An Introduction to the Single Unified Safeguarding Review (SUSR)

Wales Safer Communities Network Autumn/Winter Seminar

6th December 2022

Liane James

Welsh Government Commissioned Review of Domestic Homicide Reviews (DHR) 2017

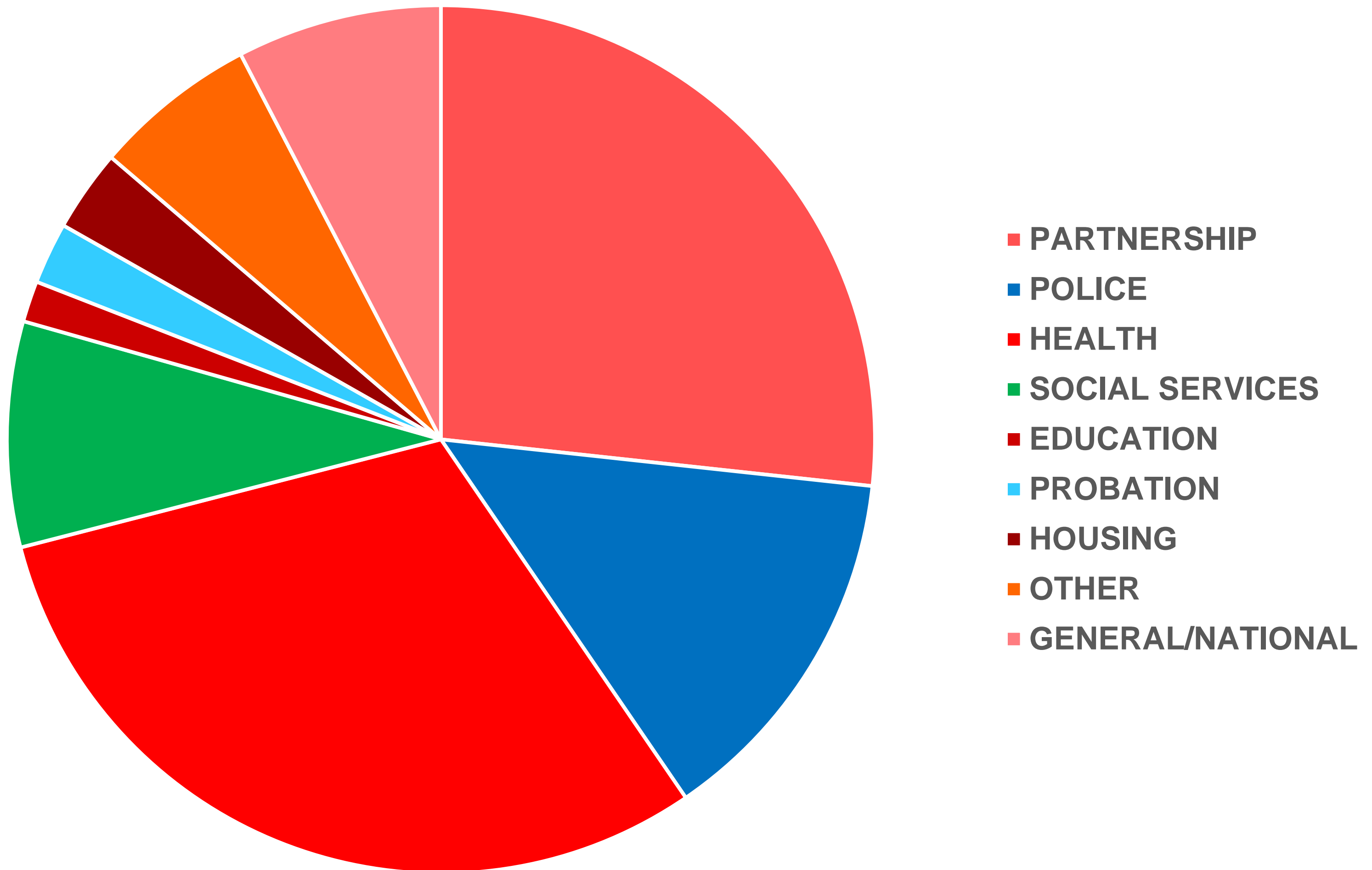
Minister for Violence against Women and Girls and Sexual Violence Carl Sargeant commissioned a review of DHRs in Wales with the aim to:-

"To assess the effectiveness of the Welsh Government, Community Safety Partnerships and other public services response to Domestic Homicide Reviews and make recommendations as to how they might be fully acted upon by Welsh Public services"

Review Findings

- History of Serious Case Review (SCR) and DHRs hindering common sense approach
- Plethora of devolved and non devolved reviews on single incidents
- Chairs paid on average 10-15k in Wales up to 28K in England
- Home Office do not hold central list of accredited Chairs and will not bar Chairs deemed to be inadequate
- Home Office not delivering for Community Safety Partnerships (CSPs) on DHRs and take too long (2016 cases)
- Since 2014, APR/CPR is considered to work better for Wales
- No Welsh Government involvement in DHRs
- Lessons identified held locally, not shared or collated centrally
- National and regional recommendations not being followed through no one collating or sharing learning once identified

Home Office Domestic Homicide Reviews
Key Findings from Analysis of DHRS
December 2016



Sadler Case Cardiff

Emma Sadler, 28 , history of substance misuse and known to police. August 2015, child taken into care, **January 2016**, full care order granted.

10th January 2016, Sadler committed arson causing the death of her father, charged with murder, sentenced to be detained indefinitely in a secure unit.

- Domestic Homicide Review – Community Safety Partnership
- Child Practice Review – Cardiff Council Children Services
- Adult Practice Review – Cardiff Council Adult Services
- Serious Further Offence Review – Community Rehabilitation Company
- Root Cause Analysis Review – Cardiff and Vale UHB
- Independent Police Complaints Commission Investigation
- Welsh Ambulance Service Internal Investigation

Seven reviews, not including the police investigation and coroner inquest

Type of report	Country	Area	Year of incident	Year of report	Months taken
DHR	England	Southampton	04/2011	11/2012	19
DHR	England	Lewisham	03/2012	4/2013	13
DHR	England	Birmingham	2011	8/2013	24
DHR	England	Barking and Dagenham	03/2013	05/2014	15
DHR	England	Islington	07/2012	8/2013	13
DHR	England	Lewisham	03/2012	4/2013	13
DHR	England	Brighton and Hove	07/2012	8/2014	25
DHR	England	Croydon	1/2013	11/2014	22
DHR	England	Kent	04/2012	5/2014	25
DHR	England	Somerset	09/2012	6/2014	21
DHR	England	Ealing	12/2012	8/2014	20
DHR	Wales	Gwynedd	3/2012	6/2014	27
DHR	Wales	Torfaen	9/2012	11/2014	26
DHR	Wales	Bridgend	10/2012	6/2015	32
DHR	Wales	Ceredigion	3/2014	7/2015	16
DHR	Wales	Camarthenshire	12/2012	9/2015	33
DHR	Wales	Newport	5/2014	9/2015	16
DHR	Wales	Newport	8/2013	3/2016	31
DHR	Wales	Bridgend	7/2013	6/2016	35
DHR	Wales	Flintshire	9/2014	2017	36
DHR	Wales	Bridgend	6/2015	5/2017	23
DHR	Wales	Monmothshire	6/2015	10/2017	28
DHR	Wales	Pembrokeshire	2/2016	10/2017	20
DHR	Wales	Powys	4/2016	1/2018	21
DHR	Wales	Cardiff	12/2014	7/2018	43
DHR	Wales	Cwm Taf	10/2015	4/2019	42
DHR	Wales	Cardiff	8/2015	2/2021	66

Key Review Recommendations

- Creation of a **Single Unified Safeguarding Review (SUSR)** which is cross agency, with a common framework, clear terms of reference, mapped in line with current APR and CPR frameworks.
- **Governance** of reviews to sit within Regional Safeguarding arrangements and not Community Safety Partnerships
- **Chairs** of the reviews independent but public servants
- Creation of **exceptional reporting process Ministerial Board**
- **Central Repository** for all reviews in Wales where key learning can be extrapolated and disseminated to prevent incidents and protect victims.
- **National Annual learning** and training events for practitioners.

Cardiff University Academic Review

Recommendations submitted to Welsh Ministers Autumn 2018.

Implementation of SUSR project agreed and commenced December 2019.

Project Delivery

SUSR Steering Group

Six key pillars delivered by Task and Finish Groups

- **Wales Safeguarding Repository**
- **Training and Learning**
- **Policy and Process**
- **Legal and Governance**
- **Mental Health Homicide**
- **Offensive Weapon Homicide**

SUSR OVERARCHING SUPPORT NETWORK

Illuminate the Past to make the Future Safer

Llywodraeth Cymru
Welsh Government

Roles of the Support Network

Regional Safeguarding Boards

SUSR Co-ordination Hub

National Independent Safeguarding Board

Regional Partnership Boards /Public Service Boards

Welsh Safeguarding Repository

Community Safety Partnerships

Ministerial Board

Regional Safeguarding Business Unit

Regional Case Review Group

UK Government

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.

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 Child Practice Reviews and Adult Practice Reviews and apparent child suicides. The group will also consider referrals for Domestic Homicide Reviews, thematic reviews and audits as appropriate. 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.

Welsh 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.

Louise Fradd 2021

Single Unified Safeguarding Review

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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

Action → Single Unified Safeguarding Review (CPR/APR/DHR/MHHR/OWHR) / Other Service Review Required

Single Unified Safeguarding Review (CPR/APR/DHR/MHHR/OWHR)

- CRG recommend panel chair and reviewers from approved list
- Panel Meeting
- Merged Timeline Agreed
- Reviewers Meet Family
- Panel Meetings
- Learning Event
- Draft Report and Action Plan to CRG
- Final report to Board (& CSP or regional equivalent if DHR)
- 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.

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

Fradd Consultancy Ltd

Single Unified Safeguarding Review

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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

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

Virtual Bi-Annual Themed Dissemination Event (Safeguardng Week)

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

Rationale for the repository

- **Improved accessibility**: The consistency with which DHR and other safeguarding reports are available is known to be inconsistent across local areas.
- **Improved learning**: Despite the significant level of resources invested in producing these reports, presently it is unclear the extent to which their findings have added to the sum of professional knowledge. Furthermore, there is a need for multi-disciplinary learning across professions.
- **Improved governance**: Whether recommendations from action plans are implemented, and their effect on professional practice ‘on the ground’, remains largely unknown.

Ystorfa Diogelu Cymru

Wales Safeguarding Repository

Offensive Weapon Homicides Reviews

- England and Wales Homicide rates increased by a third between 2014 and 2019
- Fourth leading cause of death for men aged 20-34 (behind suicide, drug overdoses and car accidents
- In 2019, homicides involving offensive weapons totalled 354 out of 732
- Of the 732 offences, 510 did not meet the criteria for an existing review of which 251 involved an offensive weapon
- The Police, Crime, Sentencing and Courts Act 2022, introduces a requirement on the police and local authorities in England and Wales and local health boards to review homicides where the victim was aged 18 or over, and the events surrounding their death involved the use of an offensive weapon.
- An OWHR will only be established if no other agency is undertaking a review on the incident. In 2022 10 incidents in SWP Pilot area, 1 qualified.

OWHR in Wales

- From the outset Welsh Government and the SUSR team have been engaged in the development of the OWHR at a strategic level
- Home Office have agreed to utilise the SUSR to deliver the requirements of an OWHR
- Statutory Guidance currently being written by the Home Office which will include a chapter on the SUSR
- The SUSR programme has a dedicated task and finish group for the SUSR chaired by Jon Drake.
- It has been agreed that South Wales will be one of the three pilot sites in England and Wales.

Next Steps

- SUSR draft statutory guidance
- Six pre-consultation engagement sessions, 12 weeks public consultation
- Stakeholder Reference Group.
- WSR Testing
- SUSR Training materials to be developed by Regional Safeguarding Boards.
- SUSR Webpage. Housed on the Welsh Government website. links to the SUSR statutory guidance, consultation information, the SUSR Toolkit and other helpful templates.
- National and International recognition - Australian, New Zealand and Scottish Governments have been provided a briefing on the SUSR