Llywodraeth Cymru
Welsh Government

Single Unified Safeguarding Review

Learning from the Past to make the Future Safer

Draft Statutory Guidance

Contents

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 groundbreaking 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. Around 190 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 shared learn.

This pioneering work all started in 2017, when Carl Sargeant, the then-Cabinet Secretary for Communities and Children, had questioned why Domestic Homicide Reviews were not being shared with Welsh Government. He commissioned two reviews which included an Academic Review by Cardiff University and a Welsh Government practitioners review.

Evidence from both reviews highlighted we needed a better coordinated system for reviews in Wales, resulting in the call for a single review of an incident to simplify and concentrate efforts, reducing trauma to families, 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 uses social and computer science to extract hidden 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*, 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 which breaks down silos, draws together insights from different spheres of expertise and encourages partnership working across the whole of the public service as well as with wider social partners.

The SUSR lays out a framework for how Regional 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, is 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 Introduction

1.1 The development of the Single Unified Safeguarding Review process in Wales has been undertaken to ensure that following a significant event that triggers the review process, all aspects are considered across all relevant agencies, devolved and non-devolved, rather than in organisational silos. In particular it will:

a) 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 laid down in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[1] to enable a greater understanding of what happened during an incident or a series of incidents/actions over a period of time and why it happened. The 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.

b) Implement the findings of the 2018 academic report led by Professor Amanda Robinson (2018)[2] from Cardiff University and a Welsh Government practitioner's report by Assistant Chief Constable Liane James (2018)[3]. The reports analysed the existing safeguarding review landscape alongside a sample of Domestic Homicide Reviews, Adult Practice Reviews, Child Practice Reviews and Mental Health Homicide Reviews. These reports highlighted the need for co-ordination, collaboration, communication, and governance to be improved when conducting reviews in Wales. The reports made recommendations based on their findings which are reflected in the new processes of the Single Unified Safeguarding Review system. The reports 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 ultimately resulted in the recommendation for a single review process.

1.2 The combined evidence from both the academic and practitioners' reviews mentioned above, provided Welsh Ministers with powerful evidence to support the need for change in relation to the review processes in Wales. Consequently, the Single Unified Safeguarding Review process has been developed to strengthen the review landscape within Wales. The Single Unified Safeguarding Review 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);

[1] *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.* Safeguarding Boards Regulations (2015)

[2] 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'*

[3] James, L. (2018) *'Domestic Homicide Reviews in Wales: Illuminate the Past to Make the Future Safer'*

    - Child Practice Review (whether concise or extended);
    - Domestic Homicide Review;
    - Mental Health Homicide Review; and
    - Offensive Weapons Homicide Review[4].
- 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;
- use the insight and learning from the Review to enact positive change in practice to prevent future harm;
- to provide a framework in which a national body fulfils a co-ordination/operational role to oversee the end-to-end process (the Single Unified Safeguarding Review Co-ordination Hub);
- ensure that the governance structure is in place and effective;
- ensures clear linkages between local, regional, and national bodies while respecting regional and local variations in arrangements;
- retain the final review Report in a central repository (the Wales Safeguarding Repository) and facilitate pan-Wales training and local, regional, national, and international learning; and
- use the Repository to support any changes to practices, processes and cultures which will prevent future harm.

1.3 "*Safeguarding*" – the definition of safeguarding in this context is keeping people safe whether that is from abuse as defined in the *Social Services and Well-being (Wales) Act 2014*[5] or from being the victim of homicide or suicide where coercion is involved.

1.4 "*The Review*" – in this Guidance, this refers to the Single Unified Safeguarding Review.

1.5 This guidance is issued under section 139 of *The Social Services and Well-being (Wales) Act 2014*[6]. The criteria for conducting a Single Unified Safeguarding Review consist of several inter-related parts, as laid down in *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[7], the *Domestic Violence, Crime and Victims Act (2004)*[8] 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*[9].

1.6 This Single Unified Safeguarding Review Guidance has been developed using the Child Practice Review, Adult Practice Review and Domestic Homicide Review

[4] Offensive Weapon Homicide Reviews are to be piloted (2023) using the Single Unified Safeguarding Review process in Wales and therefore may be subject to change.
[5] Social Services and Well-being (Wales) Act 2014 Social Services and Wellbeing Act
[6] Section 139 *The Social Services and Well-being (Wales) Act 2014.* Section 139
[7] Regulation 4(3) and 4(4). Safeguarding Boards Regulations 2015
[8] Section 9(1). Domestic Violence, Crime and Victims Act 2004
[9] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

guidance building on the areas of strength in each set of guidance and incorporating the Offensive Weapon Homicide Review guidance and information on Mental Health Homicide Reviews. The draft created collaboratively by practitioners at both operational and strategic levels has been further refined with wide engagement. This Single Unified Safeguarding Review statutory guidance will now replace Working Together to Safeguard People Volumes 2 (Child Practice Reviews) and 3 (Adult Practice Reviews). As a result, any consequential changes to Volume 1 (Introduction and Overview) will be made to reflect this.

Partnerships in Wales

1.7 The Single Unified Safeguarding review 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, and to ensure that relevant lessons are learnt across the governance structures and required changes and adjustments made where appropriate locally, regionally, and nationally.

1.8 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) and the third sector work closely together to deliver effective services.

1.9 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*[10]), Regional Partnership Boards (*Social Services and Well-being (Wales) Act 2014*[11]), Regional 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*[12]), Regional Violence Against Women, Domestic Abuse and Sexual Violence Boards (*Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015*[13]), alongside Local Criminal Justice Boards, Integrated Offender Management Groups, Multi-agency Public Protection Arrangements and Substance Misuse Area Planning Boards. Please use Appendix One as a reference point for these structures.

1.10 The existing governance structures should be utilised throughout application of

[10] Well-being of Future Generations (Wales) Act 2015 Wellbeing of Future Generations Act
[11] Social Services and Wellbeing (Wales) Act 2014 Social Services and Wellbeing Act
[12] The Crime and Disorder Act 1998 The Crime and Disorder Act
[13] Violence Against Women, Domestic Abuse and Sexual Violence (Wales) Act 2015 Violence Against Women Act

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*. In fact, we believe that the strong partnerships that already exist in Wales are in a strong position to deliver Single Unified Safeguarding Reviews and monitor progress of Action Plans.

1.11 In order to achieve these aims, a support network for the Single Unified Safeguarding Review process has been developed (please see Figure1 and Figure 2). The new systems mentioned above have been summarised below:

Single Unified Safeguarding Review Ministerial Board for Wales

a) The Ministerial Board provides political and strategic oversight of Single Unified Safeguarding Reviews, ensuring national issues are considered and a pan-Wales response is provided when required. The Board will provide support for agreed and necessary legislative changes and securing the resources so that best practice is implemented and shared. The Board will also act as a platform for escalating any regional issues which are identified that require a national or UK response. Please see Section 5 for the roles and responsibilities of the Ministerial Board.

Single Unified Safeguarding Review Strategy Group

b) The purpose of the Strategy Group is to provide leadership, oversight, and direction to both the Single Unified Safeguarding Review Ministerial Board and Operational Management Board.

c) The Single Unified Safeguarding Review Strategy Group will advise, inform, and influence Welsh Government, UK Government (Home Office and Ministry of Justice), the Victims Commissioner, Domestic Abuse Commissioner and representative bodies in local government, policing, criminal justice and the third sector on themes and other information linked to the recommendation from reviews in Wales.

d) The Single Unified Safeguarding Review Strategy Group will identify, celebrate and promote effective practice and encourage the adoption, upscaling and mainstreaming of initiatives that are proven to be ‘what works’.

Single Unified Safeguarding Review Operational Management Board

e) The purpose of the Board is to provide leadership, oversight and direction to a shared programme between Welsh Government, Local Government, Policing in Wales, Cardiff University and other key partners. It ensures effective shared leadership is provided in contributing to the delivery of the Single Unified Safeguarding Review programme, specifically in regard to the Co-ordination Hub and the Wales Safeguarding Repository. It ensures key links with the other parts of the Single Unified Safeguarding Review

programme are maintained. This includes providing governance to the Single Unified Safeguarding Review Co-ordination Hub and the Wales Safeguarding Repository.

Single Unified Safeguarding Review Victim and Family Reference Group

f) The Victim and Family Reference Group will provide a forum for the victim and family voice across Wales to inform the delivery of the Single Unified Safeguarding Review and its national governance and oversight work. Please see Section 6 for more information.

Regional Safeguarding Boards

g) Regional Safeguarding Boards have been responsible for undertaking Adult Practice Reviews and Child Practice Reviews. They will now take on extra responsibilities for instigating all Single Unified Safeguarding Reviews (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, the Single Unified Safeguarding Review Co-ordination Hub, and the Wales Safeguarding Repository;
- working with Community Safety Partnerships who have responsibility for Domestic Homicide Reviews and will be key partners with the Regional Safeguarding Boards where the case involves a homicide; and
- working with Public Services 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.

h) Please refer to paragraph 5.3 which outlines the role and responsibilities of the Regional Safeguarding Board.

The Single Unified Safeguarding Review Co-ordination Hub

i) The role of the Single Unified Safeguarding Review Co-ordination Hub is to support the Single Unified Safeguarding Review process and assist in the identification and dissemination of key messages, themes, and issues, by working collaboratively with the Wales Safeguarding Repository, Regional Safeguarding Boards, Community Safety Partnerships, and other key partners and partnerships.

j) The Co-ordination Hub will collate the outcomes of Learning Events (see Section 7) ensuring all outcomes are disseminated across Wales, and with

relevant UK bodies where appropriate. This will include delivery of themed training and Bi-annual Themed Dissemination Events (see Section 8 of this guidance for more information) to share good practice and lessons learned across Wales. This will ensure learning is achieved and implemented to safeguard individuals and communities across Wales.

The Wales Safeguarding Repository

k) All completed Single Unified Safeguarding Reviews will be retained in the Wales Safeguarding Repository. Their findings will be used to inform learning on a pan-Wales basis through the creation of thematic reports. Please see the Wales Safeguarding Repository (Section 8 of this guidance) for more detail.

1.12 The Single Unified Safeguarding Review process has been created by practitioners and strategic leads to develop 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;
- eliminating duplication of effort will ensure the most efficient utilisation of resources and achieve best value;
- producing a Review Report that is focussed on improving service delivery with a clear Action Plan that will be monitored and reviewed by the Single Unified Safeguarding Review Co-ordination Hub and shared with Regional Safeguarding Boards, Community Safety Partnerships and other relevant groups to ensure that recommendations are implemented;
- ensuring the victim/family impacted is at the heart of the review process at all stages;
- taking a “one public service” approach so that victims and families are not left to make sense of the work of different professions or agencies;
- enabling the sharing of information, recommendations, and thematic learning to safeguard future generations; and
- ensuring that these recommendations are actioned to improve practices and prevent future harm.

1.13 It also builds upon the Child Practice Review and Adult Practice Review framework, and Domestic Homicide Review guidance 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 see 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;
- focuses on key learning identified through the review process which results in relevant recommendations and actions to improve future practice.

1.14 Accompanying this guidance is a set of training tools and materials supporting the Single Unified Safeguarding Review arrangements. Please refer to the Single Unified Safeguarding Review Toolkit for templates which must be used throughout the Single Unified Safeguarding Review process. This will ensure that a standardised approach across Wales is maintained for consistency throughout the whole Single Unified Safeguarding Review process. These templates can be accessed through the Single Unified Safeguarding Review Co-ordination Hub.

1.15 The development of these arrangements has been informed by extensive discussion, consultation, feedback and testing through workshops of stakeholders, and pilots of Single Unified Safeguarding Reviews by Regional Safeguarding Boards and Community Safety Partnerships. They have all made an invaluable contribution to developing the detail of this guidance.

1.16 This Statutory Guidance should be read in conjunction with all of the Appendices associated with this guidance.

SUSR OVERARCHING SUPPORT NETWORK

Learning from the Past to make the Future Safer

Llywodraeth Cymru
Welsh Government

Roles of the Support Network

Ministerial Board:

Political and strategic oversight of safeguarding reviews, ensuring national issues are considered and a Pan Wales response is provided when required. Providing support for legislative changes and securing the necessary resources so that best practice is implemented and shared and that regional issues can be escalated if required to gain a national /UK response.

National Independent Safeguarding Board:

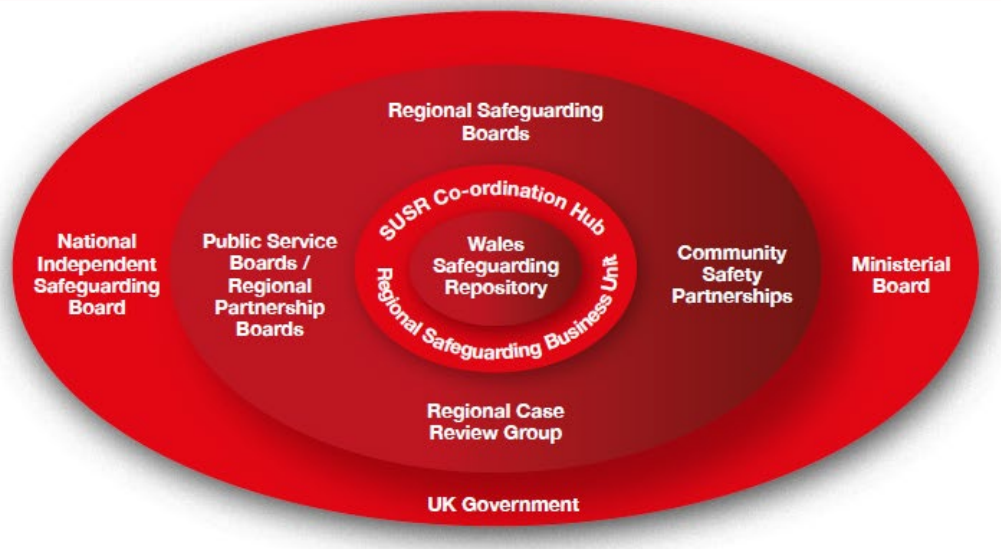
Provides support and advice to Regional Safeguarding Boards to ensure the adequacy and effectiveness of arrangements to safeguard children and adults in Wales and to make recommendations to Welsh Ministers as to how those arrangements could be improved.

Public Services Boards and Regional Partnership Boards:

Every Welsh local authority area has a range of existing multi-agency arrangements in place. These existing partnerships will include Public Services Boards and Regional Partnership Boards. Regional Safeguarding Boards and/or Community Safety Partnerships may choose to involve these Boards 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.

Regional Safeguarding Boards:

Safeguarding Boards have to safeguard Children and Adults that are at risk of abuse, neglect and other kinds of harm. The Board must seek to achieve its objectives by co-ordinating and ensuring the effectiveness of what is done by each person or body represented on the Board; to set out its proposals for achieving its objectives at the beginning of each financial year; and co-operate with and supply the National Board with any information it requests. Each Board is expected to identify and benchmark the areas of practice which require improvement, review the training needs of practitioners and ensure training is provided to interagency and individual organisations.



Regional Case Review Group:

Multi-partnership group which considers all referrals for Single Unified Safeguarding Reviews for their region. Each Regional Safeguarding Board will have their own Case Review Group made up of representatives and experts from different agencies. The group will ensure that all Reviews are appropriately resourced, and that strategic and operational Action Plans are co-ordinated and managed effectively.

SUSR Co-ordination Hub:

Will co-ordinate key aspects of the SUSR process, manage the findings arising from the repository and identify learning events required which will help to share good practice and lessons learned. Responsible for communicating and informing public services of recommendations and emerging themes and Quality Assurance is applied across the SUSR process.

Wales Safeguarding Repository:

All completed safeguarding reviews will be coded and submitted into the repository to be collated and curated. Findings from social science coding and machine learning will be circulated to the Co-ordination Hub, to ensure lessons identified are learned and embedded into current practice.

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Figure 1

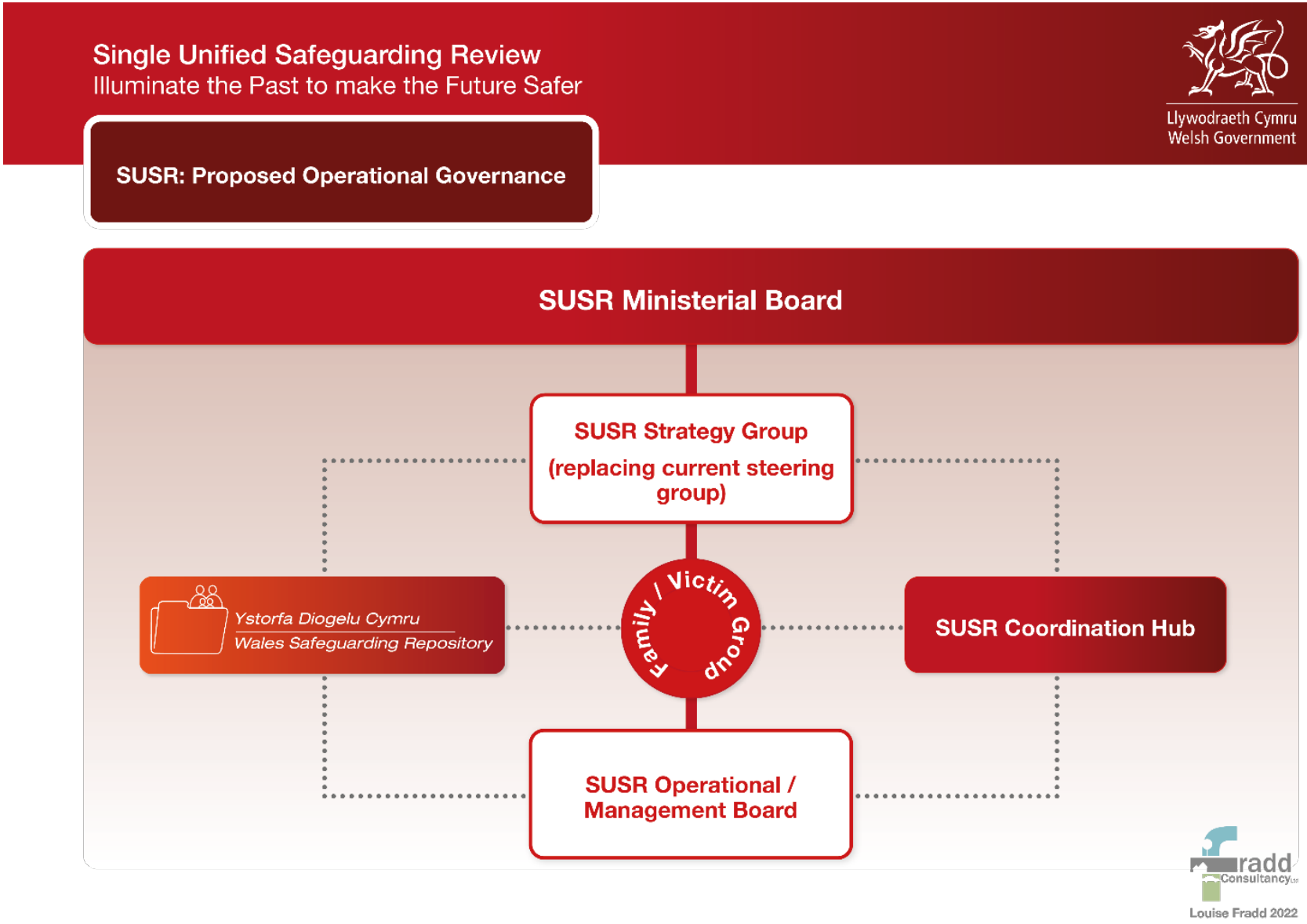
Single Unified Safeguarding Review
Illuminate the Past to make the Future Safer
Llywodraeth Cymru
Welsh Government
SUSR: Proposed Operational Governance
SUSR Ministerial Board
SUSR Strategy Group
(replacing current steering group)
Family / Victim Group
Ystorfa Diogelu Cymru
Wales Safeguarding Repository
SUSR Coordination Hub
SUSR Operational / Management Board
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Figure 2

2 The Purpose and Principles underpinning the Single Unified Safeguarding Review

Purpose

2.1 The Single Unified Safeguarding Review has been built with practitioners to ensure that lessons can be identified and implemented quickly on a pan-Wales basis, enabling learning to be shared with a view to affecting timely policy and process change and ultimately reducing the risk of reoccurrence and saving lives.

2.2 The Single Unified Safeguarding Review 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, the Single Unified Safeguarding Review 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 family and principal individuals through numerous reviews, causing delays in the identification and implementation of the identified learning.

2.3 The Single Unified Safeguarding Review 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 or who has been a victim of homicide, and their family, where every effort will be made to ensure that their voices 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 7 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.

2.4 A Single Unified Safeguarding Review is **not** an inquiry into how the victim died or sustained injuries or into who is culpable; that is a matter for the coroners, the police, Crown Prosecution Service and criminal courts respectively to determine as appropriate. Single Unified Safeguarding Reviews are not specifically part of any disciplinary investigation or process. Where information emerges in the course of the Single Unified Safeguarding Review indicating that disciplinary action should be initiated, the relevant agency's disciplinary procedure should be followed separately from the Single Unified Safeguarding Review process. Alternatively, some Single Unified Safeguarding Reviews may be conducted concurrently with (but separate to) disciplinary action.

Principles

2.5 The Single Unified Safeguarding Review is underpinned by a set of principles to guide Regional Safeguarding Boards, their partner agencies and other community partners in their responsibilities for learning, reviewing, and improving safeguarding policy and practice. The principles have been intrinsically linked in shaping the design and development of the Single Unified Safeguarding Review for multi-agency safeguarding reviews. The principles identified are as follows:

a) professionals in all services working with children and/or adults at risk and their families in the local 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) practices are improved based on learning to work towards the prevention of harm to child and/or adult at risk;
c) organisational cultures, and the processes that underpin the culture, 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 for learning and reviewing that 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

2.6 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 single review process, which avoids the need for multiple reviews in relation to one incident(s), creates a simplified yet concentrated approach. This approach will reduce further trauma for victims and families. It will eliminate any potential duplication of effort, and will utilise resources and deliver learning in a timely and proportionate manner.

2.7 The outcomes of the Single Unified Safeguarding Review process will have local,

regional, and national impacts on practices across Wales. These include:

- providing one process for either a single or multiple review in Wales, making it clearer for all partner agencies involved;
- reducing trauma for the subject of the review, their families, and other principal individuals by carrying out a single review rather than multiple reviews;
- monitoring and disseminating the Action Plan by the Single Unified Safeguarding Review Co-ordination Hub to Regional Safeguarding Boards, Community Safety Partnerships and other relevant groups;
- an improved governance system 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 the Single Unified Safeguarding Review Reports to produce thematic reports. The learning from the thematic reports will be disseminated nationally by the Single Unified Safeguarding Review Co-ordination Hub along with any recommendations and actions which will need to be implemented as a result;
- previous learning being taken into account; and
- ensuring engagement and involvement with the Police and Crime Commissioners, the Home Office, the Victims Commissioner and the Domestic Abuse Commissioner where there is a domestic homicide or offensive weapons homicide involved in the Single Unified Safeguarding Review.

2.8 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 and ultimately reduce harm going forward.

3 When to conduct a Single Unified Safeguarding Review

3.1 The Single Unified Safeguarding Review has been developed to enable Regional Safeguarding Boards, Community Safety Partnerships (in cases of Domestic Homicide) and their partner agencies to work within an open and transparent environment, which promotes learning. This is based on how they work individually and collectively with regard to their own and others' casework and from additional sources, such as audits, research, and inspection. This will be further strengthened through:

- the development of 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 Single Unified Safeguarding Review Co-ordination Hub

3.2 To ensure that learning is disseminated, and Action Plans implemented, the Regional Safeguarding Board Business Unit in partnership with Community Safety Partnerships, and the Single Unified Safeguarding Review Co-ordination Hub will produce Update Reports (refer to the Single Unified Safeguarding Review 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 Regional Safeguarding Boards, and where necessary, the Single Unified Safeguarding Review Strategy Group and the Ministerial Board for escalation where barriers are identified. In the case of a Single Unified Safeguarding Review that involves an Offensive Weapon Homicide the Update Report, and the appropriate Action Plans will be presented to the Home Office Oversight Board.

3.3 In summary, the criteria for conducting a Single Unified Safeguarding Review consist of several inter-related parts, as laid down in *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[14], the *Domestic Violence, Crime and Victims Act (2004)*[15] and s*ection 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*[16].

Criteria for a Single Unified Safeguarding Review

3.4 A key criterion for a Single Unified Safeguarding Review is multi-agency learning, which is both 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 at the heart of the process and forms a

[14] Regulation 4(3) and 4(4). Safeguarding Boards Regulations 2015
[15] Section 9(1). Domestic Violence, Crime and Victims Act 2004
[16] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

key component when determining whether or not a Single Unified Safeguarding Review is required.

3.5 A Regional Safeguarding Board must undertake a Single Unified Safeguarding Review where **one or more** of the following is applicable:

a) Abuse or neglect of a **child** is known or suspected, within the area of the Regional Safeguarding Board, and the child has:
   i. died; or
   ii. sustained potentially life-threatening injury; or
   iii. sustained serious and permanent impairment of health or development.

In the event that the child has, in the preceding six months, been on the child protection register or been Looked After, then the Review Panel must give due regard to the additional factors as outlined in the exemplar Terms of Reference;

b) Abuse or neglect of an **adult at risk** is known or suspected, within the area of the Regional Safeguarding Board, and the adult at risk has:
   i. died; or
   ii. sustained potentially life-threatening injury; or
   iii. sustained serious and permanent impairment of health or development.

In the event that the adult at risk has on any date during the six months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect, then the Review Panel must give due regard to the additional factors outlined in the exemplar Terms of Reference.

c) Where the Single Unified Safeguarding Review meets the criteria for Adult Practice Reviews or Child Practice Reviews (a and b in this guidance), please consider the following. As set out in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[17]*,* Regional Safeguarding Boards must undertake a Single Unified Safeguarding Review in accordance with regulation 4 and determine whether a concise or extended review is required. Consideration must also be given to the number of Reviewers who are commissioned.

d) A Domestic Homicide when
   i. the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse, or neglect by:
      - a person to whom the subject of the review was related or with whom they were related or had been in an intimate personal relationship, or;

[17] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 (legislation.gov.uk)

- a member of the same household as themselves, held with a view to identifying the lessons to be learnt from the death; or
- where a victim took their own life (suicide) and the circumstances give rise to concern, for example it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable.

Please view section 2 within the Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016)[18] to view this criterion.

The Domestic Homicide Review Statutory Guidance issued under *section 9(3) of the 2004 Domestic Violence, Crime and Victims Act*[19], 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 this guidance. This means that those persons involved in a Domestic Homicide Review must take this guidance into account and, if they decide to depart from it, have clear reasons for doing so. Certain stages of The Single Unified Safeguarding Review process require departure from the Domestic Homicide Review guidance which are necessary to enhance the review process. Within this statutory guidance, where these departures are made, clear reasons for doing so are provided. All departures from the Domestic Homicide Review guidance have been co-ordinated and agreed with the Home Office Domestic Homicide Review team.

e) A Mental Health Homicide when:
   i. a homicide is committed, and the alleged perpetrator has been in contact with primary, secondary, or tertiary Mental Health services within the last year.

In this criteria 'contact' may include an assessment or intervention. Specific consideration must also be given to the Mental Health (Wales) Measure 2010[20] which defines the provision of mental health services to patients in specific situations.

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.

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

[18] Section 2. Multi-agency Statutory Guidance
[19] Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. Domestic Violence, Crime and Victims Act
[20] Mental Health (Wales) Measure 2010. National Service Model for Local Primary Mental Health Support Services Mental Health (Wales) Measure 2010

Action following the Regional Safeguarding Board decision:
Where a Single Unified Safeguarding Review Case Review Group has determined that a Mental Health Homicide will be subject to a Single Unified Safeguarding Review, the Single Unified Safeguarding Review will be considered to be an appropriate process for the purposes of the National Patient Safety Incident Policy[21]. On the conclusion of the review, the findings from the Single Unified Safeguarding Review should be reported back to the NHS Wales Delivery Unit via a "Learning from Events" form available on the Delivery Unit's website[22].

Where the Case Review Panel has determined that a Mental Health Homicide will **not** be subject to a Single Unified Safeguarding Review (for example, there has been no multi-agency involvement), the relevant Health Board or Trust will consider carrying out an appropriate review in line with their internal processes.

f) An Offensive Weapon Homicide if:
   i. it occurred in the South Wales Police area which is one of the three pilot areas for an Offensive Weapons Homicide Review;
   ii. the person was aged 18 or over, and the death occurred within Wales; or
   iii. the death, or the events surrounding it, involved the use of an Offensive Weapon.

The following criteria is set out in the *Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022*[23]. The criteria to be met is as follows:

   i. 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.
   ii. 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.
   iii. one or more review partners has information about, or would reasonably be expected to have information about –
      - the person who died or is likely to have 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,*

[21]Patient Safety Incidents NHS Wales Patient Safety
[22] NHS Wales Delivery Unit Delivery Unit
[23] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

mental health and safeguarding; and

- *does not include information that only became known to a review partner after the record of the death, of the person who died or is likely to have died was made.)*

iv. 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).

v. As set out in section 26 of the *Police, Crime, Sentencing and Courts Act 2022*, an Offensive Weapons Homicide Review is not required to be carried out in relation to a death where a Domestic Homicide Review in England, or a Single Unified Safeguarding Review (which meets any of the criteria a-d) by a Regional Safeguarding Board in Wales is to be carried out.

An Offensive Weapon is defined, for the purposes of an Offensive Weapons Homicide Review, in section 1 of the *Prevention of Crime Act 1953*[24] 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]."

3.6 As the Single Unified Safeguarding Review is the main Review process in Wales, new review types that may emerge will be incorporated within the Single Unified Safeguarding Review 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.

[24] Section 1. Prevention of Crime Act 1953

4 What is the Single Unified Safeguarding Review Process?

4.1 A Single Unified Safeguarding Review is made up of a number of interconnected activities which are summarised below, all of which are intended to contribute to the rigour of the process and to maximise the learning drawn from the case being reviewed. The purpose of each component of the process are described in more detail in the appropriate paragraphs contained within this section. The overall process is shown in the flowchart (Figure 3) at the end of this section.

4.2 The purpose of the various components that make up the Single Unified Safeguarding Review are described in more detail in Section 5. The following provides a brief summary of the process as a whole.

4.3 The Single Unified Safeguarding Review process will be managed by the appropriate Regional Safeguarding Board. The Regional Safeguarding Board will:

- establish a Case Review Group in consultation with the Chair of the Regional Safeguarding Board working in partnership with the Community Safety Partnerships especially where a Domestic Homicide has occurred;
- support the Case Review Group in the appointment of an appropriate Reviewer(s); and
- oversee the engagement with individuals involved in the review process. For example, the involvement of relevant review partners i.e., local authority, Police and Crime Commissioners, and Health Board representatives within the Review Panel (when there is a Single Unified Safeguarding Review where an Offensive Weapon Homicide has occurred, please refer to the Offensive Weapons Homicide Review Statutory Guidance for further information on identifying the relevant review partners[25]).

4.4 The Review is managed by a Case Review Group and a Reviewer(s) is appointed to work with the Review Panel (see Section 5 for role descriptions), which is composed of relevant agencies and partners that have been involved in the case. The Review provides:

- direct engagement with victims, family members and principal individuals as they wish and is appropriate, thus 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; and
- a planned and facilitated practitioner-focused Learning Event (see Section 7 for more information) conducted by the Reviewer(s), to examine practice within a limited timeline, using a systems approach.

4.5 The outcome is a draft Single Unified Safeguarding Review Report and an outline Action Plan which is produced by the Reviewer(s) using recommendations from

[25] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

the Report and presented in a timely manner to the Regional 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 within and as a result of the Report. Victims, families or principal individuals will be able to choose, if they wish, a suitable pseudonym for the victim to be used in the Report. Gender anonymisation should be discussed as part of this conversation. See Section 6 for more information and guidance on engagement with victims, families, and principal individuals.

4.6 The Regional Safeguarding Board members must 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.

4.7 The final Report is approved by the Regional Safeguarding Board Chair, submitted to the Single Unified Safeguarding Review Co-ordination Hub to be retained in the Wales Safeguarding Repository, and published by the Regional Safeguarding Board. However, in the following circumstances, the above publishing process will not apply until after the following is undertaken:

- A Single Unified Safeguarding Review involving a Domestic Homicide will be sent by the Single Unified Safeguarding Review Co-ordination Hub 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.
- A Single Unified Safeguarding Review involving an Offensive Weapons Homicide will be sent by the Single Unified Safeguarding Review Co-ordination Hub to the Secretary of State for the Home Office. It will be placed in the Wales Safeguarding Repository and published by Regional Safeguarding Boards within one calendar 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.

4.8 The Action Plan will be finalised within four weeks of the final Report being approved by the Chair, approved by the Regional Safeguarding Board, and forwarded by the Chair to the Welsh Government, and the Single Unified Safeguarding Review Co-ordination Hub to be retained in the Wales Safeguarding Repository, to ensure learning is disseminated and acted upon. The implementation of the Action Plan will be regularly reviewed by both the Single Unified Safeguarding Review Co-ordination Hub, the appropriate Regional Safeguarding Board Business Unit and, the Community Safety Partnership and the Home Office Oversight Board for Offensive Weapons Homicides. Progress in relation to the implementation of the recommendations through the Action Plan will be reported to, and monitored by, the relevant Regional Safeguarding Board and Community Safety Partnership. The Single Unified Safeguarding Review Co-ordination Hub will provide monitoring reports to the Single Unified Safeguarding Review Strategy Group and issues will be escalated to the Ministerial Board where barriers are identified. See the Governance flowchart (Figure 2).

4.9 Action Plans are a fundamental outcome of the Single Unified Safeguarding Review process and should consider the recommendations from the Single Unified Safeguarding Review Report. This will lead to improvements in relation to safeguarding across all agencies and will aid early intervention and prevention (see the Single Unified Safeguarding Review Toolkit for Action Plan template and guidance). The recommendations 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 the benefits to the relevant agencies and partners; and
- identify what problems will be corrected or avoided.

4.10 It is important that recommendations are concise and relevant and should not be general statements, this is a key factor that will be assessed by the Reviewer(s) prior to the Report being finalised.

4.11 When conducting Single Unified Safeguarding Reviews, those agencies involved in delivering the review process must adhere to the Welsh Language Standards where applicable. Those participating in a Single Unified Safeguarding Review must be given the opportunity to contribute to the review in their preferred language of Welsh or English. When Single Unified Safeguarding Review Reports are published, they must be published in both Welsh and English.

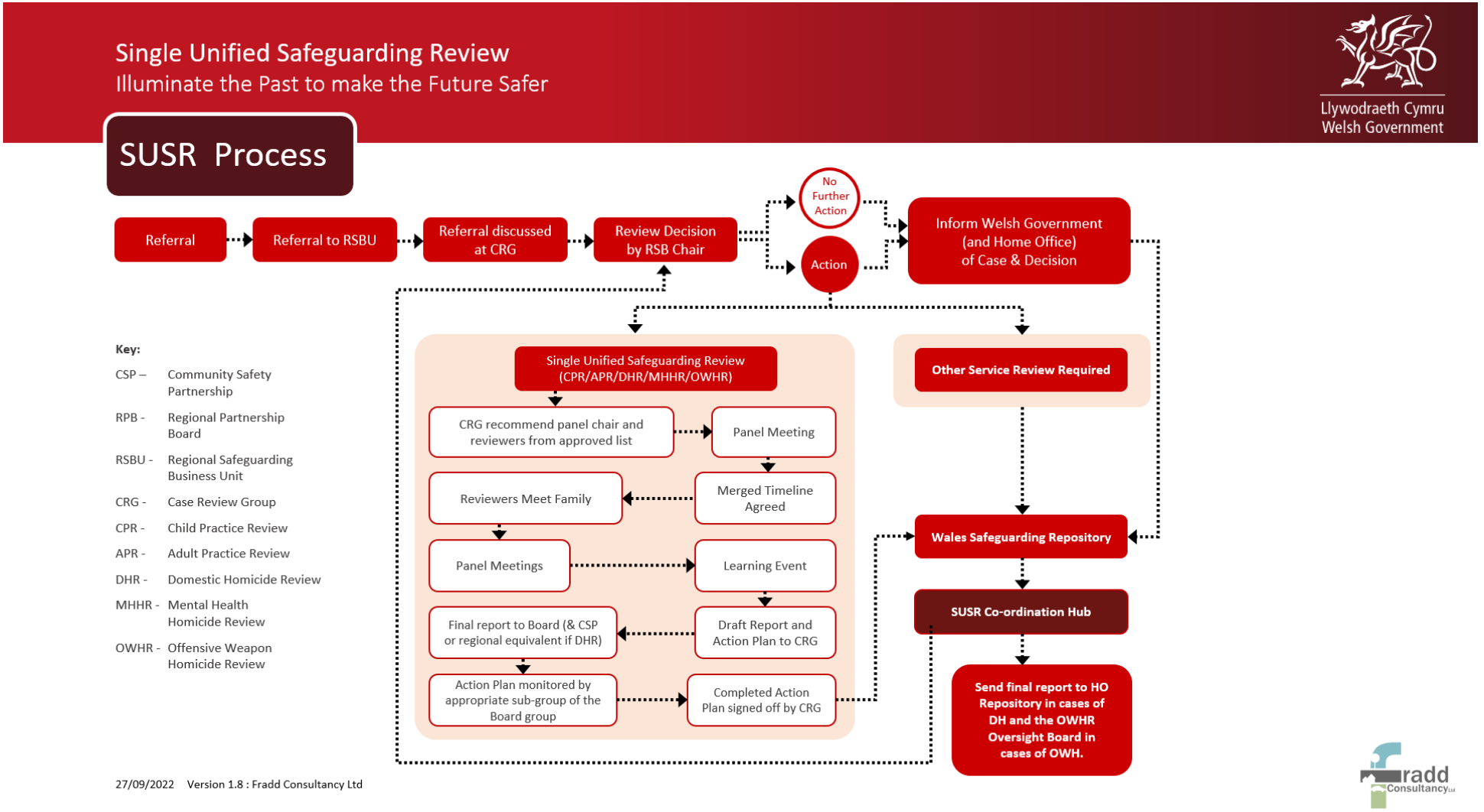
Single Unified Safeguarding Review
Illuminate the Past to make the Future Safer
Llywodraeth Cymru
Welsh Government
SUSR Process
Referral
Referral to RSBU
Referral discussed at CRG
Review Decision by RSB Chair
No Further Action
Action
Inform Welsh Government (and Home Office) of Case & Decision
Key:
CSP – Community Safety Partnership
RPB - Regional Partnership Board
RSBU - Regional Safeguarding Business Unit
CRG - Case Review Group
CPR - Child Practice Review
APR - Adult Practice Review
DHR - Domestic Homicide Review
MHHR - Mental Health Homicide Review
OWHR - Offensive Weapon Homicide Review
Single Unified Safeguarding Review (CPR/APR/DHR/MHHR/OWHR)
CRG recommend panel chair and reviewers from approved list
Panel Meeting
Reviewers Meet Family
Merged Timeline Agreed
Panel Meetings
Learning Event
Final report to Board (& CSP or regional equivalent if DHR)
Draft Report and Action Plan to CRG
Action Plan monitored by appropriate sub-group of the Board group
Completed Action Plan signed off by CRG
Other Service Review Required
Wales Safeguarding Repository
SUSR Co-ordination Hub
Send final report to HO Repository in cases of DH and the OWHR Oversight Board in cases of OWH.
27/09/2022 Version 1.8 : Fradd Consultancy Ltd
fradd Consultancy Ltd

Figure 3

5 Implementing the Single Unified Safeguarding Review Process

Roles and Responsibilities

5.1 This section sets out the roles and responsibilities of those involved in the Single Unified Safeguarding Review process.

5.2 Within the Single Unified Safeguarding Review process, there will always be both a Chair of the Review Panel and a Reviewer(s). The Chair of the Review Panel is appointed by the Review Panel to ensure the momentum of the review process is maintained. The Reviewer is the author of the Single Unified Safeguarding Review Report and meets with the subject of the review when appropriate, their family and principal individuals, and representatives of involved agencies, among other responsibilities.

5.3 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 Single Unified Safeguarding Review process to avoid confusion. The detailed responsibilities of the Chair of the Review Panel and the Reviewer(s) can be found in the Single Unified Safeguarding Review Toolkit.

Regional Safeguarding Boards

5.4 Achieving improvement in safeguarding policy, systems and practice is a core business of Regional Safeguarding Boards. To meet the statutory requirements set out under the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[26], Regional Safeguarding Boards have responsibility for:

- establishing Single Unified Safeguarding Reviews and ensuring they are effectively managed;
- 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 Single Unified Safeguarding Review Report and submitting it to the Single Unified Safeguarding Review Co-ordination Hub to place within the Wales Safeguarding Repository;
- implementing and auditing changes in local policy, systems, and practice to

[26] The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 (legislation.gov.uk)

identify what difference they have made in partnership with the Single Unified Safeguarding Review Co-ordination Hub; and

- working with the appropriate Community Safety Partnership especially when the Single Unified Safeguarding Review 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.

5.5 The Regional Safeguarding Board also has a role in the delivery of Offensive Weapons Homicide Reviews, see 'Delivering Offensive Weapons Homicide Reviews in Wales' section 5 of the Offensive Weapons Homicide Review Statutory Guidance[27]. The Regional Safeguarding Board will:

- receive the referral when a homicide occurs which is likely to qualify for an Offensive Weapons Homicide Single Unified Safeguarding Review;
- the Chair of the Regional Safeguarding Board will liaise with the Chair of the Community Safety Partnership to inform them that a referral has been made.
- aid the Relevant Review Partners[28]: police, local authority, and health board in ensuring the legislative requirements placed on them for Offensive Weapons Homicide Reviews are met by the Single Unified Safeguarding Review process, with those authorities' agreement and engagement as part of the Case Review Group and Review Panel (it is the Case Review Group which incorporates the Relevant Review Partners that will determine whether or not a Single Unified Safeguarding Review is to be conducted); and
- enact the recommendation of the Case Review Group and subsequent decision of the Regional Safeguarding Board Chair as to whether an Offensive Weapons Homicide Single Unified Safeguarding Review is to be delivered and communicate this to the Single Unified Safeguarding Review Co-ordination Hub so that they meet the statutory requirement (on behalf of the police, local authority, and health board) to notify the Secretary of State for the Home Office within one month of the incident occurring.

5.6 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. In order 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 Regional Safeguarding Boards to ensure that they have selected someone with the requisite skills and knowledge pertinent to the case.

[27] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

[28] Section 9. Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

5.7 These responsibilities require committed, well-functioning, challenging, inspirational and strongly led Regional 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 Regional Safeguarding Board members but work locally with children and/or adults at risk, and their families.

5.8 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, therefore, and Regional Safeguarding Boards should discuss how best to secure participation of such representatives at Board, subgroup or task and finish group level (see paragraph 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 Three. When it would be useful for these community partners to be involved in the Review process, then the Reviewer(s) should ensure that engagement is invited.

5.9 Furthermore, Regional Safeguarding Boards have the power to request specified information from a 'qualifying person or body', 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*[29]. 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 Regional Safeguarding Boards when requested. (see paragraph 218 - 226 of *Working Together to Safeguard People Vol 1*).

5.10 Therefore, 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.

5.11 Regional Safeguarding Boards need to be focused on learning and outcomes, and to be encouraging a supportive environment. In order to remain in touch with the challenging and complex work of safeguarding work undertaken by professionals in the various local agencies, the Regional Safeguarding Board needs to be able to maintain a close oversight and understanding of practice.

Role of the Regional Safeguarding Board Chair

5.12 Each Regional Safeguarding Board has a Chair and this role is fundamental to

[29] Section 137. Social Services and Well-being (Wales) Act 2014

the decision making and communication within the Single Unified Safeguarding Review process. The role of the Chair will need to effectively communicate key decisions with the Regional Safeguarding Board; the Chair of the Community Safety Partnership in the case of a Domestic or Offensive Weapon Homicide; the Home Office and Ministers. The role is outlined in more detail below:

Step One: 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 Regional Safeguarding Board, with the following information:

- 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;
- an assessment of the likely communication and media issues, as known at the time.

Step Two: The Chair of the Regional Safeguarding Board will pay due regard to the Chair of the relevant Community Safety Partnership on the recommendation of the Regional Safeguarding Board, if it involves either a Domestic or Offensive Weapon Homicide.

Step Three: the Chair of the Regional Safeguarding Board will inform the Case Review Group (and the Chair of the Community Safety Partnership in the case of a domestic or offensive weapon homicide) of their decision on whether or not to approve the recommendation.

Step Four: if the Chair has approved the recommendation to undertake a Single Unified Safeguarding Review the process will commence.

Step Five: if the Chair declines the recommendation to undertake a Single Unified Safeguarding Review or agrees with the recommendation not to undertake a Single Unified Safeguarding Review, the Regional Safeguarding Board will be informed by the Chair and further discussions held. If the final decision is not to undertake a Single Unified Safeguarding Review, then the Chair of the Regional Safeguarding Board will need to inform the Single Unified Safeguarding Review Co-ordination Hub in writing, with the reasons given, and any conflicting views also reported. However, the following considerations must also be applied when a Domestic Homicide is involved, the Chair of the Regional Safeguarding Board must liaise with the Chair of the appropriate Community Safety Partnership and inform the Home Office. If the Home Office state that a Review must be undertaken the Single Unified Safeguarding Review process will be instigated by the Regional Safeguarding Board (please refer to paragraph 5.10).

Step Six: As local circumstances determine, the Chair of the Regional Safeguarding Board should appoint an independent Reviewer (or two Reviewers if an extended Review is being conducted) who is responsible for managing and co-ordinating the review process, and for producing the final Report based on evidence the Review Panel decides is relevant.

Step Seven: The Chair approves the final Report produced by the Review Panel (and will liaise with the Chair of the Community Safety Partnership if it includes a Domestic or Offensive Weapon Homicide and submit to the Home Office for sign off in the case of a Domestic Homicide by the Quality Assurance Panel) and will ensure that:

- it is submitted to the Single Unified Safeguarding Review Co-ordination Hub;
- a copy is retained in the Wales Safeguarding Repository and the Home Office Repository if it involves a Domestic Homicide;
- it is published by the Regional Safeguarding Board and Community Safety Partnership if it involves a Domestic or Offensive Weapon Homicide for a minimum of 12 weeks; and
- learning is shared.

Step Eight: The Chair alongside the Regional Safeguarding Board must ensure that the recommendations are implemented and where issues arise regarding their implementation that these are raised through the appropriate governance structure within the Single Unified Safeguarding Review process and with other relevant partnerships including the Community Safety Partnership, Regional Partnership Boards and Public Service Boards.

Community Safety Partnerships

5.13 This subheading applies to Single Unified Safeguarding Reviews which meet the criteria for a Domestic Homicide as set out in Section 3 (d).

5.14 Where a Domestic Homicide has occurred, the police will inform both the Chair of the Regional 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 Single Unified Safeguarding Review to the Chair of the Regional Safeguarding Board. The Chair of the Regional 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 Single Unified Safeguarding Review should be undertaken the process will commence;
- if both Chairs agree that a Single Unified Safeguarding Review should **not** be undertaken a report stating the reasons why will be submitted to the relevant Home Office officials and to the Co-ordination Hub. If the Home Office overturn the decision the Single Unified Safeguarding Review process will commence; and
- if there is no consensus between the Chairs on whether or not a Single Unified Safeguarding Review 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, the Single Unified Safeguarding Review process will be followed;
- should **not** be undertaken then a report will be produced on the reasons why a Single Unified Safeguarding Review 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.

5.15 If it is decided that a Single Unified Safeguarding Review will be undertaken, then a manager/lead from the relevant Community Safety Partnership are expected to join the Review Panel.

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

- inform the Home Office of the decision whether to undertake a Single Unified Safeguarding Review (this decision will be reviewed by the Home Office Quality Assurance Panel and ultimately the Secretary of State for the Home Office, who may choose to direct a Single Unified Safeguarding Review of a Domestic Homicide case if the initial decision is not to undertake one). 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 family are not going to be informed, the Home Office needs to be advised of the Chair's rationale for not doing so.
- complete the final sign off of the Single Unified Safeguarding Review; and
- submit the final Report to the Home Office and await any further comments, prior to its publication. It will then also be shared with the Domestic Abuse Commissioner.

5.17 Once the Review and Action Plan has been returned by the Home Office Quality Assurance Panel, the Report will be provided to the Single Unified Safeguarding Review Co-ordination Hub to be processed and retained in the Wales Safeguarding Repository and published by the appropriate Community Safety Partnership and Regional Safeguarding Board on their websites for a minimum period of twelve weeks. The Single Unified Safeguarding Review 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.

5.18 Chairs of Community Safety Partnerships are expected to:

- share the learning and recommendations from Single Unified Safeguarding Review Reports;
- escalate any issues that are relevant (such as domestic homicides) to

the Public Services Board and/or Regional Partnership Board;
- ensure that appropriate partner agencies from Community Safety Partnerships attend Learning Events; and
- ensure that there is appropriate Community Safety Partnership representation on Case Review Groups and Review Panels

5.19 The Domestic Homicide Review Statutory Guidance issued under *section 9(3) of the 2004 Act*[1], 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 this Act. This means that those persons involved in a Domestic Homicide Review must take this guidance into account and, if they decide to depart from it, have clear reasons for doing so." Certain stages of The Single Unified Safeguarding Review process require departure from the Domestic Homicide Review guidance which are necessary to enhance the review process. Within this statutory guidance, where these departures are made, clear reasons for doing so are provided. All departures from the Domestic Homicide Review guidance have been co-ordinated and agreed with the Home Office Domestic Homicide Review team.

Case Review Group

5.20 The Case Review Group will make the initial recommendation as to whether or not to undertake a Single Unified Safeguarding Review. The Case Review Group must be composed of personnel with the appropriate level of expertise and seniority to ensure that the right decisions are made. This group will determine who the relevant review partners are in relation to the incident and inform them of their duty to be fully engaged in discussions and decisions.

5.21 Any member of the Regional Safeguarding Board, Community Safety Partnership (where a Domestic Homicide has occurred or otherwise relevant), agency or practitioner can refer a case to the Regional Safeguarding Board which is believed meets the criteria outlined in Section 3 of this guidance. Advice may be sought from the relevant agency from a Regional Safeguarding Board member prior to making a referral. However, any such referral should be directed to the Regional Safeguarding Board Business Unit Manager (or equivalent) who will ensure the Chair of the Regional Safeguarding Board is informed. Each Regional Safeguarding Board will have a standing Case Review Group. The referral should then be forwarded to the Chair of this group for its consideration. The Single Unified Safeguarding Review Referral Form can be found in the Toolkit and must be used to complete this stage of the process.

5.22 There are matters which may require negotiation and resolution by the Case

[1] Section 9(3) of the Domestic Violence, Crime and Victims Act 2004. Domestic Violence, Crime and Victims Act

Review Group including:

More than one Regional Safeguarding Board is involved:

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

More than one Regional 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 Regional Safeguarding Board should take lead responsibility for undertaking a Review. However, co-operation and careful planning may be required between Regional Safeguarding Boards in order 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 Single Unified Safeguarding Review that involves an Offensive Weapons Homicide, the Regional Safeguarding Board, in which the incident happened, must 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[30]:

- 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 of that review). The review process must consider each child's or adult's perspective and experience individually but should normally ensure that the learning arising from the children's or adult's circumstances is brought together in one comprehensive Single Unified Safeguarding Review Report at the conclusion of the review. It is important that the Chair of the Regional 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.

[30] *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.

5.23 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 Regional Safeguarding Board (copied for information to the Community Safety Partnership Chair where there is a domestic homicide element), with the following information:

- 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;
- an assessment of the likely communication and media issues, as known at the time.

5.24 A Single Unified Safeguarding Review Report template has been provided (see Single Unified Safeguarding Review Toolkit) to:

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

5.25 The Chair of the Regional Safeguarding Board will inform the Case Review Group of their decision as to whether the recommendation to hold a Single Unified Safeguarding Review is approved and inform the Regional Safeguarding Board. Should the recommendation for a Single Unified Safeguarding Review be declined by the Chair of the Regional Safeguarding Board, then the Regional Safeguarding Board should be informed, and further discussion held. If the final decision is no, then the Chair of the Regional Safeguarding Board will need to inform the Single Unified Safeguarding Review Co-ordination Hub in writing, with the reasons given, and any conflicting views also reported. However, the following considerations must also be applied when:

- a Domestic Homicide is involved, the Chair of the Regional Safeguarding Board will have to liaise with the Chair of the appropriate Community Safety Partnership and inform the Home Office.
- an Offensive Weapons Homicide is involved a notification must be sent to the Secretary of State for the Home Office within one calendar month of the relevant review partners becoming aware of a death for which it is likely they are under a duty to carry out an offensive weapons homicide review[31].

5.26 The Single Unified Safeguarding Review Strategy Group should be informed of the number of cases that meet the criteria for a Single Unified Safeguarding Review that has been considered by the Case Review Groups, including those where the lead Regional Safeguarding Board may be in another country, and should be informed of the outcome of the recommendation.

[31] This notification and deadline are a legislative requirement set out in section 27 of the Police, Crime, Sentencing and Courts Act 2022. Further guidance and a template for the notification is available in the Offensive Weapons Homicide Review statutory guidance at section 2.16 -2.22 and Annex 2.

5.27 The recommendation of the Case Review Group will go to the Chair of the Regional Safeguarding Board. In the case of a Domestic Homicide, the Chair of the Regional 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 Single Unified Safeguarding Review should be undertaken the process will commence;
- if both Chairs agree that a Single Unified Safeguarding Review should **not** be undertaken a report stating the reasons why will be submitted to the relevant Home Office officials and to the Co-ordination Hub. If the Home Office overturn the decision the Single Unified Safeguarding Review process will commence; and
- if there is no consensus between the Chairs on whether or not a Single Unified Safeguarding Review 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, the Single Unified Safeguarding Review process will be followed;
    - should **not** be undertaken then a report will be produced on the reasons why a Single Unified Safeguarding Review 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.

5.28 If the decision is yes, the Case Review Group will establish a Single Unified Safeguarding Review multi-agency Review Panel and appoint a Reviewer(s) (Report author). However, when the:

- Single Unified Safeguarding Review involves a Domestic Homicide, the selection of the Panel and Reviewer(s) by the Case Review Group must reflect Domestic Homicide Review Guidance[32] on independence and membership.

5.29 It is important to note that the Offensive Weapons Homicide Review legislation[33] provides for relevant review partners to request information from review partners. These legislative responsibilities can be delegated to a Reviewer (Independent Chair) (please refer to the Offensive Weapons Homicide Review statutory guidance for further information).

Review Panel

5.30 The Review Panel manages the Review process 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

[32] Section 4. Multi-agency Statutory Guidance 2016

[33] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

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. For an Offensive Weapons Homicide the relevant review partners will be invited to form part of this panel. The Review Panel members will agree on the appointment of the Chair of the Review Panel.

5.31 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. 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.

5.32 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 Regional 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 the course of a Single Unified Safeguarding Review. The Review Panel will have responsibility for agreeing any variation to the Terms of Reference.

5.33 The final Terms of Reference (with personal identifiers removed) will be included in the Single Unified Safeguarding Review Report prepared at the completion of the Review.

5.34 An example of a Single Unified Safeguarding Review Terms of Reference is included in the Single Unified Safeguarding Review Report Template.

5.35 The Review Panel will produce an Agency Timeline (see Section 7) using information 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.

5.36 If panel members have little or no experience of applying a “diverse lens” to the review process, the Single Unified Safeguarding Review Panel members and Chair should seek expertise from independent lead professionals and/or specialist support agencies.

The Reviewer(s)

5.37 As local circumstances determine, the Chair of the Regional Safeguarding Board should appoint an independent Reviewer (or two Reviewers if an extended Review is being conducted) who is responsible for managing and co-ordinating the review process, and for producing the final Report based on evidence the Review Panel decides is relevant. Please note that this role is known as an 'Independent Chair' within Domestic Homicide Review and Offensive Weapons Homicide Review processes but will be referred to as 'Reviewer' throughout the Single Unified Safeguarding Review process.

5.38 The Reviewer is the author of the Single Unified Safeguarding Review Report. When appointing the Reviewer, and if:

- a Domestic Homicide forms part of the Single Unified Safeguarding Review 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 Regional Safeguarding Board and Community Safety Partnership, placed within the Wales Safeguarding Repository and the Home Office Repository, and shared with the Domestic Abuse Commissioner; or
- an Offensive Weapons Homicide 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 section 3.12 'Delegating functions' of the Offensive Weapons Homicide Review statutory guidance[34].

5.39 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.

5.40 If they have not previously undertaken the role of Reviewer then they will have the opportunity to 'shadow' an experienced, accomplished Reviewer. This will act as a mentoring opportunity to ensure that new Reviewers properly understand their role in practice. Reviewers may also refer to the Single Unified Safeguarding Review Best Practice guide to ensure that they are learning from other experienced Reviewers across Wales.

5.41 The Report should clearly demonstrate the Reviewer's independence from the Regional 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' must be included as an appendix which sets out the Reviewer's career history, relevant experience, and independence.

[34] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

5.42 In the case of a Domestic Homicide, the Reviewer must not be a member of the relevant Community Safety Partnership. If a Reviewer was previously a member of one of the agencies associated with the review or on one of the agencies on the relevant Community Safety Partnership, the independence statement must make it clear how much time has elapsed since the person left that agency. If the Single Unified Safeguarding Review involves a Domestic Homicide, please refer to the relevant section within the *Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews*[35].

5.43 Regional 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.

5.44 An Approved Chairs and Reviewer(s) List will be produced and facilitated by the Single Unified Safeguarding Review Co-ordination Hub and will be constantly reviewed and updated, which Regional Safeguarding Boards can refer to the list when commissioning a Reviewer(s).

5.45 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 Single Unified Safeguarding Review;
c) senior managerial and leadership experience, thus providing the appropriate strategic vision required;
d) good analytical, interviewing and communication skills;
e) an understanding of the importance of providing services and support in Welsh as well as English without individuals having to ask; and
f) completion of the appropriate training and/or relative experience relating to the specialist areas being addressed by the Single Unified Safeguarding Review.

5.46 Please refer to the Single Unified Safeguarding Review Key Competency Framework for further information about the requirements of the roles within the Single Unified Safeguarding Review process. This is available via the Single Unified Safeguarding Review Co-ordination Hub.

5.47 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:

[35] Section 4. Multi-agency Statutory Guidance 2016

a) a thorough knowledge of safeguarding systems, issues, responsibilities, and practice;
b) an understanding of multi-disciplinary working;
c) an ability to enquire and communicate about practice with professionals and with children and family members;
d) an understanding of the importance of providing services and support in Welsh to all participants in the review process; and
e) skills in facilitating and managing group processes effectively.

5.48 In appointing a Reviewer(s), the Regional Safeguarding Board will need to be satisfied that safe recruitment practices have been observed.

5.49 In summary, the roles and responsibilities identified above reflect the need for the Single Unified Safeguarding Review to:

a) be undertaken by an independent Reviewer(s) who will be supported by the Review Panel;
b) for the independent Reviewer and /or Panel and Chair, to consult with and pay due regard to the family's views and wishes and feelings within the context of the statutory guidance, where possible and considered appropriate, and to be taken into consideration by the panel when formulating the Terms of Reference;
c) have clarity and clear boundaries that distinguish between the professional roles and responsibilities of the Review Panel, Reviewer(s) and Chair of the Review Panel who will all have an objective view of the circumstances leading to the review and family members who may be invested in the events and the process itself;
d) ensure that the Review Panel and the Regional Safeguarding Board are responsible and accountable for the final Report, its content and agreed Action Plan; and
e) to share a copy of the final Report with:
    - victims;
    - key family members in advance of publication and respond to any data protection issues
    - the Single Unified Safeguarding Review Co-ordination Hub who will forward a copy to:
        - the Secretary of State for the Home Office (for an Offensive Weapons Homicide);
        - the Wales Safeguarding Repository (and the Home Office Repository in the case of a Domestic Homicide), the timing of this to be determined by the Review Panel and chair of the Regional Safeguarding Board;
        - Partnerships, highlighting any relevant recommendations.

The Single Unified Safeguarding Review Co-ordination Hub

5.50 The role of the Single Unified Safeguarding Review Co-ordination Hub is to

galvanise, support and progress reviews to ensure learning is achieved and implemented to safeguard communities. The Co-ordination Hub is at the heart of the Single Unified Safeguarding Review process, ensuring that it operates both effectively and efficiently. The Co-ordination Hub sets out to undertake the following five components:

a) Co-ordination
    - Manage and update the Welsh Approved Chairs and Reviewer(s) List for Single Unified Safeguarding Reviews;
    - Receive, manage, and oversee all recommendations from Single Unified Safeguarding Reviews in Wales and monitor progress of Action Plans and escalate to the Strategy Group or Ministerial Board where necessary;
    - Provide secretariat function for Single Unified Safeguarding Review Ministerial Board and other governance groups;
    - Hold and manage the Single Unified Safeguarding Review active list of reviews and support progress with Regional Safeguarding Boards Business Units;
    - Produce and Review Single Unified Safeguarding Review policies and guidance; and
    - Co-ordinate and manage Single Unified Safeguarding Review budget.

b) Welsh Safeguarding Repository
    - Manage the input and output flow of the Wales Safeguarding Repository;
    - Release completed Single Unified Safeguarding Reviews to the Wales Safeguarding Repository for inputting, ensuring that the Wales Safeguarding Repository Submission Form has been completed correctly;
    - Receive and action themes identified by the Wales Safeguarding Repository and inform Training and Learning Co-ordinators. These will be shared pan-Wales with relevant agencies for them to implement in order to improve practices; and
    - Oversee Wales Safeguarding Repository external gateway access.

c) Training and Learning
    - Manage the outcomes of Learning Events ensuring all outcomes are shared across Wales. This includes any thematic learning;
    - Co-ordination of national Single Unified Safeguarding Review training courses for Review Panel Chairs, Reviewers, and Panel members; and
    - Manage the Welsh Approved Chairs and Reviewer(s) List and liaise with Regional Safeguarding Board Business Managers to co-ordinate courses.

d) Communication

- Produce monthly communique informing public services and partners of recommendations, best practice and themes emerging from Single Unified Safeguarding Reviews; and
- At the conclusion of each Single Unified Safeguarding Review formulate and publish seven-minute briefing documents. A template for this is available in the Single Unified Safeguarding Review Toolkit.

e) Process Review
   - Receive completed reviews from Regional Safeguarding Board Business Units which have been through a local Quality Assurance process;
   - Provide link to Home Office, including engagement with the Offensive Weapons Homicide Review Oversight Board, its Secretariat, and the relevant Domestic Homicide Review team, and share Single Unified Safeguarding Review Reports and Action Plans where appropriate; and
   - Provide liaison between Welsh Government and Regional Safeguarding Board Business Units and Community Safety Partnerships (where appropriate) when additional work is required on Single Unified Safeguarding Review Action Plans.

Single Unified Safeguarding Review Ministerial Board for Wales

5.51 The Board is the overarching body bringing together the devolved and non-devolved aspects of safeguarding under one governance model. The purpose of the Board is set out in four areas below:

a) Leadership
   - Provide a National Forum to assist the prevention, management of and learning from safeguarding reviews in Wales.
   - Encourage the development and implementation of a consistent approach across Wales with key partners.
   - Consider any potential changes that 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 and recommendations emerging from Single Unified Safeguarding Reviews.

b) Process
   - Have a strategic oversight of the number of current Single Unified Safeguarding Reviews and during transition, safeguarding reviews (including Domestic Homicide Reviews) and the emerging national issues, patterns and common learning themes which require a pan-Wales/UK response.
   - Ensure there is a focus on learning by the appropriate agencies, on

outcomes from completed reviews, and that there are mechanisms in place to deliver against those outcomes.

- Receive and act upon escalated issues from regions which cannot be solved at that level and require a pan-Wales/UK response, including potential changes to existing policies and legislation.

c) Holding and Generating Information
   - Receive key themes and learning identified by the Single Unified Safeguarding Review Co-ordination Hub using data from within the Wales Safeguarding Repository.
   - Receive monitoring reports on how the learning arising from the information obtained from the repository is put into practice.

d) Wider Learning Opportunities
   - Encourage the exploration of safeguarding opportunities from an international perspective and identify and share best practice.

Single Unified Safeguarding Review Victim and Family Reference Group

5.52 To ensure that victims, family, and principal individuals remain at the heart of the Single Unified Safeguarding Review process a Victim and Family Reference Group will be used to provide a forum for the victim and family voice across Wales.

5.53 Members of the group will inform the Single Unified Safeguarding Review process by providing representation on behalf of victims and families in Wales in a diverse and inclusive way, consulting with their stakeholders to:

a) shape production of Single Unified Safeguarding Review products that can be incorporated within the Single Unified Safeguarding Review Toolkit;
b) develop and inform future good practice guidance on victim and family engagement in the Single Unified Safeguarding Review process; and
c) review and inform the response to:
   - the Single Unified Safeguarding Review Reflections form on victim and family feedback; and
   - Wales Safeguarding Repository themes linked to the victim and family engagement process.

5.54 In addition to this, members of the group may be invited to represent the Victim and Family Reference Group at other meetings supporting the wider Single Unified Safeguarding Review governance structure of the Single Unified Safeguarding Review in Wales, for example the Single Unified Safeguarding Review Strategy Group or Single Unified Safeguarding Review Ministerial Board. In these circumstances the Chair of the Victim and Family Reference Group will appoint a

representative in consultation with the group to undertake the role. The chosen member will be required to report back to the Victim and Family Reference Group on any work undertaken in that representative role.

6 Engagement of Victims, Family and Principal Individuals in the Single Unified Safeguarding Review process

6.1 This section outlines how the Single Unified Safeguarding Review process ensures appropriate engagement with the individuals who wish to contribute to the review. Those individuals will be different for every review and will not always be those immediately related to the person subject to the Single Unified Safeguarding Review process. Therefore, for the purposes of this guidance, this group of individuals may include:

- victims;
- key family members who are close to the subject of the review; and /or
- principal individuals (for example (but not limited to), perpetrator, friends, community representatives/support services, neighbours, colleagues, faith and community leaders or employers).

6.2 The involvement of the victim, family and principal individuals, whilst voluntary, is at the heart of the Single Unified Safeguarding Review process. They must be given the opportunity to be engaged in the review process and treated as a key stakeholder where appropriate and possible. Their perspectives and experiences are essential to developing learning within a review.

6.3 Whilst guidelines for engagement have been identified, the Reviewer will need to apply the guidelines in a balanced way ensuring that the principle focus of the review, to learn lessons, is central to decision making. In many cases victims, perpetrators and family members will have different and even conflicting views. In these circumstances the Reviewer's role is to take a balanced view, capturing their views to inform the professional judgement of what lessons can be learnt from the case.

Guidelines for engagement

6.4 The purpose of a Single Unified Safeguarding Review is to learn lessons to improve practice and the experience and views of the victim, family and principle individuals are important as they add significant information and a perspective that may not appear in official records. As each case is unique, the plan to engage victims, families and significant others will need to be considered at the outset. Where a decision is made not to engage with an individual (for example a perpetrator or someone hostile to the reviewing process) the reasons should be carefully recorded. The key guidelines for engagement are:

a) the families and principal individuals of the person subject to the Single Unified Safeguarding Review will be identified and contacted as early as possible and will be kept informed of the review process, if they so wish;

b) victims, families and principal individuals will have a reliable, dedicated contact person(s) for the Single Unified Safeguarding Review process;
c) victims, families and principal individuals will be treated with respect and courtesy. Specific additional needs will be appropriately considered, to support them to effectively participate in or make contributions to the review including any specialist support for example, cultural or language requirements (please refer to the Anti-Racism Action Plan for Criminal Justice in Wales[36]);
d) professionals will be open and transparent with victims, families, and principal individuals and will, as appropriate, be provided with the information they need including information about how any personal data will be processed (reasons for non-disclosure will be made clear to families when a request is declined);
e) reviewers will be well informed about the case before speaking to victims, 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[37] for additional information and guidance);
f) communications with victims, families and principal individuals will be clear and jargon free and communication will be in the language of their choice. Victims, families, and principle individuals will be able to choose either English or Welsh as their preferred language for communication throughout the process. An element of creativity may also be required to engage with children and young people;
g) reviewers will provide the opportunity for victims, families and principal individuals to view the draft Report in private with plenty of time to do so and have the opportunity to comment and identify any factual inaccuracies. Where comments/amendments from victims, family members and principal individuals cannot be met in the Report an explanation should be provided to them; and
h) victims, 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 individual, perpetrator or family member and the feelings of the individual to engage. Consideration should always be given to give significant individuals to put their views in writing for consideration by the Reviewer.

[36] Criminal Justice Anti-Racism Action Plan for Wales: Criminal Justice Anti-Racism Action Plan
[37] Trauma-Informed Wales (traumaframeworkcymru.com)

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

6.5 Children and young people have sometimes been excluded from making a contribution. Experience reinforces the importance for all individuals (including young people) to be involved, to contribute in as small a way as they wish, to help them influence the learning of those involved in the review and have the opportunity to see and discuss the Report and its findings at the conclusion of the review.

6.6 Regional 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.

6.7 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 how they would 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 Regional Safeguarding Board in relation to the date of publication and other sensitive issues for the family. Copies of the Report should not be given to family members to retain until it has been finalised, approved by the Regional Safeguarding Board, published, and shared with the Single Unified Safeguarding Review Co-ordination Hub to be included in the Wales Safeguarding Repository.

6.8 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 an associated suicide) has occurred

6.9 This section has been taken from the *Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016)*[38]. As set out in section 3.5 (d) above, a domestic homicide also includes where the victim has taken their own life and the SUSR process is committed to ensuring that in Wales any death that occurs and is in scope of the definition is given equal priority and due consideration.

6.10 Where victims have taken their own lives, care needs to be taken to ensure that

[38] Multi-agency Statutory Guidance for the conduct of Domestic Homicide Reviews (2016) Multi-agency Statutory Guidance 2016

all opportunities to ascertain the events and potential abuse, or perpetration that may have contributed to the decision. Where a victim 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. The shame and stigma 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 individual, 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. 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. Where the perpetrator of a domestic homicide has taken their own life, criminal proceedings are more challenging, information may therefore be more limited, or less detailed.

6.11 The benefits of involving family, principal individuals and perpetrators include:

a) assisting the victim'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 they need after 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, must be afforded the same status as other contributions. Participation by the family also humanises the deceased helping the process to focus on the victim's and 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 lives of the victim and/or perpetrator in order to see the homicide through the eyes of the victim and/or 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 victim and/or 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 very 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;

g) enabling families and principal individuals to choose, if they wish, a suitable pseudonym for the victim 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.

6.12 Reviewers will need to take into consideration when and how they engage with perpetrators to ensure that due regard is given to criminal or coroner proceedings (see Section 11) and to ensure the safety of family and principal individuals who are engaging in the Single Unified Safeguarding Review process.

6.13 The 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 recorded. 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.

6.14 When considering whether to interview family and principal individuals, the Review Panel must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial. The chair will need to discuss the timescales for interviews with the Senior Investigating Officers and take guidance from the Senior Investigating Officers in relation to any ongoing criminal proceedings.

6.15 When meeting with family and principal individuals, the Reviewer 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 and may reach conclusions that the family and principal individuals disagree with;

b) communicate, where appropriate, directly or, if preferred by the family and principal individuals, through a designated advocate, where one has been assigned, who has, where possible, an existing working relationship with the family and principal individuals, for example a local domestic abuse service representative;

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

d) make a decision regarding the timing of contact with the family and principal individuals based on information from the 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 Single Unified Safeguarding Review 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;
g) explain clearly how the 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 other domestic violence and abuse victims;
i) share completed and full versions of the Review Reports with the family prior to sending them to the Home Office. Regional 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 legal 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 Regional 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 help create the change after the Review.

6.16 The Review Panel should consider approaching the family of the perpetrator who may also have relevant information to offer. The Chair of the Review Panel and Reviewer(s) should also be mindful that the perpetrator or members of the perpetrator's family might in some cases pose an ongoing risk of violence to the victim'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.

6.17 The Review Panel should also access other networks which victims and perpetrators may have disclosed to, for example, employers, health professionals, local professionals in domestic violence prevention work, or local domestic abuse service agencies. Information leaflets (available in English and other languages) explaining Domestic Homicide Review process are available for the following (see the Single Unified Safeguarding Review Toolkit for templates):

- Family members
- Friends
- Employers and colleagues

6.18 Particular consideration should be given to Reviews where so-called 'honour'-based abuse is suspected. Extra caution will need to be taken around confidentiality in relation to agency members and interpreters where there are possible links with the family, who may be the 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.

Honour Killings and associated victim suicides

6.19 "Honour" Killings and suspected victim suicides and possible "honour" based abuse must consider the levels of participation and engagement of families. In such reviews, the panel must identify risks of engagement with members of the family, community, or staff within specific agencies, minimising the adverse impact this can have on the Single Unified Safeguarding Review process due to honour-based abuse and coercion experienced by the victim. In addition, panel members may have little or no experience of applying a "diverse lens" to the review process. The Single Unified Safeguarding Review panel members and Chair should seek expertise from independent lead professionals and/or specialist support agencies.

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

For Homicides involving an Offensive Weapon

6.21 This only applies during the 18-month pilot phase in the South Wales Police area. Following the pilot, adjustments will be made accordingly.

6.22 The Review Panel should have regard to section 4 of the Offensive Weapons Homicide Review statutory guidance[39] when considering engagement with family, and principal individuals in relation to an Offensive Weapons Homicide.

6.23 Whilst the scope and Terms of Reference of the Review will be determined through discussions 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 with the Review running in parallel with any criminal investigations and proceedings. Family members and friends of the victim 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 victim 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.

6.24 The three key points for engagement with the family members and/or next of kin of the victim 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.

6.25 It may be that family members and/or next of kin of the victim 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 in a position to be able to provide advice on a suitable time period.

6.26 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. Regional Safeguarding Boards should

[39] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

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 legal form of undertaking to maintain confidentiality of an unpublished review.

6.27 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.

7 Undertaking the Review

7.1 A Single Unified Safeguarding Review has a number of stages that need to be undertaken as part of the overall process. These are outlined below in chronological order.

Agency Timelines

7.2 A key point for consideration is the timeline of events in the child and/or adult subject to the review and their family's life that should be reviewed to take into account the circumstances of the incident, key points include:

- how far back should enquiries cover?
- what is the appropriate cut-off point?
- what history/background information will help to better understand the events leading to the incident?

7.3 The overall purpose of the Single Unified Safeguarding Review is to identify and learn lessons. The Review Panel has to take cognisance of that when compiling an Agency Timeline. To enable the Single Unified Safeguarding Review 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.

7.4 History has shown with Serious Case Reviews (replaced in Wales in 2014 by Adult Practice Reviews and Child Practice Reviews) how 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.

7.5 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 Single Unified Safeguarding Review Report template. In cases where a Domestic Homicide has occurred, the Review Panel should refer to the *Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Review December 2016*[40] in relation to

[40] Section 4. Multi-Agency Statutory Guidance 2016

timelines.

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

7.7 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 current decision making.

7.8 If there has been no agency engagement prior to the incident, the reasons for this should be incorporated into the analysis of whether or not a Single Unified Safeguarding Review should be undertaken. If it is proposed not to undertake a Single Unified Safeguarding Review, it is recommended that a Multi-Agency Professional Forum (please refer to Section 8 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 alongside the completed template, for not undertaking a Review, to the Home Office as well as the Single Unified Safeguarding Review Co-ordination Hub.

7.9 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 clarification of 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 Oversight Board in cases of an Offensive Weapons Homicide.

7.10 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.

7.11 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.

7.12 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 Single Unified Safeguarding Review or cannot be conducted as laid out in the 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*[41]. This should result in a proposal to terminate the Single Unified Safeguarding Review. The process to terminate a Single Unified Safeguarding Review involves:

- an agreement by the Review Panel;
- a Termination Report (please see the Single Unified Safeguarding Review Toolkit for template) which is presented to the Regional Safeguarding Board;
- the approval of the Chair of the Regional Safeguarding Board;
- notifying the Safeguarding Team of the Welsh Government;
- 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.

7.13 The Termination Report will need to set out not only the reasons for the termination, but also what alternative action is proposed to enable learning.

Creating a Learning Event

7.14 Learning is at the heart of the Single Unified Safeguarding Review process. The flow diagram in Figure 4 identifies the stages where learning must be shared (please refer to Section 8 for more detail on the initial stages). This section concentrates on the third stage known as the Learning Event.

7.15 Learning Event: The Reviewer(s) (one if the Single Unified Safeguarding Review is concise or two if it is extended when the Child or Adult Practice Review criteria is met) and the Review Panel will initiate a Learning Event at the start of the Single Unified Safeguarding Review process. 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.

7.16 The Learning Event is a critical part of the Single Unified Safeguarding 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 child and/or adult at risk, and their family; and
- practitioners are able to reflect on what happened and identify learning for future practice.

[41] Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 Police, Crime, Sentencing and Courts Act

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

7.18 Practitioners and managers are expected to attend the Learning Event if asked. 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 in order to provide support to the Reviewer(s) in carrying out an effective Learning Event.

7.19 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.

7.20 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 the Single Unified Safeguarding Review Co-ordination Hub.

Producing a Single Unified Safeguarding Review Report

7.21 Following the Learning Event, the Reviewer(s) in liaison with the Regional Safeguarding Board Business Unit, has responsibility for collating and combining the learning to date for discussion with the Review Panel in the form of a draft Report, using the agreed Single Unified Safeguarding Review template. The Reviewer(s) also has responsibility for confirming that the learning process was undertaken appropriately.

7.22 The draft Single Unified Safeguarding Review Report must:

- be written using the Single Unified Safeguarding Review Report template;
- 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 the subject's family;
- include the practice and organisational learning identified during the Review, including highlighting effective 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 affordable, 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 7.31 for more information)

7.23 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 Single Unified Safeguarding Review Report and an outline Action Plan will then be presented to the Regional 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 draft Single Unified Safeguarding Review Report. A template has been provided for the Single Unified Safeguarding Review Report.

7.24 The Review Panel will have responsibility for producing a summary of the merged Agency Timeline. The Agency Timeline should have all personal identifiers removed (the summary Timeline should be included with the Report when published and shared with the Single Unified Safeguarding Review Co-ordination Hub).

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

7.25 The draft Single Unified Safeguarding Review Report and an outline Action Plan should be presented to the Regional Safeguarding Board by the Chair of the Review Panel and the Reviewer(s). The presentation of the Single Unified Safeguarding Review Report is an important means of the Regional Safeguarding Board maintaining a close relationship with practice. In order to carry out this role, when presenting the draft Single Unified Safeguarding Review Report to the Regional Safeguarding Board members, the Reviewer(s) will need to take them through the detail of the Agency Timeline as well as the practice and organisational issues arising from the Review. The role of the Regional 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. The learning and actions will be shared more widely afterwards by the Single Unified Safeguarding Review Co-ordination Hub.

7.26 The Regional Safeguarding Board may identify additional learning issues or actions of strategic importance for individual agencies or for the collective

responsibility of the Regional Safeguarding Board. These must be included in the final Single Unified Safeguarding Review Report and in the Action Plan, as appropriate.

7.27 The Review Panel and the Reviewer(s) will then complete the final Single Unified Safeguarding Review Report to reflect the range of learning identified. The Regional Safeguarding Board has responsibility for accepting the Report, making a recommendation to the Chair, 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 Single Unified Safeguarding Review Co-ordination Hub to the Secretary of State for the Home Office. It will be placed in the Wales Safeguarding Repository and published by Regional 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.

7.28 The Chair of the Regional Safeguarding Board will submit the Report to the Single Unified Safeguarding Review Co-ordination Hub and Welsh Government. Welsh Government will also forward the information on to relevant policy leads and inspectorates. The Single Unified Safeguarding Review Co-ordination Hub will require the Report at least two weeks before the proposed date of publication by the Regional Safeguarding Board. However, the Report cannot be finalised if:

- a Domestic Homicide forms part of the Single Unified Safeguarding Review, prior to publication the Single Unified Safeguarding Review 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 and the Home Office 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.
- An Offensive Weapons Homicide forms part of the Single Unified Safeguarding Review, it will be placed in the Wales Safeguarding Repository and published by Regional 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.

7.29 The finalised Single Unified Safeguarding Review Report will be published on the Regional Safeguarding Board website and where relevant, the Community Safety Partnership's website, for a minimum of twelve weeks. Following the

publication period, reference will be made on the relevant Regional Safeguarding Board or Community Safety Partnership's website that a copy of the Report will be available on request.

- When a Domestic Homicide has occurred, the Single Unified Safeguarding Review Co-ordination Hub will also send the final Single Unified Safeguarding Review Report to the Home Office for inclusion in the Home Office Domestic Homicide Review Repository;
- When an Offensive Weapons Homicide as occurred, the Report will also be published by the Secretary of State for the Home Office.

7.30 The Review process will be completed as soon as possible, but not normally longer than twelve months from the date of referral to the Regional Safeguarding Board's Case Review Group.

7.31 Regional 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 Single Unified Safeguarding Review Co-ordination Hub to be included in the Wales Safeguarding Repository. To complete this process Regional Safeguarding Boards must return a 'Wales Safeguarding Repository Submission Form' to the Single Unified Safeguarding Review Coordination Hub. This submission form will require Boards to provide:

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

7.32 Recommendations to be shared with other regional partnership arrangements where there are aspects of a Review which are relevant to their work so that they can be acted upon. For example, Public Services Boards, Regional Partnership Boards, Local Criminal Justice Boards and others as mentioned in the introduction.

Action Plan

7.33 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 Regional 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 effective 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 see the Action Plan Guidance within the Single Unified Safeguarding Review Toolkit for information when preparing an Action Plan. The Toolkit also includes a Single Unified Safeguarding Review Action Plan template which must be used.

7.34 The finalised Action Plan will be prepared by the Review Panel and the Reviewer(s) reflecting discussion by the Regional Safeguarding Board. This should be within four weeks of the Regional Safeguarding Boards consideration of the Report and sent to the Chair of the Regional Safeguarding Board for signing off by the member agencies.

7.35 The Action Plan should have a clear focus on improving outcomes for children and/or adults at risk, and their families and identifying opportunities for early intervention and prevention. It should then be sent to the Single Unified Safeguarding Review Co-ordination Hub and included in the Wales Safeguarding Repository. 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 incorporated in the Action Plan and sent to the Single Unified Safeguarding Review Co-ordination Hub. The Single Unified Safeguarding Review 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 the Action Plan should be shared with the Offensive Weapons Homicide Review Oversight Board.

7.36 The Action Plan should contain recommendations that will lead to improvements in safeguarding practice. The recommendations 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 the benefits to the relevant agencies and partners; and
- what problems will be corrected or avoided.

7.37 It is important that recommendations are concise and relevant and should not be general statements, this is a key factor that will be assessed prior to the Single Unified Safeguarding Review Report being finalised.

7.38 The Action Plan will be reviewed, and progress will be monitored by the Case Review Group and the Single Unified Safeguarding Review Co-ordination Hub and reported to the Regional Safeguarding Board. In addition, where the Single Unified Safeguarding Review contains an Offensive Weapons Homicide, the Oversight Board, and the family will be updated on the implementation of the Action Plan where appropriate. The Single Unified Safeguarding Review Co-ordination Hub will be responsible for disseminating the Single Unified Safeguarding Review Report and Action Plans to the Single Unified Safeguarding Review Strategy Group, the Ministerial Board and to local staff as appropriate.

7.39 Consideration will be required by the respective Regional Safeguarding Board and the Single Unified Safeguarding Review Co-ordination Hub of the critical learning points and how they will be incorporated into any changes in operational systems and practice, training, and supervision, and in shaping priorities for future work undertaken by the Regional Safeguarding Board. Seven Minute Briefings should be produced as part of this process (template available in the Single Unified Safeguarding Review Toolkit).

7.40 Action Plans must be included in the 'Wales Safeguarding Repository Submission Form' to ensure the recommendations are incorporated in the Repository.

7.41 Action Plans should lead to improvements in safeguarding practice, both locally and on a pan-Wales basis, and the Regional Safeguarding Board (with Community Safety Partnerships where appropriate) will need to ensure they are carefully audited to see whether they have been carried out and with what effect, and whether they are achieving the intended outcomes. Where appropriate, actions could be undertaken by the Public Services Boards or Regional Partnership Boards. For example, where the issues raised relate to priorities identified in the Public Services Board's Well-being Plan.

7.42 The Reviewer(s) may be requested by the Review Panel and/or the Single Unified Safeguarding Review Co-ordination Hub, as part of taking forward the Action Plan, 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.

7.43 The Regional Safeguarding Boards will need to include any issues emerging from the Single Unified Safeguarding Review into the work programme of the Multi-Agency Professional Forum (please refer to paragraph 8.9 for further information).

7.44 On completion of the work, the Action Plan will need to be signed off by the Regional Safeguarding Board and sent to the Single Unified Safeguarding Review Co-ordination Hub to ensure it is incorporated within the Wales Safeguarding Repository and into future Learning Events on a pan-Wales level. This should be included in the 'Wales Safeguarding Repository Submission Form'.

7.45 Review Panel Chairs and Reviewers will also complete a 'Single Unified Safeguarding Review Reflections' form within two weeks of each Single Unified Safeguarding Review (please refer to the Single Unified Safeguarding Review Toolkit). These reports provide Chairs and Reviewers an opportunity to reflect on the review process, what went well, what didn't and identify any process improvements or learning gaps / opportunities for those involved in undertaking the Review. Completed forms will be sent to the Single Unified Safeguarding Review Co-ordination Hub. These will be used to inform and potentially refine the Single Unified Safeguarding Review process.

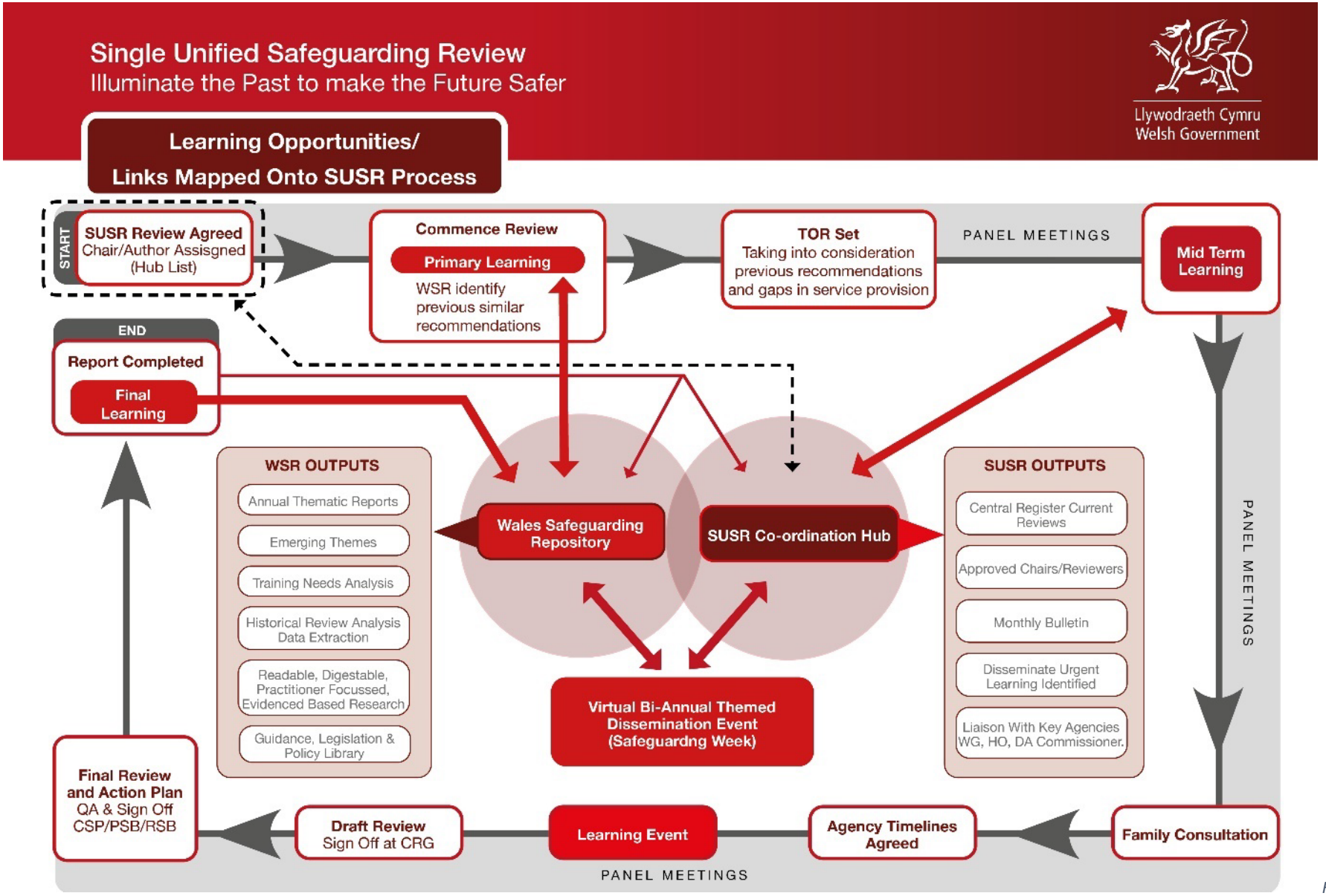
Single Unified Safeguarding Review
Illuminate the Past to make the Future Safer
Llywodraeth Cymru
Welsh Government
Learning Opportunities/
Links Mapped Onto SUSR Process
START
SUSR Review Agreed
Chair/Author Assisgned
(Hub List)
Commence Review
Primary Learning
WSR identify
previous similar
recommendations
TOR Set
Taking into consideration
previous recommendations
and gaps in service provision
PANEL MEETINGS
Mid Term
Learning
END
Report Completed
Final
Learning
WSR OUTPUTS
Annual Thematic Reports
Emerging Themes
Training Needs Analysis
Historical Review Analysis
Data Extraction
Readable, Digestable,
Practitioner Focussed,
Evidenced Based Research
Guidance, Legislation &
Policy Library
Wales Safeguarding
Repository
SUSR Co-ordination Hub
Virtual Bi-Annual Themed
Dissemination Event
(Safeguardng Week)
SUSR OUTPUTS
Central Register Current
Reviews
Approved Chairs/Reviewers
Monthly Bulletin
Disseminate Urgent
Learning Identified
Liaison With Key Agencies
WG, HO, DA Commissioner.
PANEL MEETINGS
Final Review
and Action Plan
QA & Sign Off
CSP/PSB/RSB
Draft Review
Sign Off at CRG
Learning Event
Agency Timelines
Agreed
Family Consultation
PANEL MEETINGS

Figure 2

8 How to disseminate learning using the Single Unified Safeguarding Review process

8.1 The dissemination of learning is a key aim of the Single Unified Safeguarding Review process and is a statutory obligation for Regional Safeguarding Boards[42] and Community Safety Partnerships. The ethos behind the Single Unified Safeguarding Review process is to ensure that all learning is embedded into future practice to ultimately prevent similar incidents in the future. To do this, the Single Unified Safeguarding Review system has been created to ensure that when reviews are conducted, wider and deeper learning is achieved which is embedded in all organisations and to enact positive change. Learning dissemination mechanisms and processes are outlined in the below subheadings.

8.2 The Single Unified Safeguarding Review Co-ordination Hub will be instrumental in the dissemination of learning across the whole of Wales. The Hub will monitor and review progress on recommendations from Single Unified Safeguarding Reviews and assist in unblocking impediments to implementation of them.

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

8.3 The Wales Safeguarding Repository has a key role 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 Single Unified Safeguarding Reviews 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 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 extract new learning.

8.4 As can be seen in the Learning Flowchart (Figure 4) in Section 7 of this guidance, the Wales Safeguarding Repository will enable practitioners to search for Primary Learning. Review Panel Chairs and Reviewers will need to use the Wales

[42] Regulation 3. The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015 (legislation.gov.uk)

Safeguarding Repository to search for and identify recommendations from any similar previous cases before they commence the Single Unified Safeguarding Review. It can then be assessed whether these recommendations were implemented or whether they need to be highlighted again. When the Review Panel create the Terms of Reference for a Review, any relevant previous recommendations from other reviews should be taken into consideration.

8.5 If any urgent mid-term learning is identified during the course of the Review process, then practitioners can implement any immediate changes as a result of this learning before the completion of the Single Unified Safeguarding Review. If this is the case, the Review Panel should share this learning with the Regional Safeguarding Board for further dissemination. This will ensure that important learning can be disseminated and implemented without possible delays. The Single Unified Safeguarding Review Co-ordination Hub is responsible for the dissemination of all learning on a pan-Wales basis.

8.6 The Single Unified Safeguarding Review Co-ordination Hub will use the Wales Safeguarding Repository to interrogate themes in order to get a better understanding of incidents in Wales. The Hub will regularly publish reports which investigate these themes. These reports will be shared with all relevant organisations in Wales to ensure that best practice is disseminated.

Bi-Annual Themed Dissemination Event

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

8.8 These events will be co-ordinated and organised by the Single Unified Safeguarding Review Co-ordination Hub. They will be held on a Wales-wide basis. The Wales Safeguarding Repository will be utilised to determine relevant themes for discussion. Direction can be sought from the Single Unified Safeguarding Review Strategy Group and Single Unified Safeguarding Review Ministerial Board.

Multi-Agency Professional Forums

8.9 Multi-Agency Professional Forums 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)[43],

[43] *The Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015.* Safeguarding Boards Regulations (2015)

the Regional Safeguarding Board are required to arrange and facilitate an annual programme of Multi-Agency Professional Forums. They can be conducted when a case does not meet the criteria for a Single Unified Safeguarding Review. 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 Regional Safeguarding Board's future audit and training priorities.

8.10 Multi-agency Professional Forums are defined in the *Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015*[44] 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."

8.11 This 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 will always be met.

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

8.13 Responsibility for establishing a programme of work for the forums will initially fall to the Regional Safeguarding Boards in liaison with the Single Unified Safeguarding Review Co-ordination Hub, utilising the Wales Safeguarding Repository and engaging or involving Community Safety Partnerships to maximise the understanding and impact of the lessons learned.

8.14 The forums have two main purposes – they can be used for case Learning Events and for dissemination and exploration of learning from audits, inspections, and Reviews but they can also be used to provide other important opportunities for local multi-agency practitioner and manager learning:

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 Single Unified Safeguarding Review.
b) **Dissemination of new knowledge and findings**: from multi-agency safeguarding audits and from Single Unified Safeguarding Reviews,

[44] Section 2. Safeguarding Boards (Functions and Procedures) (Wales) Regulations 2015

inspections or other local or national sources, in order to ensure continuing local multi-professional learning and development.

8.15 The forums 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 Regional Safeguarding Board, and families where appropriate. The learning may be disseminated more widely by the Single Unified Safeguarding Review Co-ordination Hub on a local, regional, or national level, whilst also informing the Regional Safeguarding Board's annual Review of its Business Plan.

8.16 The forums 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.

8.17 The learning from forums which have been concerned with 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.

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

8.19 Where the learning from these forums is of wider relevance, the Regional Safeguarding Board will liaise with the Single Unified Safeguarding Review 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 should be managed by the Single Unified Safeguarding Review Co-ordination Hub. For Offensive Weapons Homicides, engagement will also be with the Offensive Weapons Homicide Review Oversight Board.

8.20 The effectiveness of these forums requires the commitment of senior agency representatives who are Regional Safeguarding Board members and positive support from agencies to enable professional staff to make use of these learning

opportunities.

8.21 The programme of work will require resourcing by the Regional Safeguarding Board and periodic evaluation to ascertain the impact on Single Unified Safeguarding Review practice. The findings should be reported back to the Regional Safeguarding Board and the Single Unified Safeguarding Review Strategy Group.

8.22 Multi-Agency Professional Forums are built on long-standing, prior experience and draw on good practice across Regional Safeguarding Boards in Wales.

9 Sharing information and protecting personal data

Regional Safeguarding Boards/Community Safety Partnerships

9.1 Personal and special category data will be processed during the Single Unified Safeguarding Review process (outlined in sections above);

9.2 Regional Safeguarding Boards/Community Safety Partnerships (or lead authority) will have data protection obligations in relation to that personal data under the *UK GDPR and the Data Protection Act 2018*[45]. Specific considerations will include:

- Adherence to the data protection principles
- Provision of privacy information to individuals
- Data subjects' rights

9.3 Such information must be included in the information sheet provided to individuals involved in the Single Unified Safeguarding Review see the Single Unified Safeguarding Review Toolkit for the template.

9.4 Regional Safeguarding Boards/Community Safety Partnerships must ensure that privacy information provided to individuals includes provision for the publication of Single Unified Safeguarding Review Reports and the sharing of Single Unified Safeguarding Review Reports with the Wales Safeguarding Repository (the Home Office Repository in the case of Domestic Homicides, and with the Secretary of State for the Home Office for Offensive Weapons Homicides).

9.5 The responsibility for retaining and determining future access by third parties to Serious Case Reviews, Child Practice Reviews and Adult Practice Reviews rests with the Local Authority where the subject was ordinarily resident. Thus, the ownership of the document that will have been historically agreed by the Chair of the respective Local Safeguarding Children's Boards or the Regional Safeguarding Board will be with the Local Authority not the board who performed the Review.

The Wales Safeguarding Repository

9.6 Single Unified Safeguarding Review Reports and Action Plans will be shared by Regional Safeguarding Boards with the Single Unified Safeguarding Review Co-ordination Hub. The Reports will then be incorporated into the Wales Safeguarding Repository (in the case of Domestic Homicides, also the Home Office Repository and for publication by the Secretary of State for the Home Office for Offensive Weapons Homicides).

[45] UK GDPR and the Data Protection Act 2018

9.7 The Wales Safeguarding Repository will be used to provide information in relation to Single Unified Safeguarding Reviews and to assist Regional Safeguarding Boards in their statutory duty to facilitate pan-Wales learning and training.

9.8 The Report provided to the Single Unified Safeguarding Review Co-ordination Hub for inclusion in the Wales Safeguarding Repository will be the same version published on the Regional Safeguarding Board/ Community Safeguarding Partnership website. The full published Report will form part of the 'Wales Safeguarding Repository Submission Form' for inclusion in the Repository.

9.9 The Single Unified Safeguarding Review Reports should be prepared on the basis that all personal identifiers (e.g., names) are removed or pseudonymisation is used. This will reduce potential for individuals referred to in the Report to be identifiable (individuals' identity or their whereabouts will not be revealed in the Report). 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. The Single Unified Safeguarding Review Reports should therefore be treated as if they contain personal data and are covered by relevant data protection laws. Reports may also include special category data (e.g. data concerning health) or information in relation to criminal convictions. The additional safeguards when processing special category data must be observed and adhered to.

9.10 Single Unified Safeguarding Review Reports will also contain the personal data of the Reviewer(s).

9.11 The Welsh Government and Cardiff University will initially be joint controllers of personal data processed in the Wales Safeguarding Repository and will ensure compliance with its relevant obligations under data protection laws 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
- Managing and responding to individual rights requests (e.g., subject access requests)

9.12 All of the information included on the 'Wales Safeguarding Repository Submission Form' (including Single Unified Safeguarding Review Reports), will be retained in the Wales Safeguarding Repository indefinitely in order to ensure that relevant findings and learning can be drawn from the Reports and Action Plans.

Information and data sharing

9.13 Sharing personal data across local partners/bodies is key to the success of Single Unified Safeguarding Reviews. The aim of the process is to share all of the relevant information each organisation has about an individual involved in the Review. This could be any service user, whether the victim, the alleged perpetrator(s) or a person connected to the incident. Only information relevant to the Review needs to be shared in order to successfully carry out the Single Unified Safeguarding Review.

9.14 It is understood that information on alleged perpetrators or other individuals connected with the incident may not be shared in the initial stages of the Single Unified Safeguarding Review by the police Senior Investigating Officer or Crown Prosecution Service as it could threaten the integrity of the criminal investigation or criminal proceedings. This may remain the case for the duration of the Review 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 Review. 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.

9.15 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, 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, aiding to identify any lessons to be learnt from the incident and to consider whether it would be appropriate for anyone to take action in respect of those lessons learnt.

9.16 All material generated or obtained by the Single Unified Safeguarding Review whilst the criminal case is ongoing must be made available to the police Senior Investigating Officer and disclosure officer to assess its relevance to the criminal case. Where relevant it is for the Crown Prosecution Service to decide whether it should be disclosed to the defence. Where the information 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.

10 Applying the Single Unified Safeguarding Review process to historic abuse

10.1 It is the responsibility of the Regional Safeguarding Board to determine whether a case meets the prescribed criteria for undertaking a Single Unified Safeguarding Review (see Section 3). The Regional Safeguarding Board may decide that a Single Unified Safeguarding 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.

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

10.3 Historic Reviews that meet the criteria for a Single Unified Safeguarding Review should follow the principles, approach and process outlined within this Guidance.

11 Relationship with other formal processes

11.1 The Single Unified Safeguarding Review 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 through the relevant agency's own staff procedures.

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

Parallel Processes

11.3 Where the case is subject to police investigations or judicial/coronial proceedings, these should not automatically inhibit the setting up of a Single Unified Safeguarding Review 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.

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

11.5 The Review Panels are independent from the criminal justice process, and it is not possible to enforce any demands 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 Single Unified Safeguarding Review. 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 Single Unified Safeguarding Review. If the Senior Investigating Officer, the Crown Prosecution Service or the Coroner make representations of concern that the Single Unified Safeguarding Review will jeopardise the ongoing criminal investigations, criminal or coronial proceedings, there should be discussion with

and agreement sought of the Review Panel Chair on the way forward, which will be reflected in the Terms of Reference of the Single Unified Safeguarding Review.

11.6 A request could be made to the Review Panel that the scope of the Single Unified Safeguarding 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 satisfied. 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.

11.7 If the scope of the Review is temporarily restricted, this certainly does not negate the need for or delay setting up a Review Panel to carry out the Single Unified Safeguarding Review, to allow for the securing of any records pertaining to the death or serious injury against loss and interference and identify primary learning.

11.8 It is essential that necessary learning is not delayed to prevent the same mistakes 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 for action providing that it does not compromise the integrity of relevant criminal or coronial proceedings.

11.9 It should be recognised that while there are such significant legal and operational imperatives that need to be understood and acknowledged, there are significant developments in Wales which support the aim and purpose of the Single Unified Safeguarding Review 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 Single Unified Safeguarding 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

11.10 Every Regional Safeguarding Board has 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 victim, family and principal individuals 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
Regional 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: Mental Health Homicide Referral Routes and supporting information

Referral routes
Anyone can make a referral 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[46], Welsh Government of a mental health homicide under the National Reporting Incidents framework[47]. Additional information to support this decision making is included in the two boxes below:

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 murder, the 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 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[48], 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.

[46] NHS Wales Delivery Unit Delivery Unit
[47] NRLS Reporting
[48] Patient Safety Incidents NHS Wales Patient Safety

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.

Mental Health (Wales) Measure 2010[49]
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[50] *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;

[49] Mental Health (Wales) Measure 2010. National Service Model for Local Primary Mental Health Support Services Mental Health (Wales) Measure 2010
[50] Mental Health Act 1983

- 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 arrangement in pace 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.

Appendix Three: Local Partners

- 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 Regional Safeguarding Boards.

Similarly for areas with Prisons or secure detention centres Regional 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.