Easy Read

Llywodraeth Cymru
Welsh Government

Single Unified Safeguarding Reviews (SUSR)

This document was written by the **Welsh Government**. It is an easy read version of the '**Single Unified Safeguarding Review**'.

October 2024

How to use this document

This is an easy read document. But you may still need support to read it. Ask someone you know to help you.

Words in **bold blue writing** may be hard to understand. You can check what the words in blue mean on **page 41**.

Where the document says **we**, this means **Welsh Government**. For more information contact:

Website: www.gov.wales/single-unified-safeguarding-review-guidance

E-mail: SUSRWales@gov.wales

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Introduction

We need to improve learning from **safeguarding** reviews in Wales.

Safeguarding means protecting a person's health, wellbeing, and human rights. Especially children and adults most at risk, to make sure they can live free from abuse and harm.

When a child or adult that we are **safeguarding** comes to harm, we must look at what happened.

We must work together to see if anything could have been done differently to stop the harm from happening.

This is called a **safeguarding review**.

In the past, when a **safeguarding** problem happened, we used to have lots of meetings to talk about it.

We found out that having lots of meetings about difficult topics made people feel:

- Upset

- Tired
- Frustrated

This was unfair on the people involved. We wanted to make the process easier for them.

So we developed the **Single Unified Safeguarding Review (SUSR).** A way of dealing with safeguarding problems.

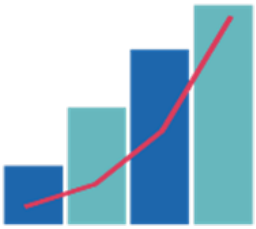
Some of the aims of the **SUSR** are:

- Make 1 **safeguarding** review process for everyone in Wales to follow.

- Bring lots of professionals into **1 meeting** to talk about **safeguarding** problems. Rather than having lots of meetings.

- Make life easier for families or victims involved. Make sure they have fewer meetings to go to.

- Get things done more quickly without losing quality.



- Make sure we do things better in the future.

- Make sure staff have much needed support from managers.

- Make sure staff understand the impact difficult situations have on families.

- Make sure we learn from complicated cases.

To achieve our aims for the **SUSR** we have created a support network.

The support network will include:

- We will write reports about things that most often went wrong or right. And the problems it caused or things that went well.

Storfa Ddiogelu Cymru
Wales Safeguarding Repository

- A **place** where all finished **SUSR** reports will be kept. Professionals will be able to read these past reports to help them learn.

- A **team** who will make sure we learn from things that have gone wrong or well. They will work with partners to make sure everyone learns from past reviews.

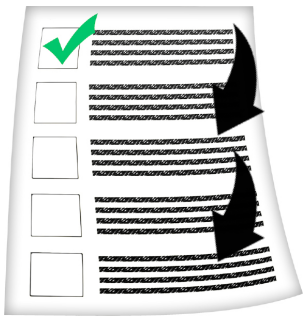
They will deliver training and host events to share best ways of working and lessons learned across Wales.

- A **Board** that will link what we learn to policies and plans in Wales. They will support changes to the law and make sure we are working in the best ways.

They will talk about serious issues that need to be dealt with on a national or UK level.

Why we created SUSRs

We created **SUSRs** to keep people safe from harm in the future.



We want to make the **safeguarding** process better. And to make it easier to learn from cases.

SUSRs are not about blame. They are to make sure we learn from every case.

It is important that everyone is open and honest during **SUSRs**. Because that is how we will make things better.

It is also important that people who have been hurt and their families have their say. Because their voice matters.

When to do SUSRs

We won't do a **SUSR** for everyone who has been hurt. We will do a **SUSR** when:

We think a child or adult at risk has been **abused** or **neglected.**

Abuse is when someone hurts you or treats you badly. There are different types of **abuse**.

Neglect is a type of **abuse**. It means someone has not given you the care you need.

And they have either died or nearly died. **Or** if they have been harmed in a very bad way.

We will also see if we knew about this child or adult at risk before.

And if we should have done something differently to keep them safe.

We will do a SUSR when:

There has been a **domestic homicide** of someone aged over 16.

Domestic Homicide is when someone is killed by a person they are related to, or had a relationship with. **Homicide is another word for murder**.

And we think this person died from violence, **abuse** or **neglect** by someone they are related to, or had a relationship with.

We will also do a **SUSR** if someone dies by **suicide**. **And** we think they did it because someone was harming them.

Suicide is what we call it when a person ends their own life.

We have very strict rules to follow when reviewing **domestic homicides**.

We will do a SUSR when:

- there has been a **homicide**

- **and** the **perpetrator** is someone who has used mental health services in the last year.

A **perpetrator** is someone who carries out harmful or illegal acts.

This is called a **mental health homicide**. We must report **mental health homicides** to Welsh Government.

And after the **SUSR** we must report what we find out back to NHS Wales.

If a **SUSR** is not needed, the health board should still investigate the **homicide**.

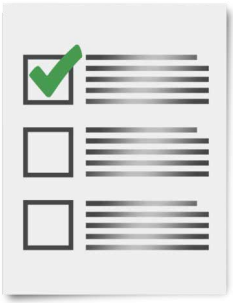
How to do SUSRs

Safeguarding Boards oversee **safeguarding** in their area. There are 6 in Wales. **Safeguarding Boards** will manage the reviews in their area. **Safeguarding Boards** will put together a **Case Review Group**.

The Case Review Group will decide if a Review should be done and a Review Panel set up. The Review Panel will:

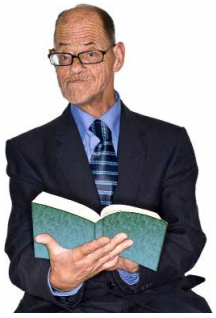
- Talk to the child or adult at risk if they want to be involved. And to their family members.

- Talk to staff who have been working with the child or adult at risk.

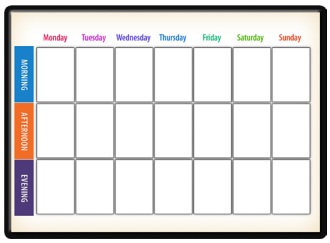


- Make sure things are done properly. And that staff learn from the case.

- Send a report back to their **Safeguarding Board**. With an action plan.



The **Safeguarding Board** will read the report and action plan. And decide what needs to happen next.



This process should not take more than 12 months.

The **Safeguarding Board** will then make sure the right people read the report. And get a chance to learn from it.

They will follow the action plan to make things better.

Storfa Ddiogelu Cymru
Wales Safeguarding Repository

All **SUSR** reports are stored at **The Wales Safeguarding Repository (WSR)**. Storing them in one place makes it easier for everyone to find them.

Who does SUSRs

It is important that the right people do **SUSRs**. And that they are clear on what their roles are.

Every **SUSR** will have the following people involved:

- **The Case Review Group**
- **The Review Panel and Chair**
- **The Reviewer**

- **The Safeguarding Board and Chair**
- **SUSR Ministerial Board for Wales**

- **SUSR Coordination Hub**
- **Community Safety Partnerships**. If needed.

The Case Review Group

The Case review group decide if a **SUSR** is needed. Then they double check with the chair of the Safeguarding Board.

When more than one board is involved, they will make sure all boards work together properly.

When more than one child or adult at risk is involved, they make sure everyone is treated fairly.

The Chair of the Safeguarding Board

The chair of the Safeguarding Board will make the final decision on whether a **SUSR** should be done.

The Review Panel

The Chair of the Review Panel will make sure the Review stays on track once it starts.

The review panel manages the review process. And gets all the information about the case together.

They also make sure that everyone learns from the review.

Review panels should all be professionals. And should be the same group of people all the way through the review.

But they must not have had anything to do with the case before.

The Reviewer

The reviewer talks to all the people involved in the case.

The reviewer writes the final report. And makes sure it gets shared with all the right people.

The Safeguarding Board

Safeguarding Boards link what is learnt to policies and plans in their area and across Wales.

They make sure all **SUSRs** are done properly. And that actions are taken to improve things.

SUSR Ministerial Board for Wales

The purpose of this board is:

- To know about all the reviews that are happening in Wales. And to make sure everyone is doing them in the same way.

- To help with any difficult reviews.

- To think about any changes needed in the law.

- To improve **safeguarding** across Wales.

SUSR Coordination Hub

The role of the hub is:

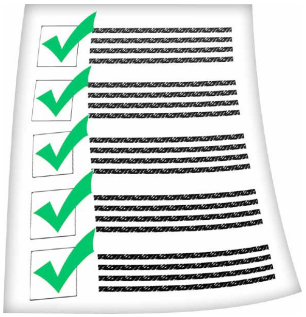
- To create a list of trained chairs and reviewers that can work on **SUSRs.**

- To take care of the money needed to do **SUSRs**.

Storfa Ddiogelu Cymru
Wales Safeguarding Repository

- To gather all the information about reviews. And to store completed **SUSRs** at the **Wales Safeguarding Repository (WSR).** The **WSR** was created as a place to store all **SUSR** reports.

- To run training events across Wales. To share what people have learnt.



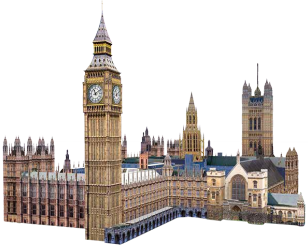
- To check what needs to be done after a review. And to make sure it happens.

Community Safety Partnerships

For **domestic homicides** the rules are a bit different.

In such cases, someone from the **community safety partnership** will be involved in the **SUSR** process.

The chair of the Safeguarding Board and a person from the **community safety partnership** decide together if a **SUSR** is needed.



They will let the **Home Office** know what they decide. And they will let the family of the victim know too. The Home Office is a department in the UK Government.

Once the review is finished, the reviewer should send their final report to the **Home Office**.

Involving family and key individuals in SUSRs

For every review that we do, different people will need to be involved. They can be:

- Key family members
- Victim

- **Perpetrator**
- Friends

- Community staff
- Neighbours

- Colleagues
- Employers

We have created some guidelines for this:

- Families and key individuals will be contacted as soon as possible. They will be kept up to date about what is happening in the review, if that is what they want.

- Families and key individuals will be told about the process and what will happen.

- We will provide families and key individuals with a contact person.

- We will support families and key individuals through the review process.

- We will use easy to understand language throughout.

- We will communicate in a language of your choice.

- If families and key individuals feel that the report is not quite right, they can suggest changes.

- Families and key individuals should know who to contact if these guidelines are not followed.

When the review is about a child or adult at risk.

In the past, children and younger adults were not always given the opportunity to be involved in reviews.

In our experience we find that it is best if all people, are involved.

The Reviewer will try different ways of working to involve families and key individuals.

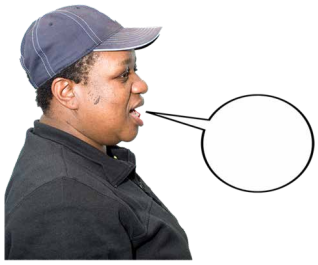
We will give feedback from reports to families and key individuals in the format they want.

When a domestic homicide has happened

We feel that it would be a good idea to speak to family members and friends after a **domestic homicide**.

The benefits of involving family and friends are:

- Helping to support victims of crime. Help them to recover as best they can.



- Giving family the chance to meet with the review panel and make their voices heard.

- Helping families have a say in how we can stop **domestic homicides**.

- Allows the review panel to see the victim and or **perpetrator** through their family's eyes.

- Families will be able to choose a different name for the victim, to be used in the report. This is so the victim cannot be identified if this is what the family want.

When family members become involved with a review, the chair of the panel will:

- Offer the services of an **advocate**.

An **advocate** is someone who works and speaks up in support of another person.

- Talk with the **advocate** on behalf of the family involved. And update them about the review.

- The chair will think about any ethnic, cultural or language needs of the family.

- The chair will explain how taking part in the review will help other victims.

Sometimes, there is reason to believe an **honour killing** has taken place.

An **Honour killing** is when someone is killed because their family believe they have brought dishonour on the family.

Before involving families in reviews, all risks must be identified. We must think about the impact involving family and key individuals will have on the victim.

Sometimes people who carry out **honour killings** will say they did it because of their culture and values.

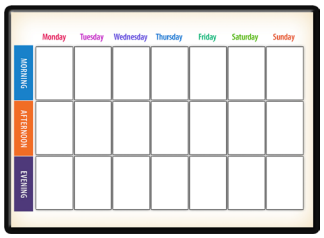
The review panel must get expert advice and information from outside professionals and organisations.

The stages of SUSRs

There are many stages to go through to complete a **SUSR:**

Timelines

Timelines tell us what happened and when.



Timelines should go back far enough so we can understand the full story. But they should not go back more than 12 months in most cases.

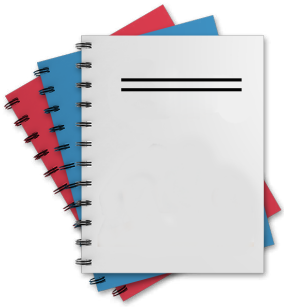
Other documents

It is useful to create a document showing all the family members in a case. And how they relate to each other.

We might realise we can't do a review on a certain case. If we stop, we will write a report to explain why.

Learning from SUSRs

During the **SUSR** process we will hold a learning event. So everyone who is involved can discuss the case and learn from it.



We will use old cases to help us.

After the review, we will write a report about what we have learnt.

We will also write an action plan. This will say what we need to do to improve **safeguarding**.

This whole process is very important. And helps everyone to do a better job in the future.

How to learn from SUSRs

The most important part of **SUSRs** is what we can learn from them.

This will help keep children and adults at risk safer in the future.

Storfa Ddiogelu Cymru
Wales Safeguarding Repository

The **Wales Safeguarding Repository (WSR)** was created as a place to store all **SUSR** reports. Storing all reports in one place makes it easier for everyone to learn from them.

The **SUSR Coordination Hub** will use the **WSR** to understand what cases are happening in Wales. And to see how to make **safeguarding** better.

The **SUSR Coordination Hub** will plan a big event to share what we have learnt every 6 months.

Multi-Agency Professional Forums (MAPFs) are events to share information and learn from incidents that are not being reviewed but may help with learning. They are arranged by the **Safeguarding Boards**.

MAPFs give everyone the chance to talk about incidents that are not being reviewed but may help with learning and to learn from each other.

MAPFs help to keep children and adults at risk safer in the future.

Anything new we learn at **MAPFs** should be shared with all professionals across Wales.

Protecting private information

Some of people's private information will be shared in **SUSRs**.

But people's private information should be protected as much as possible.

For example, we should use fake names in reports to protect people.

And we should make sure reports and documents are kept somewhere safe.

We might need to tell people what information we have about them.

We need to make sure we follow the law.

Doing SUSRs on old cases

Not all cases should have reviews done on them.

Boards decide which cases will be reviewed. And which won't.

Sometimes **Boards** decide that it would be useful to do a **SUSR** on an old case.

They do this if they think we can learn a lot from these cases.

We follow the same rules for **SUSRs** even if they happened a long time ago.

Other Processes

SUSRs are about learning and making improvements.

SUSRs are not about punishing staff for mistakes.

During a **SUSR,** we might realise that staff did something wrong. Or that they broke the law.

We might need to talk to the police.

But this should not stop us from doing the **SUSR**.

If someone complains, we have a complaints process that should be followed.

Hard words

Abuse

Abuse is when someone hurts you or treats you badly. There are different types of abuse.

Advocate

This is someone who works and speaks up for another person.

Domestic homicide

Domestic Homicide is when someone is killed by a person they are related to, or had a relationship with. Homicide is another word for murder.

Honour killings

An Honour killing is when someone is killed because their family believe they have brought dishonour on the family.

Neglect

This is a type of abuse. It means someone has not given you the care you need.

Perpetrator

This is someone who carries out harmful or illegal acts.

Safeguarding

This means protecting a person's health, wellbeing, and human rights.

Suicide

Suicide is what we call it when a person ends their own life.