Symposium 2

Learning across statutory review practices – Origins, ambitions and future directions

Dr Elizabeth Cook, City, University of London

Dr James Rowlands, University of Westminster

11th June 2024

Setting the Scene

- There are numerous statutory review systems in operation in England and Wales which examine different types of serious injury or deaths
- These include reviews into domestic abuse-related deaths, as well as safeguarding children and adults
- While having differences in terms of the types of deaths considered, these review systems often:
  - Share principles and use similar practice
  - Involve a range of stakeholders
  - (Re)produce overlapping learning
  - Face related challenges
- Yet there is limited dialogue between these different statutory review systems

Aims of Today

- We are seeking to develop a dialogue across different statutory review systems
- Our focus is how these different statutory review systems are conducted and practised, their ambitions, and common challenges for reform in the future (not their substantive findings, as important as these are)
- In this symposium, we will:
    - Hear some short ‘snapshot’ presentations on different review systems
    - Invite you to discuss the connections between these systems, drawing on your existing knowledge
    - Capture and bring together these discussions, including as part of a Q&A with the presenters

Today's Presenters

- Snapshot presentations:
  - Domestic Homicide Reviews – Sumanta Roy, Head of Research, Evaluation and Development, Imkaan
  - Children's safeguarding – Professor Emeritus Jonathan Dickens, University of East Anglia
  - Adult safeguarding – Professor Emeritus Michael Preston-Shoot, University of Bedfordshire
  - Wales Single Unified Safeguarding Review (SUSR) – Dr Bethan Davies, Research Associate, Security, Crime and Intelligence Innovation Institute, Cardiff University

- Ambitions for learning and change across systems:
  - Frank Mullane, CEO of Advocacy After Domestic Abuse (AAFDA):

How the DHR system can be improved to better understand the experiences of minoritised women and girls?

Sumanta Roy, IMKAAN

11th June 2024

Establishment and Purpose

- Domestic Homicide Reviews (DHR's) - A legal requirement in 2011 under **Section 9 of the Domestic Violence, Crime and Victims Act 2004** (2004) (came into force on *13 April 2011*).

- First DHR in England and Wales was the Pemberton Review (2008) - identified multiple systemic failures (policing, risk assessment and response)

- A multi-agency review to establish **learning, lessons and missed opportunities for intervention** about the way relevant agencies responded (individually and collectively) to protect the victim of murder.

- Intended as a **professionally curious** not **passive exercise** to understand what happened through the eyes of the victim and apply learning to improve national/local policy and practice to prevent domestic abuse and homicide.

Learning

- Majority of victims are **female**
- Experiences of violence for Black/minoritised (B/m) women are impacted by **intersectional social location.**
- **Meaningful input** from families, friends, work colleagues (not in collusion with perpetrators) - reduces potential for victim blaming and further harm/trauma
- **Expert B/m specialist input** - more likely to identify and understand nuanced impacts of violence/ gaps in support responses.
- Reviews with such input more likely to challenge **racialised stereotypes/cultural reductionism** rendering victims invisible, absolving agencies from improvement and learning.
- **System response:** consequences for women's help seeking and responses of agencies to women's immigration status, housing status, access to advice.

44 cases - "Majority had no support in place (68%) , support from a mainstream agency; (18%) majority had no contact with a specialist Black/minoritised domestic abuse organisation prior to death".

"The victim had left the perpetrator but was given incorrect advice by a mainstream service about her eligibility for the DDVC and returned to the perpetrator who killed her."

(Centre for Women's Justice & Imkaan, 2023)

Challenges

- Lack of intersectional analysis /trained DHR chair; absence of specialist B/m input.
- '*Pathologised presence'* or '*absence of minoritised issues in DHR narrative*
- Balance of power weighted towards statutory agencies; organisational 'defensive culture'/ resistance, *'marking their own homework'.*
- Lack of resources for B/m specialist frontline sector participation/ chronic underfunding
- Not making the connections between other forms of VAWG – risk of honour – based abuse / presence of sexual violence
- How can we truly understand what isn't working/ identify patterns and disproportionality when most agencies don't collect intersectional data?

"The DHR states we have not identified any equality and diversity issues – however, the DHR mentions that the victim was worried about what would happen to him as a Black man if he was to be found harassing a white woman" (Chantler et al, 2022)

Expert panel input:

- Black and minoritised specialist (35%)
- 'Cultural' experts with no understanding of DA/VAWG (19%)
- Mainstream DA expert without understanding of minoritised women's contexts (22%)

(Centre for Women's Justice/Imkaan, 2023)

The Road Ahead

- Current consultation on statutory DHR guidance (2024):
  - ✓ Better recognition of some elements of continuum of violence (economic, abuse coercive control);
  - ✓ Recognition of domestic violence related deaths linked to suicide
  - ✓ Consider structural factors e.g. service availability in rural and other areas/ impacts of insecure immigration status
- Public repository of DHRS provides opportunity for data but learning on minoritised women's femicide limited without political will, independent review of femicide/minoritised women and mechanisms for scrutiny.

Key References

1. Chantler, Khatidja, Bracewell, Kelly, Baker, Victoria, Heyes, Kim , Traynor, Peter and Ward, Megan (2022), An analysis of minoritisation in domestic homicide reviews in England and Wales. Critical Social Policy. ISSN 0261-0183.
2. Centre for Women's Justice and Imkaan (2024) Life or Death: Preventing Domestic Homicides and Suicides of Black and Minoritised Women.
3. Montique B (2019), London Domestic Homicide Case Analysis and Review of Local Authorities DHR Process.

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Local reviews of serious child abuse cases

Emeritus Professor Jonathan Dickens, University of East Anglia

11th June 2024

Establishment and Purpose

Reviews of serious child abuse cases have a long history, but *ad hoc* prior to 1988.

A government-prescribed system of locally-based multi-agency reviews was established in 1988, in the first edition of *Working Together.* These became known as **'serious case reviews' (SCRs)**.

The system and the reviews were much criticised over the years – large number, high cost, lengthy delays, variable quality, predictable findings, and limited impact (Wood report 2016).

A new system was introduced in 2018-19. A national Child Safeguarding Practice Review Panel was established.

Local authorities have to notify the Panel of every death/incident of serious harm where abuse or neglect is known or suspected, and undertake a 'rapid review'. If this shows a need for further learning, they may commission a **'local child safeguarding practice review' (LCSPR)**. This is a local decision.

The 'overall purpose' of local reviews is to 'identify improvements to practice'. Reports are published; agencies named, not individuals. (The Panel also has the power to commission national reviews.)

Learning

Criticisms of practice in reviews tend to fall into three broad areas:

- *Inaccurate / poor quality assessments*
- *Shortcomings in inter-agency working and information sharing*
- *Not knowing the children and understanding their views and experiences*

These are the aspects that media coverage often highlights, **'the same old failings' – but they are at a very high level of generality.** Local lessons and detail are diluted.

The 'explanations' are often clichéd and superficial - 'lack of professional curiosity', lack of 'challenge', not 'thinking the unthinkable'.

The wider national and socio-political context is often mentioned but less often *applied*, analytically and rigorously, to make sense of what happened – e.g. shortage of services and resources to meet identified needs; the tensions between information sharing and family privacy.

Challenges and Success

Many of the old challenges continue in the new LCSPR system – e.g. delay; shortage of skilled and experienced reviewers; getting the balance right between description and analysis; probing into what happened without unfair blame; explicitly addressing the impact of race and racism on families' lives and services offered; producing clear action plans and implementing them.

Successes include **greater involvement of practitioners and children/family members** (but of course these come with challenges too). Also, **determined and skilled work at local level to spread the messages**, make changes and monitor them. There are examples of creative action at local level (e.g. an initiative to work with local minicab firms, bars, nightclubs and hotels to raise awareness of child sexual exploitation).

The Road Ahead

A realistic view of the potential and limitations of LCSPRs – they are only a small part of a large and complex system – national policy and legislation, funding, inspections, scandals, organisational structures and restructurings, the availability (or not) of services, the balances of state intervention and family autonomy.

A clearer understanding of the practice of local reviews – from deciding to hold one, commissioning, conducting it, deciding on actions, implementation and follow-up. At the moment, all we have is the report – we need to know much more about what goes on behind that.

Properly funded and supported child welfare and safeguarding services - social care, health, education, policing and family justice.

Five Key References

Child Safeguarding Practice Review Panel (2024) *Annual Report 2022/23: Patterns in practice, key messages and 2023/24 work programme*, London: CSPRP. Online.

Dickens, J., Taylor, J., Cook, L., Cossar, J., Garstang, J. and Rimmer, J. (2022) *Serious Case Reviews 1998-2019: Continuities, Changes and Challenges*, London: DfE. Online.

Dickens, J., Cook, L., Cossar, J., Okpokiri, C., Taylor, J. and Garstang, J. (2023a) 'Re-envisaging professional curiosity and challenge: Messages for child protection practice from reviews of serious cases in England', *Children and Youth Services Review*. Online.

Dickens, J., Cook, L., Cossar, J., Okpokiri, C., Taylor, J. and Garstang, J. (2023b) 'The multiple and competing functions of local reviews of serious child abuse cases in England', *Critical Social Policy*. Online.

HM Government (2023) *Working Together to Safeguard Children 2023: A guide to multi-agency working to help, protect and promote the welfare of children,* London: HM Govt. Online.

Safeguarding Adult Reviews (England)

Professor Michael Preston-Shoot, University of Bedfordshire

11th June 2024

Establishment and Purpose

- Established by Section 44, Care Act 2014.
- Mandatory (s44(1-3)) and discretionary (s44(4)) reviews.
- Duty to cooperate (s44(5)) and to share information (s45).
- Statutory guidance (chapter 14) gives Safeguarding Adults Boards discretion of methodology, choice of reviewer and publication, and advises on subject (when alive) and family involvement, and on time objective for completion.
- The purpose is to identify lessons, apply learning to future work and improve how agencies work (singly and together) to safeguard adults.

Learning

- National library now hosted by the National Network for SAB Chairs (https://nationalnetwork.org.uk)
- Range of methodologies, including reviews in rapid time, SCIE learning together, significant incident learning process, Welsh model, and hybrid. Hybrid the most common approach.
- Two national analyses of SARs, covering April 2017 to March 2019 (231 reviews), and April 2019 to March 2023 (652 reviews). Occasional regional reviews. Published research on reviews focusing on specific types of abuse/neglect (for example, self-neglect, homelessness, alcohol-dependence, discriminatory abuse).
- Learning across five domains – direct practice, inter-agency working together ("the team around me", organizational support, SAB governance, and the national context. Findings on shortcomings predominant. Findings and recommendations focus mainly on direct practice and inter-agency working together.
- Reviews tend to start again rather than to build on prior learning. Findings and recommendations are therefore repetitive rather than analyzing what has (not) changed.
- Reviews tend to neglect the national legal, policy and financial context within which adult safeguarding is located.

Challenges and Success

- Establishment of a functioning national repository – but voluntary and only 50% complete.
- Completion of two national analyses – but no guarantee of DHSC funding going forward.
- Establishment of an escalation protocol between the national network for SAB Chairs and DHSC to enable findings and recommendations on the national context to be raised – but few escalations so far and no fundamental change yet.
- SCIE quality markers updated as standards for best governance of reviews, and proposals to develop training and accreditation systems for reviewers – but quality of reviews remains variable and challenges in identifying reviewers.
- Improvement priorities identified by the two national analyses, some of which have been taken forward (for example on discriminatory abuse, homelessness, and organizational abuse) – the national network for SAB chairs will take ownership of oversight for delivery by SABs and DHSC of recently identified improvement priorities.
- Limited research evidence of the effectiveness of different methodologies.
- Challenges in capturing the impact of learning.

The Road Ahead

- Implementation of the service improvement priorities identified in the second national analysis.
- Further escalations to DHSC, for example on definitions of types of abuse/neglect, an adult safeguarding power of entry, out of authority placements, shortage of specialist placements, and transitional safeguarding.
- Continued exploration of training for, and accreditation of reviewers.
- Developing approaches to ensure reviews build on learning rather than just repeat it.
- Developing approaches for capturing evidence of outcomes of review recommendations.
- Developing guidance on managing parallel processes (inquests, criminal proceedings) and on governance of joint reviews (domestic homicide, child safeguarding, mental health etc.).
- Further national analyses, either of all SARs or reviews on selected themes?

Five Key References

Michael Preston-Shoot, Suzy Braye, Oli Preston, Karen Allen and Kate Spreadbury (2020) *National SAR Analysis April 2017 – March 2019: Findings for Sector-Led Improvement*. London: LGA/ADASS.

Suzy Braye, Michael Preston-Shoot, Helen Stacey, Conn Doherty, with Patrick Hopkinson, Karen Rees, Kate Spreadbury and Gill Taylor (2024) *Analysis of Safeguarding Adult Reviews April 2019 – March 2023. Findings for sector-led improvement*. London: LGA/ADASS.

Karl Mason, Anusree Biswas Sasidharan, Adi Cooper, Katy Shorten and Jeanette Sutton (2022) 'Discriminatory abuse: time to revive a forgotten form of abuse?' *Journal of Adult Protect*ion, 24 (2), 115-125.

Michael Preston-Shoot (2021) 'On (Not) Learning from Self-Neglect Safeguarding Adult Reviews.' *Journal of Adult Protection,* 23 (4) 206-224.

SCIE (2022) Safeguarding Adults Review Quality Markers. London: Social Care Institute for Excellence.

Wales Single Unified Safeguarding Review (SUSR)

Dr Bethan Davies, Cardiff University

11th June 2024

Establishment and Purpose

- **Single Unified Safeguarding Review** established by **Welsh Government** to improve the way the circumstances surrounding a person's death or serious injury is reviewed after an incident.
- Single review process where a multi-agency approach is required, incorporating:
    - Adult Practice Review (APR)
    - Child Practice Review (CPR)
    - Domestic Homicide Review (DHR)
    - Mental Health Homicide Review (MHHR)
    - Offensive Weapons Homicide Review (OWHR; pilot)
- Recognising need for co-ordination, collaboration, communication, and governance to be improved when conducting reviews in Wales. Building on APR & CPR processes, plus policy and academic research.
- Eliminate the need for families to take part in the onerous and traumatising cycle of multiple reviews.
- Implementation: 2024/25

Learning

A key criterion for SUSR is **multi-agency learning**. SUSR supports lessons to be identified and implemented quickly on a pan-Wales basis, enabling learning to be shared with a view to affecting timely policy & process changes.

Learning event: brings together all practitioners who have been involved with the case so that they can share their understanding of what has happened and identify key learning points.

Wales Safeguarding Repository (WSR) is embedded in the SUSR process. All reviews from Wales will be stored in the repository (including 'legacy' DHRs, MHHRs, APRs, CPRs), and reviewers will use the WSR to identify previous similar cases early on in the review process – 'primary learning'.

- Other professionals can access the reviews on the WSR to inform better learning and training, and improve future safeguarding practices.
- SUSR Co-ordination Hub will use the repository to explore themes from previous reviews, and publish reports to ensure best practice is disseminated.

Challenges and Success

Successes (to date):

- Statutory guidance consultation complete – 2023
- Wales Safeguarding Repository – positive user testing feedback, informing development
- Pilot SUSRs
    - Cardiff and Vale pilot SUSR report signed off by the Safeguarding Board in April 2024. The SUSR prevented the need for three separate reviews (APR, DHR, MHHR). Submitted to HO Quality Assurance Panel (DHR).

Challenges:

- Shifting timelines

The Road Ahead

- **<u>Implementation!</u>**
- Statutory guidance being updated and completed
- Training for practitioners has commenced and further dates being identified
- Accessibility audit of Wales Safeguarding Repository

Adolygiad Diogelu Unedig Sengl
Single Unified Safeguarding Review

Ystorfa Diogel Cymru
Wales Safeguarding Repository

Key References

1. Robinson, A., Rees, A. and Dehaghani, R. (2018) *Findings from a thematic analysis of reviews into adult deaths in Wales: Domestic Homicide Reviews, Adult Practice Reviews and Mental Health Homicide Reviews.* Project Report. Cardiff: Cardiff University.
2. Robinson, A., Rees, A. and Dehaghani, R. (2019) Making connections: a multi-disciplinary analysis of domestic homicide, mental health homicide and adult practice reviews. *Journal of Adult Protection,* 21(1), pp.16-26.
3. Welsh Government (2024) *Guidance: Single Unified Safeguarding Review.* Available at: https://www.gov.wales/single-unified-safeguarding-review-guidance#116879

Ambitions for learning and change across systems

Frank Mullane, CEO of Advocacy after Fatal Domestic Abuse

11th June 2024

Why do we review?

- Satisfy stakeholders
- Change outcomes

Satisfy stakeholders

- Family and friends (Healing)
  - Narrate story correctly
  - Provide information
  - Show change or that there will be change

Quote from a family

'All I want is for the truth to come out ……Whatever the truth, I can handle it. Once it is out, I can rest, but if I don't try now then the alternative is a lifetime of speculation.'

Satisfy stakeholders

- Professionals
  - Learning
  - Healing

Quote on Complexity

"When you go behind the label 'human error', you see people and organisations trying to cope with complexity, continually adapting, evolving along with the changing nature of risk in their operations. Such coping with complexity is not easy to see when we make only brief forays into intricate worlds of practice."

(Woods, D., Dekker, S., Cook, R., & Johannesen, L. (2010) Behind Human Error (p. xix). Farnham: Ashgate).

Satisfy stakeholders

- State's and Public's need to restore confidence
  - Support rule of law
  - Public perception of public protection agencies
  - Social contract

Change Outcomes

- Less domestic abuse
- Less fatal domestic abuse

Roundtable Discussion

On your table, please consider the following questions

1.How familiar are you / your sector with different review systems?

2.How are the lessons from review systems useful for you / your sector?

3.What are the challenges in applying lessons from review systems?

You have 20 minutes to discuss 3 questions

1. Please record your discussion using the flip chart paper and post-it notes provided
2. Towards the end of the discussion, your table facilitator will also ask for you to agree on the x3 most important points per question to also capture on Padlet

Panel Discussion / Q & A

Next Steps

- Following today, we will be producing a policy brief
- We are also developing a research proposal to continue to explore work across statutory review systems
- For more information, contact Elizabeth.Cook@city.ac.uk or J.Rowlands@westminster.ac.uk

Thank you!