Easy Read

Llywodraeth Cymru
Welsh Government

Safeguarding Reviews

Learning from the past to make the future safer

This document was written by the Welsh Government. It is an easy read version of '**Single Unified Safeguarding Review – Illuminating the Past to make the Future Safer**'.

October 2022

How to use this document

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

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

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

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Introduction

We need to change the way we deal with **safeguarding** problems in Wales.

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

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

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

This is called a **safeguarding review**.

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

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

- Upset

- Tired
- Frustrated

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

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

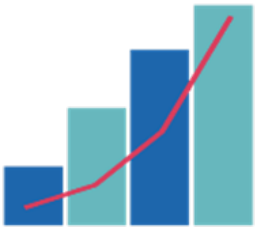
Some of the aims of the **SUSR** are:

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

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

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

- Get things done more quickly without losing quality.



- Make sure we do things better in the future.

- Make sure staff have much needed support from managers.

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

- Make sure we learn from complicated cases.

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

The support network will include:

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

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

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

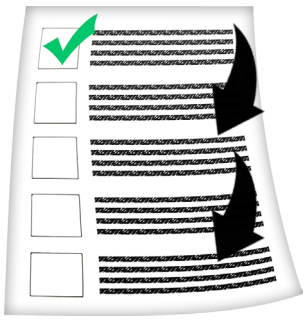
They will deliver training and host events to share best ways of working and lessons learned across Wales.

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

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

Why we created SUSRs

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



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

SUSRs are not about blaming staff for making mistakes. They are to make sure we learn from every case.

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

It is also important that people who are at risk have their say. Because their voice matters.

When to do SUSRs

We won't do a **SUSR** for every case we see. We will do a SUSR when:

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

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

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

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

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

And if we should have been working harder to keep them safe.

We will do an SUSR when:

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

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

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

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

Suicide is when someone is very sad and they decide to kill themselves.

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

We will do an SUSR when:

- there has been a **homicide**

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

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

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

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

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

We will do an **SUSR** when:

There has been a **homicide** using an **offensive weapon**. And the person is aged over 18 and is in Wales.

An **offensive weapon** is something someone would use to cause harm to another person. For example, a knife.

There are rules about doing SUSRs for **offensive weapon homicides**. For example:

- The body of the person must have been found.

- Or part of the body of the person must have been found.

- We must know who the dead person is.

- Or we think we know who caused the death.

- We had information about the people involved before the **homicide** happened. For example, we knew they were at risk. Or we knew they were likely to cause harm.

How to do SUSRs

Regional Safeguarding Boards will manage the reviews in their area. **Regional Safeguarding Boards** will put together a **Case Review Group**.

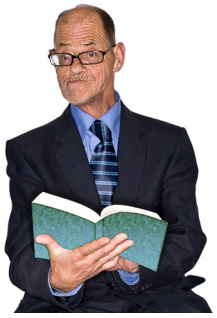
The **Case Review Group** will:

- Talk to the child or adult at risk if needed. And to their family members.

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

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

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



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

This process should not take more than 12 months.

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

They will make a **very clear** action plan on how to make things better.

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

Who does SUSRs

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

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

The Case Review Group

- **The Chair**
- **The Review Panel**

- **The Reviewer**
- **The Regional Safeguarding Board**
- **SUSR Ministerial Board for Wales**

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

The Case Review Group

Case review groups decide if a **SUSR** is needed. Then they double check with the chair.

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

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

The Chair

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

They also make sure the review stays on track once it starts.

The Review Panel

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

They also make sure that everyone learns from the review.

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

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

The Reviewer

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

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

The Regional Safeguarding Board

Regional Safeguarding Boards link what we learn to policies and plans in Wales. They support changes to the law and get the things we need to make sure we are working in the best ways.

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

SUSR Ministerial Board for Wales

The purpose of this board is:

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

- To help with any difficult reviews.

- To think about any changes needed in the law.

- To improve **safeguarding** across Wales.

SUSR Coordination Hub

The role of the hub is:

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

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

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

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

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

Community Safety Partnerships

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

In such cases, someone from the community safety partnership should join the **SUSR** too.

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

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

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

Involving family and key individuals in reviews

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

- Key family members
- Victim

- **Perpetrator**
- Friends

- Community staff
- Neighbours

- Colleagues
- Employers

We have created some guidelines for this:

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

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

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

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

- We will use easy to understand language throughout.

- We will communicate in a language of your choice.

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

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

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

In the **past**, children and younger adults were not always able to speak at reviews.

In our experience we find that it is best if all people, including young people, are involved. Even if a small amount.

Regional Safeguarding Boards will try different ways of working with families.

Regional Safeguarding Boards oversee **safeguarding** in their area. There are 6 in Wales.

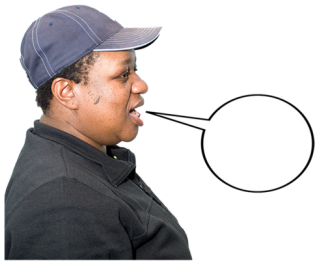
We will give feedback from reports to family members in the format they want.

When a domestic homicide has happened

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

The benefits of involving family and friends are:

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



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

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

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

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

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

- Offer expert advice to people who need an **advocate**.

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

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

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

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

Sometimes, there is reason to believe **honour killings** have taken place.

Honour killings are when family members are killed, especially girls. They are killed because their family believe they have brought dishonour on the family.

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

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

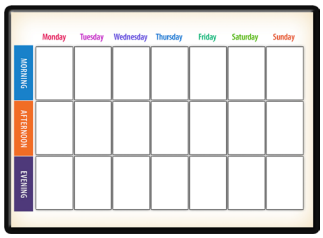
The review panel must get expert advice and information from outside professionals and organisations.

The stages of SUSRs

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

Timelines

Timelines show the dates of when certain things happened.



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

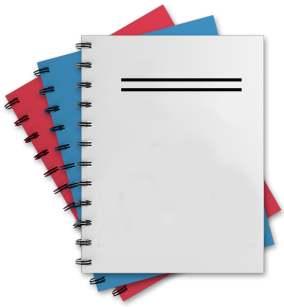
Other documents

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

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

Learning from SUSRs

At the start of every **SUSR** we will hold a learning event. So everyone can discuss the case and learn from it.



We will use old cases to help us.

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

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

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

How to learn from SUSRs

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

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

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

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

The **SUSR Coordination Hub** will run learning events every 6 months.

Multi-Agency Professional Forums (MAPFs) are events to share information and learn from **SUSRs.**They are arranged by the **Regional Safeguarding Boards**.

MAPFs give everyone the chance to talk about **SUSRs**. And to learn from each other.

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

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

Protecting private information

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

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

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

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

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

We need to make sure we follow the law.

Doing SUSRs on old cases

Not all cases should have reviews done on them.

Boards decide which cases have **SUSRs**. And which don't.

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

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

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

Other Processes

SUSRs are about learning and making improvements.

SUSRs are not about punishing staff for mistakes.

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

We might need to talk to the police.

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

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

Hard words

Abuse

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

Advocate

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

Domestic homicide

This is when someone has died due to neglect, violence, or abuse from someone the victim was related to or in a relationship with.

Homicide

When some is killed by someone else.

Honour killings

These are the killings of female family members by male members because they feel dishonour has been brought on the family

Neglect

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

Offensive weapon

An offensive weapon is something someone would use to cause harm to another person. For example, a knife.

Perpetrator

This is someone who carries out harmful or illegal acts.

Safeguarding

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

Suicide

Suicide is when someone is very sad and they decide to kill themselves.