Vulnerability Knowledge & Practice Programme

College of Policing

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A Brief Guide to Statutory Reviews

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Introduction

The statutory reviews included in this document generally take place following the death of, or serious harm to, an individual which meets the criteria for a review, as detailed in relevant legislation.

The review has no power to determine civil or criminal liability, but instead, can make findings of fact and recommendations for improvement to ensure the welfare of individuals experiencing vulnerability related harm. This guide focuses on a number of different reviews, related to safeguarding, where the police are often a key responsible agency. Although further types of review exist, this guide focuses on those review types that occur where there has been a serious incident involving individuals who are vulnerable. The College of Policing (CoP) has adopted the THRIVE definition of vulnerability which states that:

"a person is vulnerable if, as a result of their situation or circumstances, they are unable to take care of or protect themselves or others from harm or exploitation".

This document focuses on the statutory reviews system within England and Wales, although the process of reviews differs between the two countries. In England, responsibility for each review type is governed by different bodies at a national level and locally by partnerships (all of which varies depending on the review type). In some cases joint reviews may be carried out, for example in a domestic homicide where children have been involved both a Domestic Abuse Related Death Review and a Child Practice Review may be conducted. In October 2024, Wales moved to a **single unified review process**. This combines the Welsh approaches for Adult and Child Practice Reviews, Mental Health Homicide Reviews, Domestic Abuse Related Death Reviews, and Offensive Weapon Homicide Reviews.

The purpose of this document is to provide information about:

- the types of statutory reviews that exist which are linked to vulnerability;
- the governance related to reviews and the key agencies involved;
- guidance on the process of conducting and writing reviews;
- information about where review repositories, if available, are located.

This is not an exhaustive list but seeks to provide useful information on the most common types of statutory reviews that the police are involved in. The information will be most relevant to those involved in writing/commissioning reviews; however, it is applicable to all individuals seeking more information about statutory reviews.

Types of Statutory Reviews

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1 Domestic Abuse Related Death Reviews

2 Rapid Reviews and Child Safeguarding Practice Reviews

3 Single Unified Safeguarding Review System (Wales)

4 Safeguarding Adult Reviews

5 Multi-Agency Public Protection Arrangement Serious Case Reviews

6 Offensive Weapon Homicide Reviews

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1

Domestic Abuse Related Death Reviews

Overview

Domestic Abuse Related Death Reviews (DARDRs) (formally Domestic Homicide Reviews) were established on a statutory basis under section nine of the **Domestic Violence, Crime and Victims Act (2004)**. This provision came into force on 13th April 2011, with recent terminology changes reflected in amendments to the **Victim and Prisoners Act (2024)**.

What are Domestic Abuse Related Death Reviews?

Consultation is underway on amendments to the statutory guidance concerning domestic abuse related death reviews (DARDRs). The Victim and Prisoners Act (2024) defines DARDRs as a review into the circumstances of the death of a person which is held:

- Where the death has, or appears to have, resulted from domestic abuse towards the person, within the meaning of the Domestic Abuse Act 2021, and
- With a view to identifying the lessons to be learned from the death.

The **Domestic Abuse Act (2021)** defines domestic abuse as the behaviour of a person towards another person, where the two people are aged 16 or over and are personally connected to each other, and the behaviour is abusive. Abusive behaviour is defined as: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional, or other abuse.

Main Purpose

To identify lessons to be learnt from the death, prevent domestic abuse and homicide, and improve service reviews for victims. DARDRs aim to develop a coordinated multi-agency approach to ensure abuse is identified and responded to effectively, at the earliest opportunity.

There is an emphasis on professional curiosity to determine the trail of abuse, with a focus on the past intended to increase the safety of the future.

A DARDR does not seek to apportion blame or guilt for the death. It can be held in addition to an inquest/inquiry into the death and does not replace this process.

Governance

When a domestic abuse related death occurs, the relevant police force should inform the relevant Community Safety Partnership (CSP) in writing of the incident.

The chair of the CSP holds responsibility for establishing whether a homicide is to be the subject of a DARDR, however this decision should be taken in consultation with local partners who understand dynamics of the domestic abuse.

On a national level, the Home Office has overall responsibility for the governance of DARDRs, however the Domestic Abuse Commissioner's Office share this responsibility and have oversight on the implementation of recommendations. The Domestic Abuse Commissioner's Officer have also established a domestic homicide and suicide oversight mechanism in order to examine reviews. On a local level the governance of DARDRs is the responsibility of CSPs.

Key Responsible Agencies within the Partnership

- Police
- Local Authorities
- Fire and Rescue Authorities
- Probation Service
- Health Services

Guidance on the Process

Statutory guidance relating to the conduct of DARDRs can be found at: **Domestic homicide reviews: statutory guidance**. Following a consultation on amending the legislation which ended in August 2023, this guidance will be updated. A person establishing or participating in a DARDR must act in accordance with this guidance and must have clear reasons if they choose to depart from it.

When the criteria for a DARDR is met, the CSP will request the establishment of a review panel. The panel should meet as many times as is considered necessary to ensure there is robust oversight and rigorous challenge of practice within the case. The chair and panel should consider the scope of the review process and draw up clear terms of reference which are proportionate to the nature of the homicide. The terms of reference will likely: set out the need to identify the relevant facts, issues, and lessons to be learnt; set out the timescale of the review, including information about the period of time under review and the deadline of the report; provide information about the chair/author and the agencies required to contribute to the review; provide information about family involvement and how this will be managed; and discuss how media and communication will be managed. Guidance on relevant issues to be considered within the terms of reference can be found from page 13 within the statutory guidance.

Families should be given the opportunity to engage with the review, if they wish to do so, and the chair/review panel should make every effort to include the family and ensure best practice is followed when engaging with them.

The review panel chair will write to the senior manager in each of the agencies, bodies, or organisations identified as part of the review to commission an individual management review (IMR). IMRs focus on individual and organisational practice to determine whether practice needs to be changed or improved, identify any learning, and form part of the DARDR report.

Mandatory training for review chairs is also available, and is delivered by Advocacy After Fatal Domestic Abuse (**Home Office Funded DHR Chair Training - AAFDA**).

Writing Domestic Homicide Reviews

The review should 'articulate life through the eyes of the victim and their children' (Home Office, 2016, p. 7) and gather information from those around the victim to help understand their reality.

Guidance on writing the report can be found here: **Domestic Homicide Review Toolkit - Guide to Overview Report Writing**.

Top Tips

- Ensure that the language used within the report can be clearly understood by the victim's family, friends, the perpetrator, the public, and by all agencies involved.
- Ensure the terms of reference are clearly answered and addressed within the report.
- Be careful of expressing opinions – ensure the report is evidence based and factual.
- Use the words of those involved in the review within the report.
- Be mindful of hindsight bias – the report should focus on how things were viewed at the time rather than based on what is known after the event.
- Recommendations should be single-topic and specific, and should be SMART (Specific, Measurable, Achievable, Realistic, and Timely).
- Reports should be anonymised and should not identify the victim, perpetrator, or their families.

Repositories and Helpful Resources

A library of domestic abuse related death reviews can be found here: **Domestic Homicide Library**

The Homicide Abuse Learning Together (HALT) study was completed in 2022 and analysed all publicly available DHRs between 2011-2018. They have produced a number of briefing documents located here: **Resources and Publications**.

Advocacy After Fatal Domestic Abuse (AAFDA) are an independent organisation which offer advocacy and peer support following fatal domestic abuse.

Useful Reading

Please use this link to access a collection of documents, produced by the Home Office, that relate to DHRs: **https://www.gov.uk/government/collections/domestic-homicide-review**

Additional Documents

Professionals' Perspectives about DHRs:
https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.13725

DHR Committees' Recommendations and Impacts: A Systematic Review:
https://journals.sagepub.com/doi/full/10.1177/10887679221081788

Domestic Homicide Project within the VKPP
https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/

Domestic Homicide Reviews: The role of family, friends, and community – a hierarchy of testimony?
https://www.aafda.org.uk/news/domestic-homicide-reviews-the-role-of-family-friends-and-community-a-hierarchy-of-testimony#:~:text=A%20Domestic%20Homicide%20Review%2C%20whilst,those%20that%20are%20left%20behind

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Rapid Reviews and Child Safeguarding Practice Reviews

Overview

Working Together to Safeguard Children (2023) sets out the statutory requirements for rapid reviews and child safeguarding practice reviews (CSPRs).

What are Rapid Reviews and Child Safeguarding Practice Reviews?

Serious child safeguarding cases are those in which:

- Abuse or neglect of a child is known or suspected, AND
- the child has died or been seriously harmed.

A rapid review will initially be undertaken and completed. A decision will then be taken as to whether a local and/or national CSPR is required.

Main Purpose

To identify improvements to be made to safeguard and promote the welfare of children, at local and national level. This should happen in a way that contributes to continued systems improvement, without seeking to hold individuals, organisations, or agencies to account. Rapid reviews and CSPRs (if undertaken) further seek to prevent or reduce the risk of a similar incident recurring in the future.

Governance

At a national level, responsibility for how the system learns from serious child safeguarding incidents lies with the Child Safeguarding Practice Review Panel (the Panel). At a local level, the responsibility lies with the safeguarding partners.

Working Together (2023) emphasises the importance of effective multi-agency working and sets out that every local authority, integrated care board, and constabulary in England must be covered by a multi-agency safeguarding arrangement (MASA). Local Child Safeguarding Partnerships must publish their arrangements for commissioning and publishing CSPRs, how they will be undertaken, and the arrangements for embedding learning across organisations and agencies. An independent scrutineer or scrutiny group should also be established in order to provide effective support and challenge at both a strategic and operational level.

The Panel must be notified of every serious child safeguarding incident meeting the criteria for a rapid review and CSPR. The rapid review and CSPR are overseen, and the reviewer supervised, by safeguarding partners.

The December 2023 update of Working Together distinguishes between Lead Safeguarding Partners (LSPs) and Delegated Safeguarding Partners (DSPs). Each statutory safeguarding partner agency should have an LSP to aid strong, joined-up leadership and clear accountability. For police, the LSP should be the Chief Constable.

The LSPs are jointly responsible for the strategic leadership of all relevant agencies, for providing shared oversight of learning, and ensuring recommendations are implemented and that a demonstrable impact on practice is evidenced in the yearly report.

The DSPs, in contrast, are responsible for leading operational delivery and carry out functions to oversee and ensure effective partnership working. They are responsible for the delivery of "high-quality" and "timely" rapid reviews, as well as CSPRs. While the DSP should be sufficiently senior to speak with authority, take decisions on behalf of the LSP, and hold their sectors to account, ultimate accountability stays with the LSP.

Local safeguarding partners (local authorities, chief officers of police, and integrated care boards) must carry out a rapid review into all incidents notified to the Panel and send a copy to the Panel. Local safeguarding partners should also notify the Panel, Ofsted, and the Department for Education (DfE) if they intend to carry out an CSPR. The final report should be published as soon as possible, and no later than six months, from the date of the decision to initiate a review.

If a case is particularly complex, or of national importance, the Panel may decide to commission a national CSPR.

Key Responsible Agencies within the Partnership

- Local Authority
- Police
- Integrated Care Boards
- Education
- Probation Service

Guidance on the Process

The local authority is responsible for notifying the Panel, Ofsted, and the DfE through a serious incident notification (SIN) of a serious injury to, or death of, a child where abuse or neglect is known, or suspected to be, the cause of, or a contributory factor.Notifications must also be made to the Secretary of State and Ofsted when any looked after child dies, and when a care leaver up to and including the age of 24 dies. The SIN must be submitted within five working days of becoming aware of the incident, via the **child safeguarding incident notification system**.

Where abuse or neglect was known or suspected, the safeguarding partners are then required to carry out a rapid review which should be submitted to the Panel within 15 working days of the SIN. Decisions about whether to proceed to a CSPR, and the recommendations and action plans identified within rapid reviews and CSPRs, need to be agreed by senior representatives of each of the three partners and reviewed by the Panel. If a case involves services delivered across multiple safeguarding partnerships, the safeguarding partners should liaise to agree which partnership will take the lead in conducting the rapid review. Consideration should also be given as to whether a joint CSPR may be required.

The reviewer(s) for an CSPR must have the appropriate knowledge and expertise of the child safeguarding system to undertake the review. The methodology will set out the principles and approach to learning and should describe what was done and how. The focus within the review should be an analysis of why certain events occurred, as opposed to focusing solely on what happened.

The scope, aims, and terms of reference of the CSPR should be determined by the chair at the start, and should be specified clearly in the final report. The lived experience of a child, and their voice, should be a key feature throughout a review, and the review should also consider the impact of the child's identity on their lived experience and on professional decision making.

A copy of the full report (regardless of whether the safeguarding partners decide to publish the report in its entirety) must be sent to the Panel and the Secretary of State no later than seven working days before it is published. The LSPs hold accountability for ensuring that any learning identified within the review is implemented.

Writing Rapid Reviews and Child Safeguarding Practice Reviews

Whilst the Panel provide guidance on writing rapid reviews and CSPRs they are clear that each review should be unique and there is not a 'one size fits all' approach. This guidance is located here: **Guidance for Safeguarding Partners**.

Top Tips:

- Rapid reviews should record: the date of birth, sex, and ethnicity of the child and whether the child had any known disability; an overview of the family structure and relevant background information on the family; immediate safeguarding arrangements for any children involved; a concise summary of the facts about the serious incident; a clear decision about whether the criteria for a CSPR have been met; any immediate learning already identified and plans to disseminate such learning; and detail on which agencies have been involved in the rapid review.
- Consideration should also be given to understanding the child's lived experience and how their voice can be heard in the review.
- CSPRs should not be written in the same way as previous Serious Case Reviews and the Panel encourage creative thinking about how best to approach the review of a case.
- Where human errors are identified, this should be the starting point to explore the presence of deeper systems-based issues. The review should therefore focus on why the person acted in the way they did and appropriately consider the environment and context in which individuals were working to understand what learning can be drawn from the case.
- Issues related to intersectionality, the interconnected relationship of social categories such as race, gender, and sexual orientation, should be considered at each stage of the process.
- The Panel produce **national reviews and thematic analyses** that draw together learning which may be useful to those undertaking reviews.

Repositories and Helpful Resources

A library of CSPRs can be found here: **National review repository**.

Guidance on the process can be found here: **Child Safeguarding Practice Review Panel guidance for safeguarding partners (publishing.service.gov.uk)**

Useful Reading

Working Together to Safeguard Children:
Working together to safeguard children - GOV.UK (www.gov.uk)

The Child Safeguarding Practice Review Panel: Annual report 2022 to 2023:
Child Safeguarding Practice Review Panel: annual report 2022 to 2023 - GOV.UK (www.gov.uk)

Case Review Process in UK Nations: NSPCC:
Case review process in each UK nation | NSPCC Learning

Independent Scrutiny and Local Safeguarding Children Partnership Arrangements:
Full-Report-Independent-Scrutiny-August-2022.pdf (vkpp.org.uk)

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Single Unified Safeguarding Review System (Wales)

Overview

The guidance on the **single unified safeguarding review** (SUSR) system replaces the statutory guidance on child practice reviews and adult practice reviews within Wales. The SUSR ensures that, when a qualifying event triggers a review process, all aspects are considered across all relevant devolved and non-devolved agencies, as opposed to these being considered in organisational silos.

What are Single Unified Safeguarding Reviews?

A SUSR should be carried out when the legal grounds for undertaking one or more type of review are met. These legal grounds are set out in:

- **Safeguarding Boards (Functions and Procedures) (Wales) Regulations (2015)**
- **Domestic Violence, Crime and Victims Act (2004)**
- **Section 24 of the Police, Crime, Sentencing and Courts Act 2022**
- Police, Crime, Sentencing and Courts Act (2022) (Offensive Weapon Homicide Reviews).

Main Purpose

The SUSR seeks to develop a proportionate mechanism to conduct a single review process that incorporates a multi-agency approach following the most serious of incidents within Wales.

The SUSR involves practitioners, managers, and senior officers to explore the individual and collective work of agencies with a child and/or an adult at risk (including domestic homicide). The primary aim of the review is to generate professional and organisational learning, and promote improvement in future inter-agency practice, to ensure that individuals are kept safe.

Governance

The SUSR includes both a chair of the review panel and a reviewer(s). The chair is appointed by the review panel and has responsibility for ensuring the momentum of the review is maintained. The reviewer(s) is responsible for authoring the report; meeting with the subject of the review and/or their family; and meeting with representatives of involved agencies.

Safeguarding Boards have a responsibility to:

- Establish SUSRs and ensure they are manged within a timely manner.
- Inform the Welsh government that a SUSR is to be undertaken.
- Contribute to the review and identify strategic implications for improving systems and practice within agencies.
- Sign off the final report and action plan.
- Publish the SUSR report and submit it to the SUSR Co-ordination Hub.
- Provide the Coroner with a copy of the report.
- Implement and audit changes in local policy, systems, and practice to identify what difference(s) they have made.

Key Responsible Agencies within the Partnership

- Any agency who is involved with a child and/or adult at risk may be involved, including:
- Local Authority
- Police
- Health Board
- Education
- Probation Service

Guidance on the Process

An initial referral is made to the relevant Safeguarding Board (SB) and Community Safety Partnership (CSP) if it involves a domestic or offensive weapons homicide. The Safeguarding Board Case Review Group, which involves individuals of appropriate expertise to contribute to the review, will determine if the criteria for a SUSR is met. This decision is ratified by the chair of the SB and/or the CSP, who is then required to notify the Welsh government of the decision.

SUSRs are managed by the Case Review Group and the reviewer(s) appointed to work with the review panel. The review will include:

- Direct engagement with the subject of the review and/or their families as they wish and is appropriate.
- Where appropriate, direct engagement with the perpetrator(s)/alleged perpetrator(s).
- The involvement of practitioners working with the child and/or adult at risk and their family.
- An opportunity for the reviewer(s) to utilise the Wales Safeguarding Repository to undertake learning associated with historical reviews.
- A practitioner-focused learning event to examine practice using a systems approach.

The Review Panel should appoint a chair and hold meetings to agree the agency timeline. The reviewer(s) and, if appropriate, the chair should meet the subject of the review and/or their families at the beginning of the review to determine their desired level of involvement.

A draft report and action plan is produced by the reviewer(s). Within 12 months of the review commencing, the report should be: approved by the SB chair; forwarded to the Co-ordination Hub; and published by the SB. The action plan should be finalised by the Case Review Group within four weeks of the final report being approved by the SB chair. The Co-ordination Hub will provide update reports to the Strategy Group and issues will be escalated to the Ministerial Board where barriers are identified.

Writing a Single Unified Safeguarding Review Report

Templates for SUSRs are located here: **Single Unified Safeguarding Review: Toolkit**

Top Tips:

- The report should ensure that all personal identifiers are removed. The subject of the review/ their families should be provided with the opportunity to choose, if they wish, a pseudonym to be used in the report.
- The involvement of the subject of the review and/or their families, whilst voluntary, is at the heart of the review.
- The report should be succinct and focused on improving practice and include any practice and organisational learning identified during the review. This should include both good practice and considerations about what could be done differently to improve future practice.

Repositories and Helpful Resources

Information and guidance on the SUSR process is located here:
https://www.gov.wales/single-unified-safeguarding-review-guidance#116879

The Wales Safeguarding Repository is a multi-disciplinary instrument instigated on behalf of the Welsh Government to bring together different types of safeguarding reviews into one central repository. For more information, contact: **SUSRWales@gov.wales**

Useful Reading

National Independent Safeguarding Board for Wales:
Find Your Regional Board - Safeguarding Board Wales

Single Unified Safeguarding Review Ministerial Board:
https://www.gov.wales/single-unified-safeguarding-review-ministerial-board

Information regarding Wales National Safeguarding Week taking place between the 11th-15th November 2024:
https://www.northwalessafeguardingboard.wales/wales-national-safeguarding-week-11th-15th-november-2024-2/

4

Safeguarding Adult Reviews

Overview

Safeguarding Adult Reviews (SARs) enable partner agencies to come together to learn lessons following the death or serious harm of an adult with care and support needs.

What are Safeguarding Adult Reviews?

The Care Act 2014, S44(1)(2)(3), requires a Safeguarding Adult Review (SAR) be completed following the death or serious harm of an adult with care and support needs as defined by the Act where:

- The death or harm is suspected, or known to, result from neglect or abuse, including self-neglect; AND,
- there is concern that agencies could have worked better to protect the adult from harm.

A discretionary SAR can also be conducted into any incident or case involving adult(s) at risk of abuse or neglect, where the conduct of such a review is believed to be in the public interest, or where it believes there will be value in doing so.

Main Purpose

To promote learning and improve practice, with a focus on: establishing lessons to be learnt from how professionals and agencies work together; determining the effectiveness of safeguarding procedures and identifying good practice; and identifying how to improve inter-agency and individual agency practice.

Governance

Responsibility for the governance of SARs on a national basis rests with the Department of Health and Social Care. At the local level, each local authority must set up a Safeguarding Adult Board (SAB) who work to protect adults at risk within their area from abuse and neglect through coordinating and reviewing a multi-agency response.

One of the core duties of the SAB is the conduct of SARs, and these statutory functions cannot be delegated to another partner. SABs must be comprised of individuals from the local authority; the integrated care boards within that local authority; and the chief officer of police in the local authority area, however other individuals or organisations can be invited to be part of the board.

"Decision-making should be timely once individuals and agencies involved in the case have been consulted and all relevant information considered. Reasons for decisions should be recorded. Decision-making can be challenged in the High Court by way of judicial review or investigated by the Local Government and Social Care Ombudsman" **(Local Government Association)**.

Key Responsible Agencies within the Partnership

Partners involved with a SAR will be any organisation that has worked with the adult, including Health, Police, and the Local Authority. Such roles can include (but are not limited to):

- Operational
- Supervisory line management
- Strategic leadership within the Senior Management Team
- Corporate/cross authority
- Providers of services
- Voluntary organisations

Guidance on the Process

The specific circumstances of a case will determine the process for undertaking a SAR and no one specific model will fit all cases. The approach to SARs needs to be proportionate according to the scale and level of complexity of the issues being examined. The review should provide detail on why a specific methodology was chosen and should record the approach used to review the case.

SABs are responsible for commissioning SARs and should follow statutory guidance outlined within the **Care Act 2014**. SARs must be led by individuals who are independent of the case under review and of the organisations whose actions are being reviewed. Those undertaking a SAR must have the appropriate skills and experience including: strong leadership and an ability to motivate others; an ability to handle multiple perspectives; extensive safeguarding knowledge; and collaborative problem-solving experience. SABs also have a responsibility to follow through on any recommendations and action plans established from SARs.

Professionals should communicate with the adult who is the subject of the review where possible, their family, and, where appropriate and helpful, with the person who caused the abuse or neglect. Where necessary, the local authority must arrange for an independent advocate to support and represent an adult who is the subject of a SAR, and professionals must ensure that families have been offered an opportunity to engage with the review process.

The SAR process should encourage honesty and transparency from individuals and organisations by ensuring they are involved in the process.

Writing Safeguarding Adult Reviews

SARs must reflect the six safeguarding principles as detailed within the Care Act 2014: empowerment, prevention, proportionality, protection, partnership, and accountability. The terms of reference are agreed by the SAB, and these should be published and openly available.

Top Tips:

- Provide a sound analysis written in plain English.
- SARs must be conscious of protected characteristics such as race, ethnicity, age, and gender and ensure that these are routinely addressed in reports and their significance is considered.
- The report should clearly acknowledge any delays in producing the SAR.
- SARs do not have to be published, but SABs must include details of any SARs in progress, and the findings and recommendations from completed reviews, within their annual reports.

Repositories and Helpful Resources

A library of Safeguarding Adult Reviews can be found here: **National Network for Chairs of Adult Safeguarding Boards**.

Useful Reading

Care and Support Statutory Guidance:
Care and Support Statutory Guidance GOV.UK (www.gov.uk)

Safeguarding Adult Reviews:
Safeguarding Adult Reviews (SARs) (ssaspb.org.uk)

Briefing for Safeguarding Adult Board Chairs and Business Managers – Analysis of Safeguarding Adult Reviews:
Briefing for Safeguarding Adult Board Chairs and business managers - Analysis of Safeguarding Adults Reviews | Local Government Association

Analysis of Safeguarding Adult Reviews: April 2017 - March 2019:
Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association

5 Multi-Agency Public Protection Arrangement Serious Case Reviews

Overview

Serious Case Reviews (SCRs) for multi-agency public protection arrangements (MAPPA) examine whether multi-agency public protection arrangements were effectively applied, and whether agencies worked together to do all they reasonably could to effectively manage the risk of further offending.

What are MAPPA Reviews?

A MAPPA SCR is commissioned if:

- The MAPPA offender (in any category) was being managed at level two or three when the offence was committed, or at any time in the 28 days before the offence was committed; AND,
- The offence is murder, attempted murder, manslaughter, rape, or attempted rape.

A discretionary MAPPA SCR may also be commissioned if it is considered to be in the public interest. This includes circumstances where:

- A MAPPA offender managed at level one is charged with one of the offences detailed above; or,
- A MAPPA offender managed at any level is charged with any serious further offence (SFO) listed within the SFO Procedures Policy Framework; or,
- It is assessed it would be within the public interest to undertake a review.

Main Purpose

To establish whether there are lessons to be learnt, decide how such lessons are to be acted upon, and inform the future development of MAPPA policies and procedures to better protect the public. Reviews may also identify examples of good practice.

Governance

On a national level, responsibility for MAPPA SCRs rests with the Ministry of Justice; at a local level responsibility rests with Strategic Management Boards (SMBs). Each MAPPA area must form a Strategic Management Board who are responsible for managing MAPPA activity within that area. The SMB will consist of representatives from the Police, Prison Service, and Probation Service and the SMB hold responsibility for commissioning a MAPPA SCR. The SMB are also responsible for any reports generated by the MAPPA SCR process; will appoint an appropriate SCR lead; and will ensure the victim, and their family, are kept informed through the SCR process.

Key Responsible Agencies within the Partnership

- Police
- Probation services
- Prison services.

Guidance on the Process

The format of the review should be appropriate to the complexity of the case, however a suggested methodology includes: examination of the recent multi-agency public protection meeting minutes; review of the Violent and Sex Offender Register (ViSOR) record; a decision on what information, if any, is required from other agencies and requesting of that information; identification of potential interviewees and the conduct of interviews; examination of individual agency findings and other reports and reviews.

The purpose of the MAPPA SCR is to look objectively and critically at whether multi-agency public protection arrangements were effectively applied and to identify any areas of good practice.

The focus of any review is likely to be whether the offender was:

- Identified as a MAPPA offender at the correct time.
- Referred to the appropriate management level.
- Managed effectively via multi-agency public protection meetings.

Writing MAPPA Reviews

The MAPPA SCR lead is responsible for producing the report for the SMB.

Top Tips:

- The report should include: the background to the case; a list of the relevant agencies and their role; a chronology of events; an assessment of practice against MAPPA guidance and legislation; a conclusion, learning points, and an action plan.
- Ensure RESTRICTED marking is applied to the report as it contains sensitive and identifiable information.
- The MAPPA SCR lead should ensure that contributing agencies are satisfied that their information appropriately represented in the report.
- Use a Lay Adviser to provide an independent voice to the review. Information about the role of the Lay Adviser can be found from page 29 of the **MAPPA Guidance.**

Repositories and Helpful Resources

MAPPA SCRs are not published and therefore there are no repositories available for this type of review. Overview reports may however be produced and shared externally.

Useful Reading

MAPPA guidance:
mappa_guidance-nov-2021.pdf (proceduresonline.com)

MAPPA Annual Report 2021/22:
MAPPA_Annual_Report_2022.pdf (publishing.service.gov.uk)

Learning for the Police from Multi-Agency Public Protection (MAPPA) Serious Case Reviews:
https://www.vkpp.org.uk/assets/Files/Publications/Learning-for-the-Police-from-Multi-Agency-Public-Protection-Arrangements-MAPPA-Serious-Case-Reviews.pdf

Research Briefing: The National MAPPA Research:
https://www.aru.ac.uk/-/media/Files/pier/National-MAPPA-Research-Briefing.pdf

Independent Review of the case of Leroy Campbell: final report: HMI Probation:
Independent review of the case of Leroy Campbell: final report (justiceinspectorates.gov.uk)

6 Offensive Weapon Homicide Reviews

Overview

An offensive weapon homicide review (OWHR) is arranged (as set out under the **Police, Crime, Sentencing and Courts Act 2022)** when it is considered that:

- Death was, or likely to have been, homicide.
- The death occurred, or is likely to have occurred, in England or Wales.
- Such other conditions specified by the Secretary of State in regulations are satisfied.
- The review partner is one of the relevant review partners in respect of the death.

What are Offensive Weapon Homicide Reviews?

Offensive weapon homicide reviews (OWHRs) aim to identify the lessons to be learnt from the death, to consider whether any action should be taken as a result of this learning, and to share the outcome.

The homicide is considered to qualify for a OWHR if:

- The person was 18-years-old or older; AND,
- The death, or the events surrounding it, involved the use of an offensive weapon.

An offensive weapon is defined 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" (**The Crown Prosecution Service**, last updated April 2023).

Main Purpose

The intention is that OWHRs will improve the national and local understanding of what causes homicide and serious violence, better equip services for prevention, and save lives.

Governance

The OWHR process is currently in its pilot phase. The pilot began in April 2023 and is due to run for 18-months in three areas:

1. London:
- Barnet, Brent, Harrow, Lambeth and Southwark

2. West Midlands:
- Birmingham and Coventry

3. South Wales

The OWHR Oversight Board (OB) is a non-statutory committee composed of experts in safeguarding (such as policing, local authorities, and health), preventing homicide, and serious violence and public protection. OBs oversee the local delivery of the OWHRs and consider whether lessons learnt from reviews are being acted upon and shared locally and nationally.

OBs also review completed OWHRs to ensure consistency in the criteria and approach taken for reviews and to identify themes for learning on a national level. They also have responsibility to monitor the application and implementation of learning/recommendations in policy and practice.

Key Responsible Agencies within the Partnership

Partners need to discuss whether there is an appropriate existing structure already in place that brings agencies together, or whether a new structure needs to be created for OWHRs. Some examples of existing partnerships include:

- the local Community Safety Partnership (CSP)
- Violence Reduction Unit (VRU)
- Police and Crime Commissioner (PCC)
- Deputy Mayors for Policing and Crime.

Relevant review partners include:

- Police
- Local Authority
- Integrated Care Board/Local Health Board

Guidance on the Process

Before an OWHR commences, the review partners should check to see if another statutory review approach is applicable to the case to avoid duplication.

Interviews, group briefings, or communication in writing can be used to follow up on the information received at the initial stage (for example, details of the decision to undertake a review; the leading agency in the review, as well as the independent Chair, evidence, and investigation for criminal proceedings, etc.). The family/next of kin should be approached once the terms of reference for the OWHR have been agreed and an independent Chair/lead agency is in place.

OWHRs need to be completed within twelve months of the incident to ensure that any recommendations and learning is timely and relevant. A copy of the OWHR report must be provided for publication to the Secretary of State. In Wales, the report must also be sent to the First Minister for Wales.

Writing Offensive Weapon Homicide Reviews

A chronology of the individuals' engagement with services should be included. This should also identify where services could not be given and the rationale behind these decisions. It is recommended that the chronology covers the 24 months preceding the death.

The OWHR report must include: the findings of the review, any conclusions drawn by the review partners, and should outline any recommendations on the basis of these findings. The report should also define actionable positive outcomes and, where relevant, include best practice examples that can be shared with other partners.

Top Tips:

- The review should focus on the lessons learnt and consider interaction between the different services, focusing on the effectiveness of the whole system response.
- When writing the report, pseudonyms should be used for both the victim and the perpetrator.
- The national guidance provides further detail about what information must be removed from reports before they are sent for publishing.

Repositories and Helpful Resources

Whilst the OWHR pilot continues, all the reports from England and Wales will be published in a single specified site on the GOV.UK website (not yet live). OWHRs carried out in Wales under the Single Unified Safeguarding Review (SUSR) process will also be published in the Wales Safeguarding Repository and as part of the SUSR process, on the relevant Regional Safeguarding Board website.

Useful Reading

The Police, Crime, Sentencing and Courts Act, 2022: **The Police, Crime, Sentencing and Courts Act 2022 (Offensive Weapons Homicide Reviews) Regulations 2022 (legislation.gov.uk)**

Homicide reviews: Police, Crime, Sentencing and Courts Act 2022 factsheet: **https://www.gov.uk/government/publications/Police-crime-sentencing-and-courts-bill-2021-factsheets**

National Guidance for Offensive Weapon Homicide Reviews: **https://www.gov.uk/government/publications/offensive-weapons-homicide-reviews/offensive-weapons-homicide-reviews-statutory-guidance-accessible-version**

7

Child Death Reviews

Overview

Child death reviews aim to establish the cause of death of any child to provide answers for the parents and family about what has happened and identify if the death can provide any lessons to be learnt from.

What are Child Death Reviews?

The child death review process covers children defined as a person under 18 years of age. Whilst child safeguarding practice reviews explore the death/serious injury of a child where abuse or neglect is known or suspected, child death reviews examine the deaths of all children, regardless of the circumstances of the death.

Child deaths are initially reviewed by the professionals directly involved in the care of the child, or involved in the investigation following their death, within a child death review meeting that focuses on individual child and local systems learning. The death is then reviewed by the Child Death Overview Panel (CDOP) who focus on local and national systems and learning.

Main Purpose

To identify any issues relating to the death(s) that are relevant to the welfare of children in the area or to public health and safety, and to consider whether action should be taken in response to the identified learning.

Governance

Child death review partners are responsible for establishing a structure and process to review all child deaths within their area, and if appropriate, the deaths of children who do not reside there but have died within that area. Partners are local authorities and any integrated care boards for the local area, as set out in the Children Act 2004 (amended by the Children and Social Work Act 2017). Practitioners in all agencies should notify the review partners of the death of any child they become aware of through the child death notification form.

The registrar of births and deaths have a requirement to provide child death review partners with the particulars of the death entered into the register that relates to any individual who is under the age of 18 at the time of their death. The coroner also has a duty to notify the child death review partners within three working days of deciding to investigate a death or commission a post-mortem.

Child death review partners for a local authority area within England must prepare and publish a report which provides a summary of the learning and the actions that have been taken to prevent future child deaths. The panel must also notify any individual person or agency where it has been found that they need to act on learning identified within the review.

The outcome of the panel discussions should be recorded on a final analysis form which should be submitted to NHS digital and the National Child Mortality database.

Key Responsible Agencies within the Partnership

- Public Health
- Designated Doctor for child deaths in that area
- Social Services
- Police
- Designated Doctor/Nurse for safeguarding
- GP/Health Visitor
- Nursing and/or Midwifery
- Any other professionals that Child Death Review partners consider should be involved.

Guidance on the Process

Immediately following the child's death, senior professionals with responsibility for the child at the end of their life should: identify the available facts about the circumstances of the child's death; determine whether the death meets the criteria for a joint agency response; determine whether a medical certificate of cause of death can be issued or whether the death should be referred to the coroner; identify how best to support the family; and determine whether any actions are necessary to ensure the health and safety of others.

Following these immediate decisions, a number of investigations may follow including: a coronial investigation; a joint agency response; or an NHS serious incident investigation.

A joint agency response should be triggered if a child's death: is, or could be, due to external causes; is sudden, with no immediate apparent cause; occurs in custody or when a child is detained under the Mental Health Act (1983); where there are suspicions that the death may not have been natural; or in the case of a stillbirth where no healthcare professional was present.

Following this, a child death review meeting should be held with all multi-agency professionals involved. This response should aim to: establish the cause of the death and identify any contributory factors; provide support to the family; learn lessons to reduce the risk of future child deaths, and promote the safety and wellbeing of other children.

The review by the CDOP is the final, independent scrutiny of a child's death by professionals with no responsibility for the child during their life. If the results of any investigation suggest evidence of abuse or neglect as a possible cause of death, relevant safeguarding partners, and the Child Safeguarding Practice Review Panel should be notified immediately.

Writing Child Death Reviews

Forms are provided by the National Child Mortality Database to support child death overview panels to assess the causes of a child's death. These can be found on the National Child Mortality Database website: **Child Death Reviews: forms for reporting child deaths**.

Top Tips:

- The National Child Mortality Database holds a number of resources to support panel members and those involved in a Child Death Review. These resources can be found here: **Child Death Review guidance and support**.

Repositories and Helpful Resources

The National Child Mortality Database holds information about all child deaths in England and shares this information through a number of annual reports. Their publications can be accessed here: **National Child Mortality Database**.

Useful Reading

Child Death Review: Statutory and Operational Guidance (England): **Child Death Review Statutory and Operational Guidance (England) (publishing.service.gov.uk)**

A Thematic Review of Vulnerability, which increases the risk of poor outcomes, in Infants: **Vulnerability in infants: a study of sudden and unexplained deaths (ncmd.info)**

Child Mortality in England during the First Two Years of the COVID-19 Pandemic: **Child mortality in England During the Covid-19 Pandemic (ncmd.info)**

8

Independent Investigation Reports

Overview

In April 2013 NHS England became responsible for commissioning independent investigations into homicides committed by patients who are currently being treated for mental illness, or who have been in receipt of specialist mental health services at any point within six months prior to the incident. These are sometimes referred to as Mental Health Homicide Reviews, or Mental Health Reviews.

What are Independent Investigation Reports?

Article 2 of the Human Rights Act (1998) imposes a procedural obligation on the State to investigate in circumstances where:

- The person has died while they are detained (for example under the Mental Health Act, 1983) or has attempted suicide while detained and sustained serious injury (or potential serious injury).
- The State owed a duty to take reasonable steps to protect the person's life and the State knew, or ought to have known, there was a real and immediate risk to the person's life. This includes voluntary psychiatric inpatients.

The investigation should thoroughly review the care and treatment received by the patient.

Main Purpose

To determine what, if anything, went wrong with the care of the patient; minimise the possibility of a reoccurrence of similar events; and make recommendations for the delivery of health services in the future.

Governance

The Learning from Deaths national guidance is incorporated which provides a framework to standardise and improve how NHS providers identify, report, investigate, and learn from deaths. More information can be found within the governance section of this report: An independent review of the Independent Investigations for Mental Health Homicides in England.

Key Responsible Agencies within the Partnership

Independent Investigation Reports are carried out separately from any police, legal, or coroner's proceedings. They are carried out by an independent, expert organisation who are provided with access to all information about the individual patient's care and treatment, within the usual confines of patient confidentiality.

The police do not have a direct role within this type of review, but they may be asked to contribute information to inform the review.

Guidance on the Process

The review will follow a staged process involving: fact-finding related to the incident and analysis of the incident; writing of the report; and the provision of post-investigative support. The guidance notes that this process should be timely and should adhere to NHS England's terms of reference.

The methodology should be chosen dependent on what is most appropriate to the case under review. The review should aim to gather data and evidence in order to identify areas of good practice, alongside areas of improvement; identify contributory factors to the homicide; and identify any lessons which may inform future prevention of similar incidents.

The final report is shared with NHS organisations who were responsible for the care of the patient and their families, and the families of the victim. These NHS organisations are then responsible for producing an action plan that responds to the learning identified within the review. NHS England will work with these organisations to ensure that changes are made and will publicise the report on their website. Learning identified within this review may be relevant for the police. An independent investigation review may also run in parallel with another review type, including a domestic abuse related death review.

Writing Mental Health Reviews

The Patient Safety Incident Response Framework has recently been introduced by NHS England, with this framework superseding the previous Serious Incident Framework. The framework sets out the NHS's approach to developing and maintaining effective systems and processes for responding to patient safety incidents. This framework can be found here: NHS England » Patient Safety Incident Response Framework.

This framework integrates four keys aims:

1. Compassionate engagement and involvement with those affected by incidents of patient safety.
2. Application of a number of systems-based approaches to learning from patient safety incidents.
3. Considered and proportionate responses to incidents.
4. Supportive oversight focused on strengthening the response system.

Top Tips:

- Be clear and concise when writing an independent investigation report and focus on the future prevention of such incidents. The review should identify lessons to be learnt from the patient's treatment and care.
- Share the final report with the NHS organisations that were responsible for the care of the patient, as well as the families of the victim and the patient.
- Any recommendations arising from the review must be measurable, achievable, and sustainable.

Repositories and Helpful Resources

A library of Independent Investigation Reports can be found here: **NHS England » Independent investigation reports (Reviews are split by region)**.

Useful Reading

An independent review of the Independent Investigations for Mental Health Homicides in England:
independent-investigations-for-mental-health-homicides-in-england-exec-summary.pdf

Information on MHRs by an investigative and review provider, Sancus Solutions:
Mental Health Homicide & Serious Incident Investigations & Reviews - Sancus Solutions

Patient Safety Incident Response Framework:
NHS England » Patient Safety Incident Response Framework

9 Individual Management Reviews

Overview

A review panel chair will write to individual agencies involved in a review to commission individual management reviews (IMRs). These are then used to inform the overarching statutory review.

What are Individual Management Reviews?

IMRs detail the involvement of a single agency with the individual subject to the review. They should provide a chronology of the agency's involvement with the subject of the review and/or the suspected perpetrator (if relevant) and provide an analysis of the agency's involvement.

Main Purpose

To enable an agency to look openly and critically at organisational practice, and the context within which individuals were working, to identify systems learning and consider whether change is required. IMRs also aim to identify how any required changes are actioned and identify good practice within agencies.

Governance

The review panel chair is responsible for commissioning an IMR from an agency. Within that agency, the senior manager is responsible for quality assurance of the report and will often be responsible for ensuring that recommendations identified within the IMR are acted upon. The senior manager is also responsible for managing a feedback and debrief process for staff involved in the review. These structures may however vary within organisations.

Those conducting the IMR should not have been involved with the victim, perpetrator, or either of their families, and should not be the immediate line manager of any staff involved in the IMR.

Key Responsible Agencies within the Partnership

Any individual agency who was involved with a specific case may be required to conduct an IMR. These will often be key safeguarding agencies including:

- Police
- Local Authority
- NHS and Health Services
- Probation Services

Guidance on the Process

An IMR should begin as soon as the decision has been taken to proceed with a review and once the terms of reference have been set.

All agencies should first ensure that the records relating to a case are secured against loss or interference, and they should then develop a chronology of their involvement with the victim, perpetrator, or their families.

As part of the IMR, all relevant documents should be examined, and consideration should be given to speaking to members of staff who are involved. A written record of these conversations should be retained and shared with the individual spoken to. The purpose of an IMR is not to apportion blame, instead the focus is on identifying lessons to be learnt. If the review finds that policies and procedures have not been adhered to, relevant staff or managers should be interviewed to establish the reasons for this.

Writing Individual Management Reviews

The review should consider the events that occurred, the decisions made, and the actions taken, or not taken. Where judgements were made, or actions taken, that indicate that practice or management should be improved, the review should consider both what happened, and why it happened.

Top Tips:

- The names of all staff involved must be anonymised at all stages and not disclosed under any circumstance.
- Analysis should consider whether practitioners were sensitive to the needs of those involved, and whether the service provided was compliant with the relevant policies and procedures in place.
- Analysis should explore whether, and how, the victim's wishes and feelings, and those of relevant family members, were considered.
- Analysis should also consider whether practice was sensitive to the diverse needs and identities of those involved, particularly their ethnic, cultural, linguistic, and religious identity.

Repositories and Helpful Resources

Individual management reviews are not published and thus there are no searchable repositories for this type of review.

Useful Reading

Guidance for the Completion of Individual Management Reviews for Agencies produced by Hampshire Safeguarding Adults Board:
HSAB-IMR-guidance-for-completion.pdf (hampshiresab.org.uk)

Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews: Section Seven within this Guidance has information relating to IMRS:
DHR-Statutory-Guidance-161206.pdf (publishing.service.gov.uk)

Inquiries and reviews – statutory and independent, child and adult safeguarding, domestic homicide, and offensive weapons homicide:
Inquiries and reviews – statutory and independent, child and adult safeguarding, domestic homicide, and offensive weapons homicide | The Crown Prosecution Service (cps.gov.uk)

10 Other Report Types

Regulation 28 Reports

Overview

Coroners can issue a Regulation 28 Report (under **The Coroners and Justice Act 2009**) to an individual, organisation, local authority or government department and their agencies if they believe action should be taken to prevent further deaths. Regulation 28 Reports are also known as Reports to Prevent Future Deaths or Prevention of Future Death Reports.

What are Regulation 28 Reports?

- Regulation 28 reports set out the coroner's concerns raised from the inquest and request that action should be taken to prevent future death.
- The person, body, or organisation in receipt of this report then has 56 days to provide the coroner with their response.
- Responses need to include details of the actions taken that address the concerns raised.

Main Purpose

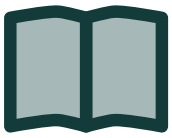
Reports should be intended to improve public health, welfare, and safety and should clearly state the concerns of the coroner and what action, in their opinion, should be taken to prevent future deaths.

The Role of the Police

Whilst the police do not have a specific role in contributing to Regulation 28 reports, the actions directed by the coroner may provide learning for, and require action by, the police.

Repositories and Helpful Resources

A library of Prevention of Future Deaths reports can be found here:
Prevention of Future Death Reports.



Useful Reading

Prevention of Future Death Reports for Suicide submitted to coroners in England and Wales: January 2021 to October 2022

A Thematic Review of recent Prevention of Future Deaths Reports:
A thematic review of recent Prevention of Future Deaths ('PFD') reports | Hill Dickinson

Major Crime Investigations

Overview

When a homicide or major crime occurs, the Senior Investigating Officer (SIO) is responsible for acting as the lead investigator to establish what occurred and identify the perpetrator(s). Statutory safeguarding reviews (those detailed above) will often occur at the same time as major crime investigations.

What are Major Crime Investigations

Investigations into homicides and major crimes, including high profile and complex investigations into serious sexual offending, acquisitive, organised, and other violent crime.

Main Purpose

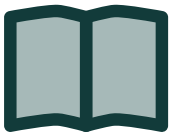
To establish the facts of what occurred and identify the perpetrator(s).

Those overseeing major crime investigations need to consider the susceptibility of victims, witnesses, and suspects to harm; ensure that safeguarding is appropriately considered; and that relevant information is shared appropriately with partner agencies and parallel proceedings, including statutory reviews.

The Role of the Police

Major crime investigations are overseen by the SIO, and often run in parallel to statutory safeguarding reviews. The SIO is responsible for sharing information with the individual/agency conducting the statutory review, however, will need to balance the need to provide the reviewer with appropriate information, whilst avoiding any potential risk to the proper conduct of the criminal investigation.

SIOs need to ensure they are familiar with the local arrangements regarding statutory safeguarding reviews within their policing area and are familiar with the governance arrangements concerning these reviews. They must also ensure that there are appropriate, formal communication routes between the investigation team and those responsible for the statutory review.



Useful Reading

Major Crime Investigation Manual: **Major-Crime-Investigation-Manual-Nov-2021.pdf (college.police.uk)**

Vulnerability Knowledge & Practice Programme

NPCC National Police Chiefs' Council

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