VISION

Policy Briefing

Learning across statutory review practices

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

Violence and abuse require a multisector response involving health and social care, criminal, civil and family justice, education, housing, civil society or social justice organisations, and more. Statutory reviews provide a window into the effectiveness of such responses, offering opportunities to identify learning and drive changes to practice, policy and systems, and, therefore, prevent violence and abuse in the future. However, while there are numerous statutory review systems in England and Wales, there has been limited dialogue *between* them.

How was this briefing developed?

This policy brief[1] summarises themes arising from a symposium held as part of the VISION Annual Conference 2024.[2] Following a series of presentations from five panellists, as part of breakout roundtable discussions, attendees were invited to explore **how different statutory reviews are conducted and practised**, their **ambitions**, and **challenges** for the future. The key questions identified at the end of this brief have been developed in response to the themes that emerged from these exploratory discussions.

Who is this briefing for?

This briefing is for practitioners and managers who participate in or lead statutory reviews. The briefing will also be of interest to policy makers and senior leaders from local and national government who commission or oversee statutory review processes.

What are statutory reviews and why do we need them?

While their definition and scope vary, this briefing defines a statutory review as an investigation into a case where a person has died or been seriously harmed *and* violence, abuse and/or neglect is known or suspected to have taken place and/or there is concern about how services worked together.[3] Statutory reviews are *not* part of the criminal justice system, although they may run alongside or be informed by criminal investigations or the coronial system. Their focus is on accountability, not blame.

Numerous statutory review systems have been introduced in England and Wales to examine different types of serious injury or death, while work is ongoing in Wales to bring these systems together through the Single Unified Safeguarding Review (SUSR).

The statutory review systems covered within the symposium[4] are listed in *Box 1* and include those into domestic abuse-related deaths, as well as adults with care or support needs (e.g., mental health, substance misuse, learning disabilities) and children who have been killed or seriously harmed from abuse or neglect. While considering different types of violence and abuse, statutory reviews often use similar practices, involve multiple stakeholders usually as part of a panel, document the circumstances of injury or death, and seek to identify learning.

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[2] https://vision.city.ac.uk/vision-annual-conference/.

[3] It should be noted that the term 'statutory review' has been applied in a range of settings (e.g., judicial review, taxation, non-violent fatalities, such as aviation disasters).

[4] The full slide deck from the panel are available here: https://shorturl.at/iP8I6.

However, these statutory review systems also face related practice challenges, not least regarding the quality and impact of the recommendations they generate, and how these are shared across cases. Fundamentally, within statutory review systems, there is limited engagement with previous learning locally and nationally. Meanwhile, between review systems, work often happens in silos, with little analysis of how these systems work alongside one another.

Box 1: Snapshots of key statutory reviews

Area	Homicide	Child Safeguarding	Adult Safeguarding
England	**Domestic Homicide Review (DHR)**	**Local Child Safeguarding Practice Review (LCSPR)**	**Safeguarding Adult Review (SAR)**
Wales		Child Practice Review (CPR)	Adult Practice Review (APR)
	Single Unified Safeguarding Review (SUSR)		

Challenges identified in working across statutory review systems

Amongst attendees, there was great variation in familiarity with different statutory reviews. This ranged from having no knowledge of reviews, to being a panel member, a researcher analysing reviews, or being in a role involving reviewing reviews. An early concern that emerged from the symposium was the **availability of guidance and frameworks** for conducting statutory reviews, including questions of best practice, as well as how to manage overlaps (including where parallel or joint reviews needed to be held into the same case, or if reviews ran alongside criminal investigations or inquests).

There were also common themes regarding review processes, notably a **lack of resourcing,** including for panel member training, for expert panel members including specialist and/or led-by-and-for[4] services to be involved, and shortages in and variable quality of those leading reviews (often known as “reviewers” or “independent chairs”).

Specific concerns were raised regarding the process of involving **testimonial networks**, principally family, but potentially others who knew them too (e.g., friends, neighbours, colleagues, and community members). These perspectives can potentially bring crucial insights, but practice is not consistent within or across review systems.

There were also recurring points regarding **findings** (i.e., learning *about* a case) where issues emerged relating to both breadth and depth. It was noted that reviews were often more being focused on answering “what” happened rather than questioning “why”. Further, there were concerns about the limited engagement with, or reporting on, the lived experience of the subjects of review (such as documenting experiences by

[4] Specialist ‘by and for’ services are defined by NAVCA as domestic abuse services “run by and for the users and communities they aim to serve” (Voice4Change (2011). *Voice4Change England and NAVCA Specialist Services: A Guide for Commissioners.* Available at: https://voice4change-england.com/wp-content/uploads/2020/11/v4ce_and_navca_-_commissioning_specialist_services.pdf

Protected Characteristics, as well as analysing how these experiences intersect and ensuring that any findings do not reproduce stereotypes).

There were several issues that emerged specifically relating to the **scope and feasibility of recommendations**. Translating learning into recommendations was considered challenging. It was noted that findings were often made to local authorities or other public bodies that did not have the funding necessary to implement changes, or that findings were not handed to the 'right person'. An underlying tension emerged in terms of the **affordability and feasibility** of recommendations, while simultaneously seeking to **address systemic factors** – such as racial minoritisation and misogyny – that drive violence and abuse, and/or cause disproportionate impacts.

In addition, others noted that findings and recommendations from reviews were often **inaccessible,** either because reports were hard to find or because information was difficult to extract from reviews. This was exacerbated by the length and language of some reports. This was also linked to the variable resources available to analyse findings and recommendations routinely (although each statutory review system could identify examples of good practice). Nonetheless, it was noted that reviews needed to improve how they **collected and recorded data**, though fundamentally, this would require changes in how agencies collected data at the point of service contact (e.g., police).

Finally, there were concerns about the **lack of alignment** between government departments and different statutory reviews, with review systems often operating in silos. These concerns related to both process (such as templates and reporting methods) and how findings and recommendations were communicated.

Key questions for statutory review systems in the future

To improve learning across statutory review systems, we pose seven key questions:

How can local ownership and investment in top-down recommendations be improved? To increase accountability for implementation, stakeholders involved at ground level must be enabled to participate equally, lead, and take ownership of changes to policy and practices. There must be a robust framework and sufficient resources to deliver reviews, including equitable support for contributing skills and knowledge.

How can data be collected to an agreed minimum standard and regular, systematic analysis of reviews be funded? This includes ensuring case characteristics that are required for intersectional analyses (such as ethnicity, age, disability) are consistently reported. While review systems have at different times produced summary learning, funding could be allocated to support regular, systematic analyses.

How can we ensure that intersectional analyses of harms from violence and abuse inform prevention? This must include methodologies that will help those involved in commissioning and delivering reviews set terms of reference or key lines of enquiry that enable reviewers and panels/boards/partnerships to identify the widest possible learning, including building on other review findings.

How can reviews produce feasible recommendations, but remain ambitious? In addition, recommendations should identify which organisation or budget should be responsible for delivering an action plan and funding the change. This must be aligned with legal requirements, such as the Public Sector Equality Duty. Funding must be available to support implementation, locally, but also at a national level too.

What mechanisms can be put in place to share findings from reviews across *all* government departments and public bodies? Findings from different statutory review systems (both individual cases and in aggregate) must be delivered across multiple

government departments and public bodies, not only the key governing body (e.g., Department for Education, Department for Health and Social Care, Home Office).

What mechanisms can be identified to ensure the integration of findings? The availability of reviews on different repositories is an important development. However, attention must next turn to how findings from these repositories, as well as systematic analysis, can be delivered to local and national stakeholders in a timely manner.

What opportunities can be provided to stakeholders to learn from and across review systems? Opportunities for cross-system learning are required so that we do not repeat the mistakes of other systems as new ones are developed. Central repositories are key. However, other mechanisms to share learning could be identified which cascade findings beyond statutory services and to families and civil society or social justice organisations driving social change outside of institutions.

Box 2: Key questions for the future

- How can local ownership and investment in top-down recommendations be improved?
- How can data be collected to an agreed minimum standard and regular, systematic analysis of reviews be funded?
- How can we ensure that intersectional analyses of harms from violence and abuse inform prevention?
- How can statutory reviews produce feasible recommendations, but remain ambitious?
- What mechanisms can be put in place to share findings from reviews across *all* government departments and public bodies?
- What mechanisms can be identified to ensure the integration of findings?
- What opportunities can be provided for stakeholders to learn from and across review systems?

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