Adolygiad Diogelu Unedig Sengl

Single Unified Safeguarding Review

Llywodraeth Cymru
Welsh Government

Single Unified Safeguarding Review

Statutory Guidance

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Contents

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Foreword

Whenever any life is lost or is significantly impacted by abuse, as public servants, we need to make sure that no opportunity to protect that person from harm was missed so that we can better protect others in the future.

In Wales, we are used to working together with the common goal of looking after our more vulnerable citizens. The Single Unified Safeguarding Review (SUSR) is a unique and ground breaking example of how, through collaboration and co-production across political, organisational, and geographical boundaries, we can tackle a complex problem and deliver a shared response. Almost 200 stakeholders have been engaged in the design and delivery of the SUSR, all of whom have put the person who has been harmed, their families and communities first. This transformation supports our one public service ethos, creates a stronger culture of accountability, and dispersed leadership empowering people to share learning.

This pioneering work started in 2017, when Carl Sargeant, the former Cabinet Secretary for Communities and Children, questioned why Domestic Homicide Reviews were not being shared with Welsh Government. He commissioned an academic review by Cardiff University and a Welsh Government practitioners review into the potential issues arising from Safeguarding Reviews in Wales.

Evidence from both reviews highlighted the need for a better coordinated system for safeguarding reviews in Wales, resulting in the call for a single review of an incident to simplify and concentrate efforts, reducing trauma to families, avoiding duplication of effort, saving valuable time and identifying learning at the earliest opportunity.

Carl Sargeant also commissioned Cardiff University to develop a repository for Wales where reviews could be stored and used to synthesise findings and recommendations to improve future practice. The outcome of this work is the Wales Safeguarding Repository which enables users to extract underlying patterns and knowledge from the reviews by using text mining and machine learning methods.

The SUSR ties into our wider aspiration for One Welsh Public Service. In line with the Five Ways of Working set out in the *Well-being of Future Generations (Wales) Act 2015*[1], we know that we can only deliver the best outcomes for current and future generations, if we support an integrated and collaborative approach to policy and delivery. An approach which breaks down silos, draws together insights from different spheres of expertise and encourages partnership working across the whole public service and with wider social partners.

The SUSR lays out a framework for how Safeguarding Boards should work in partnership with Community Safety Partnerships and other partnerships in the area, such as Public Service Boards and Regional Partnership Boards, to protect people from harm – sharing lessons and ensuring we work together to secure the wellbeing of every person in Wales.

The SUSR is evolutionary and still on a journey, but what is clear, it is being seen as a beacon both nationally and internationally for others to follow. With Wales seeking to further develop a one public service approach, the SUSR is seen as an example of how change can happen as a consequence of all of us working together for the common good.

1 Five Ways of Working (sustainable development principle) **Well-being of Future Generations Wales Act 2015**

Glossary Of Terms

Word	Meaning
Abuse	"abuse[2]" means physical, sexual, psychological, emotional, or financial abuse (and includes abuse taking place in any setting, whether in a private dwelling, an institution or any other place), and "financial abuse" includes: • having money or other property stolen; • being defrauded; • being put under pressure in relation to money or other property; and • having money or other property misused.
Adult at Risk	An "adult at risk", is an adult who: a) is experiencing or is at risk of abuse or neglect; b) has needs for care and support (whether or not the authority is meeting any of those needs); and c) as a result of those needs is unable to protect himself or herself against the abuse or neglect or the risk of it[3]. For the purposes of this Statutory Guidance, where the term 'adult at risk' is used, this may also include the subjects of the review who meet the criteria for a Domestic Homicide Review.
Child Protection Register	A list created and held by a local authority which contains the names of children who are the subject of a child protection plan in its area. Inclusion of a child's name on the register arises following a decision of a child protection conference that the child is at continuing risk of significant harm in the form of physical abuse, emotional abuse, sexual abuse, or neglect[4].

2 Section 197(1) **Social Services and Well-being (Wales) Act 2014**
3 Section 126(1) **Social Services and Well-being (Wales) Act 2014**
4 **The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015**

Word	Meaning
Domestic Abuse[5] 'DA'	1) Behaviour of a person ("A") towards another person ("B") is "domestic abuse" if— a. A and B are each aged 16 or over and are personally connected to each other, and b. the behaviour is abusive. 2) Behaviour is "abusive" if it consists of any of the following— a. physical or sexual abuse; b. violent or threatening behaviour; c. controlling or coercive behaviour; d. economic abuse (see subsection (4)); e. psychological, emotional, or other abuse; 3) and it does not matter whether the behaviour consists of a single incident or a course of conduct. 4) "Economic abuse" means any behaviour that has a substantial adverse effect on B's ability to— a. acquire, use, or maintain money or other property, or b. obtain goods or services.
Honour-based abuse	The Crown Prosecution Service defines So-called Honour-based abuse as "an incident or crime involving violence, threats of violence, intimidation coercion or abuse (including psychological, physical, sexual, financial or emotional abuse) which has or may have been committed to protect or defend the honour of an individual, family and/or community for alleged or perceived breaches of the family and/or community's code of behaviour." Additionally, Honour-based crimes could include: • Attempted murder • Manslaughter • Procuring an abortion • Encouraging or assisting suicide • Conspiracy to murder • Conspiracy to commit a variety of assaults[6].

5 Section 1 of the **Domestic Abuse Act 2021 (legislation.gov.uk)**
6 **So-Called Honour-Based Abuse and Forced Marriage: Guidance on Identifying and Flagging cases | The Crown Prosecution Service (cps.gov.uk)**

Word	Meaning
National Independent Safeguarding Board 'NISB'	The NISB (established under section 132 *of the Social Services and Well-being (Wales) Act 2014*[7]), is an advisory board that advises Welsh Ministers on safeguarding people in Wales. It works alongside Safeguarding Boards to secure consistent improvements in safeguarding policy and practice throughout Wales[8].
Neglect[9]	"neglect" means a failure to meet a person's basic physical, emotional, social, or psychological needs, which is likely to result in an impairment of the person's well-being (for example, an impairment of the person's health or, in the case of a child, an impairment of the child's development).
Principal Individuals	As set out in **Section 6** of this Guidance, Principal Individuals are for example (but not limited to) friends, community representatives/ support services, neighbours, colleagues, faith and community leaders or employers known to the subject of the Review.
Public Services Board 'PSB'	Public Services Boards (established by section 29(1) *of the Well-being of Future Generations (Wales) Act 2015*[10]), improve joint working across all public services in each local authority area in Wales. Each board must carry out a well-being assessment and publish an annual local well-being plan. The plan sets out how they will meet their responsibilities under the Well-being of Future Generations (Wales) Act 2015[11].
Relevant Review Partners	As set out in the Police, Crime, Sentencing and Courts Act 2002 (Offensive Weapons Homicide Reviews) Regulations 2022: police, local authority, and integrated care board/local health board in the area the death occurred or was likely to have occurred, or where the body or part of the body was first found (or the first body/part of the body in the case of multiple deaths)[12].
Review Partners	Police, local authorities, and integrated care board/local health boards in England and Wales who are not relevant review partners. For example, the authorities for a current or previous area where the subject of the Review resided, or in a current or previous area the alleged perpetrator(s) resided in, as long as this area is different from that where the death occurred or was likely to have occurred, or where the body or part of the body was first found[13].

7 Section 132 **Social Services and Well-being (Wales) Act 2014**
8 **working-together-to-safeguard-people-volume-i-introduction-and-overview**
9 Section 197(1) **Social Services and Wellbeing (Wales) Act 2014**
10 Section 29(1) of the **Well-being of Future Generations (Wales) Act 2015**
11 **Public Services Boards | GOV.WALES**
12 **Home Office – Offensive Weapons Homicide Reviews – Statutory Guidance – March 2023 (publishing.service.gov.uk)**
13 **Offensive Weapons Homicide Reviews Statutory Guidance – March 2023**

Word	Meaning
Safeguarding	The meaning of safeguarding for the purposes of this guidance is keeping people safe whether that is from abuse as defined in the Social Services and Well-being (Wales) Act 2014[14] or from being the victim of homicide or suicide where coercion is involved.
Safeguarding Boards	There are six safeguarding boards (established by *section 134 of the Social Services and Well-being (Wales) Act 2014*[15]) in Wales. These are also referred to as 'Regional Safeguarding Boards', 'Safeguarding Adult Boards' or 'Safeguarding Children Boards'.
Subject of the Review	This refers to the person whose circumstances meet the criteria for a Single Unified Safeguarding Review. The Reviewer has discretion to describe the subject of the Review in the most appropriate way. The Reviewer can therefore choose to refer to the subject in any way they deem appropriate (for example, victim; survivor; perpetrator; alleged perpetrator; individual; child).
Suicide	Suicide is death resulting from an intentional self-inflicted act[16].
The Review	In this guidance, the "Review" (or SUSR) refers to the Single Unified Safeguarding Review.
Violence Against Women, Domestic Abuse, and Sexual Violence 'VAWDASV'	VAWDASV stands for Violence Against Women, Domestic Abuse and Sexual Violence. It incorporates Violence Against Women (and Girls), Domestic Abuse, Rape and Sexual Violence, Sexual Harassment, Female Genital Mutilation, Honour Based Violence, Forced Marriage, Stalking, Trafficking and other forms of violence[17].
Wales Safeguarding Repository 'WSR'	All completed SUSR Reports will be retained in the Wales Safeguarding Repository. Registered users can extract learning from the WSR through its unique system utilising social science and computer science methodologies. The findings of completed SUSRs will be used to inform learning and enhance future safeguarding practices.

14 Section 197(1) **Social Services and Well-being (Wales) Act 2014**
15 Section 134 **Social Services and Well-being (Wales) Act 2014**
16 **Talk to me 2 - Suicide and Self Harm Prevention Strategy For Wales 2015-2020**
17 **VAWDASV – Wales Safer Communities**

1. About this Statutory Guidance

This statutory guidance is issued by the Welsh Ministers under section 139 of the Social Services and Well-being (Wales) Act 2014. It applies from 1 October 2024.

1.1 This statutory guidance replaces Working Together to Safeguard People Volumes 2 (Child Practice Reviews) and 3 (Adult Practice Reviews). As a result, consequential changes to Volume 1 (Introduction and Overview) will be made to reflect this.

1.2 The criteria for undertaking a Single Unified Safeguarding Review (SUSR) are set out in **Section 4** of this Guidance.

1.3 In summary, the criteria for when a SUSR should be carried out is met where the legal grounds for undertaking one or more particular types of review apply. Those various legal grounds are set out in:

- the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[18];
- the *Domestic Violence, Crime and Victims Act 2004*[19]; and
- section 24 of the *Police, Crime, Sentencing and Courts Act 2022 and the Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022*[20].

1.4 It should be noted that this statutory guidance will be reviewed and amended after the first twelve months of implementation, to consider:

- any issues arising from the implementation process and if greater clarity is required;
- aspects arising from the Offensive Weapon Homicide Review pilot;
- changes to the revised Domestic Homicide Review Statutory Guidance presently being undertaken by the Home Office; and
- whether the processing of data is still meeting its intended purpose and is still effective, necessary and proportionate.

18 Regulation 4(3) and 4(4). **Safeguarding Boards Regulations 2015**
19 Section 9(1). **Domestic Violence, Crime and Victims Act 2004**
20 Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 **Police, Crime, Sentencing and Courts Act**

2. Introduction

2.1 The development of the SUSR in Wales ensures that when a qualifying event triggers a Review process, all aspects are considered across all relevant agencies, devolved and non-devolved, rather than in organisational silos. It will:

- build upon the good practice that emerged from the creation of the Adult Practice Review (April 2016) and Child Practice Review (January 2013) processes which replaced the former Serious Case Review guidance. The Adult Practice Review and Child Practice Review processes are set out in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[21]. The Adult and Child Practice Review approach seeks to improve understandings of organisations and agencies' actions leading up to the incident. It considers whether different actions or non-action may have resulted in different outcomes for the child or adult. The overall aim is to create a learning environment; and
- implement the findings of the 2018[22] academic report by Cardiff University and a Welsh Government practitioner's report (2018)[23]. These reports highlighted the need for co-ordination, collaboration, communication, and governance to be improved when conducting safeguarding reviews in Wales. They also exposed the complexity of devolved and non-devolved bodies undertaking reviews in isolation and in some cases without Welsh Government knowledge or oversight. This resulted in the recommendation for a single review process.

2.2 The 2018 reports provided Welsh Ministers with powerful evidence to support the need for change in relation to review processes. Consequently, the SUSR process has been developed to strengthen the review landscape within Wales. The SUSR aims to:

- create a single Review process which incorporates a multi-agency approach where the criteria for one or more of the following reviews is met:
  - Adult Practice Review (whether concise or extended);
  - Child Practice Review (whether concise or extended);
  - Domestic Homicide Review;
  - Mental Health Homicide Review; and
  - Offensive Weapons Homicide Review[24];
- eliminate the need for families to take part in an onerous and traumatising cycle of information-giving and waiting for the conclusions of multiple reviews;
- ensure the subject and family are at the heart of the process;
- use the insight and learning gained from the Review process to deliver positive change in practice to prevent future harm;
- provide national support to the Safeguarding Boards which fulfils a co-ordination/ operational role to oversee the end-to-end process via **the SUSR Co-ordination Hub**;

21 The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 **Safeguarding Boards Regulations (2015)**
22 Robinson, A., Rees, A. and Dehaghani, R. (2018) '*Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews*'
23 James, L.A. (2018) '*Domestic Homicide Reviews in Wales*'
24 Offensive Weapon Homicide Reviews are being piloted (2023-24) using the Single Unified Safeguarding Review process in Wales and therefore may be subject to change

- ensure that the support network for the Safeguarding Boards and other key partners is in place and is effective;
- ensure clear linkages between local, regional, and national bodies while respecting regional and local variations in arrangements;
- retain the final SUSR reports in a central repository (**the Wales Safeguarding Repository**) and facilitate pan-Wales training and local, regional, national, and international learning; and
- use the Wales Safeguarding Repository (refer to **Section 8**) and associated learning to support any changes to practices, processes and cultures which will prevent future harm.

2.3 This SUSR has been developed by using good practice from a number of existing review processes and guidance documents including:

- Child Practice Review.
- Adult Practice Review.
- Domestic Homicide Review.

It also incorporates the more recent Offensive Weapon Homicide Review guidance and information on Mental Health Homicide Reviews.

2.4 The SUSR has reflected these by ensuring that it:

- involves agencies, staff, and families in a collective endeavour to reflect and learn from what has happened, to improve practice in the future, with a focus on accountability and not on culpability;
- has the potential to develop more competent and confident multi-agency practice in the long term, where staff have a better understanding of the knowledge base and perspective of different professionals with whom they work;
- strengthens the accountability of managers to take responsibility for the context and culture in which their staff are working and to ensure that they have the support and resources they need;
- recognises the impact of the tragic circumstances of non-accidental deaths or serious harm on families and on staff, and provides opportunities for serious incidents to be reviewed in a culture that is fair and just;
- allows a more constructive and appropriate use of resources than in the previous system and works to shorter timescales; and
- focuses on key learning identified through the Review which results in relevant recommendations and actions to improve future practice.

2.5 The SUSR has been created collaboratively by practitioners, at both operational and strategic levels, and has been further refined with wider engagement. It provides a more effective and efficient multi-agency process that will be detailed, but more streamlined in its approach by:

- delivering a single review instead of multiple reviews in relation to an incident(s);
- creating a simplified yet concentrated approach to reviews which reduces trauma to families;
- providing the most efficient utilisation of resource;

- producing a Review Report that is focussed on improving service delivery with a clear Action Plan, which will be monitored and reviewed to ensure it is implemented to improve practices and prevent future harm;
- ensuring the subject of the Review and/or their families and Principal Individuals (see glossary for definition) impacted are at the heart of the Review process at all stages;
- taking a "one public service" approach so that the subject of the Review and/or their families and Principal Individuals are not left to make sense of the work of different professions or agencies; and
- enabling the sharing of information, recommendations, and thematic learning to safeguard future generations.

2.6 Accompanying this statutory guidance is a set of training tools and materials supporting the SUSR arrangements, which should be used throughout the process. This will provide a standardised and consistent approach across Wales when implementing a SUSR. These materials can be accessed through the Co-ordination Hub or via the following link: **SUSR Toolkit**.

2.7 This statutory guidance should be read in conjunction with all the associated Appendices. Hyperlinks are provided within the text where these connections should be considered.

Partnerships in Wales

2.8 A SUSR happens in a unique delivery and legislative context. It is essential for devolved and non-devolved organisations to work in partnership in Wales, at all levels, to deliver the best possible outcomes for people. It will also ensure that relevant lessons are learnt across these governance structures and required changes and adjustments made where appropriate locally, regionally, and nationally.

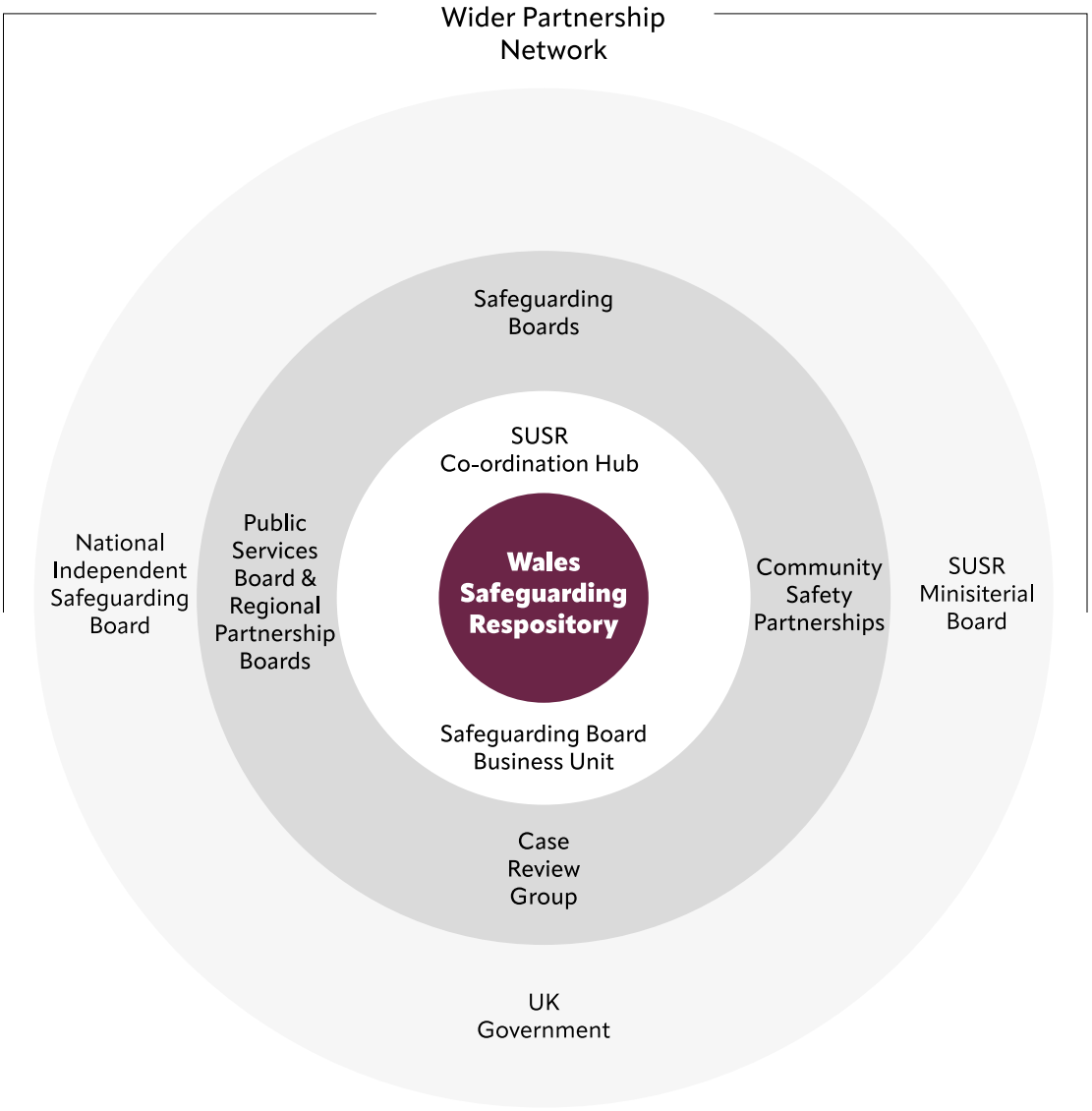
2.9 This partnership approach is well-embedded, with strong working relationships and robust governance underpinning innovative work at the strategic and operational level in Wales. Organisations such as the Welsh Government, Public Health Wales, local authorities, local health boards, His Majesty's Prison and Probation Service, Policing in Wales (Chief Constables and Police and Crime Commissioners), the National Independent Safeguarding Board, Inspectorates and Regulators and the third sector work closely together to deliver effective services.

2.10 Every Welsh local authority area will have a range of existing multi-agency arrangements in place. These existing partnerships will include Public Services Boards (*Well-being of Future Generations (Wales) Act 2015*[25]), Regional Partnership Boards (*Social Services and Well-being (Wales) Act 2014*[26]), Safeguarding Boards for both Adults and Children (Social Services and Well-being (Wales) Act 2014), Regional or Local Community Safety Partnerships (*The Crime and Disorder Act 1998*[27]), Regional Violence Against Women, Domestic Abuse and Sexual Violence Boards (*Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015*[28]), alongside Local Criminal Justice Boards, Integrated Offender Management Groups, Multi-agency Public Protection Arrangements and Substance Misuse Area Planning Boards. Please refer to **Appendix One** as a reference point for these structures.

25 Well-being of Future Generations (Wales) Act 2015 **Wellbeing of Future Generations Act**
26 Social Services and Wellbeing (Wales) Act 2014 **Social Services and Wellbeing Act**
27 The Crime and Disorder Act 1998 **The Crime and Disorder Act**
28 Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 **Violence Against Women Act**

2.11 The existing governance structures should be utilised for the purposes of the SUSR throughout the application of this guidance. Flexibility is designed to allow authorities to build on existing infrastructure, strengths, and capabilities as per the *Well-being of Future Generations (Wales) Act 2015*. The partnerships that already exist in Wales are in a strong position to deliver SUSRs and monitor progress of the accompanying Action Plans. Please refer to Figure 1 below which illustrates the wider partnership network.

Figure 1



Support Network

2.12 To achieve these aims, a support network for the SUSR process has been developed (please see Figure 2), to aid the delivery process and to share learning. The support network is outlined below.

SUSR Ministerial Board for Wales

2.13 The Ministerial Board is the overarching body bringing together the devolved and non-devolved aspects of safeguarding under one model. It will provide political and strategic oversight of the SUSR process, ensuring national issues are considered and a pan-Wales response is provided when required.

2.14 The Ministerial Board will also act as a platform for escalating any regional issues which are identified that require a national or UK response. Terms of Reference can be found here: **www.gov.wales/single-unified-safeguarding-review-ministerial-board/terms-reference**

2.15 The Ministerial Board will receive reports from the Strategy Group which will cover the following matters:

- key issues emerging from Reviews and potential changes Welsh Government may have to make in terms of statutory responsibilities linked to legislation, guidance, policy, or resource allocations as a result of action plans or recommendations;
- Home Office updates;
- emerging good practice and how the learning is being spread across Wales; and
- issues from Regions within Wales that require a pan-Wales/UK response.

SUSR Strategy Group

2.16 The purpose of the Strategy Group is to provide oversight, and direction to the Ministerial Board. Membership of the Strategy Group is formed of key strategic partners within the safeguarding field, to ensure that appropriate knowledge and expertise is available when making key decisions and recommendations. Terms of Reference can be found here: **www.gov.wales/single-unified-safeguarding-review-strategy-group-terms-reference**

2.17 The Strategy Group will:

- advise and inform Welsh Government, UK Government (Home Office and Ministry of Justice), Commissioners and representative bodies in local government, policing, health, criminal justice and the third sector on themes and other information linked to the recommendations arising from SUSRs in Wales;
- identify, celebrate and promote good practice and encourage the adoption, upscaling and mainstreaming of initiatives that are proven to be 'what work'; and
- review strategic issues arising from SUSRs that cannot be resolved at a local or regional level and provide potential solutions or agree to escalate issues to the Ministerial Board.

Victim and Family Reference Group

2.18 The Victim and Family Reference Group provides a forum for the victim and family voice across Wales, to inform the delivery of the SUSR. By working closely with the other groups and boards that form part of the SUSR support network, it will ensure that the victim and family voice remains at the heart of the SUSR. Terms of Reference can be found here: **www.gov.wales/single-unified-safeguarding-review-victim-and-family-reference-group-terms-reference**

2.19 Members of the group will provide representation on behalf of victims and families in Wales in a diverse and inclusive way. They will also support their stakeholders to contribute to specific and relevant work of this group in a timely and meaningful way.

2.20 The Victim and Family Reference Group will work to:

- review thematic reports (produced using the Wales Safeguarding Repository) in relation to victim and family engagement and key emerging issues;
- provide guidance on victim and family issues related to the SUSR review, when escalated;
- work with the Co-ordination Hub, Safeguarding Boards and Community Safety Partnerships to review recommendations and actions relating to victims and families;
- shape production of SUSR products that can be incorporated within the SUSR toolkit;
- develop and inform future good practice guidance on victim and family engagement in the SUSR process;
- consider, and provide guidance on feedback received from SUSR reflections forms in relation to victim and family engagement; and
- respond to relevant SUSR policy, statutory guidance, and legislative developments.

2.21 In addition to this, members from the group will be identified to provide victim and family representation on the wider SUSR governance structure groups including the SUSR Ministerial Board and Strategy Group.

Safeguarding Boards

2.22 Safeguarding Boards have been responsible for undertaking Adult Practice Reviews and Child Practice Reviews. They will now take on extra responsibilities for instigating all SUSRs (which will replace Child and Adult Practice Reviews). They will be at the core of the process with additional responsibilities, including:

- the overall management of the process in their region;
- effective partnership working with the appropriate agencies involved in the Review process, linking with the SUSR Co-ordination Hub, and use of the Wales Safeguarding Repository;
- working with Community Safety Partnerships (in relation to Domestic Homicides) and ensuring key representatives are involved from the Partnership in the SUSR process; and
- working with Public Service Boards and Regional Partnership Boards for the area when a homicide has occurred, for example where the findings from the Review relate to the priorities identified in the Public Services Board's Well-Being Plan.

SUSR Co-ordination Hub

2.23 The role of the Co-ordination Hub is to support the Review process and assist in the identification and dissemination of key messages, themes, and issues, by working collaboratively with Safeguarding Boards, Community Safety Partnerships, National Independent Safeguarding Board and other key partners. The Hub will collate the outcomes of Primary and Mid-Term Learning ensuring that they are disseminated across Wales, and with relevant UK bodies where appropriate.

2.24 The Co-ordination Hub will help to facilitate, with the Safeguarding Boards, bi-annual themed dissemination events to share good practice and lessons learned across Wales. This will ensure learning is achieved and implemented to safeguard individuals and communities across Wales.

2.25 The Co-ordination Hub will:

- ensure that the relevant coroner is informed, if required, when a SUSR is to be undertaken;
- monitor alongside the Safeguarding Boards the implementation of Action Plans and recommendations;
- co-ordinate training requirements linked to the SUSR process; and
- administer access to the Wales Safeguarding Repository.

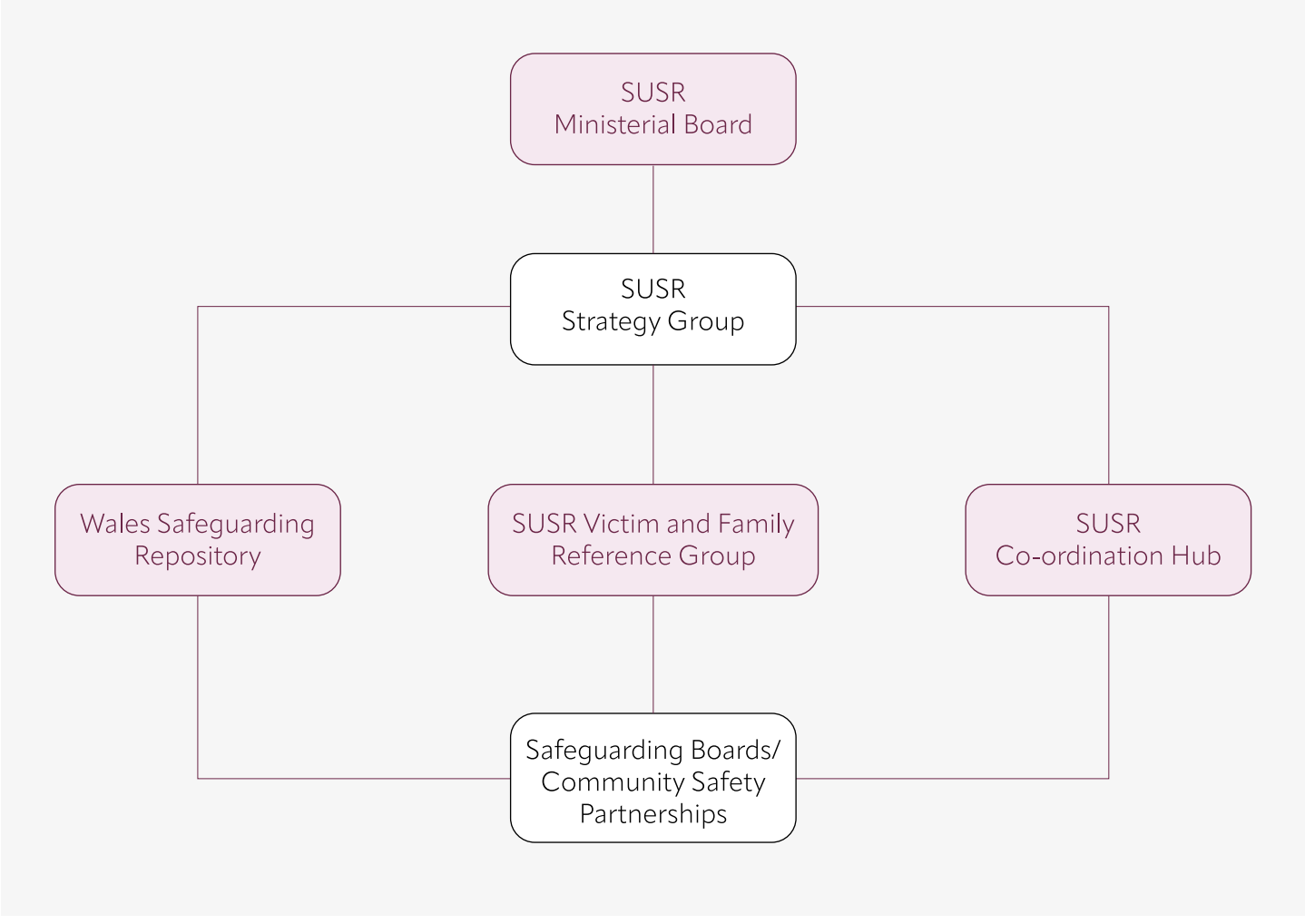
Wales Safeguarding Repository

2.26 All completed SUSRs will be retained in the Wales Safeguarding Repository. Their findings will be used to help inform learning on a pan-Wales basis through the creation of thematic reports and the identification of good practice. It can also be used to help inform other research studies that may be undertaken (please refer to **Section 9**).

Figure 2

Adolygiad Diogelu Unedig Sengl
Single Unified Safeguarding Review

SUSR Support Network



3. Purpose and Principles Underpinning the Single Unified Safeguarding Review

Purpose

3.1 The Single Unified Safeguarding Review (SUSR) seeks to develop a single, proportionate mechanism in which to conduct a review following the most serious of incidents in Wales. Where one or more review criteria are met (please refer to **Section 4**), the SUSR process will avoid the need to undertake a series of multiple reviews (e.g., Domestic Homicide Reviews, Child Practice Reviews, Adult Practice Reviews, Mental Health Homicide Reviews and Offensive Weapons Homicide Reviews) in relation to the same single incident. Multiple reviews have caused significant duplication of effort and resources, whilst also putting the subject and/or their families and Principal Individuals through numerous reviews, causing delays in the identification and implementation of any learning.

3.2 The SUSR involves practitioners, managers, and senior officers exploring the detail and context of agencies' work both individually and collectively, with a child and/or adult at risk (including domestic abuse) or who has been a victim of homicide, and their family, where every effort will be made to ensure that they are at the heart of the Review. The output of a Review is to generate professional and organisational learning and promote improvement in future inter-agency practice to keep people safe. It is not about apportioning blame but ensuring that lessons are identified and implemented through a clear Action Plan (see **Section 8** for more information on Action Plans). This will only be achieved with open and honest discussions. The undertaking of a Review does not necessarily mean that there has been malpractice.

3.3 A SUSR is not an inquiry into how the subject of the Review died or sustained injuries or into who is culpable; that is a matter for the coroner, the Police, Crown Prosecution Service and criminal courts respectively to determine as appropriate. A SUSR is not specifically part of any disciplinary investigation or process. Where information emerging during a Review indicates that disciplinary action should be initiated, the relevant agency's disciplinary procedure should be followed separately from the Review process. Alternatively, some SUSRs may be conducted concurrently with (but separate to) disciplinary action.

Principles

3.4 The SUSR is underpinned by a set of principles to guide Safeguarding Boards, their partner agencies and other community partners in their responsibilities to learn, review and improve safeguarding policy and practice. The principles have shaped the design and development of the SUSR for multi-agency safeguarding reviews. The principles are:

a) professionals in all services working with children and/or adults at risk and their families in the Safeguarding Board area are given the assistance they need, so they can undertake the complex and difficult work of protecting children and adults at risk with confidence and competence;

b) practice is improved and informed on learning to work towards the prevention of harm to a child and/or adult at risk;

c) organisational cultures, and the processes that underpin cultures, are fair and just, and promote supportive management and work environments for professionals; and

d) a culture of transparency is created that:

- provides regular opportunities to address multi-agency collaboration and practice, and multi-agency learning, reflection, and development;
- has processes in place for learning and reviewing, are flexible and proportionate and are open to professional and public challenge;
- engages with children and/or adults at risk and their families in individual cases and takes account of their wishes and views;
- provides accountability and reassurance to children and/or adults at risk, and their families and the wider public;
- identifies promptly the need for systemic or professional changes and ensures timely action is taken;
- shares and disseminates new knowledge or lessons learned on a multi-agency basis locally, regionally, and nationally; and
- the work of learning, reviewing, and improving local multi-agency safeguarding and community safety policy and practice is audited and evaluated for its effectiveness.

Outcomes

3.5 The overarching outcome is the creation of a proactive approach to taking solutions forward and a positive shared learning culture, which is an essential requirement for achieving effective and improved multi-agency service delivery. Therefore, a SUSR which avoids the need for multiple reviews in relation to one incident(s), creates a simplified yet concentrated approach. This will reduce further trauma for the subject of the Review and/or their families and Principal Individuals and practitioners involved in the Review. It will eliminate any potential duplication of effort and will utilise resources and deliver learning in a timely and proportionate manner.

3.6 The outcomes of the SUSR process will have local, regional, and national impact on practice across Wales. This includes:

- providing one process for either a single or multiple review in Wales, providing clarity for all partner agencies involved;
- reducing trauma for the subject of the Review and/or their families, and other Principal Individuals by carrying out a single review rather than multiple reviews;
- continuous monitoring of the Action Plans and the dissemination of learning;

- an improved support network, which will ensure Welsh Government oversight of recommendations for both devolved and non-devolved services in Wales. This will be achieved where escalation of issues to the Ministerial Board is necessary;
- the Wales Safeguarding Repository, which will enable practitioners to draw together learning from SUSRs to produce thematic reports. The learning from the thematic reports will be disseminated nationally by the SUSR Co-ordination Hub along with any recommendations and actions which will need to be implemented as a result;
- previous learning being considered; and
- ensuring engagement and involvement with the Welsh Government, Home Office, relevant Commissioners, Coroner, and Inspectorates as appropriate.

3.7 The evolution of practices in this way will ensure that they remain fit for purpose in an ever-changing society. This will help to prevent similar incidents taking place, and ultimately reduce harm going forward.

4. When to Conduct a Single Unified Safeguarding Review

4.1 The criteria for when a Single Unified Safeguarding Review (SUSR) should be carried out applies where the legal grounds for undertaking **one or more** particular types of review are met. Those various legal grounds are set out in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[29], the *Domestic Violence, Crime and Victims Act 2004*[30], section 24 of the *Police, Crime, Sentencing and Courts Act 2022*, and the Police, Crime, Sentencing and Courts Act 2022 (*Offensive Weapons Homicide Reviews) Regulations 2022*[31].

Criteria for a Single Unified Safeguarding Review

4.2 A key criterion for a SUSR is multi-agency learning, which is proportionate in its approach, and identifies clear recommendations that improve future service delivery and early intervention and prevention by the various partners/agencies involved. This is a key component when determining whether a SUSR is required.

4.3 A Safeguarding Board must undertake a SUSR where the following criteria is met:

4.4 Criteria for a concise review: Abuse or neglect of a child is known or suspected within the area of the Safeguarding Board, and –

(a) the child has:

(i) died; or

(ii) sustained potentially life-threatening injury; or

(iii) sustained serious and permanent impairment of health or development; and

(b) the child was neither on the child protection register nor was a looked after child on any date during the 6 months preceding –

(i) the date of the event referred to in sub-paragraph (a)(i) or (a)(ii) above; or

(ii) where sub-paragraph (a)(iii) applies, the date on which a local authority or relevant partner[32] identifies that a child has sustained serious and permanent impairment of health and development.

29 Regulation 4(3) and 4(4). **Safeguarding Boards Regulations 2015**
30 Section 9(1). **Domestic Violence, Crime and Victims Act 2004**
31 Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 **Police, Crime, Sentencing and Courts Act**
32 Local authority of relevant partner means a person or body referred to in Section 28 **Children Act 2004** or body mentioned in Section 175 **Education Act 2002**

4.5 Criteria for an extended review: abuse or neglect of a child is known or suspected within the area of the Safeguarding Board and –

(a) the child has:

(i) died; or

(ii) sustained potentially life-threatening injury; or

(iii) sustained serious and permanent impairment of health or development; and –

(b) the child was on the child protection register and/or was a looked after child (including a care leaver under the age of 18) on any date during the 6 months preceding –

(i) the date of the event referred to in sub-paragraph (a)(i) or (a)(ii); or

(ii) where sub-paragraph (a)(iii) applies, the date on which a local authority or relevant partner identifies that a child has sustained serious and permanent impairment of health and development.

4.6 Criteria for a concise review: Abuse or neglect of an adult at risk is known or suspected within the area of the Safeguarding Board and that adult has not been, on any date during the 6 months preceding the date of the event, a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority and the adult has:

(i) died; or

(ii) sustained potentially life-threatening injury; or

(iii) sustained serious and permanent impairment of health.

4.7 Criteria for an extended review: Abuse or neglect of an adult at risk is known or suspected within the area of the Safeguarding Board and that adult has been, on any date during the 6 months preceding the date of the event, a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority and the adult has:

(i) died; or

(ii) sustained potentially life-threatening injury; or

(iii) sustained serious and permanent impairment of health.

4.8 Where the SUSR meets the criteria for Adult Practice Reviews or Child Practice Reviews as set out in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[33], Safeguarding Boards must conduct that Review as a SUSR and in accordance with this Guidance and determine whether a concise or extended review is required. Consideration must also be given to the number of Reviewers who are commissioned.

4.9 A Safeguarding Board should undertake a SUSR when the following criteria is met:

4.10 Criteria for a Domestic Homicide: a death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by:

(a) a person to whom they are related or who they were or had been in an intimate personal relationship, or

(b) a member of the same household.
This includes where a victim took their own life (suicide) and the circumstances give rise to concern, for example they were suffering from domestic abuse.

33 The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015

(Please refer to section 9(1) of the Domestic Violence, Crime and Victims Act 2004 to view this criterion.)

4.11 The Domestic Homicide Review Statutory Guidance issued by the Home Office under section 9(3) of the *Domestic Violence, Crime and Victims Act 2004* (*"the 2004 Act"*)[34], states that a person establishing or participating in a Domestic Homicide review (whether or not held pursuant to a direction under section 9(2) of the 2004 Act) must have regard to the Home Office guidance. This means that persons involved in a Domestic Homicide Review must take the Home Office guidance into account and, if they decide to depart from it, have clear reasons for doing so. Certain stages of the SUSR process necessarily require departure from the Home Office guidance, to enhance the Review process (for example Safeguarding Boards should be responsible for undertaking the Review rather than Community Safety Partnerships). Within this statutory guidance, where these departures are made, clear reasons are provided. All departures from the Home Office guidance have been co-ordinated and agreed with the Home Office Domestic Homicide Review team, please refer to **Appendix Two** which highlights the departures and the reasons why. The SUSR process should be followed in Wales where a domestic homicide that meets the criteria for a Review has occurred.

4.12 Criteria for a Mental Health Homicide: a homicide is committed, and the alleged perpetrator has been in contact with primary, secondary, or tertiary Mental Health services within the last year.

4.13 In this criteria 'contact' may include an assessment or intervention. Specific consideration must also be given to the Mental Health (Wales) Measure 2010[35] which defines the provision of mental health services to patients in specific situations.

4.14 NHS Wales responsible bodies are required to report certain incidents to Welsh Government through the NHS Wales National Reportable Incidents Framework. It should be noted that a Mental Health Homicide would require such a referral.

4.15 Further information regarding the Mental Health (Wales) Measure 2010 and Nationally Reportable Incidents are included within **Appendix Three: Mental Health Homicide Referral routes and supporting information**.

4.16 If it is determined that a Mental Health Homicide will be subject to a Review, the SUSR will be considered as an appropriate process for the purposes of the National Patient Safety Incident Policy[36]. The findings from the SUSR should be reported back to the NHS Wales Delivery Unit via a "Learning from Events" form available on the Delivery Unit's website[37]. The Co-ordination Hub should inform Healthcare Inspectorate Wales (HIW) when a Review has commenced and when it has been completed and placed within the Wales Safeguarding Repository.

4.17 If the above criteria are not met for a SUSR, the relevant Health Board or Trust may consider carrying out an appropriate review in line with their internal processes.

34 Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. **Domestic Violence, Crime and Victims Act**
35 **Mental Health (Wales) Measure 2010**
36 Patient Safety Incidents **NHS Wales Patient Safety**
37 NHS Wales Delivery Unit **Delivery Unit**

4.18 Criteria for an Offensive Weapon Homicide:

- a death occurred or is likely to have occurred in the South Wales Police area which is one of the three pilot areas for an Offensive Weapons Homicide Review (on completion of the pilot this may be extended to the whole of Wales);
- the person was aged 18 or over; and
- the death, or the events surrounding it, involved the use of an Offensive Weapon;
- review partners are the Relevant Partners for that person's death, in the South Wales Police Force area (Please refer to **Section 6** paragraph 6.4 for Relevant Partners).

4.19 The following additional conditions for the carrying out of an offensive weapon homicide review are specified in regulation 4(2) of the *Police, Crime, Sentencing and Courts Act 2022*[38] (Offensive Weapons Homicide Reviews) Regulations 2022. The additional conditions to be met are:

(a) one of the following has been located –

- the body of the person who has died; or
- part of the body of the person who died.

(b) the identity of one of the following has been recorded –

- the person who died; or
- at least one person who caused, or is likely to have caused, that person's death.

(c) one or more review partners has information about, or would reasonably be expected to have information about –

- the person who died or
- at least one person who caused, or is likely to have caused, that person's death.

("information" means information that there is a risk a person may commit, or be a victim of, antisocial or criminal behaviour. This:

- includes information relating to the person's education, antisocial or criminal behaviour, housing, medical history and mental health;
- includes safeguarding information about the person;
- does not include information that only became known to a review partner after the earlier of either:
  1. the recorded time of death of the person who died, or
  2. the recorded death of the person who died.)

(d) the death is not a "death or serious injury matter" within the meaning of section 12(2A) of the Police Reform Act 2002 (i.e. caused by a police officer in the course of their official duties).

4.20 In accordance with section 26(1)-(4) of the *Police, Crime, Sentencing and Courts Act 2022*, an Offensive Weapons Homicide Review is not required to be carried out if a SUSR (which meets the conditions to undertake a review from any of the criteria in 3.4 – 3.16 above) is to undertaken by a Safeguarding Board.

38 Police, Crime, Sentencing and Courts Act 2022 (**Offensive Weapons Homicide Reviews) Regulations 2022**

4.21 An Offensive Weapon is defined, for the purposes of an Offensive Weapons Homicide Review, in section 1(4) of the *Prevention of Crime Act 1953*[39] as:

> "any article made or adapted for use for causing injury to the person or intended by the person having it with him for such use by him or by some other person."

Other Potential Review Criteria

4.22 As the SUSR is the main Review process in Wales, new review types that emerge may be incorporated within the SUSR process where deemed appropriate. It is anticipated that such reviews would be discussed with the relevant agencies/governing bodies, considered by the Strategy Group and ratified by the Ministerial Board.

4.23 Multi-Agency Professional Forums (MAPFs) can be used if the criteria for a SUSR is not met. The Safeguarding Board can refer the case to the MAPF, to enable them to undertake a more proportionate approach than that required by a SUSR. MAPFs are a mechanism for producing organisational learning, improving the quality of work with families, and strengthening the ability of services to keep people safe. They utilise case information, findings from protection audits, inspections and reviews to develop and disseminate learning to improve local knowledge and practice, and to inform the Board's future audit and training plans (refer to **Section 9** for more detail on MAPFs).

39 Section 1. **Prevention of Crime Act 1953**

5. The Single Unified Safeguarding Review Process

5.1 A Single Unified Safeguarding Review (SUSR) is made up of several interconnected activities which are summarised below. Each activity contributes to the rigour of the process and maximises the learning drawn from the case being reviewed. The overall process is shown in the flowcharts below (**Figure 3, 4 and 5**).

5.2 The following provides a summary of the process. The flowcharts can be used alongside the text in this section, as a visual aid, in relation to the steps required when undertaking a SUSR. Greater detail in relation to the process is provided in **Section 6**.

Figure 3

Adolygiad Diogelu Unedig Sengl
Single Unified Safeguarding Review

SUSR Process Overview

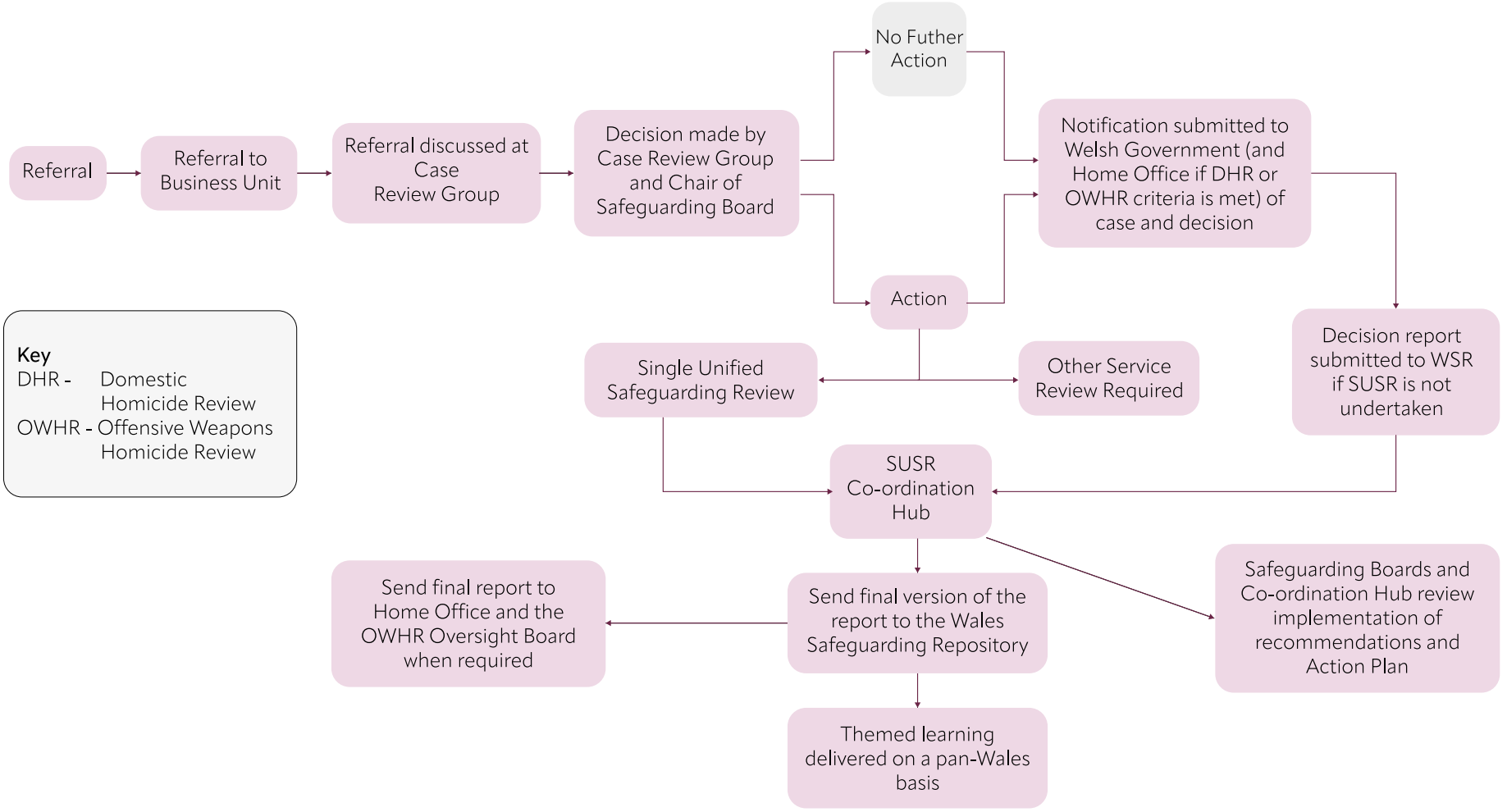


Figure 4

Adolygiad Diogelu Unedig Sengl
Single Unified Safeguarding Review

SUSR Process

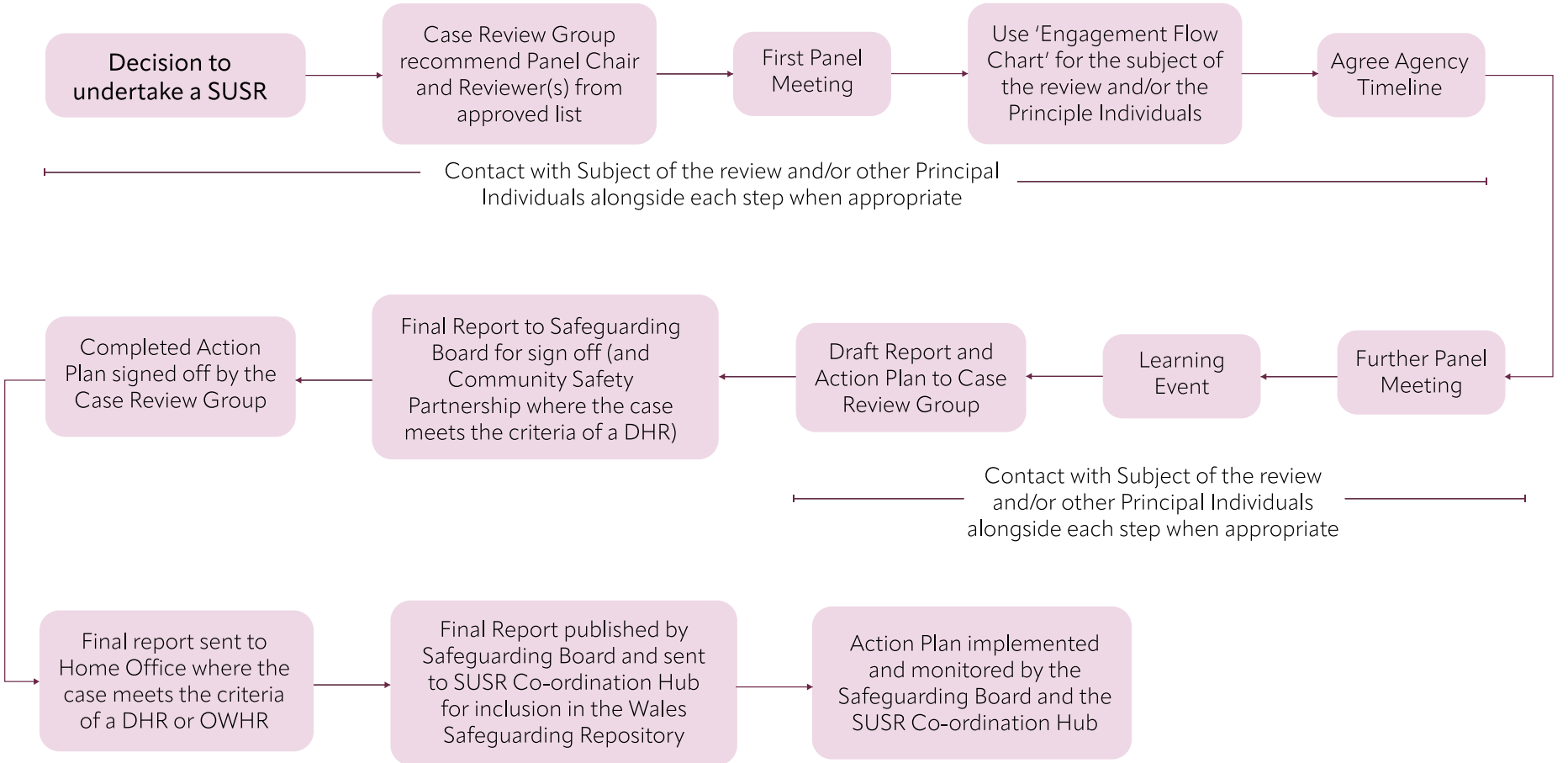
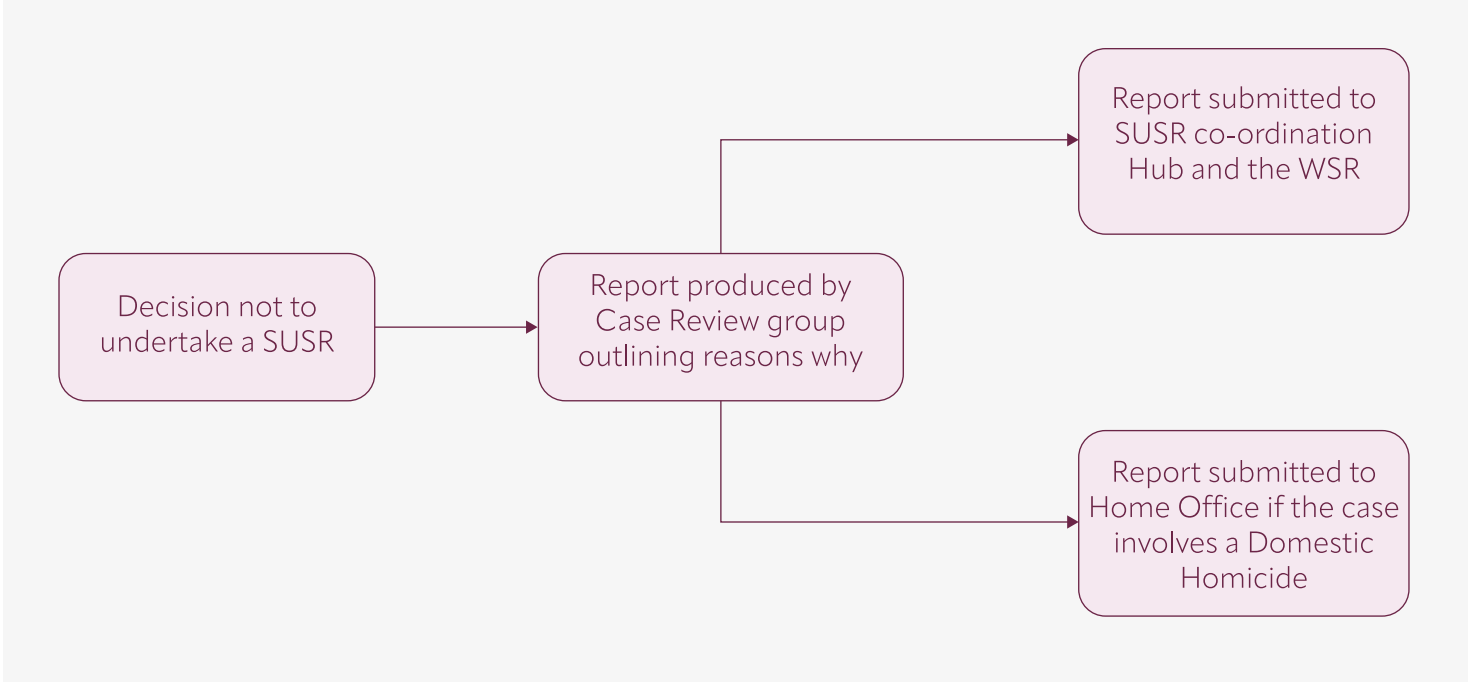


Figure 5

Adolygiad Diogelu Unedig Sengl
Single Unified Safeguarding Review

Decision not to undertake a SUSR



5.3 An initial referral is made to the relevant Safeguarding Board (and Community Safety Partnership if it involves a Domestic or Offensive Weapon Homicide). The referral should be managed by the Safeguarding Board. The Safeguarding Board Case Review Group should have individuals with the appropriate expertise who can effectively contribute to the Review.

5.4 The Case Review Group should determine whether the case meets the criteria for a SUSR. This decision should be ratified by the Safeguarding Board Chair (and the Chair of the Community Safety Partnership if it involves a Domestic or Offensive Weapon Homicide). The Chair of the Safeguarding Board should notify Welsh Government and the Home Office if required, of the decision (see **Section 6** for more detail).

5.5 If a SUSR is to be undertaken, it should be managed by the Case Review Group and a Reviewer(s) appointed to work with the Review Panel (see **Section 6** for role descriptions), which is composed of relevant agencies and partners that have been involved in the case. The Review facilitates:

- direct engagement with the subject of the Review and/or their families and Principal Individuals as they wish and is appropriate, enabling their perspectives to be included in the Review process;
- (where deemed appropriate) direct engagement with perpetrators/alleged perpetrators enabling their perspectives to be included in the Review process;
- involvement of practitioners who have been working with the child and/or adult at risk and their family;
- an opportunity for the Reviewer(s) to utilise the Wales Safeguarding Repository to undertake primary and mid-term learning associated with historical reviews; and
- a planned and facilitated practitioner-focused Learning Event (see **Section 8** for more information) conducted by the Reviewer(s), to examine practice within a limited timeline, using a systems approach.

5.6 The Review Panel should appoint a Chair and hold meetings to agree the Agency Timeline (refer to **Section 8**). The Reviewer(s) and potentially the Chair of the Review Panel should meet the subject of the Review and/or their families and Principal Individuals. Contact should be made with them at the beginning of the Review process to ascertain their desired level of involvement and to determine how they can be effectively engaged in the process (refer to **Section 7** for more information on engaging with the subject of the Review and/or their families and other Principal Individuals).

5.7 The Review Panel and Reviewer(s) should facilitate the Learning Event, which will be an opportunity for services and agencies who had contact with the subject(s) of the Review to come together and learn from one another.

5.8 A draft SUSR Report and an outline Action Plan should then be produced by the Reviewer(s). The outline Action Plan will be prepared using recommendations from the draft Report. This should be presented in a timely manner (within 12 months of the commencement of the Review[40]) to the Safeguarding Board. The draft Report and outline Action Plan will be prepared in a way which removes any personal identifiers [or uses pseudonyms] to reduce the potential of individuals being identified. The draft Report should be presented to the subject of the Review and/or their families and Principal

40 The Review commences when the Chair of the Safeguarding Board confirms that a review should be undertaken

Individuals enabling them to choose, if they wish, a suitable pseudonym to be used in the Report. Gender anonymisation should be discussed as part of this conversation and any concerns that they have in relation to the report.

5.9 The Safeguarding Board members should consider, challenge, and contribute to the conclusions of the Review, and identify the strategic implications for improving practice and systems to be included in the Action Plan.

5.10 Within 12 months of the Review commencing the final Report should be:

- approved by the Safeguarding Board Chair;
- forwarded to the Co-ordination Hub (to be placed in the Wales Safeguarding Repository); and
- published by the Safeguarding Board.

However, in the following circumstances, the publishing process set out in this paragraph will not take place until the following is undertaken:

- A SUSR involving a Domestic Homicide is sent by the Safeguarding Board to the Home Office Quality Assurance Panel prior to being finalised and placed in the Wales Safeguarding Repository and shared with the Community Safety Partnership. Once approved by the Quality Assurance Panel it should be published by the relevant Community Safety Partnership and Safeguarding Board.
- A SUSR involving an Offensive Weapons Homicide is sent by the Safeguarding Board to the Secretary of State for the Home Office. It should be placed in the Wales Safeguarding Repository and published by Safeguarding Boards within one calendar month of the date of it being sent to the Secretary of State, unless notification is received from the Secretary of State that amendments are needed in advance of that date. The amendments should be considered by the Chair of the Safeguarding Board prior to publication.

5.11 The Action Plan should be finalised by the Case Review Group within four weeks of the final Report being approved by the Chair of the Safeguarding Board. The Chair should forward the report and Action Plan to the Co-ordination Hub. It will then be retained in the Wales Safeguarding Repository, to ensure learning is disseminated and acted upon (for more information on Action Plans please refer to **Section 8**). The Co-ordination Hub will provide update reports to the Strategy Group and issues will be escalated to the Ministerial Board where barriers are identified. Please refer to the Support Network flowchart (**Figure 2**).

5.12 All standardised SUSR templates can be found in the **SUSR Toolkit**.

5.13 When conducting SUSRs, those agencies involved in delivering the Review must adhere to the Welsh Language Standards where applicable. Those participating in a SUSR must be given the opportunity to contribute to the Review in their preferred language. When SUSR Reports are published, they must be published in both Welsh and English.

6. Implementing a Single Unified Safeguarding Review

Roles and Responsibilities

6.1 This section sets out the roles and responsibilities of those involved in a Single Unified Safeguarding Review (SUSR).

6.2 Within the SUSR, there will always be both a Chair of the Review Panel and a Reviewer(s)[41]. The Chair of the Review Panel is appointed by the Review Panel to ensure the momentum of the Review is maintained. The Reviewer is the author of the SUSR Report and their responsibilities include meeting with the subject of the Review where appropriate, their family and Principal Individuals, and representatives of involved agencies.

Role of Safeguarding Boards

6.3 Achieving improvement in safeguarding policy, systems and practice is a core business of Safeguarding Boards. To meet the requirements set out in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[42] and this statutory guidance, Safeguarding Boards have responsibility for:

- establishing SUSRs and ensuring they are effectively managed within a timely manner (within 12 months);
- informing Welsh Government (the SUSR Co-ordination Hub) through the completion of the notification form that a SUSR is to be undertaken;
- contributing to the Reviews and providing professional challenge;
- identifying strategic implications for improving systems and practice in individual agencies or on an interagency basis;
- signing off the final Report and Action Plan when a Review has been completed;
- publishing the SUSR Report and submitting it to the SUSR Co-ordination Hub to place within the Wales Safeguarding Repository;
- providing the Coroner with a copy of the SUSR Report if required;
- implementing and auditing changes in local policy, systems, and practice to identify what difference(s) they have made in partnership with the SUSR Co-ordination Hub;

41 The Reviewer is known as the Independent Chair within the Domestic Homicide Review and the Offensive Weapons Homicide Review processes, but will be referred to as the Reviewer throughout the SUSR process to avoid confusion

42 **The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015**

- working with the appropriate Community Safety Partnership especially when the SUSR involves a Domestic Homicide or where otherwise deemed relevant; and
- involving the Regional Partnership Board and Public Services Board for the area where there are wider implications that need to be considered. For example, where the findings from the Review relate to the priorities identified in the Public Services Board's Well-being Plan.

6.4 The Safeguarding Board is responsible for delivering a SUSR linked to an Offensive Weapon homicide (see *Delivering Offensive Weapons Homicide Reviews in Wales section 5 of the Offensive Weapons Homicide Review Statutory Guidance*[43]). The Safeguarding Board will:

- receive the referral when a homicide occurs which is likely to qualify for an Offensive Weapons Homicide SUSR;
- liaise, through the Chair of the Safeguarding Board, with the Chair of the Community Safety Partnership to inform them that a referral has been made;
- aid the Relevant Review Partners[44]: police, local authority, and local health board in ensuring the legislative requirements placed on them in conducting Offensive Weapons Homicide Reviews are satisfied through the SUSR process, with those authorities' agreement and engagement as part of the Case Review Group and Review Panel (it is the Case Review Group, incorporating the Relevant Review Partners, that will determine whether or not a SUSR is to be conducted);
- carry out the recommendation of the Case Review Group and subsequent decision of the Safeguarding Board Chair as to whether an Offensive Weapons Homicide SUSR is to be delivered. Then notify the SUSR Co-ordination Hub and Secretary of State for the Home Office (so that they meet the statutory requirement on behalf of the police, local authority, and health board) within one month of the incident occurring; and
- ensure that information is shared by partners. These responsibilities can be delegated to a Reviewer. Information in relation to data protection considerations and sharing in that context are set out in section 10.

6.5 The skill set, knowledge and experience of Review Panels and Review Panel Chairs will change depending upon the type of incident. For example, where an offensive weapon related homicide has been committed, crime and justice representatives may well be more prevalent on the panels. To aid the selection of appropriately skilled individuals, the SUSR Co-ordination Hub will hold a list of Approved Chairs and Reviewers, which can be utilised by Chairs of Safeguarding Boards to ensure that they have selected people with the requisite skills and knowledge pertinent to the case.

6.6 These responsibilities require committed, well-functioning, challenging, and strongly led Safeguarding Boards, with the full and consistent support of their membership. They may also require active partnership with other organisations and partners within the community that are not Safeguarding Board members but work locally with children and/or adults at risk, and their families.

43 **Offensive Weapons Homicide Reviews Statutory Guidance 2023**
44 Section 9 **Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022**

6.7 Such engagement may take place with relevant organisations and individuals including those from the statutory, independent and third sectors. Independent and third sector representatives have a significant contribution to make alongside Safeguarding Board partners and statutory agencies. Safeguarding Boards should discuss how best to secure the participation of such representatives at Board, subgroup or task and finish group level (see paragraphs 174-181 of *Working Together to Safeguard People Volume 1*). A **non-exhaustive** list of local partners that should be considered for membership or participation is attached in **Appendix Four**. Where it is deemed useful for these community partners to be involved in the Review process, then the Reviewer(s) should ensure that engagement is invited.

6.8 Furthermore, Safeguarding Boards have the power to request specified information from a 'qualifying person or body' (see paragraphs 218-226 of Working Together to Safeguard People Vol 1), where the purpose of the request is to enable or assist the Board to perform its functions under the *Social Services and Wellbeing (Wales) Act 2014*[45]. A 'qualifying person or body' means a person or body whose functions or activities are considered by the Board to be such that they are likely to have information relevant to the exercise of a function of the Board. This enables those persons or bodies to lawfully provide information to Safeguarding Boards when requested. Where it is considered that engagement with relevant community partners or specified information from a 'qualifying person or body' would assist the Review process, then the Reviewer(s) should ensure that such engagement or information is requested. See **Section 10** on data sharing.

6.9 The Safeguarding Board role is to focus on learning and outcomes, whilst also encouraging a supportive environment. To remain in touch with the challenging and complex nature of safeguarding work undertaken by professionals in the various local agencies, Safeguarding Board's will maintain a close oversight and understanding of practice.

Role of Case Review Group

6.10 The Case Review Group will make the initial recommendation as to whether to undertake a SUSR. The Case Review Group should include personnel with the appropriate level of expertise and seniority to ensure that the right decisions are made in relation to the application of the SUSR criteria. This group will determine membership of the Review Panel (both statutory and invited) dependent upon the criteria of the Review and inform them of their duty to be fully engaged in discussions and decisions.

6.11 Any member of the Safeguarding Board, Community Safety Partnership (where a Domestic Homicide has occurred or otherwise relevant), agency or practitioner can refer a case to the Safeguarding Board which is thought to meet any of the criteria outlined in **Section 4** of this guidance. Advice may be sought from the relevant agency from a Safeguarding Board member prior to making a referral. However, a referral should be directed to the Safeguarding Board Business Unit Manager (or equivalent) who will ensure the Chair of the Safeguarding Board is informed. The referral should then be forwarded to the Chair of the Case Review Group for its consideration as soon as possible. The SUSR Referral Form can be found in the **SUSR Toolkit** and should be used to complete this stage of the process.

45 Section 137 – Social Services and Well-being (Wales) Act 2014

6.12 There are matters which may require negotiation and resolution by the Case Review Group including:

More than one Safeguarding Board is involved:

- Where a referral received by the Case Review Group involves more than one Safeguarding Board, co-operation and careful planning between the respective Case Review Groups of those Safeguarding Boards will be required to agree the way forward. The guiding principle should normally be that the Safeguarding Board in which the child or adult at risk is or was normally resident should take lead responsibility for conducting the Review. Decisions reached about how the Review will be handled should be reported to the respective Safeguarding Boards and shared, where relevant, with Community Safety Partnerships and other relevant Boards/Partnerships.
- In the case of a SUSR that involves an Offensive Weapons Homicide, the Safeguarding Board, in which the incident happened, should take lead responsibility for conducting the Review, to ensure compliance with existing regulatory requirements[46].

More than one Safeguarding Board in different countries is involved:

- Where a referral received by the Case Review Group involves more than one authority in different countries within the United Kingdom, the principle of ordinary residence will determine which Safeguarding Board should take lead responsibility for undertaking a Review. However, co-operation and careful planning may be required between Safeguarding Boards to agree how the respective review procedures will be followed and how any additional matters will be addressed by the Review. These decisions may also need to involve the respective governments to ensure agreement where there are cross-border differences in arrangements for reporting and publication.
- In the case of a SUSR that involves an Offensive Weapons Homicide, the Safeguarding Board, in which the incident happened, should take lead responsibility for conducting the Review, to ensure compliance with existing regulatory requirements.

More than one index child or adult at risk subject to Review[47]:

- There may be cases where more than one child or adult at risk has died or has suffered serious harm as a result of abuse or neglect and each child or adult at risk is the subject of the same Review (i.e., there are several index individuals subject of that review). The Review must consider each child's or adult's perspective and experience individually but ensure that the learning arising from the children's or adult's circumstances is brought together in one comprehensive SUSR report at the conclusion of the Review. It is important that the Chair of the Safeguarding Board is informed by the Case Review Group of each child or adult to be included in the Review in its recommendation for the way forward.

6.13 The Case Review Group's decision about how to proceed on receipt of a referral will be forwarded as a recommendation to the Chair of the Safeguarding Board (copied for information to the Community Safety Partnership Chair where there is a domestic homicide element), with the following information:

46 Part 3 Relevant Review Partners **Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022**

47 Index child is a term used to indicate the child who is the subject and focus of a review, to distinguish that child from other children who may also be involved

- a brief outline of the circumstances of the case;
- the reasons for holding a Review;
- the proposed Terms of Reference;
- a timetable for the Review; and
- an assessment of the likely communication and media issues, as known at the time.

6.14 A SUSR Report template has been provided (see **SUSR Toolkit**) to:

- simplify the process;
- ensure consistency; and
- provide a Report for submission to the SUSR Co-ordination Hub and the Wales Safeguarding Repository.

6.15 The Chair of the Safeguarding Board will inform the Case Review Group of their decision as to whether the recommendation to hold a SUSR is approved and inform the Safeguarding Board. If the decision is yes, the Case Review Group will establish a multi-agency Review Panel and appoint a Reviewer(s) whose appointment should be ratified by the Chair of the Safeguarding Board.

Role of the Safeguarding Board Chair

6.16 Each Safeguarding Board has a Chair and this role is fundamental to the decision making and communication within the SUSR process. The Chair should effectively communicate key decisions to the Safeguarding Board, Reviewer, Review Panel and the Chair of the Community Safety Partnership in the case of a Domestic or Offensive Weapon Homicide; the Home Office and Ministers.

6.17 The key steps to be undertaken by the Safeguarding Board Chair are outlined below.

Step One: The Case Review Group's decision about how to proceed on receipt of a referral should be forwarded in writing as a recommendation to the Chair of the Safeguarding Board, with the information outlined in paragraph 6.13.

Step Two: The Chair of the Safeguarding Board should inform the Case Review Group of their decision on whether to approve the recommendation. If the recommendation to undertake a SUSR has been approved, the process will commence.

Step Three: If the Chair declines the recommendation to undertake a SUSR or agrees with the recommendation not to undertake a SUSR, the Safeguarding Board should be informed by the Chair and further discussions held. If the final decision by the Chair of the Safeguarding Board is not to undertake a SUSR, the Chair of the Safeguarding Board should inform the SUSR Co-ordination Hub in writing, with the reasons given, noting any conflicting views. However, the following steps should also be taken when a Domestic Homicide is involved – the Chair of the Safeguarding Board should liaise with the Chair of the appropriate Community Safety Partnership and inform the Home Office. If the Home Office state that a review should be undertaken a SUSR will be instigated by the Safeguarding Board.

Step Four: As local circumstances determine, the Chair of the Safeguarding Board must ensure that the Case Review Group appoint an independent Reviewer(s). The Reviewer(s) is responsible for managing and co-ordinating the Review, and for producing the final Report based on evidence the Review Panel decides is relevant. As part of this process, reference should be had to the Approved Chairs and Reviewers List which can be obtained from the Co-ordination Hub.

Step Five: The Chair of the Safeguarding Board approves the final Report produced by the Review Panel (and will liaise with the Chair of the Community Safety Partnership if a Domestic or Offensive Weapon Homicide is involved and submit the Report to the Home Office for sign off in the case of a Domestic Homicide by the Quality Assurance Panel). The Chair should also ensure that the final Report:

- is presented to the subject of the Review and/or their families;
- is submitted to the SUSR Co-ordination Hub;
- a copy is retained in the Wales Safeguarding Repository;
- is published by the Safeguarding Board (and the Community Safety Partnership if it involves a Domestic or Offensive Weapon Homicide) for a minimum of 12 weeks; and
- learning is shared.

Step Six: The Chair of the Safeguarding Board should ensure that the recommendations are implemented. Where issues arise regarding their implementation the Chair should progress these through the appropriate support structure within the SUSR, and with other relevant partnerships including the Community Safety Partnership, Regional Partnership Boards and Public Service Boards.

Paragraphs 6.39 to 6.44 outline in more detail the role of the Chair of the Safeguarding Board with the Community Safety Partnership when the Review involves a Domestic Homicide.

Role of the Chair of the Review Panel

6.18 The Review Panel members should agree on the appointment of the Chair of the Review Panel. The Review Panel Chair should have a working knowledge of the services they are affiliated to, but not have had direct involvement in the case subject to Review.

6.19 The Chair of the Review Panel should conduct each meeting in accordance with the Terms of Reference and this statutory guidance, allowing each agency to participate fully in discussions. They should also provide professional, constructive challenge to Panel Members and Reviewer(s) as appropriate.

6.20 The Chair should ensure that the engagement needs of the victim and/or family are taken into consideration throughout the SUSR and offer advocacy arrangements to the adults, children and family members involved, to ensure that they are fully supported to share information and to make their views known.

6.21 The Chair should work with the Reviewer(s) to support the learning event(s). The Chair will attend the learning event(s) on behalf of the Review Panel to ensure that the questions and issues identified by the Panel are fully addressed.

Role of the Review Panel

6.22 The Review Panel contributes to the Review and plays a key role in ensuring that learning is drawn from the case. Representatives should be appointed to the Review Panel from those agencies involved in the case, including child or adult services. When the case includes a Domestic Homicide, a manager/lead from the relevant Community Safety Partnership

is expected to join the Review Panel. If the Review involves a Domestic Homicide, the selection of the Panel must reflect Home Office Guidance on independence and membership.

6.23 For an Offensive Weapons Homicide the Relevant Review Partners will be invited to form part of this panel.

6.24 The Review Panel members will agree on the appointment of the Chair of the Review Panel.

6.25 The Review Panel Members should have a working knowledge of the services they are affiliated to, but not have had direct involvement in the case subject to Review. A multi-agency Review Panel should always be convened, even where the case may involve only a single agency or a small number of agencies. As the Review Panel is an integral part of the Review process, it is essential that, once appointed, there should be consistency in Review Panel Membership and in attendance at Review Panel meetings. Deputies should only be permitted in exceptional circumstances.

6.26 An initial Terms of Reference will be developed by the Chair of the Review Panel in partnership with the Review Panel members. This initial Terms of Reference will be submitted to the Chair of the Safeguarding Board (and copied to the Community Safety Partnership Chair where relevant) based on information known at the time. It should be noted that the Terms of Reference is a living document and not set in stone. It may need to be amended, in light of any new information emerging at any point during a SUSR. The Review Panel will have responsibility for agreeing any variation to the Terms of Reference.

6.27 The final Terms of Reference (with personal identifiers removed) will be included in the SUSR Report. An example of a SUSR Terms of Reference is included in the SUSR Report Template which can be found in the **Toolkit**.

6.28 The Review Panel will produce an Agency Timeline (see **Section 8**) using information provided from the services involved in the case being reviewed. The Agency Timeline will provide information relating to significant events together with a brief analysis of relevant context, issues, or events. Information about action already taken or recommendations by staff for future improvements in systems or practice may be included, if appropriate. The preparation of Agency Timelines and analyses should be undertaken by managers who have not had operational responsibility for the case, but understand the service, thus ensuring that they are independent and objective.

6.29 If panel members have little or no experience of applying understandings of diversity and intersectionality to the Review process, the SUSR Panel members and Chair should seek expertise from independent lead professionals and/or specialist support agencies.

Role of the Reviewer(s)

6.30 The Reviewer is the author of the SUSR Report. When appointing the Reviewer, and if:

- a Domestic Homicide forms part of the SUSR process, the Reviewer should be made aware of the requirement for the final Report to be submitted to the Home Office Quality Assurance Panel. This may potentially require further changes to be made to the Report before it is finalised, published by the

relevant Safeguarding Board and Community Safety Partnership, placed within the Wales Safeguarding Repository and submitted to the Home Office and shared with the Domestic Abuse Commissioner; or

- an Offensive Weapons Homicide has triggered a SUSR, the relevant review partners for the death will need to agree to delegate their responsibilities under the Offensive Weapons Homicide Review legislation to a Reviewer (Independent Chair), see paragraph 3.14 'Delegating functions' of the Offensive Weapons Homicide Review statutory guidance[48]. The Reviewer should be an experienced individual who is not 'directly associated' with any of the agencies involved in the Review. Relevant experience may be determined by issues of language, ethnicity, religion, or health, such as disability, or other factors instrumental to the circumstances of the case.

6.31 If they have not previously undertaken the role of Reviewer the individual will have the opportunity to 'shadow' an experienced Reviewer. This will act as a mentoring opportunity to ensure that new Reviewers properly understand their role in practice.

6.32 The Report should clearly demonstrate the Reviewer's independence from the Safeguarding Board that commissioned the Review and the agencies involved in the Review. To assure readers that the Reviewer has no conflict of interest, an 'independence statement' should be included as an appendix to the Report, which sets out the Reviewer's career history, relevant experience, and independence.

6.33 In the case of a Domestic Homicide, the Reviewer should not be a member of the relevant Community Safety Partnership. If a Reviewer was previously a member/employee of one of the agencies associated with the Review or on one of the agencies on the relevant Community Safety Partnership, the independence statement should make it clear how much time has elapsed since the person left that agency. If the SUSR involves a Domestic Homicide, please refer to paragraphs 36 to 39 within the *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*[49].

6.34 Safeguarding Boards may wish to consider the development of a regional agreement, where experienced individuals from neighbouring areas are exchanged or loaned to the Review Panel, to help share good practice and promote dissemination of new information and learning.

6.35 The Approved Chairs and Reviewer(s) List is produced and facilitated by the SUSR Co-ordination Hub and will be constantly reviewed and updated. This list should be referred to when commissioning a Reviewer(s).

6.36 The skills and expertise required by a Reviewer(s) to be included on this list are, for example:

a) enhanced knowledge of the subject area of the Review in question, for example, domestic violence/abuse, 'honour'-based violence, mental health, child abuse;

b) an understanding of the role and context of the main agencies to be involved in the SUSR;

c) senior managerial and leadership experience, thus providing the appropriate strategic vision required;

d) good analytical, interviewing and communication skills;

e) an ability to effectively engage with the subject of the Review and/or their families and Principal Individuals, and if appropriate, with the perpetrator(s)/alleged perpetrator(s);

48 **Offensive Weapons Homicide Reviews Statutory Guidance 2023**
49 Section 4.**Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016)**

f) an understanding of the importance of providing services and support in Welsh as well as English without individuals having to ask; and

g) completion of the appropriate training and/or relative experience relating to the specialist areas being addressed by the Review.

6.37 When choosing a Reviewer(s), it is important to remember that the quality and experience of the Reviewer(s) is crucial to the quality of the outcome. The role requires a wide range of knowledge, skills and abilities which include:

a) the ability to approach the Review in a trauma informed way;

b) a thorough knowledge of safeguarding systems, issues, responsibilities, and practice;

c) an understanding of multi-disciplinary working;

d) an ability to enquire and communicate about practice with professionals and with children and family members;

e) an understanding of the importance of providing services and support in Welsh to all participants; and

f) skills in facilitating and managing group processes effectively.

6.38 Please refer to the SUSR Key Competency Framework for further information about the requirements of the roles within the SUSR process. This is available via the SUSR Co-ordination Hub. In appointing a Reviewer(s), the Safeguarding Board will need to be satisfied that safe recruitment practices have been observed.

Role of Community Safety Partnerships

6.39 The role of the Community Safety Partnership applies to a SUSR which meets the criteria for a Domestic Homicide as set out in **Section 4(d)**.

6.40 Where a Domestic Homicide has occurred, the police (or other agency) will inform both the Chair of the Safeguarding Board and the Chair of the local Community Safety Partnership for the area in which the subject of the Review resided. Once the referral has been received, the Case Review Group (to include Community Safety Partnership representation) will recommend whether the homicide is to be subject of a SUSR to the Chair of the Safeguarding Board. The Chair of the Safeguarding Board will then communicate the decision to the Chair of the Community Safety Partnership. The following steps will then be taken:

- if both Chairs agree that a SUSR should be undertaken, the SUSR process will commence;
- if both Chairs agree that a SUSR should not be undertaken a report stating the reasons why this decision has been reached will be submitted to the relevant Home Office officials and to the Co-ordination Hub. If the Home Office overturns the decision, the SUSR process will commence; and
- if there is no consensus between the Chairs on whether a SUSR should be convened the decision will be discussed with the relevant officials within the Home Office. If the Home Office state that a Review:

- should be undertaken, a SUSR will be initiated; or
- should not be undertaken then a report will be produced on the reasons why a SUSR is not being undertaken and submitted to the Co-ordination Hub for inclusion in the Wales Safeguarding Repository, to ensure that the information is captured and recorded.

6.41 If it is decided that a SUSR will be undertaken, then a manager/lead from the relevant Community Safety Partnership will join the Review Panel.

6.42 The Chair of the Safeguarding Board, following discussion with the Chair of the Community Safety Partnership, will:

- inform the Home Office of the decision on whether to undertake a SUSR (a decision not to undertake a Review will be considered by the Home Office Quality Assurance Panel and ultimately the Secretary of State for the Home Office, may choose to direct that a SUSR is initiated). This should be sent in writing to the Home Office Domestic Homicide Review enquiries inbox: **DHRENQUIRIES@homeoffice.gsi.gov.uk**;
- inform the family or others linked to the subject of the Review, in writing, of its decision as well as send the family relevant correspondence from the Quality Assurance Panel regarding its position. If the proposal is that the family are not informed, the Home Office needs to be advised of the Chair's rationale for not doing so;
- complete the final sign off of the SUSR Report; and
- submit the final Report to the Home Office and await any further comments, prior to its publication. It should also be shared with the Domestic Abuse Commissioner.

6.43 Once the Report and Action Plan have been approved by the Home Office Quality Assurance Panel, the Report will be provided to the SUSR Co-ordination Hub to be processed and retained in the Wales Safeguarding Repository. The Report will be published by the appropriate Community Safety Partnership and Safeguarding Board on their websites for a minimum period of twelve weeks. The SUSR Co-ordination Hub will ensure that any recommendations from the Action Plan that are relevant, to either a specific or all Community Safety Partnerships, are communicated accordingly.

6.44 Chairs of Community Safety Partnerships are expected to:

- ensure that there is appropriate Community Safety Partnership representation on Case Review Groups and Review Panels;
- share the learning and recommendations from Single Unified Safeguarding Review Reports;
- escalate any issues that are relevant to the Public Services Board and/or Regional Partnership Board; and
- ensure that appropriate partner agencies from Community Safety Partnerships attend Learning Events.

7. Engagement of the Subject of the Review, and/or Their Families and Principal Individuals in the Single Unified Safeguarding Review

7.1 This section outlines how to ensure there is appropriate engagement with the individuals who wish to contribute to the Single Unified Safeguarding Review (SUSR). Those individuals will be different for every Review and will not always be those immediately related to the person who is the subject of the SUSR. Therefore, for the purposes of this guidance, this group of individuals may include:

- victims or survivors;
- key family members who are close to the subject of the Review;
- Principal Individuals – for example (but not limited to) friends, community representatives/support services, neighbours, colleagues, faith and community leaders or employers) known by the subject of the Review; and
- perpetrators and/or alleged perpetrators.

7.2 The involvement of the subject of the Review, and/or their family and Principal Individuals, whilst voluntary, is at the heart of the SUSR. They should be given the opportunity to be engaged in the Review and treated as a key stakeholder where appropriate and possible. Their perspectives and experiences are essential to developing learning within a Review. Where deemed safe and appropriate to do so, perpetrators/alleged perpetrators should also be given the opportunity to be engaged with the Review using the guidelines for engagement as set out below. However, before including information about the perpetrator in the SUSR, the Reviewer(s) should consider what they can learn from this information to ensure that the SUSR does not repeat the perpetrator's narrative unchecked.

7.3 Whilst guidelines for engagement have been developed the Reviewer will need to apply the guidelines in a balanced way ensuring that the principle focus of the Review (to learn lessons) remains central to decision making. In many cases the subject of the Review, and/or their families and Principal Individuals will have different and possibly conflicting views. In these circumstances the Reviewer's role is to capture those views and take a balanced view, to inform an overall professional judgement of what lessons can be learnt from the case.

7.4 If there has been engagement with the subject of the Review and/or their family and Principal Individuals, the Review team should include comments or feedback from them in the Review Reflections form (please refer to the template in **SUSR Toolkit**). This can be completed during debrief sessions held with the subject of the Review and/or their family or Principal Individuals. Engagement of any perpetrators/alleged perpetrators can also be considered in this form.

Guidelines for engagement

7.5 The purpose of a SUSR is to learn lessons to improve practice. The experiences and views of the subject of the Review, and/or their families and Principal Individuals are important as they add significant information to the Review and a perspective that may not otherwise be reflected in other records. The plans to engage the subject of the Review, and/or their families and Principal Individuals will need to be considered at the outset of the SUSR process and may be adapted as necessary to reflect the unique circumstances of each case. Where a decision is made not to engage with an individual (for example an alleged perpetrator or someone hostile to the reviewing process) the reasons should be recorded by the Reviewer in the SUSR Report.

7.6 The SUSR Victim and Family Reference Group have produced a SUSR Engagement Flow Chart which builds on and complements the guidance in this section. Practitioners can use this flow chart to identify good practice and help with key decision making during the course of the Review. The Engagement Flow Chart (see **SUSR Toolkit**) should be read alongside the guidelines outlined below:

a) the subject of the Review and/or their families and Principal Individuals of the person subject to the SUSR, will be identified by the Review panel and contacted by the appropriate nominated person identified by the Review Panel, as early as possible and kept informed of the Review process, if they so wish;

b) the subject of the Review and/or families and Principal Individuals will have a dedicated contact person(s) for the SUSR process and offered advocacy arrangements;

c) the subject of the Review and/or their families and Principal Individuals will be treated with respect and courtesy. Specific additional needs will be considered, recorded and provided for where possible. This will ensure that appropriate support is provided for them to effectively participate in or make contributions to the Review. This will include any specialist support for example, cultural or language requirements (please refer to the Anti-Racism Action Plan for Criminal Justice in Wales[50]);

d) professionals will be open and transparent with the subject of the Review and/or their families, and Principal Individuals. They will be provided with necessary information (including information about how any personal data will be used). The reasons for any refusal to disclose requested information will be provided;

50 Criminal Justice Anti-Racism Action Plan for Wales: **Criminal Justice Anti-Racism Action Plan**

e) reviewers will be well informed about the case before speaking to the subject of the Review and/or their families and Principal Individuals and should be appropriately trained and/or experienced in working with and supporting individuals who have been exposed to trauma (please refer to the Trauma-Informed Wales Framework[51] for additional information and guidance);

f) communications with the subject of the Review and/or their families and Principal Individuals will be clear and jargon free and communication will be in the language of their choice throughout the process. An element of creativity may also be required to engage with children and young people;

g) reviewers will provide an opportunity for the subject of the Review and/or their families and Principal Individuals to view the draft Report in private with plenty of time to do so and to comment upon and identify any factual inaccuracies. Where comments/amendments from the subject of the Review and/or their family members and Principal Individuals cannot be accommodated in the final Report, an explanation should be provided;

h) the subject of the Review and/or their families and Principal Individuals will know who to contact, and have their concerns addressed by accountable services if any of these guidelines are not met;

i) where there are significant numbers of people of interest in the case the Reviewer will have to balance the need to complete the Review in a timely way, the significance of the subject of the Review and/or their families and Principal Individuals, and the extent of the individual's desire to engage. In such cases the Reviewer may consider accepting views/comments in writing;

j) the Review Panel should seek expertise and/or advice if they feel that they do not have the skills required to undertake the engagement required. The Review Panel Chair can seek advice on behalf of the Review panel from the Victim and Family Reference Group on such issues; and

k) obtain comments or feedback from the **family or community** involved at the end of the Review through the completion of the Review Reflections Form (please refer to the SUSR Toolkit), to help determine if the SUSR process can be improved.

When the subject of the Review is a Child or an Adult at Risk

7.7 Experience reinforces the importance for all individuals (including young people) to be involved where possible, to contribute in as small a way as they wish, to help them influence the learning of those involved in the Review. They should also have an opportunity, if appropriate, to see and discuss the Report and its findings at the conclusion of the Review.

7.8 Safeguarding Boards should think creatively about how families can be engaged in the Review and how explanatory information (including privacy information) is provided to children and adult family members, taking account of age and of circumstances such as disability and first language and if advocacy support is appropriate. An Easy Read and a Young Persons Guide on the SUSR process are available and should be shared where appropriate to help individuals understand how they can contribute to the Review process.

51 Trauma-Informed Wales (traumaframeworkcymru.com)

7.9 Careful arrangements need to be made for reporting back at the conclusion of the Review and sharing the findings of the Report. The Reviewer and/or the Review Panel Chair may be the most appropriate person to do this. Family members will vary in their response as to whether and if so, how they want to receive feedback, not necessarily face-to-face but by telephone or letter. The timing of sharing the content of the Report will need to be carefully considered by the Safeguarding Board in relation to the date of publication and any other sensitive issues or significant dates for the family. It is preferable that a copy of the Report is not given to family members to retain until it has been finalised, approved by the Chair of the Safeguarding Board, published, and shared with the SUSR Co-ordination Hub for inclusion in the Wales Safeguarding Repository.

7.10 The feedback may have a number of functions according to the circumstances. It may provide reassurance or validation, help to draw a line, or provide a turning point in a programme of care and treatment or it may bring distress or revive painful memories. In some circumstances, appropriate support from key professionals may need to be made available to the respective children or family members.

When a Domestic Homicide (or Domestic Abuse related suicide) has occurred

7.11 This section has been produced taking into account key aspects from the *Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016)*[52]. A domestic homicide also includes where the subject of the Review has taken their own life and the SUSR process is committed to ensuring that, in Wales, any death that occurs within scope of the definition in section 9 of the Domestic Violence, Crime and Victims Act 2004 is given equal priority and due consideration.

7.12 Where the subject of the Review has taken their own life, care needs to be taken to explore all opportunities to establish the chain of events and identify potential abuse, or perpetration that may have contributed to the decision. Where a subject of the Review has taken their own life, often this is a last resort and as a result of feeling unable to access support or shame, stigma and guilt around what has happened to them, which may mean that interaction and access to information held by services, may be limited.

7.13 Any shame and stigma associated with the death may also be a cultural consideration for the family and community, as well as fear of authority or discrimination, uncertain immigration status and other racial, cultural, and language-based barriers to accessing support. Culturally sensitive involvement of family, Principal Individuals, perpetrators/ alleged perpetrators and their families may be the only way in which the Review process can ascertain whether the death meets the criteria of a Review, and if it does, to understand the lessons learned.

7.14 The coroner's verdict on cause of death is also important to inform whether there was intent to take life, or whether there may be any third-party involvement. Even if a coroner does not make a finding of suicide, this does not mean that a Review should not be commissioned. Where the perpetrator/alleged perpetrator of a domestic homicide has taken their own life, criminal proceedings are more challenging as information may be more limited or less detailed. To clarify, Reviews are not commissioned when a perpetrator/alleged perpetrator of domestic abuse takes their own life.

52 **Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016)**

7.15 The benefits of involving subject, family and Principal Individuals include:

a) assisting the subject of the Review's family with the healing process which links in with Ministry of Justice objectives of supporting victims of crime to cope and recover for as long as needed following the homicide;

b) giving family members the opportunity to meet the Review Panel if they wish and be given the opportunity to influence the scope, content, and impact of the Review. Their contributions, whenever given in the Review journey, should be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the subject of the Review, and alleged perpetrator's perspectives rather than just agency views;

c) helping families satisfy the often expressed need to contribute to the prevention of other domestic homicides;

d) enabling families to inform the Review constructively, by allowing the Review Panel to get a more complete view of the life of the subject of the Review and/or alleged perpetrator in order to see the homicide through the eyes of the subject of the Review and/or alleged perpetrator, including where they have taken their own lives, or had little engagement with statutory or specialist services. This approach can help the Panel understand the decisions and choices the subject of the Review and/or alleged perpetrator made;

e) obtaining relevant information held by family and Principal Individuals which is not recorded in official records. Although witness statements and evidence given in court can be useful sources of information for the Review, separate and substantive interaction with families and Principal Individuals may reveal different information to that set out in official documents. Families and Principal Individuals should be able to provide factual information as well as testimony to the emotional effect of the homicide. In domestic homicides where murder–suicide occurs, or where there has been limited contact with services, this may be the only information available. The Review Panel should also be aware of the risk of ascribing a 'hierarchy of testimony' regarding the weight they give to statutory sector, voluntary sector and family and Principal Individuals contributions;

f) revealing different perspectives of the case, enabling agencies to improve service design and processes; and

g) enabling families and Principal Individuals to choose, if they wish, a suitable pseudonym for the subject of the Review to be used in the Report. Choosing a name rather than the common practice of using initials, letters and numbers, nouns, or symbols, humanises the review and allows the reader to follow the narrative more easily. It would be helpful if Reports outline where families and Principal Individuals have declined the use of a pseudonym.

7.16 Reviewer(s) will need to take into consideration when and how they engage with perpetrators/alleged perpetrators to ensure that due regard is given to the integrity of any criminal or coroner proceedings (see **Section 12 Parallel Processes**) and to ensure the safety of family and Principal Individuals who are engaging in the SUSR.

7.17 The Reviewer(s)/Review Panel should be aware of the potential sensitivities and need for confidentiality when meeting family and Principal Individuals during the Review and all such meetings should be documented. Consideration should also be given at an early

stage to working with Family Liaison Officers and Senior Investigating Officers involved in any related police investigation to identify any existing advocates and the respective positions of the family and Principal Individuals with regards to the homicide.

7.18 When considering whether to interview family and Principal Individuals, the Reviewer(s) must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial. The Reviewer(s) will need to discuss the timescales for interviews with the Senior Investigating Officers and take guidance from them in relation to any ongoing criminal proceedings.

7.19 When meeting with family and Principal Individuals, the Reviewer(s) should:

a) meet with family and Principal Individuals at the earliest opportunity and offer signposting to specialist and expert advocacy support services to those who do not have a designated advocate. The Reviewer cannot be the advocate for the family and Principal Individuals as they need to be fully independent, bearing in mind that they may reach conclusions that the family and Principal Individuals disagree with;

b) communicate directly with the family and Principal Individuals or through a designated advocate at their request. It is preferable to use any existing designated advocate who has already established an existing working relationship with the family and Principal Individuals (e.g. a local domestic abuse service representative);

c) take into account their ethnic, cultural, and linguistic needs;

d) make a decision regarding timings of contact with the family and Principal Individuals based on information from any designated advocate and taking account of other ongoing processes i.e., post-mortems, criminal investigations;

e) ensure initial contact is made in person (but make clear there are different ways in which family and Principal Individuals can contribute to the Review e.g., in writing, via electronic communication) and deliver the relevant information leaflet (see the SUSR Toolkit for a template);

f) ensure regular engagement and updates on progress through the advocate or agreed communications route, including the timeline expected for publication of the final report;

g) explain clearly how any information disclosed (including personal data) will be used and whether this information will be published;

h) explain how their information has assisted the Review and how it may help prevent other victims;

i) share completed and full versions of the Review Reports with the family prior to its finalisation. Safeguarding Boards should ensure that adequate time is given to the family to consider and absorb the Report, identify if any information has been incorrectly captured and record any areas of disagreement. In some cases, this may involve drawing up a form of undertaking to maintain confidentiality of an unpublished Review;

j) maintain reasonable contact with the family and Principal Individuals, through a designated advocate if appropriate, even if they decline involvement in the Review process. This is particularly important when the Review is completed, has been assessed and is ready for publication. They should also be informed

about the potential consequences of publication i.e., media attention and renewed interest in the homicide. The Safeguarding Board and Community Safety Partnership should ensure the family and Principal Individuals are fully sighted on any media statements and be mindful of the need to consider key dates, such as birthdays, anniversaries, etc; and

k) invite the family and Principal Individuals to discuss the recommendations and their proposed implementation after the conclusion of the Review.

7.20 The Review Panel should consider approaching the family of the perpetrator and/or alleged perpetrator who may also have relevant information to offer. The Chair of the Review Panel and Reviewer(s) should be mindful that the alleged perpetrator or members of the alleged perpetrator's family might in some cases pose an ongoing risk of violence to the subject of the Review's family or friends, or vice versa. If there is concern that there may be a risk of imminent physical harm to any known individual(s), they should contact the police immediately so that steps can be taken to secure protection.

7.21 The Reviewer(s) should also access other networks to whom the subject of the Review and alleged perpetrators may have disclosed relevant information to – for example, employers, health professionals, local professionals in domestic violence prevention work, or local domestic abuse service agencies.

When an "Honour" Killing (or an associated suicide) has occurred

7.22 "Honour" Killings and suspected victim suicides and possible "honour" based abuse must take into account the potential levels of participation and engagement of families in the death(s) concerned. In such reviews, the Review Panel must identify risks of attempting to engage and engaging with members of the family, community, or staff within specific agencies. Identifying these risks can help to minimise the adverse impact of this on the SUSR, due to honour-based abuse and coercion experienced by the subject of the Review. In addition, the Review Panel members may have little or no experience of applying an understanding of diversity and intersectionality to the Review process. In such circumstances the Review Panel Chair should seek expertise from independent lead professionals and/or specialist support agencies, including the SUSR Victim and Family Reference Group.

7.23 Honour Based Violence and perpetrators/ alleged perpetrators of honour killings often seek to justify the homicides by asserting that their actions uphold cultural and moral standards held by the family. Consequently, the Review Panel needs to provide assurance and confidence to the process, which includes a better understanding and awareness to these associated risks after death relating to honour killings. Suicides where the subject of the Review has been subjected to other harmful cultural practices, such as female genital mutilation and forced marriage, may also require specialist support for the Reviewer(s) and members of Review Panel to understand how all forms of VAWDASV may contribute to the death of the subject of the Review. In many cases these harmful cultural practices are interlinked; for example, escaping an abusive forced marriage may lead to perceived dishonour.

7.24 Extra caution will need to be taken around confidentiality in relation to working with agency members and interpreters where there are possible links with the family, who may be the perpetrators and/or alleged perpetrators. Extra caution will also be required when considering the level of participation from family members and should be carefully considered in consultation with a practitioner with expertise in this area, for example, a specialist Black and Minority Ethnic organisation, or relevant independent cultural expertise as relevant to the community.

When an Offensive Weapon Homicide has occurred

7.25 The Review Panel should have regard to section 4 of the Offensive Weapons Homicide Review statutory guidance[53] when considering engagement with family, and Principal Individuals in relation to an Offensive Weapons Homicide.

7.26 Whilst the scope and Terms of Reference of the Review will be determined through discussion between the relevant Review partners and the Case Review Group/Review Panel, it may be suitable for a number of individuals to engage with the Offensive Weapons Homicide process outside of the relevant local partners/appropriate bodies. It is, however, recognised that involving families and friends in the process may bring with it a level of complexity and challenge given the potential sensitivities involved, particularly if the Review is running in parallel with any criminal investigations and proceedings. Family members and friends of the subject of the Review may be connected to the homicide or could be witnesses or vulnerable and at risk themselves. As a minimum the family/next of kin of the subject of the Review should be approached as part of the formal Review process and with the agreement of the police Senior Investigating Officer to avoid undermining the integrity of the investigation or proceedings. Engagement with the alleged perpetrator(s) family as well as friends and representatives from wider support networks should also be considered, where deemed appropriate. These individuals should be approached through the agreement/suggestion of the family/next of kin where possible, as well as with the agreement of the police Senior Investigating Officer investigating the death. For the family or others with a connection to the alleged perpetrator(s), engagement would only be appropriate after they have been formally charged.

7.27 The three key points for engagement with the family members and/or next of kin of the subject of the Review during an Offensive Weapons Homicide would be:

- when a decision has been made to undertake a Single Unified Safeguarding Review;
- to ask the family if they want to contribute or input into the Review; and
- on completion of the final Report.

7.28 It may be that family members and/or next of kin of the subject of the Review are not ready to engage with the process. In these situations, where the family or next of kin respond and ask for more time before they feel able to engage, consideration should be given by the Reviewer to what might be a suitable period of time before it would be appropriate to follow-up with them. If the family and/or next of kin have an advocate, then they may be able to provide advice on a suitable time period.

7.29 In terms of providing the family member and/or next of kin with a copy of the draft Report, consideration will need to be given to whether any of the content requires redaction, to ensure that no sensitive information is disclosed, which might undermine any ongoing criminal proceedings or trial. Completed and full versions of the Review Reports should be shared with the family prior to sending them to the Secretary of State for the Home Office. Safeguarding Boards should ensure that adequate time is given to the family and Principal Individuals to consider and absorb the Report, identify if any information has been incorrectly captured and record any areas of disagreement. In some cases, this may involve drawing up a written form of undertaking to maintain confidentiality of an unpublished review.

7.30 It may be that on providing a copy of the draft Report to the family member and Principal Individuals that they ask for more time to be able to fully read the Report. Consideration should be given to such requests, but a clear deadline should be agreed with the family member and Principal Individuals given the need to finalise the Report and submit to the Secretary of State for the Home Office for publication.

8. Undertaking the Review

8.1 Once a referral for a Single Unified Safeguarding Review (SUSR) has been made, the Safeguarding Board must ensure that it is presented to the Case Review Group, as soon as possible, for consideration. The Review process (production of a final report) should not take longer than twelve months from the date of referral to the Safeguarding Board's Case Review Group. The Safeguarding Board must provide an update report to the Co-ordination Hub on progress and state if the Review will take longer than twelve months with the reasons why and a proposed end date.

8.2 A SUSR has several stages that need to be undertaken as part of the overall process. These are outlined below in chronological order.

Agency Timelines

8.3 The Chair of the Review Panel and the Reviewer(s) will be responsible for preparing an Agency Timeline with the agencies involved in the Review. This involves the preparation of a timeline of events in the life of the child and/or adult subject to the Review and/or their families and Principal Individuals which should be reviewed to consider the circumstances of the incident. Where appropriate consideration should be given to perpetrator(s)/alleged perpetrator(s) in the timeline. The Agency Timeline must consider:

- how far back the timeline should cover;
- which agencies should be invited to complete the timeline;
- what the appropriate cut-off point is; and
- what history/background information will help to better understand the events leading to the incident.

8.4 The overall purpose of the SUSR is to identify and learn lessons. The Review Panel must take cognisance of that when compiling an Agency Timeline. To enable the SUSR to explore where learning can be identified, it is imperative for the Review Panel to consider, on a case-by-case basis, how far back the agencies need to go to identify where the information lies, which will help improve services for the future. The Review Panel need to decide what is relevant and pertinent to the case and how learning can be extrapolated to improve service delivery. The Chair of the Review Panel and Reviewer(s) will challenge the timeline to ensure that it addresses the key periods of concern with the appropriate information.

8.5 Past experience in completing Serious Case Reviews (replaced in Wales in 2014 by Adult Practice Reviews and Child Practice Reviews) has shown that it can be ineffective and inefficient to trawl back many years where processes, policies and indeed people have changed. This needs to be subject to careful consideration at the start of each Review and be kept under consideration by the Reviewer during the process.

8.6 Best practice in Wales has shown that the Review Panel, in the first instance, consider the first twelve months preceding the incident. If deemed justified, proportionate, and necessary this can be extended up to two years, where the Review Panel believe the extension allows current practice to be relevant and where learning can be achieved. There may be instances where the Review Panel decide to consider significant events beyond two years. These events should be captured as contextual information within the relevant section in the SUSR Report template.

8.7 The Timeline may also be extended to include decisions and actions following the incident if professional, organisational or inter-agency learning can be identified.

8.8 Where there is significant background information or a previous incident, this must be included in the brief analysis accompanying the Timeline. Family history and/or the context in which the death has occurred is vitally important, but the critical issue in a Review is who was familiar with the family history, how it was shared within the professional network and how it was taken into account in decision making at the time.

8.9 If there has been no agency engagement with the Subject prior to the incident, the reasons for this should be incorporated into the analysis of whether a SUSR should be undertaken by the Case Review Group. If it is proposed not to undertake a SUSR, it is recommended that a Multi-Agency Professional Forum (please refer to **Section 9** for more information) is conducted to capture any learning from the case. In the case of a Domestic Homicide, any findings from the Multi-Agency Professional Forum should be sent by the Safeguarding Board alongside the completed template, for not undertaking a Review, to the Home Office as well as the SUSR Co-ordination Hub.

8.10 A full and accurate genogram (also known as a Family Association Network in the police service) should be prepared by the Review Panel as a means of clarifying family relationships. It should be used during Review Panel discussions with the Reviewer(s) and be available for reference at all stages of the Review process. The genogram should be sent as an appendix to the Report to the Home Office Quality Assurance Panel in cases of a Domestic Homicide or the Offensive Weapons Homicide Review Oversight Board in cases of an Offensive Weapons Homicide.

8.11 Each agency will need to provide the Review Panel with information in writing about its involvement with the child or adult who is the subject of the Review and/or their families and Principal Individuals where appropriate. The provision of information of an agency's involvement with any perpetrator(s)/alleged perpetrator(s) should also be considered where relevant.

8.12 The Review Panel will produce a merged Timeline of significant events from the individual agencies' Timelines. The merged Timeline, genogram and brief agency analyses will then be used by the Review Panel Members and the Reviewer(s) to develop questions and hypothesis about what happened in the case. This initial understanding will inform the preparation of a Learning Event for practitioners and line managers to test out and further explore operational practice issues. The Reviewer(s) will also have access to and will read documents and other relevant written material, as appropriate. During discussion, issues for clarification may arise and the Review Panel will ask services to respond; the Terms of Reference for the Review may be amended or extended, as a result.

8.13 At any point in the course of conducting a Review, the Review Panel and/or the Reviewer(s) may reach the conclusion that, from the analysis of Timelines or other sources, the case does not meet the criteria for a SUSR or cannot be conducted as laid out in the Statutory Guidance, (for an Offensive Weapons Homicide this decision can only be made in accordance with sections 24 and 27 of the Police, Crime, Sentencing and Courts Act 2022[54]). This should result in a proposal to terminate the SUSR. The process to terminate involves:

- an agreement by the Review Panel;
- a Termination Report (please see the SUSR Toolkit for template) which is presented to the Safeguarding Board;
- the approval of the Chair of the Safeguarding Board;
- notifying the SUSR Co-ordination Hub;
- agreement by the relevant Community Safety Partnership and the Home Office in cases of Domestic Homicide; and
- notifying the Secretary of State for the Home Office in cases of Offensive Weapons Homicides.

8.14 The Termination Report will need to set out the reasons for the termination and what alternative action is proposed to enable learning.

Creating a Learning Event

8.15 Learning is at the heart of the SUSR process. The flow diagram below (Figure 6) identifies the stages where learning must be shared (please refer to **Section 9** for more detail on the initial stages). This section concentrates on the Learning Event.

8.16 Learning Event: The Reviewer(s) and the Review Panel will initiate a Learning Event once the Agency Timeline is completed. The Learning Event brings together all practitioners who have been involved with the case so that they can share their understanding of what has happened and identify key learning points.

8.17 The Learning Event is a critical part of the Review as it ensures that:

- the voice of practitioners directly contributes to the Review;
- practitioners can hear the perspectives of the family during the event and, with other practitioners who have worked with the Subject of the Review and their family; and
- practitioners can reflect on what happened and identify learning for future practice.

8.18 It is therefore essential that those involved in the Learning Event come to the event fully prepared to ensure that they can contribute in a meaningful manner.

8.19 Practitioners and managers are expected to attend the Learning Event if asked. If a practitioner leaves an organisation prior to a Learning Event, is should not preclude them from attending, especially if they can effectively contribute to the discussion. The Review Panel should think creatively about how relevant practitioners and line managers can be engaged in the Review. In some instances, it may be appropriate for more than one Learning Event to be held to ensure key staff are able to contribute to the learning process. The Review Panel members have responsibility for preparing and de-briefing the attendees to provide support to the Reviewer(s) in carrying out an effective Learning Event.

54 Sections 24 and 27 **Police, Crime, Sentencing and Courts Act 2022**

8.20 The Review Panel Chair will attend the Learning Event on behalf of the Review Panel to ensure that the questions and issues identified by the Review Panel are fully addressed.

8.21 At the conclusion of the Learning Event, the Reviewer(s) with the practitioners will identify single and inter-agency issues and practice learning points for consideration and further discussion by the Review Panel, and where wider learning is required, the SUSR Co-ordination Hub.

Producing a Single Unified Safeguarding Review Report

8.22 Following the Learning Event, the Reviewer(s) in liaison with the Safeguarding Board, has responsibility for collating and combining the learning identified to date for discussion with the Review Panel in the form of a draft Report, using the agreed SUSR report template. The Reviewer(s) also has responsibility for confirming that the learning process was undertaken in line with the statutory guidance.

8.23 The SUSR Report must:

- be succinct and focused on improving practice;
- include the circumstances which led to the Review;
- ensure that the Report does not reveal the identity or whereabouts of the child or adult who is the subject of the Review or that of their families and Principal Individuals;
- include any practice and organisational learning identified during the Review, including highlighting good practice, and considerations about what needs to be done differently to improve future practice;
- identify actions that will bring about improvements in systems and practice. These should be specific, workable, and have clearly defined anticipated outcomes;
- once finalised, be published for a minimum period of twelve weeks; and
- included on the Wales Safeguarding Repository submission form for inclusion in the Repository (see **paragraph 8.31** for more information).

8.24 Meetings between the Reviewer(s) and the Review Panel provide an opportunity for professional challenge, which ensures quality assurance. Practice issues originally identified by the Review Panel can be re-examined in the light of the Reviewer(s)'s findings and the Learning Event, and there may be issues identified for further clarification either with practitioners, managers or the Review Panel. Once agreed, the draft Report and an outline Action Plan will then be presented to the Safeguarding Board (and Community Safety Partnership when a domestic homicide has occurred, or where otherwise deemed relevant). All personal identifiers (e.g., names, dates of birth, address etc.) should be removed from the Review Report. It is important that the SUSR report template is used to enable it to be coded for inclusion within the Wales Safeguarding Repository.

8.25 The Review Panel will have responsibility for producing a summary of the merged Agency Timeline. The Agency Timeline must have all personal identifiers removed, be included within the final Report for publication and shared with the SUSR Co-ordination Hub.

Presentation of the Report to the Safeguarding Board (and Community Safety Partnership where appropriate)

8.26 The draft SUSR Report and an outline Action Plan must be presented to the Safeguarding Board by the Chair of the Review Panel and the Reviewer(s). The presentation of the Report is an important means of the Safeguarding Board maintaining a close relationship with practice. The Reviewer(s) will need to take the Safeguarding Board through the detail of the Agency Timeline as well as any practice and organisational issues arising from the Review. The role of the Safeguarding Board is to engage and contribute to the analysis of case issues, to provide appropriate challenge and to ensure that the learning from the Review can be used to inform systems and practice development.

8.27 The Safeguarding Board may identify additional learning issues or actions of strategic importance for individual agencies or for the collective responsibility of the Safeguarding Board. These must be included in the final SUSR Report and in the Action Plan, as appropriate.

8.28 The Review Panel and the Reviewer(s) will then complete the final SUSR Report to reflect the range of learning identified. The Safeguarding Board has responsibility for accepting the Report, making a recommendation to the Chair of the Safeguarding Board, and providing direction regarding the proposed Action Plan. The Chair has overall responsibility for accepting the final Report. The Chair will have to liaise with the Home Office prior to finalising the report when:

- a Domestic Homicide is involved the Chair of the Board will have to liaise with the Chair of the appropriate Community Safety Partnership and forward the report to the Home Office Quality Assurance Panel and await formal approval;
- a Single Unified Safeguarding Review involving an Offensive Weapons Homicide will be sent by the Safeguarding Board to the Secretary of State for the Home Office. It will be placed in the Wales Safeguarding Repository and published by Safeguarding Boards within one month of the date of it being sent to the Secretary of State, unless notification is received that any amendments are needed in advance of that date.

8.29 The Chair of the Safeguarding Board will submit the Report to the SUSR Co-ordination Hub who will forward the report of the Review to relevant policy leads, inspectorates, Commissioners and the National Independent Safeguarding Board. The SUSR Co-ordination Hub will require the Report at least two weeks before the proposed date of publication by the Safeguarding Board. However, the Report cannot be finalised if a Domestic Homicide forms part of the Review and prior to publication the SUSR Report must be forwarded to the Home Office Quality Assurance Panel. The Quality Assurance Panel will need to finalise the Report prior to being published and included in the Wales Safeguarding Repository. This will not delay identified learning from being disseminated and the Action Plan being implemented. If the Quality Assurance Panel identify further learning or recommendations, this will be incorporated within a revised Action Plan.

8.30 The finalised SUSR Report will be published on the Safeguarding Board's (and where relevant the Community Safety Partnership) website, for a minimum of twelve weeks. Following the publication period, reference will be included on the relevant Safeguarding Board and Community Safety Partnership's website that a copy of the Report is available on request. If the Report involves a Domestic Homicide the Safeguarding Board will send a copy to the Home Office and the Domestic Abuse Commissioner. If the Report involves an Offensive Weapons Homicide, the Report will be published by the Secretary of State for the Home Office.

8.31 Safeguarding Boards (and Community Safety Partnerships when a domestic homicide has occurred, or otherwise deemed relevant) must ensure that all Reports are shared with the SUSR Co-ordination Hub to be included in the Wales Safeguarding Repository. To complete this process Safeguarding Boards must return a 'Wales Safeguarding Repository Submission Form' to the SUSR Coordination Hub. This submission form will require Boards to provide:

- a unique Single Unified Safeguarding Review Reference Number (to be provided by the Co-ordination Hub);
- the full published Single Unified Safeguarding Review Report;
- the Action Plan (see paragraphs 8.33 to 8.42); and
- a Wales Safeguarding Repository Metadata section, which will provide essential quantitative data for the Wales Safeguarding Repository must be carefully gathered from the published Review Report to ensure all relevant data is captured.

8.32 Recommendations from the SUSR Report must be shared with other regional partnership arrangements where there are aspects of a Review which are relevant to their work, in order that they can be acted upon (please refer to paragraphs 2.10 to 2.11).

Action Plan

8.33 The Chair of the Review Panel, the Review Panel and the Reviewer(s) will have responsibility for preparing an outline Action Plan, to accompany the draft Report for presentation and discussion by the Safeguarding Board (and Community Safety Partnership where relevant). The Action Plan should reflect the learning identified in the Report, and incorporate the recommendations, including where appropriate good practice. The actions may be directed either at a single agency or require multi-agency action to ensure that they are implemented. The Action Plan should be outcome-focused and indicate how actions are intended to make a difference to local systems and safeguarding practice. (Please refer to the Action Plan Guidance and template within **the SUSR Toolkit** which must be used.)

8.34 The finalised Action Plan will be prepared by the Review Panel and the Reviewer(s) reflecting discussion by the Safeguarding Board. This should be within four weeks of the Safeguarding Board's consideration of the draft SUSR Report and sent to the Chair of the Safeguarding Board for signing off by the partner agencies. The SUSR Action Plan template includes a RAG (Red, Amber, Green) status which is to be kept updated by the Case Review Group and the Safeguarding Board.

8.35 The Action Plan should have a clear focus on improving outcomes for children and/or adults at risk, and their families, and on identifying opportunities for early intervention and prevention. It should then be sent to the SUSR Co-ordination Hub. However, where a Domestic Homicide forms part of the Review, the Action Plan must first be considered by the Home Office Quality Assurance Panel and any amendments proposed by the Panel will be considered by the Chairs of Safeguarding Board and the Community Safety Partnership and incorporated in the Action Plan and sent to the SUSR Co-ordination Hub. The Co-ordination Hub will ensure that any recommendations that are relevant to either a specific or all Community Safety Partnerships are communicated accordingly. For Offensive Weapons Homicides Safeguarding Boards will share the finalised Action Plan with the Offensive Weapons Homicide Review Oversight Board.

8.36 Action Plans are a fundamental outcome of the Review process and must consider the recommendations from the Report. This will lead to improvements in relation to safeguarding practices across all agencies and will aid early intervention and prevention. The actions must:

- specifically state what should be done in a clear and precise manner;
- clearly identify the steps required for its implementation, including timelines for completion, and the resources needed;
- identify key learning points and how these will be shared with key partners, to avoid similar issues arising in the future;
- identify the benefits to the relevant agencies and partners;
- identify what problems will be corrected or avoided; and
- identify who the responsible lead(s) is for the implementation of each action.

8.37 The Action Plan will be reviewed, and progress will be monitored by the Case Review Group and the Safeguarding Board and progress reports sent to the SUSR Co-ordination Hub until the objectives and targets have been achieved. The family will be updated on the implementation of the Action Plan where appropriate by the Safeguarding Board. The Co-ordination Hub will work with the Safeguarding Boards to disseminate key learning from the Report and Action Plan to the Strategy Group, the Ministerial Board and to local staff as appropriate. When a SUSR involves an Offensive Weapons Homicide, the progress reports will be forwarded by the relevant Safeguarding Board, to the Offensive Weapons Homicide Review Oversight Board.

8.38 Consideration will be given to the critical learning points by the respective Safeguarding Board and the Co-ordination Hub. In addition, learning points will be incorporated into any changes in operational systems and practice, training, and supervision. This will shape priorities for future work undertaken by the Safeguarding Board, and other key stakeholders including Community Safety Partnerships. Seven Minute Briefings must be produced as part of this process (please refer to a suggested template in the **SUSR Toolkit**).

8.39 Action Plans should lead to improvements in safeguarding practice, both locally and on a pan-Wales basis. The Safeguarding Boards (with Community Safety Partnerships where appropriate) must audit the Action Plans to ensure that they are being implemented and that the actions are delivering the desired

effect and outcomes. The audit and any issues arising relating to the implementation of the actions, must be reported to the Co-ordination Hub. The Co-ordination Hub will work with the Safeguarding Board (and Community Safety Partnership when appropriate) to determine whether the issues can be addressed or if they should be escalated to the Strategy Group.

8.40 The Reviewer(s) may be requested by the Review Panel and/or the SUSR Co-ordination Hub, to undertake an event with staff groups either to disseminate what has been learned or to follow-up the impact on practice of changes being made as the result of learning from the Review and the implementation of the Action Plan.

8.41 The Safeguarding Boards will need to incorporate any issues emerging from the Review into the work programme of the Multi-Agency Professional Forum (please refer to **paragraph 9.9** for further information).

8.42 Once the objectives and actions have been completed the Action Plan will need to be signed off by the Chair of the Safeguarding Board and sent to the SUSR Co-ordination Hub, to ensure it is incorporated into future Learning Events on a pan-Wales level.

Review Reflection Form

8.43 Review Panel Chairs and Reviewers must complete a Single Unified Safeguarding Review Reflections form within two weeks of the Review Report being finalised by the Chair of the Safeguarding Board (please refer to the **Single Unified Safeguarding Review Toolkit**). These reports provide Chairs and Reviewers with an opportunity to reflect on the Review process; what went well, what didn't go as well as might be hoped, and to identify any process improvements or learning gaps/opportunities for those involved in undertaking the Review. Completed forms will be sent to the Co-ordination Hub. These will be used to inform and potentially refine the Review process. Where relevant, Reviewers should include any comments or feedback from the family or community involved in the Review. This can be completed during any debrief sessions held with the family or community.

Figure 6

Adolygiad Diogelu Unedig Sengl
Single Unified Safeguarding Review

SUSR Learning Opportunities using the Wales Safeguarding Repository (WSR)

*See Section 7 of this guidance for more information and reference to the Engagement Flow Chart

9. Disseminating Learning using the Single Unified Safeguarding Review

9.1 The dissemination of learning is a key aim of the Single Unified Safeguarding Review (SUSR) process and is a regulatory and statutory obligation for Safeguarding Boards[55] and Community Safety Partnerships[56]. The ethos behind the SUSR process is to ensure that all learning is embedded into future practice to ultimately prevent similar incidents in the future. To do this, the SUSR has been created to ensure that when reviews are conducted, wider and deeper learning is achieved which is embedded in all organisations in order to enact positive change. This will be further strengthened through:

- the Wales Safeguarding Repository which will be utilised as a tool to inform reviews, outcomes, and future practice; and
- the dissemination of this learning through the Safeguarding Boards and SUSR Co-ordination Hub.

9.2 The Co-ordination Hub will be instrumental in the dissemination of learning across the whole of Wales. The Co-ordination Hub will monitor and review progress in actioning recommendations from SUSRs and assist in unblocking any impediments arising during the implementation process.

9.3 To ensure that learning is disseminated, and Action Plans are effectively implemented, the Safeguarding Boards and the Co-ordination Hub will produce Update Reports (please refer to the SUSR Toolkit for the Update Report template). These will summarise the learning achieved and any areas requiring further escalation. The Update Reports will be presented to the Safeguarding Boards, the SUSR Strategy Group and if necessary escalated to the Ministerial Board where barriers are identified.

The Wales Safeguarding Repository's Role in Primary, Mid-term and post-Review Learning

9.4 The Wales Safeguarding Repository has a key role to play in the dissemination of learning on a pan-Wales basis. Along with past Adult Practice Reviews, Child Practice Reviews, Mental Health Homicide Reviews and Domestic Homicide Reviews, all SUSR Reports will be coded and stored within the Wales Safeguarding Repository. Relevant stakeholders will have access to the Repository so that they can upload and search

55 Regulation 3. **The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015**
56 Section 6 **Crime and Disorder Act 1998**

for Reviews. The Wales Safeguarding Repository is a unique system that utilises social science and computer science methodologies, such as text mining and machine learning techniques to enable the user to extract new learning.

9.5 As can be seen in the Learning Flowchart (**Figure 6**) in **Section 8**, the Wales Safeguarding Repository enables practitioners to search for Primary Learning. Review Panel Chairs and Reviewers will need to use the Wales Safeguarding Repository to search for and identify recommendations from any similar previous cases before they commence their current Review. It can then be assessed whether these recommendations were implemented or whether they need to be highlighted again. When the Review Panel establish the Terms of Reference for a Review, any relevant previous recommendations from other comparable reviews should be taken into consideration.

9.6 If any urgent mid-term learning is identified during the Review process, then practitioners can implement any immediate changes as a result of this learning before the completion of the Review. If this is the case, the Review Panel must share this learning with the Safeguarding Board and the Co-ordination Hub for further dissemination. This will ensure that important learning can be disseminated and implemented without delay. The Co-ordination Hub will share this learning on a pan-Wales basis or wider where relevant.

9.7 The Co-ordination Hub and other key partners including the National Independent Safeguarding Board can access the Wales Safeguarding Repository to search for and identify themes to achieve a better understanding of incidents in Wales. These reports will be shared with all relevant organisations in Wales and used to establish good practice. The Wales Safeguarding Repository is just one tool which can be used alongside other research resources to identify good practice. Figure 7 below shows the outputs of the Wales Safeguarding Repository alongside the outputs of the SUSR Co-ordination Hub.

Bi-Annual Themed Dissemination Event

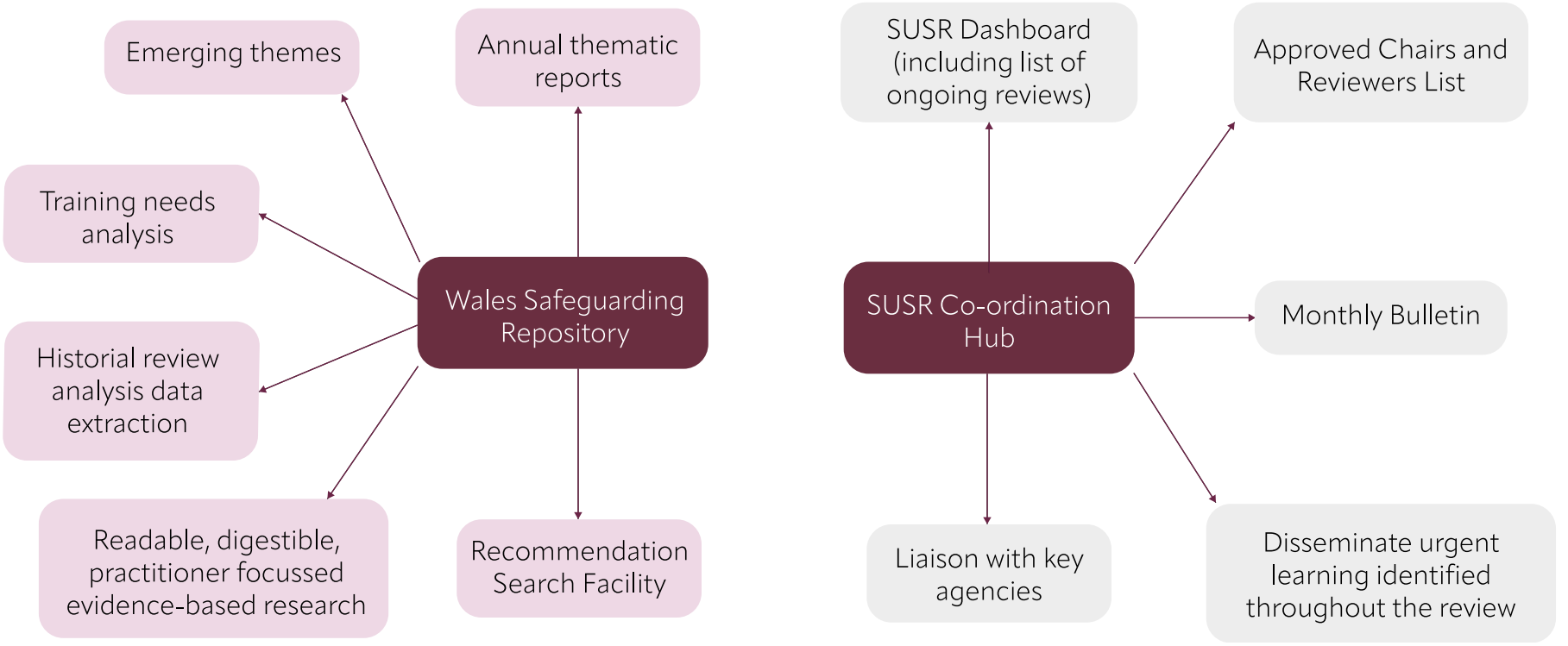
9.8 Bi-annual Themed Dissemination Events form a crucial part of the learning process. They will provide a positive approach to learning, encompassing a no blame culture.

9.9 These events will be co-ordinated and organised by the Co-ordination Hub in discussion with Safeguarding Boards, National Independent Safeguarding Board and other key partners. They will be held on a Wales-wide basis. The Wales Safeguarding Repository will be utilised to help determine relevant themes for discussion.

Figure 7

Adolygiad Diogelu Unedig Sengl
Single Unified Safeguarding Review

Wales Safeguarding Repository (WSR) and SUSR Co-ordination Hub outputs



Multi-Agency Professional Forums

9.10 Multi-Agency Professional Forums (MAPFs) are a mechanism for producing organisational learning, improving the quality of work with families, and strengthening the ability of services to keep children and adults safe. In accordance with regulation 3(2)(i)[57], Safeguarding Boards are required to arrange and facilitate an annual programme of MAPFs. They can be convened to explore learning opportunities in cases which do not meet the criteria for the completion of a SUSR. They utilise case information, findings from safeguarding audits, inspections, reviews, and other learning arising from the Wales Safeguarding Repository to develop and disseminate learning to improve local knowledge and practice, and to inform the Safeguarding Board's future audit and training priorities.

9.11 Multi-agency Professional Forums are defined in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[58] as:

> "Forums, arranged and facilitated by a Board for practitioners and managers from representative bodies, and other bodies or persons deemed relevant by the Chair of the Board, with the purpose of learning from cases, audits, inspections and reviews in order to improve future child or adult protection policy and practice."

9.12 This approach can be extended to include Domestic Homicides, Offensive Weapon Homicides and Mental Health Homicides. However, it is envisaged that when a homicide forms part of the case, then the criteria for a Single Unified Safeguarding Review is highly likely to be met.

9.13 MAPFs should be set up as a continuous programme of active learning by each Safeguarding Board and constitute an integral part of the Board's Business Plan.

9.14 MAPFs have two main purposes:

a) **Case learning:** facilitated discussion, consultation and reflection by practitioners, managers, or core groups, using a systems approach to examining and analysing individual current or no longer active cases. These may include complex cases where there have been good outcomes, current cases that have become stuck, or cases which cause professional concern or interest that do not meet the criteria for a SUSR.

b) **Dissemination of new knowledge and findings:** from multi-agency safeguarding audits and from SUSRs, inspections or other local or national sources, in order to ensure continuing local multi-professional learning and development.

9.15 MAPFs which focus on case learning should be facilitated events, undertaken in environments that provide safe, professional support and professional challenge, with a clear set of working principles or processes so that staff know what to expect and the confidentiality of any case material is respected. The forums may use a range of creative methods already familiar in training and continuing professional development, such as multi-agency supervision, appreciative inquiry, or sculpting, as appropriate. The practice learning should be recorded and formally reported to the Safeguarding Board, and families where appropriate. The learning may be disseminated more widely by the SUSR Co-ordination Hub on a local, regional, or national level, whilst also informing the Safeguarding Board's annual review of its Business Plan.

57 The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015. **Safeguarding Boards Regulations (2015)**
58 Regulation 2. **Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015**

9.16 MAPFs should allow assessments, decision making and practice to be explored openly with each other by staff. However, if any issues of individual staff training needs or staff malpractice emerge during the course of a multi-agency professional forum, these should be managed separately through the relevant agency's own staff procedures.

9.17 The learning from a MAPF related to individual cases or the dissemination of findings from audits and other sources may require local action through changes in operational policy, protocols, service delivery or practice, and this should occur promptly and without delay.

9.18 It is expected that if at any time a level of concern is identified within a MAPF that would trigger a SUSR then the case should be reported to the Chair of the Safeguarding Board and referred to the Case Review Group for consideration and action.

9.19 Where the learning from the MAPF is of wider relevance, the Safeguarding Board will liaise with the Co-ordination Hub to develop plans for dissemination locally and/or nationally, for example through the National Independent Safeguarding Board, Community Safety Partnerships, Regional Partnership Boards, Public Services Boards and relevant professionals whose roles and responsibilities encompass protection and where messages need to be conveyed to agencies locally. The process will be managed by the Co-ordination Hub in partnership with the relevant Safeguarding Board to ensure that the key points are captured and disseminated. For Offensive Weapons Homicides, engagement will also take place with the Offensive Weapons Homicide Review Oversight Board.

9.20 The effectiveness of a MAPF requires the commitment of senior agency representatives who are Safeguarding Board members and positive support from agencies to enable professional staff to make use of these learning opportunities. If a practitioner leaves an organisation prior to a MAPF being undertaken, it should not preclude them from attending, especially if they can effectively contribute to the discussion.

9.21 The programme of work will require resourcing by the Safeguarding Board and periodic evaluation to ascertain the impact on SUSR practice. The findings should be reported back to the Safeguarding Board and the Co-ordination Hub so that findings can be included in update reports to the Strategy Group, the Ministerial Board and the Victim and Family Reference Group.

9.22 MAPFs are built on long-standing, prior experience and draw on good practice across Safeguarding Boards in Wales.

10. Sharing Information and Protecting Personal Data

Introduction

10.1 Safeguarding Boards working with the Case Review Group will oversee the establishment and delivery of SUSRs and SUSR report production and publication in accordance with this Guidance.

10.2 Sharing of information that is necessary and proportionate for the purposes of a SUSR with the appointed Review Panel and Reviewer(s) is key to its success. Review partners and other relevant organisations should aim to be as open as possible in the information they share. This section is intended to support the provision of information (including personal data) and provide assurance to organisations sharing data in the context of a SUSR that they have considered the requirements of data protection legislation. Considerations in relation to the sharing of information for the purpose of a SUSR in the context of other parallel processes (e.g. criminal investigation or criminal proceedings) are considered in **Section 12** of this Guidance.

Purpose for sharing information

10.3 The aims of the SUSR have been set out in detail in this Guidance. The sharing of relevant information by each organisation connected with the circumstances relating to a SUSR is necessary to ensure that it can be carried out successfully by the Safeguarding Board.

10.4 The relevant statutory provisions which provide for the request and provision of information in the context of a SUSR are set out in **Appendix Five**.

What information should be shared

10.5 Information that is relevant to the organisation's involvement with the Subject of the Review, their family, Principal Individuals, perpetrators/alleged perpetrators and the objectives of a SUSR should be shared.

10.6 Personal data that is shared should be relevant and limited to what is necessary for the purpose of a SUSR in accordance with its Terms of Reference. Such information could include information relating to education, antisocial or criminal behaviour, housing, medical history, mental health, and safeguarding.

10.7 Information should be shared by organisations in a timely manner to ensure that a SUSR can be undertaken in accordance with the timelines outlined in **Section 5** of this Guidance. Any issues in relation to the sharing of information (including personal data) should be identified and addressed at an early stage to avoid any delay in the SUSR process.

10.8 Information on alleged perpetrators or other individuals connected with the incident may not be shared in the initial stages of a SUSR by the Police Senior Investigating Officer or Crown Prosecution Service if disclosure could threaten the integrity of the criminal investigation or any criminal proceedings. This may remain the case for the duration of the SUSR for very sensitive information. By not waiting for the resolution of criminal investigations and proceedings it may mean that some detail is excluded from the SUSR. This must be balanced against the benefits of learning being identified in a timely manner so actions and recommendations can be implemented as soon as possible. See **Section 12** of this Guidance for further information.

Data protection, privacy and confidentiality considerations

10.9 The Data Protection Act 2018 and the UK General Data Protection Regulation govern the processing of personal data.

10.10 Each data controller involved in the sharing of information for the purpose of a SUSR must satisfy themselves that they are not in contravention of data protection legislation and ensure their own compliance and accountability. This will include:

- ensuring that data shared is lawful, necessary, proportionate and accurate;
- that only the minimum amount of data necessary for the purpose of a SUSR is shared;
- ensuring necessary safeguards are put in place when sharing personal data to minimise risk and adverse effects;
- undertaking a DPIA;
- providing privacy information;
- putting relevant documentation in place (this will include a legitimate interests assessment in cases where legitimate interests is the lawful basis being relied on and a data sharing agreement/framework); and
- having an appropriate policy document for the sharing of special category data where relevant.

10.11 Information regarding the above must be included in the information sheet provided to individuals involved in a SUSR. Please refer to the **SUSR Toolkit** for the template.

10.12 The Case Review Group will determine a lead authority who will be responsible for personal data considerations in the context of a SUSR on behalf of the Safeguarding Board (this will ordinarily be the relevant Local Authority). The lead authority will ensure compliance with relevant data protection obligations including, where appropriate, the provision of privacy information to individuals whose personal data is processed in the course of a SUSR and the retention of personal data. The lead authority will also act as the point of contact for individuals seeking to exercise their rights in respect of personal data processed for the purpose of a SUSR.

10.13 Determinations will be made by the Case Review Group in consultation with the lead authority in relation to the appropriate data sharing agreements that will be put in place for a SUSR which will allow the sharing of personal data by relevant review partners. Template data sharing agreements will be provided by the Co-ordination Hub.

10.14 Where there are concerns about the sharing of personal data in the context of a SUSR these should be discussed with the Chair of the Review Panel at the earliest opportunity. Such concerns may arise in the context of special category data, particularly data concerning health. Additional conditions apply to the processing of special category data and there may be additional considerations regarding the right to privacy and the obligation of confidentiality owed in the context of data concerning health (e.g. the common law duty of confidence).

10.15 There is a gateway in data protection legislation, which permits the disclosure and sharing of personal data (including special category data and Criminal Offence Data) in the context of a SUSR, which does not rely on the consent of the individual.

Lawful basis

10.16 For the purpose of a SUSR the potential lawful bases for processing personal data under data protection law are as follows:

- Art 6(1)(c) Necessary for compliance with a legal obligation;
- Art 6(1)(e) Necessary for a task carried out in the public interest or in the exercise of official authority; and
- Art 6(1)(f) Necessary for your legitimate interests or the legitimate interests of a third party, unless there is a good reason to protect the data which overrides those interests (it should be noted that this is not available to public authorities processing data for official tasks).

10.17 UK GDPR Articles 6(1)(c) and 6(1)(e) require a basis in UK law. The processing of personal data in the context of a SUSR is underpinned by statute and the participation in, and facilitation of, a SUSR through the provision of relevant information is serving that statutory function. The following statutory framework provides the basis for any processing by an organisation for the purposes of undertaking a SUSR and any act of data sharing by a body who has received a request for information for the purpose of a SUSR:

- Section 134 of the Social Services and Well-being Wales Act 2014;
- Regulation 3 of the Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015;
- Section 9 of the Domestic Violence, Crime and Victims Act 2004; and
- Chapter 2 of Part 2 of the Police, Crime, Sentencing and Courts Act 2022 for Offensive Weapons Homicide Reviews.

10.18 Where special category data is processed for the purposes of a SUSR a condition for processing special category data under Article 9 of the UK GDPR must also be established. The potentially relevant conditions are:

- Article 9(2)(g) of the UK GDPR, where processing is necessary for reasons of substantial public interest on the basis of domestic law; and

- Article 9(j) of the UK GDPR, where processing is necessary for archiving purposes in the public interest or historical research purposes).

10.19 Article 9(2)(g) also requires a basis in UK law, under section 10(3) of the Data Protection Act 2018 there is a requirement to meet a substantial public interest condition as set out in Schedule 1, Part 2 of the Data Protection Act 2018. The relevant specific substantial public interest condition is:

- Schedule 1, Part 2, paragraph 6 of the Data Protection Act 2018, processing is necessary for the purposes of a function conferred on a person by enactment or rule of law and is necessary for reasons of substantial public interest.

10.20 There is an inherent public interest that can be demonstrated in the purpose of a SUSR which is intended to identify potential improvements in relevant services, to disseminate learning and good practice and to prevent future incidents. As outlined above, the processing of personal data in the context of a SUSR is underpinned by statute and the participation in, and facilitation of, a SUSR through the provision of relevant information is serving that statutory function.

10.21 Where Criminal Offence Data[59] is processed for the purposes of a SUSR, Article 10 of the UK GDPR specifies that processing must be carried out either under the control of official authority or a specific condition in Part 3 of Schedule 1 of the Data Protection Act 2018 must also be established. The potentially relevant condition is also:

- Schedule 1, Part 2, paragraph 6 of the Data Protection Act 2018 processing is necessary for the purposes of a function conferred on a person by enactment or rule of law and is necessary for reasons of substantial public interest.

10.22 In respect of the subsequent processing of personal data via the Wales Safeguarding Repository the relevant lawful basis for processing is under Article 6(1)(e) of the UK GDPR and the relevant conditions for processing under Articles 9(2)(g) of the UK GDPR also relying on the condition set out in the Data Protection Act 2018, Schedule 1, Part 2, paragraph 6 (statutory etc. and government purposes) and Article 9(j) (necessary for archiving purposes etc. in the public interest). In the context of Criminal Offence Data, Schedule 1, Part 2, paragraph 6 of the Data Protection Act 2018 processing is necessary for the purposes of a function conferred on a person by enactment or rule of law and is necessary for reasons of substantial public interest.

Confidentiality and privacy

10.23 In relation to any confidential information relevant for the purpose of a SUSR (e.g. information concerning health such as medical records) where an obligation of confidence is owed by an organisation or information where an individual has a right of privacy[60] disclosure is permitted where it is required by law[61] or is justified in the public interest.

59 Personal data relating to criminal convictions and offences
60 Article 8 of the European Convention on Human Rights and the Human Rights Act 1998
61 The Police, Crime, Sentencing and Courts Act 2022 provides that in the context of an OWHR a disclosure of information required or authorised by sections 27 to 29 will not amount to a breach in any obligation of confidence

10.24 Organisations who are subject to obligations of confidentiality will need to determine whether an individual whose confidential information is relevant for the purposes of a SUSR should be asked to give consent to the sharing of their confidential information. Consent should not be sought if it is impractical to do so, contacting the individual would undermine the purpose of sharing the information or a decision has already been made to disclose the information because it is in the public interest to do so. In such circumstances the individual should be told of the intention to share their information, unless it is not safe or practicable to do so. If the individual objects to the disclosure of their information any reasons given for that objection should be taken into account before their information is shared.

10.25 It should be noted that consent in relation to the Common Law Duty of Confidentiality is not being sought as a lawful basis to process personal data. As outlined above, the lawful basis for the processing of personal data for the purpose of a SUSR can be established by other means.

10.26 If an organisation determines that it is appropriate to seek consent, then consent should be sought from the individual as well as their views on the impact of disclosure. If the individual refuses to consent to the sharing of their information it will be necessary to consider whether their refusal should be overridden because there is a public interest in doing so. There is an inherent public interest in the provision of information for the purpose of a SUSR and the duty to share information can be as important as the duty to protect an individual's confidentiality[62].

10.27 Organisations should determine whether the disclosure of information is justified in the public interest for the purpose of the SUSR. In making that determination organisations should consider whether public interest in disclosing information outweighs the individual's interest in keeping the information private and confidential. Relevant factors to consider in making this determination include:

- the nature of the information to be disclosed;
- any views expressed by the individual in relation to the disclosure of their information;
- the harm or distress that could be caused to the individual;
- the potential benefits to an individual or to society arising from the release of the information; and
- the potential harm to others (whether to a specific person or people, or to the public more broadly) if the information is not disclosed.

Publication and the WSR

10.28 **Section 8** of this Guidance sets out the obligations in relation to the production and publication of Reports. With regard to the personal data of individuals referred to in the Report, Safeguarding Boards are required to ensure Reports do not reveal the identity or whereabouts of the subject of the review or that of the subject's family.

62 7th Caldicott Guardian Principle

10.29 SUSR Reports should be prepared on the basis that all personal identifiers are removed and/or pseudonymisation is used. This will reduce potential for individuals referred to in the Report to be identifiable. There is still a possibility however that, despite the use of such safeguards, individuals referred to in the Reports may be identified by reasonably available means, particularly where the incident which has triggered the Review is well known or has been covered in the media. Where pseudonymisation has been used the report will contain personal data and will therefore continue to be subject to data protection law in relation to their publication, retention and incorporation into the WSR.

10.30 **Section 7** of this Guidance sets out how the SUSR process ensures engagement with individuals who wish to contribute to a SUSR. Reviewer(s) are required to provide an opportunity (where appropriate) for the Subject of the Review, their family, and principal individuals to view the draft Report, to comment upon it and identify factual inaccuracies. This review period will also provide individuals with an opportunity to object to the processing of their personal data in the Report which can be done via the lead authority on behalf of the Safeguarding Board.

10.31 SUSR Reports and Action Plans will be shared by Safeguarding Boards with the Co-ordination Hub. The Reports will then be incorporated into the Wales Safeguarding Repository. The Wales Safeguarding Repository can be used, by those that are permitted access to obtain information in relation to SUSRs and to assist Safeguarding Boards to facilitate pan-Wales learning and training. Access to the WSR will be limited to individuals/practitioners provided with access credentials, it will not be available to the public.

10.32 The finalised Report must be published for a minimum period of 12 weeks in accordance with the statutory obligations of Safeguarding Boards (and where relevant Community Safety Partnerships). The Report will also be included in the Wales Safeguarding Repository indefinitely.

10.33 The responsibility for retaining and determining future access to reports arising from SUSRs will rest with the lead authority.

10.34 The Report provided to the Co-ordination Hub for inclusion in the Wales Safeguarding Repository will be the same version published on the Safeguarding Board/Community Safety Partnership website.

10.35 Welsh Government will be the data controller in relation to personal data contained within the WSR and will ensure compliance with the relevant obligations under data protection law including:

- compliance with the data protection principles;
- the provision of privacy information to individuals;
- the security of personal data processed in the Wales Safeguarding Repository in terms of:
  - regulating access to the Wales Safeguarding Repository; and
  - ensuring appropriate technical and organisational security measures are put in place; and
- managing and responding to individual rights requests (e.g. subject access requests).

10.36 All of the information incorporated into the WSR will be retained indefinitely in order to ensure that relevant findings and learning can be drawn from the Reports and Action Plans by permitted users and disseminated more widely by the Co-ordination Hub.

11. Applying the Single Unified Safeguarding Review to Historic Abuse

11.1 It is the responsibility of the Safeguarding Board to determine whether a case meets the prescribed criteria for undertaking a Single Unified Safeguarding Review (SUSR) (see **Section 4**). The Safeguarding Board may decide that a Review is required in relation to a case involving historic organised or multiple abuse. The aim of such a Review would be to examine what can be learned from past practice to ensure that current practice and organisational systems are strengthened and improved.

11.2 This may include putting in place a means of identifying and acting on lessons learned from the Review (e.g., in respect of policies, procedures and working practices which may have contributed to the abuse occurring) as it proceeds, and at its close, and assess its handling and identify learning for conducting similar reviews in future.

11.3 Historic Reviews that meet the criteria for a SUSR should follow the principles, approach and process outlined within this Guidance.

12. Relationship with other Formal Processes

12.1 The Single Unified Safeguarding Review (SUSR) process is about practice learning. If any issues of individual staff training needs or staff malpractice emerge during the course of a Review, these issues should be referred to and managed separately through the relevant agency's own staff procedures.

12.2 Even where there are other formal processes or investigations underway, such as complaints procedures, there is no reason to delay undertaking a Review. A SUSR is focused on learning to improve future practice and is not a process for dealing with complaints or attributing blame. Safeguarding Boards should consider how other processes may run in parallel with a SUSR. Relevant learning resulting from the different processes will be shared accordingly with relevant agencies.

Parallel Processes

12.3 Where the case is subject to police investigations or judicial/coronial proceedings, these should not automatically inhibit the setting up of a SUSR nor delay immediate remedial action being taken to improve services. It is important that the purpose of the Review process, which is to identify professional and organisational learning and to improve future multi-agency public protection practice, is understood and remains the focus.

12.4 The Crown Prosecution Service and the National Police Chiefs Council can provide guidance which recognises that Multi-Agency Reviews and criminal proceedings can be managed simultaneously. This guidance provides a framework for the sharing of relevant information generated through both processes.

12.5 The Review Panels are independent from the criminal justice process, and it is not possible to enforce any demands from that process that the timescales or methodology of the Review is altered. However, if the case is already subject of a criminal investigation the Senior Investigating Officer must be notified of the decision to instigate a SUSR. Where there are criminal proceedings or an Inquest pending, the Crown Prosecution Service or the Coroner respectively for the area where the proceedings are being taken must be notified of the Review by the Safeguarding Board. If the Senior Investigating Officer, the Crown Prosecution Service or the Coroner make representations that the Review may undermine ongoing criminal investigation, criminal or coronial proceedings, those representations must be drawn to the attention of the Review Panel Chair who will take steps to further clarify/discuss those representations as appropriate. Agreement as to the way forward in light of any discussions will be reflected in the Review Terms of Reference.

12.6 Having considered any representations received, a request could be made to the Review Panel that the scope of the Review is temporarily restricted until after the outcome of any criminal or coronial proceedings or police investigations. This could involve consideration being given to not interviewing people who may be witnesses or defendants in criminal or coronial proceedings, and not to proceed with a Learning Event until the criminal justice or coronial issues have been resolved. Where a restriction in scope is being considered by the Review Panel, this should be for a defined need and/or applicable to named individuals.

12.7 Maintaining the integrity of the criminal investigation and proceedings must be a key consideration for Review partners. They should agree with the Police Senior Investigating Officer, which individuals are to be included in the requests for information as part of the Review, clarifying what information cannot be shared and any restrictions on the timing of the release of information. Only information relevant to the Review is to be shared, to identify any lessons to be learnt from the incident(s) and to consider whether it would be appropriate for anyone to take action in respect of those lessons learnt.

12.8 Any material generated or obtained during the Review must be made available to the Police Senior Investigating Officer and disclosure officer whilst the criminal case is ongoing, to enable investigating officers to assess its relevance to the criminal case. Where relevant, it is for the Crown Prosecution Service to decide whether any information gathered during the Review should be disclosed to the defence. Where the information concerned is sensitive, the Crown Prosecution Service or the Senior Investigating Officer will consult with the relevant Review partners or Reviewer(s) before disclosure is made to the defence.

12.9 If the scope of the Review is temporarily restricted, this does not negate the need for, or justify delay in setting up, a Review Panel to carry out the Review. This approach allows for the timely securing of any records pertaining to the death or serious injury, and mitigates against the risk of loss of or interference with those records. This approach also facilitates the early identification of primary learning.

12.10 It is essential that necessary learning is not delayed, thereby preventing the repeat of ineffective practices or omissions being replicated in other cases. In these circumstances, the Review Panel should ensure that chronologies are drawn up and where necessary records are reviewed to identify any immediate lessons to be learned. These should be brought to the attention of the relevant agency or agencies, by the Safeguarding Board, for action providing that it does not compromise the integrity of relevant criminal or coronial proceedings.

12.11 There are significant developments in Wales which support the aim and purpose of the SUSR process. Understanding causes, learning lessons in managing difficult situations and relationships, prevention of crime and harm and early intervention are key elements that are being pursued by Police and Crime Commissioners and Chief Constables in Wales with partners in the Criminal Justice System in Wales. Welsh Government is represented at meetings of the Criminal Justice Board for Wales while, at the invitation of Policing in Wales, the First Minister and Minister for Social Justice chair the Policing Partnership Board for Wales and Welsh Government has supported both the Safer Communities Board for Wales and the Safer Communities Network. Through these arrangements there is real potential for lessons learned through the Review process to influence a range of approaches and processes across policing and criminal justice in the common pursuit of reducing harm and protecting the vulnerable.

Complaint Process

12.12 Every Safeguarding Board must have a complaints procedure in place for the handling of complaints about Reviews. The complaints process should address the multi-agency nature of a Review rather than the complaint against the actions of a single agency which should be pursued through their own complaints' procedure. The Reviewer(s) and Chair of the Review Panel should ensure that the subject of the Review and/or their family and Principal Individuals (and any perpetrators/alleged perpetrators where they have been engaged) are made aware of the appropriate complaints process.

Appendix One: Table of Partnerships

	Safeguarding adult/child				Domestic Homicide				Offensive Weapon Homicide				Mental Health Homicide			
	Case Review Group	Review Panel	Draft/Final Report	Action Plans	Case Review Group	Review Panel	Draft/Final Report	Action Plans	Case Review Group	Review Panel	Draft/Final Report	Action Plans	Case Review Group	Review Panel	Draft/Final Report	Action Plans
Safeguarding Board	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A	A
Community Safety Partnership			F	F	A	A	A	A	A	A	A	A			F	F
Regional VAWDASV Board						A	A	A								
Public Services Board							T	T			T	T			T	T
Regional Partnership Board			F	T			T	T			T	T			T	T
Welsh Government (safeguarding and community safety)	R		F	F	R		F	F	R		F	F	R		F	F
QA Home Office					R		D F	D F								
Secretary of State Home Office									R		F	F				
Domestic Abuse Commissioner							F	F								
Delivery Unit, Welsh Government (Health)													R		F	F
SUSR Co-ordination Hub	R		F	F	R		F	F	R		F	F	R		F	F
WSR			F	F			F	F			F	F			F	F

Key:

A = All stages
R = Recommendation
D = Draft
F = Final
T = Thematic learning themes from reports

Involvement in the Case Review Group will be from the partners who sit in a number of these groups. It is not represented in this table.

Other Boards (or their subgroups) that may need to be engaged depending on the case and recommendations and actions (this list is not exhaustive): Substance Misuse Area Planning Board, Serious Violence and Organised Crime Board, Policing in Wales, Police Partnership Board for Wales, Safer Communities Board for Wales, IOM Cymru Board, Regional Housing Support Collaborative Groups, Criminal Justice in Wales, Local Criminal Justice Boards.

Appendix Two: List of Departures from Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews

Home Office Domestic Homicide Review Statutory Guidance and the Wales Single Unified Safeguarding Review approach, due regard and benefits.

The Domestic Homicide Review Statutory Guidance issued under *section 9(3) of the Domestic Violence, Crime and Victims Act 2004*[63], states that a person establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) must **have regard** to the Domestic Homicide Review Statutory Guidance. This means that those persons involved in a Domestic Homicide Review must take the Domestic Homicide Review Statutory Guidance into account and, if they decide to depart from any element of it, have clear reasons for doing so.

Certain stages of the SUSR process require departure from the Domestic Homicide Review Statutory Guidance; these departures are necessary to facilitate the Review process. Below are key headings and bullet points that summarise the areas in which those departures are required.

These proposed departures have been subject of discussion between Welsh Government and the Home Office, and the Home Office accept that these particular nuances in approach to Domestic Homicide Reviews will arise in Welsh Domestic Homicide Reviews being completed through the SUSR process.

Process

- All reviews encompassed in one – avoids the need for parallel reviews.
- The SUSR process will use a standardised referral form for Wales.
- The referral form will go to the Safeguarding Board Business Unit.

63 Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. **Domestic Violence, Crime and Victims Act**

- The referral will be discussed by the Case Review Group.
- Approved Chairs and Reviewers List.
- Central register for current, ongoing and historic reviews.
- Standardised SUSR training for Reviewers, Chairs of Review Panels and Panel members.
- Monthly bulletins from the SUSR Co-ordination Hub.
- Standardised SUSR form for Agency Timelines.
- SUSR Toolkit – a document with standardised templates for each step of the process.
- SUSR standardised Action Plan – this shows which agency is responsible for each action.
- SUSR standardised Report template which is coded for use in the Wales Safeguarding Repository.

Support structure

- SUSR Co-ordination Hub – will ensure that Welsh Government has sight of every review.
- SUSR Ministerial Board.
- SUSR Victim and Family Reference Group – will be made up of victims, families and advocates. They will review the SUSR process during and after implementation.
- Wales Safeguarding Repository.
- SUSR Strategy Group.

Learning

- Primary Learning – interrogation of the Wales Safeguarding Repository to identify previous similar recommendations and themes.
- Learning Events.
- Mid-term Learning – allowing urgent learning to be disseminated before the conclusion of the Review.
- Thematic reports produced by the Wales Safeguarding Repository.
- Bi-annual Themed Dissemination Events.

A detailed list of all the departures made from the Domestic Homicide Review Statutory Guidance can be requested by emailing **SUSRWales@gov.wales**.

Appendix Three: Mental Health Homicide Referral Routes – Supporting Information

Referral routes

Any member of the Safeguarding Board, Community Safety Partnership (where a Domestic Homicide has occurred or otherwise relevant), agency or practitioner can raise a concern about a case which it is believed meet the criteria for a Single Unified Safeguarding Review; however, a Mental Health Homicide will always have Police involvement.

Health Boards and Local Authorities must ensure that immediate safeguards are considered at the point that the homicide is committed. In addition, Health Boards will need to inform the Delivery Unit[64] and Welsh Government of a Mental Health Homicide under the National Reporting Incidents framework[65]. Additional information to support this decision making is included in the two boxes below:

64 NHS Wales **Delivery Unit**
65 **NRLS Reporting**

Ensuring immediate safeguards

Given that police are required to attend all homicides, a Safeguarding Referral (Duty to Report) will act as the trigger for sharing information with Local Authorities and Health Boards following a Mental Health Homicide.

Following a homicide, the alleged perpetrator will be assessed by a member of the Mental Health Forensic Team. They will be responsible for ensuring a Duty to Report is made to the Local Authority and copy the Health Boards Corporate Safeguarding Team.

The Health Board will need to agree a local process whereby the Delivery Unit are informed, and the Mental Health Team have considered whether sufficient immediate safeguards are in place.

Notification – any incident meeting the definition of a Mental Health Homicide must be reported as a National Reportable Incident to the NHS Wales Delivery Unit in line with the National Patient Safety Incident policy[66] within seven days of the relevant Health Board or Trust becoming aware of the Mental Health Homicide. The notification form should stipulate, if known, whether the associated investigation will be a Single Unified Safeguarding Review or another type of investigation.

National Reportable Incident

From 14 June 2021, the following definition of a nationally reportable patient safety incident applies:

A patient safety incident which caused or contributed to the unexpected or avoidable death, or severe harm, of one or more patients, staff, or members of the public, during NHS funded healthcare.

Specific National Incident Categories for Mental Health

The following incidents are nationally reportable since 14 June 2021. Whilst these fall under the broad definition of a nationally reportable incident as set out above, they have been drawn out in the policy to ensure clarity on expectations around national reporting.

1. **Suspected homicides:** where the alleged perpetrator has been under the care of mental health services in the past 12 months.

2. **In-patient Suicides:** All completed in-patient suicides of any service user, in any clinical setting, will be reportable. The requirement extends to all service users, not just those being treated for mental health needs either within a Mental Health setting or otherwise. Detained Mental Health patients on authorised/agreed leave away from the clinical setting who complete suicide, or are suspected to have completed suicide whilst away, regardless of the agreed leave timeframe, will be reportable as in-patient suicides.

3. **Unexpected deaths in the community of patients known to MH&LD Services:** All unexpected deaths of service users known to Mental Health & Learning Disabilities services, including Drug and Alcohol Services, within 12 months immediately prior to their death, should be reported and proportionally investigated by responsible bodies.

66 Patient Safety Incidents **NHS Wales Patient Safety**

Mental Health (Wales) Measure 2010[67]

A Measure of the National Assembly for Wales to make provision about primary mental health support services; the coordination of and planning for secondary mental health services; assessments of the needs of former users of secondary mental health services; independent advocacy for persons detained under the Mental Health Act 1983[68] and other persons who are receiving in-patient hospital treatment for mental health; and for connected purposes.

Part 1 of the Measure, (often referred to as primary care mental health services), places a duty on Health Boards and Partners to provide local primary mental health support services to undertake the following functions:

- the carrying out of primary mental health assessments;
- the provision for an individual, following a primary mental health assessment, of the local primary mental health treatment identified by the assessment as being treatment which might improve or prevent a deterioration in the individual's mental health;
- the making of referrals, following a primary mental health assessment, concerning other services the provision of which might improve or prevent a deterioration in the assessed individual's mental health;
- the provision of information, advice, and other assistance to primary care providers to meet the providers' reasonable requirements for such information, advice, and other assistance for the purpose of improving the services related to mental health which they provide or arrange;
- the provision for patients and their carers of information and advice about the services available to them, to meet their reasonable requirements for such information and advice.

To note there are other models of mental health liaison in primary care whereby an assessment of an individual may take place. These are service often based in General Practitioner practices.

Part 2 of the Measure (often referred to as secondary care services) places a duty on health boards and partners to appoint a care coordinator for a relevant patient and to coordinate the provision of mental health services to agree outcomes and a care and treatment plan to achieve those outcomes. Part 2 of the Measure also places duties on Health Boards and partners to review the care and treatment plan as minimum **on an annual basis**.

Relevant Patient – A relevant patient is an individual for whom a mental health service provider is responsible for providing a secondary mental health service; or under guardianship of a local authority in Wales; or for whom a mental health services provider has decided that they would provide secondary mental health services if that individual cooperated with the provision of such services. Someone receiving services under part 2 is described as a relevant patient.

Part 3 of the Measure enables individuals who have previously been in receipt of secondary mental health services (relevant patients) to refer themselves back to secondary services for assessment directly. This allows assessments to take place without individuals necessarily needing to first go to their General Practitioner or elsewhere for a referral, therefore improving access. Health Boards are required to have an arrangement in place to receive requests (self-referral) for assessments of those eligible. A person remains eligible under Part 3 for a period of **three years** from the point of discharge.

67 Mental Health (Wales) Measure 2010. **Mental Health (Wales) Measure 2010**
68 **Mental Health Act 1983**

Appendix Four: Local Partners

A non-exhaustive list for Safeguarding Boards to consider of local partners that should be considered for membership or participation:

- Childcare and play providers.
- Children's centres.
- Faith Groups.
- Further Education Colleges including 6th Form Colleges.
- GPs, Dentists, Pharmacists, Ophthalmologists.
- Independent healthcare providers.
- Organisations providing specialist care to people with severe disabilities and complex health needs.
- Social care providers (including care home services for adults and children, domiciliary support services, fostering services, adoption services, adult placement services, residential family centre services and advocacy services).
- State and independent schools.
- Voluntary and community sector organisations, including those offering services or activities referred to in the **Code of Safeguarding Practice**.

In areas where they have significant local activity, the armed forces (in relation both to the families of service men and women and those personnel that are under the age of 18), the Immigration Service, and the National Asylum Support Service may be included in engagement with the relevant Safeguarding Boards.

Similarly for areas with Prisons or secure detention centres, Safeguarding Boards will wish to ensure effective connections are made with Prisons and Probation services. It is also important that effective links are made with Fire and Rescue Authorities (FRAs).

Executive members of statutory organisations, such as local Elected Members and Local Health Board executive members, could assist with contribution and scrutiny.

Appendix Five: Data Sharing Legislation

Social Services and Well-being Wales Act 2014

Section 137 *– Supply of information requested by Safeguarding Boards*

(1) A Safeguarding Board may, for the purpose of enabling or assisting the Board to perform its functions, ask a qualifying person or body to supply specified information to which subsection (2) or (3) applies to—

(a) the Board, or

(b) a person or body specified by the Board.

(2) This subsection applies to information relating to—

(a) the qualifying person or body to whom or to which the request is made,

(b) a function or activity of that qualifying person or body, or

(c) a person in respect of whom a function is exercisable, or an activity is engaged in, by that qualifying person or body.

(3) This subsection applies to information which—

(a) has been supplied to the qualifying person or body in compliance with another request under this section, or

(b) is derived from information so supplied.

(4) The qualifying person or body to whom or to which a request is made under subsection (1) must comply with the request unless the person or body considers that doing so would—

(a) be incompatible with the duties of the person or body, or

(b) otherwise have an adverse effect on the exercise of the functions of the person or body.

(5) A qualifying person or body who decides not to comply with a request under subsection (1) must give the Safeguarding Board which made the request written reasons for the decision.

(6) Information supplied under this section may only be used by the Board or other person or body to whom or to which it is supplied for the purpose mentioned in subsection (1).

(7) In this section—

"qualifying person or body" ("person neu gorff cymhwysol") means a person or body whose functions or activities are considered by the Board to be such that the person or body is likely to have information relevant to the exercise of a function of the Board;

"specified" ("penodedig" and "a bennir") means specified in a request made under subsection (1).

The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015

Regulation 4(5)

In undertaking a practice review a Board must—

(a) ask each representative body to provide the Board with information in writing about its involvement with the child or adult who is the subject of the Review.

Domestic Violence, Crime and Victims Act 2004

Section 9 *– Establishment and conduct of reviews*

(1) In this section "domestic homicide review" means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by—

(a) a person to whom he was related or with whom he was or had been in an intimate personal relationship, or

(b) a member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

(2) The Secretary of State may in a particular case direct a specified person or body within subsection (4) to establish, or to participate in, a domestic homicide review.

(3) It is the duty of any person or body within subsection (4) establishing or participating in a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) to have regard to any guidance issued by the Secretary of State as to the establishment and conduct of such reviews.

(3A) Any reference in subsection (2) or (3) to the Secretary of State shall, in relation to persons and bodies within subsection (4)(b), be construed as a reference to the Department of Justice in Northern Ireland.

(3B) A person or body within subsection (4)(a) that establishes a domestic homicide review (whether or not held pursuant to a direction under subsection (2)) must send a copy of any report setting out the conclusions of the review to the Domestic Abuse Commissioner.

(3C) The copy must be sent as soon as reasonably practicable after the report is completed.

(4) The persons and bodies within this subsection are—

(a) in relation to England and Wales—

chief officers of police for police areas in England and Wales;

local authorities;

local probation boards established under section 4 of the Criminal Justice and Court Services Act 2000 (c. 43);

NHS England;

integrated care boards established under section 14Z25 of the National Health Service Act 2006;

providers of probation services;

Local Health Boards established under section 11 of the National Health Service (Wales) Act 2006;

NHS trusts established under section 25 of the National Health Service Act 2006 or section 18 of the National Health Service (Wales) Act 2006;

(5) In subsection (4)(a) "local authority" means—

(a) in relation to England, the council of a district, county or London borough, the Common Council of the City of London and the Council of the Isles of Scilly;

(b) in relation to Wales, the council of a county or county borough.

(6) The Secretary of State may in relation to England and Wales by order amend subsection (4)(a) or (5).

Police, Crime, Sentencing and Courts Act 2022 for Offensive Weapons Homicide Reviews

Section 29 Information

(1) A review partner may request a person to provide information specified in the request to the review partner or another review partner.

(2) A review partner may make a request to a person under this section only if the conditions in subsections (3) and (4) are satisfied.

(3) The condition in this subsection is that the request is made for the purpose of enabling or assisting the performance of functions conferred on a review partner by sections 24 to 28.

(4) The condition in this subsection is that the request is made to a person whose functions or activities are considered by the review partner to be such that the person is likely to have information that would enable or assist the performance of functions conferred on a review partner by sections 24 to 28.

(5)The person to whom a request under this section is made must comply with the request.

(6)The review partner that made the request may enforce the duty under subsection (5) against the person by making an application to the High Court or the county court for an injunction.

(7) A review partner may provide information to another review partner for the purpose of enabling or assisting the performance of functions under sections 24 to 28.

Section 30 Information: Supplementary

(1) A person may not be required under section 29 to disclose information that the person could not be compelled to disclose in proceedings before the High Court.

(2) A disclosure of information required or authorised by sections 27 to 29 does not breach—

(a) any obligation of confidence owed by the person making the disclosure, or

(b) any other restriction on the disclosure of information (however imposed).

(3) But sections 27 to 29 do not require or authorise a disclosure of information that—

(a) would contravene the data protection legislation (but in determining whether a disclosure would do so, the duty imposed or power conferred by the section in question is to be taken into account), or

(b) is prohibited by any of Parts 1 to 7 or Chapter 1 of Part 9 of the Investigatory Powers Act 2016.

(4) Sections 27 to 29 do not affect any duty or power to disclose information apart from those sections.

(5) In this section "data protection legislation" has the same meaning as in the Data Protection Act 2018 (see section 3(9) of that Act).

Crime and Disorder Act 1998

Section 115 – Disclosure of information

Any person who, apart from this subsection, would not have power to disclose information—

(a) to a relevant authority; or

(b) to a person acting on behalf of such an authority,

shall have power to do so in any case where the disclosure is necessary or expedient for the purposes of any provision of this Act.

(2) In this section "relevant authority" means—

(a) the chief officer of police for a police area in England and Wales;

(b) the chief constable of the Police Service of Scotland;

(c) a local policing body within the meaning given by section 101(1) of the Police Act 1996;

(d) a local authority, that is to say—

(i) in relation to England, a county council, a district council, a London borough council, a parish council or the Common Council of the City of London;

(ii) in relation to Wales, a county council, a county borough council or a community council;

(iii) in relation to Scotland, a council constituted under section 2 of the Local Government etc. (Scotland) Act 1994;

(dza) a non-profit registered provider of social housing;

(da) a person registered under section 1 of the Housing Act 1996 as a social landlord;

(e) a local probation board in England and Wales;

(eb) probation trust;

(ec) a provider of probation services (other than a probation trust or the Secretary of State), in carrying out its statutory functions or activities of a public nature in pursuance of arrangements made under section 3(2) of the Offender Management Act 2007;

(f) a Local Health Board;

(fa) NHS England;

(fb) an integrated care board;

(h) the London Fire Commissioner;

(i) a fire and rescue authority constituted by a scheme under section 2 of the Fire and Rescue Services Act 2004 or a scheme to which section 4 of that Act applies;

(ia) a fire and rescue authority created by an order under section 4A of that Act;

(j) a metropolitan county fire and rescue authority.

(3) The appropriate national authority may by order amend this section so far as it extends to England and Wales by—

(a) adding an entry for any person or body to the list of authorities in subsection (2),

(b) altering or repealing any entry for the time being included in the list, or

(c) adding, altering or repealing provisions for the interpretation of entries in the list.

(4) In subsection (3) "the appropriate national authority" has the same meaning as in section 5.

Health and Social Care (Community Health and Standards) Act 2003

74 Power to require documents and information

(1) The Assembly may at any time require any person specified in subsection (2) to provide it with any information, documents, records (including personal records) or other items—

(a) which relates or relate to—

(i) the provision of health care by or for a Welsh NHS body; or

(ii) the discharge of any of the functions of a Welsh NHS body; and

(b) which the Assembly considers it necessary or expedient to have for the purposes of this Chapter.

(2) The persons referred to in subsection (1) are—

(a) the Welsh NHS body;

(b) any person providing health care for, or exercising functions of, the Welsh NHS body;

(c) a local authority in Wales.

(3) The power in subsection (1) to require the provision of records includes, in relation to records kept by means of a computer, power to require the provision of the records in legible form.

(4) Any person who without reasonable excuse fails to comply with any requirement imposed by virtue of this section is guilty of an offence and liable on summary conviction to a fine not exceeding level 4 on the standard scale.

75 Power to require explanation

(1) The Assembly may by regulations make provision requiring prescribed persons to provide to the Assembly, or to persons authorised by it, an explanation of—

(a) any documents, records or items inspected, copied or provided under sections 72 to 74,

(b) any information provided under those sections, or

(c) any matters which are the subject of the exercise of any function of the Assembly under section 70, and

in circumstances where the Assembly considers the explanation necessary or expedient for the purposes of this Chapter.

(2) Regulations under subsection (1) may require explanations to be provided at such times and places as may be specified by the Assembly.

(3) Any person who without reasonable excuse fails to comply with any requirement imposed by virtue of this section is guilty of an offence and liable on summary conviction to a fine not exceeding level 4 on the standard scale.

Limitations to note: The focus of a review under the 2003 Act is limited to the provision of health care by and for Welsh NHS bodies.

Mental Health Act 1983

120C Provision of information

(1) This section applies to the following persons–

(a) the managers of a hospital within the meaning of Part 2 of this Act;

(b) a local social services authority;

(c) persons of any other description prescribed in regulations.

(2) A person to whom this section applies must provide the regulatory authority with such information as the authority may reasonably request for or in connection with the exercise of its functions under section 120.

(3) A person to whom this section applies must provide a person authorised under section 120 with such information as the person so authorised may reasonably request for or in connection with the exercise of functions under arrangements made under that section.

(4) This section is in addition to the requirements of section 120(7)(c).

(5) "Information" includes documents and records.

(6) "Regulations" means regulations made–

(a) by the Secretary of State, in relation to England;

(b) by the Welsh Ministers, in relation to Wales.

Limitations to note: The scope of a review under the 1983 Act is limited to the exercise of powers and discharge of duties under the 1983 Act itself in respect of detention, guardianship and relevant patients (see Section 120(1) and 120 (2)).