Wales. NISB Wales.

McManus, M., Ball, E. and Monaghan, P. (2025) Thematic Review of Adult Practice Reviews (APRs) Wales 2025: Main Report. NISB Wales.

McManus, M., Ball, E. and Monaghan, P. (2025) Research Insights: Strengthening Safeguarding in Wales. Safeguarding Insights 1: Learning from Adult Practice Reviews. NISB Wales.

NISB Wales (2020) Thematic analysis of Child Practice Reviews.

Welsh Government (2024) Single Unified Safeguarding Review: statutory guidance (October 2024).

INDIVIDUAL REVIEWS AND REPORTS

CYSUR 3/2021; Norfolk SAR (2021); SAR "Paul".

Child Safeguarding Practice Review Panel (2022–23) Safeguarding children with disabilities in residential settings (Doncaster).

Cwm Taf Morgannwg Safeguarding Board (2022) Logan Mwangi Child Practice Review.

Mid and West Wales Safeguarding Children Board (2024) Lola James, concise Child Practice Review (1 August 2024).

North Wales Safeguarding Board (2025) Our Bravery Brought Justice: extended Child Practice Review (Gwynedd).

North Wales Safeguarding Adults Board (2026) Concise Adult Practice Review NWSAB/2/2024.

Pembrokeshire County Council (2016) Dylan Seabridge Child Practice Review (Child DS), via Social Care Wales.

Media: PA Media/The Independent (24 Nov 2022); Western Telegraph (8 July 2016).

RESEARCH AND NATIONAL ANALYSES

Baginsky, M. et al. (2020) Evaluation of MTM's Signs of Safety Pilots: Evaluation report. London: DfE.

Burton, V. and Revell, L. (2018) Professional curiosity in child protection: thinking the unthinkable in a neo-liberal world. British Journal of Social Work 48(6), 1508–1523.

Cossar, J., Belderson, P. and Brandon, M. (2019) Recognition, telling and getting help with abuse and neglect: young people's perspectives. Children and Youth Services Review 106, 104469.

CSPR Panel (2022a) Child Protection in England: National Review into the Murders of Arthur Labinjo-Hughes and Star Hobson. London: Child Safeguarding Practice Review Panel.

Dickens, J., Cook, L., Cossar, J., Okpokiri, C., Taylor, J. and Garstang, J. (2023) Re-envisaging professional curiosity and challenge: messages for child protection practice from reviews of serious cases in England. Children and Youth Services Review 152, 107081.

Friel, C., Symonds, J. and Cartwright, M. (2025) Views and experiences of children and social workers about communication in social work exchanges: a mixed methods systematic review. Child & Family Social Work.

Healthwatch Together (2023) Safeguarding Voices: Blackburn with Darwen section 42 enquiries.

Independent Inquiry into Child Sexual Abuse (2022) Executive Summary. https://www.iicsa.org.uk/index.html

Munro, E. (2011) The Munro Review of Child Protection: Final Report. London: DfE.

Preston-Shoot, M., Braye, S., Doherty, C. and Stacey, H. (2024) Second national analysis of safeguarding adult reviews: Final report, Stage 3. LGA / Partners in Care and Health.

Race, T. and Frost, N. (2022) Hearing the Voice of the Child in Safeguarding Processes. Child Abuse Review. doi:10.1002/car.2779.

Rees, A., Dehaghani, R., Slater, T. and Swann, R. (2021) Findings from a thematic analysis of Adult Practice Reviews in Wales. Cardiff University.

Ruch, G., Turney, D. and Ward, A. (2018) Relationship-Based Social Work (2nd ed.). London: Jessica Kingsley.

Sinclair, R. and Bullock, R. (2002) Learning from past experience: a review of serious case reviews. London: Department of Health.

Stabler, L., Wilkins, D. and Carro, H. (2020) What do children think about their social worker? A Q-method study. Child & Family Social Work 25(1), 118–126.

NSPCC LEARNING

Baker, H. et al. (2019) Let children know you're listening. NSPCC.

NSPCC Learning (2023) Summary of Risk, response and review: multi-agency safeguarding (CASPAR briefing).

NSPCC Learning (2024) The voice of the child: learning from case reviews.

NSPCC Learning (2024) Multi-agency working and information sharing: learning from case reviews; (2025) Practice points for multi-agency working and information sharing.

NSPCC Learning (2025) 'Disguised compliance': learning from case reviews.

NSPCC Learning, Responding to a disclosure (recognising and responding to abuse).

GUIDANCE, LAW AND PRACTICE RESOURCES

Cysur / Mid and West Wales Safeguarding Board, Professional Curiosity guidance and Resource Pack.

North Wales Safeguarding Adults Board (2022) Professional Curiosity Guidance.

Nottingham City Council, Confirmatory Bias. https://www.nottinghamcity.gov.uk/media/hj2ec0xc/confirmatory-bias.pdf

LLR Safeguarding Children Partnerships (2020) 'Was Not Heard' (film by young people from Leicester, Leicestershire and Rutland).

Public Health Wales, National Safeguarding Service (2026) Safeguarding training pack: Professional curiosity.

Safeguarding Network (2021/22) Making Effective Referrals: a Guide for DSLs. https://www.ncb.org.uk/sites/default/files/uploads/files/Full%20threshold%20documents%20analysis%20report.pdf

Safeguarding Wales, Wales Safeguarding Procedures: child-centred and person-centred practice; analysis and decision-making; pointers on chronologies.

Social Care Wales, Code of Professional Practice for Social Care Workers (2026).

Welsh Government, Social Services and Well-being (Wales) Act 2014.

Welsh Government (2022; 2024 update) Anti-racist Wales Action Plan.

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