Statutory Review Local Protocol and Guidance

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Contents

Glossary

BCC	Bristol City Council
BNSSG	Bristol, North Somerset, South Gloucestershire
ICB	Integrated Care Board
CSP	Community Safety Partnership
CSPR	Child Safeguarding Practice Review
DARDR	Domestic Abuse Related Death Review
DHR	Domestic Homicide Review
DSP	Delegated Safeguarding Partners
FGM	Female Genital Mutilation
IMR	Independent Management Report/Review
KAS	Keeping Adults Safe Board (Safeguarding Adults Board)
KBSP	Keeping Bristol Safe Partnership
KCS	Keeping Children Safe Board
KCOMS	Keeping Communities Safe Board (Community Safety Partnership)
LeDeR	Learning Disabilities Mortality Review
MADASV	Multi-agency Domestic Abuse and Sexual Violence Board
NSPCC	National Society for the Prevention of Cruelty to Children
QAF	Quality Assurance Framework
SAB	Safeguarding Adults Board
SAR	Safeguarding Adults Review
SCIE	Social Care Institute for Excellence
SILP	Significant Incident Learning Process
SIO	Senior Investigating Officer
SIN	Serious Incident Notification
SMART	Specific, Measurable, Attainable, Relevant and Time-bound

Child Safeguarding Practice Reviews and Rapid Reviews

The Children and Social Work Act 2017 and Working Together 2023

The Children and Social Work Act 2017 and Working Together 2023 guidance set out the legal framework in respect of local safeguarding arrangements for children. Responsibility for how a system learns lessons from serious child safeguarding incidents now rests at a national level with the Child Safeguarding Practice Review National Panel and at a local level with the three statutory safeguarding partners (integrated care board, police and local authority).

In Bristol, the Keeping Bristol Safe Partnership (KBSP) fulfils the safeguarding partner arrangements set out in The Children and Social Work Act 2017 and Working Together (2023) and holds the responsibility for the agreement and undertaking of Child Safeguarding Practice Reviews.

Child Safeguarding Practice Reviews

It is the responsibility of the KBSP to decide whether a serious child safeguarding incident meets the criteria for Child Safeguarding Practice Review (CSPR).

Serious child safeguarding incidents are those in which:

- abuse or neglect of a child is known or suspected and
- the child has died or been seriously harmed

The criteria which the local safeguarding partners must take into account to decide whether a CSPR should be conducted include whether the case:

- highlights or may highlight improvements needed to safeguard and promote the welfare of children, including where those improvements have been previously identified
- highlights or may highlight recurrent themes in the safeguarding and promotion of the welfare of children
- highlights or may highlight concerns regarding two or more organisations or agencies working together effectively to safeguard and promote the welfare of children
- is one which the CSPR Panel have considered and concluded a local review may be more appropriate

Safeguarding partners should also have regard to the following circumstances:

- where the safeguarding partners have cause for concern about the actions of a single agency
- where there has been no agency involvement and this gives the safeguarding partners cause for concern
- where more than one local authority, police area or integrated care board is involved, including in cases where families have moved around

- where the case may raise issues relating to safeguarding or promoting the welfare of children in institutional settings

The purpose of a CSPR is to:

- Establish whether there are lessons to be learnt from the case about the way in local professionals and organisations work together to safeguard and promote the welfare of children.
- Identify clearly what those lessons are, how they will be acted on, and what is expected to change as a result, and therefore, improve inter-agency working and better safeguard and promote the welfare of children.

A CSPR is not a criminal enquiry and is separate from any investigation undertaken by the Police. This process is not about blame or any potential disciplinary action, but about open and transparent learning from practice in order to improve inter-agency working.

Referrals and Notification

It is the responsibility of the local authority, Bristol City Council, to submit a Child Safeguarding Serious Incident Notification (SIN) to the National Panel using the Child Safeguarding Online Notification System in cases where:

- abuse or neglect is known or suspected, and
- a child dies or is seriously harmed in Bristol.

There is guidance about the decision process of whether to notify or not in the National CSPR Panel Guidance for Safeguarding Partners.

The notification must take place within **five working days** of becoming aware of the incident. Rapid Reviews must be conducted whenever Bristol City Council submits a Child Safeguarding Serious Incident Notification.

The KBSP must be informed before or immediately after a Child Safeguarding Serious Incident Notification is made by Bristol City Council as the local authority.

Other multi-agency safeguarding partners should also inform the KBSP of cases where it is considered that a Rapid Review should be conducted.

Referral forms are available online to multiagency partners to inform the KBSP that a case may meet the criteria for Rapid Review at Welcome to the Keeping Bristol Safe Partnership website. Once completed, this should be sent via secure email to the KBSP Business Unit at KBSP.statutoryreviews@bristol.gov.uk

As referrals can and should be made by anyone, there may be instances in which a referral is made by a professional unfamiliar with the purpose and criteria for a CSPR. The referral form contains direction on how and when a referral is appropriate, this should be carefully considered when completing the form.

Staff members in partner agencies are advised to discuss the case with their agency representative on the KBSP CSPR sub-group before submitting a referral. If the

agency does not have a representative, they can discuss the case with their child safeguarding lead in the organisation. The KBSP Business Unit can also be contacted for advice about the process.

Referral quality

The KBSP Business Unit will examine each referral to ensure that the referrer has provided sufficient evidence to set out why they believe the criteria has been met; this is not to consider whether the criteria are met, but to ensure that sufficient information to make that decision has been provided. Where this evidence is not present it will be requested from the referrer before progressing.

It is essential that the referrer should consider and explicitly answer the following questions when making a referral:

- Does the referral state explicitly how the statutory criteria has been met?
- A brief description of the circumstances of the case. For example, relevant personal history about the child and their family, the allegation(s) of abuse or neglect, a list of known agencies that should hold relevant information on the child and their family, key decisions made, and any safeguarding procedures.
- Has the child died or suffered significant harm? Is there suspicion or evidence that abuse or neglect contributed to the child's death or significant harm?
- What evidence of concern is there about how agencies worked together to safeguard the child, or what evidence is there that one or more agencies involved did not support joint agency working?
- Does the case provide an opportunity to learn from local practice that could prevent abuse or neglect from occurring?
- Are explanations provided for any delays in the referral?
- Details of any additional reviews or other processes that this case is subject to.

Receipt of referral

The KBSP Business Unit will review the referral and circulate to the CSPR sub-group Chair to consider if:

a) Bristol City Council should submit a Child Safeguarding Serious Incident Notification, or
b) A non-statutory learning review meeting should be convened without the local authority submitting a Child Safeguarding Serious Incident Notification.

The decision and the rationale will be fed back to the referrer and to agencies who provided information to support the consideration of the case.

Deciding whether to commission a CSPR

The CSPR sub-group Chair and Rapid Review panel have the delegated authority to make a recommendation about whether to undertake a statutory or non-statutory

CSPR which is then signed off by the KBSP Delegated Safeguarding Partners[1] as set out below.

Not all cases considered by the CSPR sub-group Chair and Rapid Review panel will meet the criteria for a CSPR. The following will be considered when deciding whether to complete a review:

- Has the child experienced a minor injury or incident that did not result in serious harm or death? Was the child at risk but did not suffer serious harm or death?
- Is the situation an isolated incident with no evidence of ongoing abuse or neglect?
- Were the responses from agencies appropriate and effective, and there are no significant lessons to be learned?
- Is the case already being reviewed under another statutory process?
- Did the incident occur a long time ago and where the circumstances have significantly changed, making it difficult to draw relevant lessons for current practice?

Rapid Reviews

Following a Child Safeguarding Serious Incident Notification, a Rapid Review process to gather relevant information to support decision making will be arranged.

The Rapid Review process must be completed and a report sent to the National Child Safeguarding Practice Review Panel within 15 working days of the KBSP being notified of the child safeguarding serious incident.

The KBSP will lead on informing the family, and this approach will be informed by the lead professional working with the family. Individual agencies should not inform family members about the Rapid Review.

The KBSP Business Unit will request chronologies and further supporting information to address the CSPR criteria from multi-agency partners within the CSPR sub-group and other relevant agencies making a Rapid Review panel.

Agencies are expected to have conversations with the colleagues involved with the case and complete a full desktop review to inform their information return.

The Business Unit will also arrange a rapid review learning meeting to take place within 6 – 10 working days of notification. Partners will be notified of the meeting date alongside the information request. The information submitted by agencies will

[1] Delegated Safeguarding Partners: Under Working Together 2023, the Lead Safeguarding Partners have delegated the operational delivery for children's Multi-Agency Safeguarding Arrangements. In Bristol, the lead representatives have identified the following as Delegated Safeguarding Partners (DSPs):

- Bristol City Council: Executive Director – Children and Education and Director of Children's Services
- Bristol, North Somerset, South Gloucestershire Integrated Care Board: Deputy Chief Nursing Officer
- Avon and Somerset Constabulary: Chief Superintendent

be collated and shared with attendees prior to the meeting. On consideration of the collated information, the Rapid Review panel will:

- Gather facts about the case, as far as they can be readily established.
- Identify any immediate actions that organisations need to take to ensure children's safety in the city and share immediate learning appropriately.
- Consider the potential for identifying improvements to safeguard and promote the welfare of children by undertaking a CSPR.
- Decide whether or not to undertake a CSPR (local or national).
- Inform the KBSP Delegated Safeguarding Partners of recommendations and seek a final decision.

On confirmation of the final decision of the KBSP Delegated Safeguarding Partners the Rapid Review report will be submitted to the National Child Safeguarding Practice Review Panel within 15 working days.

The final Rapid Review report will be circulated to the Rapid Review Panel and the following named professionals:

- Designated Doctor for Safeguarding
- Designated Nurse for Safeguarding
- Head of Safeguarding, Avon and Somerset Police
- Detective Chief Inspector for Operation Ruby Child Protection Investigation Team
- Deputy Director of Children, Families and Safer Communities, Bristol City Council

Wider dissemination of the report can only be made with the agreement of the CSPR sub-group Chair or KBSP Business Manager.

Rapid Review reports are not published or made publicly available. However, an anonymised professional learning briefing will be published for wider learning.

Actions identified within the Rapid Review will be directed and monitored within the CSPR sub-group and overseen by the Keeping Children's Safe Board.

If it is agreed that a local CSPR will take place, the CSPR sub-group will commission and support an independent reviewer to undertake this.

If it is agreed that a National CSPR will take place the CSPR Panel should notify the Secretary of State and discuss how this will be undertaken with the KBSP. There may be instances where a local review has been carried out which could then form part of a thematic review that the CSPR Panel undertakes at a later date.

A Rapid Review Process Flowchart can be found in Appendix 1.

Other review types and parallel processes

Where a CSPR is agreed consideration should also be given to whether the case should be referred for Domestic Homicide Review (which are applicable to those over 16 years of age) or Safeguarding Adult Review (where the case may also

involve the death of an adult at risk of abuse or neglect). This should be raised through the Business Unit of the Keeping Bristol Safe Partnership, which also supports these reviews.

Where a case meets the criteria for more than one type of review a joint review should be considered, and if commissioned the methodology chosen should allow for the review to meet the requirements of both.

Where multiple local authorities are involved, a joint CSPR should be considered. If the CSPR sub-group believes this to be appropriate, contact with the other relevant local authority should be made as soon as possible. Methodology and governance should be agreed jointly.

Consideration should also be given to other parallel processes that can be undertaken alongside a CSPR; this may include an ongoing criminal investigation/prosecution or a Mental Health Independent Review. The KBSP Business Unit should inform the relevant persons/commissioning bodies immediately and provide them the opportunity to express their views on the concurrent processes, and if necessary, jointly agree a methodology or governance.

Convening a Local Child Safeguarding Practice Review

Methodologies

The CSPR scoping document, methodology and terms of reference for the review should be finalised with the reviewer once appointed but should be drafted by the safeguarding partner representatives from the CSPR sub-group in parallel with making an appointment. The most appropriate methodology for conducting a CSPR should be determined on a case-by-case basis. Accredited methodologies include SCIE Learning Together and SILP which both use a systems learning approach. A bespoke or hybrid approach may also be undertaken.

All CSPR methodologies should demonstrate a commitment to:

- engagement with family and carers
- engagement with frontline practitioners
- taking a 'no blame' and systems learning approach
- being conducted in accordance with the NSPCC Quality Markers
- aim to complete within 6 months of initiation

Notification of CSPR to agencies

CSPR sub-group partner agencies should be given as much notice as possible that a CSPR has been agreed. Requests for Review Panel members and agency chronologies should be made along with an agreed scope and methodology with the reviewer(s). The KBSP will ask for information from agencies by issuing CSPR notification to partners' letter.

Appointment and expectations of lead reviewers

The CSPR sub-group and KBSP Business Unit must appoint an independent reviewer to conduct a local CSPR. The KBSP Business Unit holds a database of

potential CSPR reviewers. The Business Unit will write to potential reviewers, and request they express an interest in undertaking the review on behalf of the partnership. The KBSP Business Unit will request the following:

- A letter expressing interest
- A CV
- References from other partnerships, and links to any published reports.

The potential reviewer should specify a daily rate, and the expectations of the work to be provided. Where amendments to the report are required due to issues of quality, these amendments must be undertaken at the lead reviewer's expense.

The appointing group (consisting of statutory safeguarding partner representatives from the CSPR Sub-group) should consider if a reviewer has the following:

- professional knowledge, understanding and practice relevant to local child safeguarding practice reviews including the ability to engage both with practitioners and children and families
- knowledge and understanding of research relevant to children's safeguarding issues
- ability to recognise the complex circumstances in which practitioners work together to safeguard children
- ability to communicate findings effectively
- whether the reviewer has any real or perceived conflict of interest

Scoping of review

Once appointed, a 'scoping' meeting will be held between the lead reviewer(s), CSPR sub-group Chair, KBSP Statutory Review Officer, KBSP Business Manager and KBSP Legal Advisor to discuss the agreed arrangements for the review process and a draft Terms of Reference for the group.

Plans should be made to contact the family to provide an opportunity to engage with the review. All due consideration should be given to identify the most appropriate contact for the family, this may be a Family Liaison Officer, or practitioner with an existing relationship.

Agency Reports and member expectations

Any reports produced by organisations solely for use as part of a CSPR or Rapid Review methodology are the property of the KBSP.

Any request to share information with external parties should be made in writing to the KBSP Business Manager. Requests will be considered, and a response provided. Information pertaining to reviews should not be shared unless agreement from the CSPR sub-group Chair or KBSP Delegated Safeguarding Partners is obtained.

Agencies

Agencies that have, or ought to have had significant involvement in the case are required to appoint an appropriate person of sufficient experience in safeguarding who will be a member of the Review Panel.

Member Expectations

Review Panel members are expected to:

- Be independent of the case, and independent of any line management of staff involved in the case.
- Be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
- Share any relevant records pertaining to the subject of the review.
- Advise on matters of practice.
- Be consistent throughout the process and attend all review meetings. Where this is not possible, panel members should send an appropriate delegate who has been briefed on the role. Persistent non-attendance will be escalated to Keeping Children Safe (KCS) Board.
- Understand the relevant legislation Working Together 2023.
- Be aware of the highly sensitive nature of the subject discussed and ensure their communications and data storage is secure.
- Undertake attributed work and actions as appropriate to their roles to support the review, this includes submitting a chronology and agency report on behalf of your organisation.
- Review and provide feedback on all versions of draft reports.
- Ensure that the report is factually accurate and that - agency specific and partnership - recommendations are SMART.
- Read all papers shared in advance of the meeting and have sought clarification where required.
- Report back to their line managers on any issues pertaining to their agency that arise during the review.

See appendix 2 for KBSP Member Roles and Responsibilities.

Information sharing within the CSPR and Rapid Review process

Information sharing is essential to safeguard and promote the welfare of children and young people. Effective CSPRs are equally dependent on all relevant partners sharing the information they hold about the case and associated professional practice.

The Delegated Safeguarding Partners have the formal authority to request information to support both national and local CSPRs and the power to take legal action if information is withheld without good reason.

All agencies will be expected to share relevant information within the timescales requested. This may, when necessary, include sharing information without consent (such as where there is an ongoing police investigation). This includes information about parents, guardians and other family members as well as the child(ren) who are subject of the review.

When making requests for information, the Delegated Safeguarding Partners will consider their responsibilities under the relevant information law and have regard to guidance provided by the Information Commissioner's Office.

Good practice principles around information sharing will always be followed, particularly around 'how' information is shared.

In the case of any disagreement or failure to comply with a formal information request, the Independent Lead Reviewer will refer the issue to the CSPR sub-group who will seek to resolve this with the strategic Safeguarding Lead for the agency concerned. If a prompt resolution cannot be found, the issue will be escalated to the Delegated Safeguarding Partners for formal action.

Involvement of Family, Friends and Other Support Networks

The family/ carers / friends or other support networks of the subject under review should be contacted by the KBSP at the earliest opportunity. This will be done via letter.

Family members, including surviving children, will be informed of the review and invited to contribute unless there is a strong reason not to do so. Every effort should be made to ensure that the family/ carers / friends or other support networks is fully briefed on the purpose of a CSPR, the methodology, and timeframes.

Every effort should be made to support any support network wishing to engage with the review process through facilitating conversations and arranging interviews at their convenience. It is entirely the individual's decision whether they wish to do this.

An agreement should be made regarding who should be the main point of contact for the family/ carers / friends or other support networks, and how regularly they will be updated, and a record kept of contacts made. Consideration should be given to whether this first contact should be supported by an appropriate professional who may have already established a working relationship (such as their existing Social Worker, or Family Liaison Officer).

The family and other support networks involved in the review will be provided an opportunity to review the final report after it has been approved by the KBSP at least one week prior to publication. The practical arrangements for sharing the report pre-publication should be considered on a case-by-case basis, taking into account the needs of the family member/individual. A face-to-face meeting is preferable. If a face-to-face meeting is not possible and the report needs to be sent by post or email, a confidentiality agreement must be signed and returned before releasing the report.

Should the family or other support networks wish to comment on the report the KBSP may consider publishing their response alongside the final report.

It must be recognised that the context in which a CSPR is held is likely to have been distressing for those involved, and where appropriate the family should be signposted to relevant support services.

The family or other support networks may wish to engage their own legal representation. In this instance, all communication should be directed in conjunction with the KBSP legal advisor.

CSPR Meetings

The first meeting of the Review panel should:

- Confirm the members of the panel, identifying where there may be gaps in representation or submitted information.
- Confirm the terms of reference / research questions for the review.
- Discuss and analyse the submitted information to identify areas for exploration during the review.
- Identify any other agencies that may have specific expertise in an area that can support the review process.
- If applicable, invite the SIO to attend the first panel meeting to brief on the investigation and for the SIO to be party to the setting of the Terms of Reference.

Practitioner Group

In certain methodologies, frontline practitioners who had direct involvement with the child and/or their family are asked for information. They may meet for practitioner event(s) to explore key episodes or hold one to one conversations with the independent reviewer or members of the review team.

Once the review has sufficiently progressed to produce findings, the practitioners will be provided with an opportunity to provide feedback and comment on these findings.

See appendix 2 for KBSP Member Roles and Responsibilities.

Report and Quality Assurance

Once a CSPR report draft has been finalised by the Independent Reviewer, this should be quality assured by the CSPR sub-group to assess whether:

- The research question has been effectively answered and/or the terms of reference have been met.
- The report remains within the established scope with the focus on learning lessons.
- The agreed methodology has been followed.
- There are no factual or typographical errors.
- Conclusions have been evidenced.
- Any recommended improvements to be made by individuals or organisations are accompanied by a SMART (specific, measurable, attainable, relevant and time-bound) action plan.
- Language is appropriate.

- The report is publishable and no personal detail regarding the case that is not relevant to the review has been included.

The report will then proceed to the KBSP Delegated Safeguarding Partners for approval. The Delegated Safeguarding Partners must ensure that the final report includes:

- A clear summary of any recommended improvements to be made by individuals or organisations in the area to safeguard and promote the welfare of children.
- An analysis of any systemic or underlying reasons actions were taken or not taken in respect of matters covered by the report.

Publication

There is a commitment to publish CSPRs as far as possible; legal advice should be taken before doing so.

There is not a one size fits all for publishing a CSPR, and all approaches to publication should be considered on a case-by-case basis. The KBSP Business Unit will meet with Press and Communication leads for the KBSP and Bristol City Council (BCC) on a quarterly basis to review potential upcoming publications. The Press and Communication leads for Bristol City Council will manage any political engagement and brief the relevant elected members and/or committee chairs prior to publication.

Typically, three media strategies are used which the Press and Communication leads will advise on:

- **Bronze:** Standard publication on KBSP website, no joint statement and no proactive promotion.
- **Silver:** Bronze approach with an opportunity for agencies to produce their own statements alongside Board publication.
- **Gold:** A bespoke communications approach that meets the level of public interested in the case. A communications plan will be developed in collaboration across relevant agency partners to meet the needs of the situation**.** (This may include, for example, a press release or press briefing if appropriate).

Parallel processes need to be considered at point of publication, if they are still ongoing publication may not be possible.

The CSPR sub-group should consider carefully how best to manage the impact of the publication on children, family members, practitioners and others closely affected by the case. Families will be given a named contact with the KBSP, this is usually the KBSP Business Manager.

CSPR reports will be published on the KBSP website and must be available for at least three years.

Rapid Review reports are not published; however, a learning briefing will be published for each Rapid Review.

A final copy of the CSPR report must be sent to the Child Safeguarding Practice Review Panel Mailbox.NationalReviewPanel@education.gov.uk and the Secretary of State for Education Mailbox.CPOD@education.gov.uk no later than seven days before the date of publication. In addition, final reports and information about improvements should also be sent to Ofsted SCR.SIN@ofsted.gov.uk.

Where other proceedings may have an impact on or delay publication, (for example, an ongoing criminal investigation, inquest or future prosecution), the Safeguarding Partners, via the KBSP Business Unit, should inform the panel and the Secretary of State of the reasons for the delay. Safeguarding Partners, via the KBSP Business Unit, should also set out for the Panel and the Secretary of State the justification for any decision not to publish either the full report or information relating to improvements[2].

Learning and Actions

The CSPR sub-group will develop an action plan that addresses the findings of a CSPR or Rapid Review, to be agreed and supported by the Delegated Safeguarding Partners. This will be maintained by the KBSP Business Unit and monitored by the CSPR Sub-group. CSPR and Rapid Review Action plan exceptions will be reported to the Keeping Children Safe Group three times a year. Barriers to completing actions will be escalated to the KBSP Steering Group.

Action should be taken to ensure learning from CSPRs and Rapid Reviews is disseminated.

A learning briefing will be produced from each Rapid Review and CSPR Report. When a report is not published, consideration should be given about sharing the learning in a briefing.

Information about learning from Rapid Reviews held will be available in the KBSP Annual Report.

Costs

All CSPR related costs are to be divided equally between the three core partners of Bristol City Council, Avon & Somerset Constabulary and Bristol, North Somerset, and South Gloucestershire Integrated Care Board.

[2] Working together to safeguard children 2023: statutory guidance

Domestic Abuse Related Death Reviews (Domestic Homicide Reviews)

Criteria for a Domestic Homicide Review

Domestic Abuse Related Death Reviews (DARDRs) (formerly known as Domestic Homicide Reviews (DHRs)) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004) in April 2011.

The Victims and Prisoners Act 2024 amends the Domestic Violence, Crime and Victims Act 2004, emphasising the establishment and conduct of domestic abuse related death reviews which recognises the often hidden victims of domestic abuse who die by suicide, coercive and controlling behaviour and economic abuse[3].

In Bristol, the Keeping Bristol Safe Partnership have the statutory responsibility for commissioning a DHR and is constituted to perform the function of the Community Safety Partnership (CSP) via the Keeping Communities Safe (KCOMS) Board.

A Domestic Homicide Review means a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by-

a) A person to whom he was related or with whom he was or had been in an intimate relationship, or
b) A member of the same household as himself,

held with a view to identifying the lessons to be learnt from the death.

In cases of suicide, the Home Office Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (2016) states further that:

Where a victim took their own life and the circumstances give rise to concern, for example, if it emerges that there was coercive controlling behaviour in the relationship, a review should be undertaken, even if a suspect is not charged with an offence or they are tried and acquitted. Reviews are not about who is culpable[4].

The purpose of a DHR is to:

a) establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims;
b) identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result;
c) apply these lessons to service responses including changes to inform national and local policies and procedures as appropriate;
d) prevent domestic violence and homicide and improve service responses for all domestic violence and abuse victims and their children by

[3] Fatal domestic abuse reviews renamed to better recognise suicide cases - Domestic Abuse Commissioner
[4] DHR-Statutory-Guidance-161206.pdf

developing a co-ordinated multi-agency approach to ensure that domestic abuse is identified and responded to effectively at the earliest opportunity;

e) contribute to a better understanding of the nature of domestic violence and abuse; and
f) highlight good practice.

The operating principles of a DHR is:

a) to identify and learn lessons as well as identify good practice so that future safeguarding services improve their systems and practice for increased safety of potential and actual victims of domestic abuse, as defined in the Domestic Abuse Act 2021.[5]
b) not to apportion blame to individuals or organisations, rather, it is to use the study of this case to provide a window on the system.
c) a forensic and non-judgmental appraisal of the system will aid understanding of what happened, the context and contributory factors and what lessons may be learned.
d) for the review findings to be independent, objective, insightful and based on evidence while avoiding 'hindsight bias' and 'outcome bias' as influences.
e) that the review will be guided by humanity, compassion and empathy with the victim's 'voice' at the heart of the process.
f) that it will take account of the protected characteristics listed in the Equality Act 2010.
g) all material will be handled within Government Security Classifications at 'Official - Sensitive' level.

In March 2013, the Government introduced a cross-government definition of domestic violence and abuse, which is designed to ensure a common approach to tackling domestic violence and abuse by different agencies. The new definition states that domestic violence and abuse is:

"*any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass, but is not limited to, the following types of abuse:*

- *psychological*
- *physical*
- *sexual*
- *financial*
- *emotional*

Controlling behaviour is: a range of acts designed to make a person subordinate and/or dependent by isolating them from sources of support, exploiting their resources and capacities for personal gain, depriving them of the means needed for independence, resistance and escape and regulating their everyday behaviour.

[5] Domestic Abuse Act 2021

Coercive behaviour is: a continuing act or a pattern of acts of assault, threats, humiliation and intimidation or other abuse that is used to harm, punish, or frighten their victim".

This definition includes so-called 'honour-based' violence, and includes crimes such as female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group[6].

Referrals

Making a referral

Any individual, professional or agency can refer a case to the KBSP, requesting that consideration be given to convening a DHR. The request is made by submitting the KBSP DHR referral form, available online at Welcome to the Keeping Bristol Safe Partnership website. Once completed, this should be sent via secure email to the KBSP Business Unit at KBSP.statutoryreviews@bristol.gov.uk.

As referrals can and should be made by anyone, there may be instances in which a referral is made by a professional unfamiliar with the purpose and criteria for a DHR. The referral form contains direction on how and when a referral is appropriate, this should be carefully considered when completing the form.

Staff members in partner agencies are advised to discuss the case with their agency representative on the KBSP SAR/DHR sub-group before submitting a referral. If the agency does not have a representative, they can discuss the case with their adult safeguarding lead in the organisation. The KBSP Business Unit can also be contacted for advice about the process.

Referral quality

The KBSP Business Unit will examine each referral to ensure that the referrer has provided sufficient evidence to set out why they believe the criteria has been met; this is not to consider whether the criteria are met, but to ensure that sufficient information to make that decision has been provided. Where this evidence is not present it will be requested from the referrer before progressing.

It is essential that the referrer should consider and explicitly answer the following questions when making a referral:

- Does the referral state explicitly how the statutory criteria has been met?
- A brief description of the circumstances of the case. For example, relevant personal information about the victim and the circumstances leading up to the homicide or suicide, details of the known history of domestic abuse and a list of agencies that either had contact with the victim and/or perpetrator.
- Any risk assessments that were conducted including their outcomes and any actions taken as a result.
- Are explanations provided for any delays in the referral?

[6] New definition of domestic violence - GOV.UK

- Details of any additional reviews or other processes that this case is subject to.

The SAR/DHR sub-groups role is not to resolve differences between agencies about action taken or through which to escalate concerns about a case. Any case that has been subject to case resolution and required resolution at senior levels in more than two organisations *may* warrant a review to examine further issues and disseminate any learning. If a case is being referred to the SAR/DHR sub-group for this reason, please state this clearly.

Receipt of referral

The majority of cases referred are considered by the SAR/DHR sub-group, however if the decision is that it will not progress, then the KBSP Business Unit will contact the referrer with a clear rationale.

Once a completed referral is received, the KBSP Business Unit will convene a meeting for the SAR/DHR sub-group to consider the referral. This will be arranged to take place within one month.

Prior to the meeting, SAR/DHR sub-group members will review records held by their respective agencies and complete a brief agency involvement form to assist decision making.

DHR sub-group referral consideration

It is the role of the SAR/DHR sub-group to consider each referral against the criteria for commissioning, as outlined in section 9 of the Domestic Violence, Crime and Victims Act (2004)

At the meeting, the sub-group will make a recommendation as to whether the criteria for a DHR has been met. The sub-group may ask for further information to be gathered in an effort to assist them in deciding whether the threshold has been met: the outcome may be a statutory DHR, a discretionary (non-statutory) review, a single agency action in relation to practice in the case, or no further action to be taken by the SAR/DHR sub-group.

Once a decision has been made, the SAR/DHR sub-group will make a recommendation to the KCOMS Chair (also known as the CSP Chair) for their final decision.

If the KCOMS Chair agrees a DHR should be undertaken, it should be initiated immediately.

If the KCOMS Chair disagrees with the recommendation, this will be fed back to the SAR/DHR sub-group and the referral will be closed.

The decision and the rationale will be fed back to the referrer and to agencies who provided information to support the consideration of the case.

The KBSP will send in writing its confirmation of a decision to review, as well as a decision not to review a homicide, to the Home Office DHR enquiries inbox: DHRENQUIRIES@homeoffice.gsi.gov.uk.

Consideration of other processes

Where multiple local authorities are involved, a joint DHR should be considered. If the SAR/DHR sub-group believes this to be appropriate, contact with the other relevant local authority should be made as soon as possible. Methodology and governance should be agreed jointly.

Where there are possible grounds for a Safeguarding Adult Review, Domestic Homicide Review, Child Safeguarding Practice Review or other formal review process then a decision should be made at the outset as to which process is to lead and who is to chair with a final joint report being taken to the necessary commissioning bodies.

It should be recognised that running dual or multiple agency processes can be overly burdensome or distressing for professionals and family members involved; delay publication; and limit learning. The principle of proportionality should always be considered.

In some cases, a criminal investigation/prosecution may run parallel to a DHR. The KBSP Business Unit will inform the Senior Investigating Officer (SIO) of the review and provide them the opportunity to express their views. It may be appropriate that the KBSP agree to await the conclusion of the criminal proceedings before commencing a review for example. In this case, following the criminal proceedings the review should be concluded without delay.

Deciding whether to commission a DHR

The SAR/DHR sub-group have the delegated authority to make a recommendation about whether to undertake a statutory or non-statutory DHR which is then signed off by the KCOMS Chair as set out above.

Not all cases considered by the SAR/DHR sub-group will meet the criteria for a DHR. The following will be considered when deciding whether to complete a review:

- if the death is determined to be from natural causes without any evidence of violence, abuse, or neglect.
- if the death is accidental and there is no suspicion of foul play or abuse.
- if a person dies by suicide and there is no evidence or suspicion of domestic abuse or neglect leading up to the death.
- if the death occurs in a context that is not domestic, such as a random act of violence by a stranger, it would not meet the criteria for a DHR.
- whether undertaking a review be proportionate and identify new learning around domestic abuse practice that could prevent future deaths from occurring in the future.

Convening a DHR

Methodologies

The methodology for undertaking a DHR will follow the process outlined in the Home Office DHR Statutory Guidance 2016.

Accredited methodologies include SCIE Learning Together and SILP which both use a systems learning approach. A bespoke or hybrid approach may also be undertaken.

All DHR methodologies should demonstrate a commitment to:

- engagement with family and carers
- engagement with frontline practitioners
- taking a 'no blame' and systems learning approach
- being conducted in accordance with the Home Office DHR Statutory Guidance 2016
- aim to be completed within a reasonable timeframe

Notification of DHR to agencies

SAR/DHR sub-group partner agencies should be given as much notice as possible that a DHR has been agreed. Requests for Review Panel members and agency chronologies should be made along with an agreed scope and methodology with the reviewer(s). The KBSP will ask for information from agencies by issuing DHR notification to partners' letter.

Appointment and expectations of lead reviewers

All DHRs must be led by an independent reviewer.

The KBSP Business Unit holds a database of potential DHR reviewers. The Business Unit will write to potential reviewers, and request they express an interest in undertaking the review on behalf of the partnership. The KBSP Business Unit will request the following:

- How they meet the criteria for independence in Section 4 paragraph 37 of the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
- The skills and expertise they possess in order to effectively chair a review with reference to Section 4 paragraph 39 of the Home Office Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews
- References from other CSPs and links to any published reports
- Details of fees and confirmation of availability.

It is expected that those who submit an expression of interest will include relevant experience in the following:

- Strong leadership and ability to motivate others
- expert facilitation skills and experience of sensitive and complex group dynamics
- collaborative problem-solving experience and knowledge of participative approaches
- analytic skills and ability to manage qualitative data
- safeguarding knowledge
- promote an open, reflective learning culture

The potential reviewer should specify a daily rate, and the expectations of the work to be provided. Where amendments to the report are required due to issues of quality, these amendments must be undertaken at the lead reviewer's expense.

The KBSP Business Unit will meet with the statutory safeguarding partner representatives from the DHR sub-group to make the appointment to conduct the DHR.

Failure for the lead reviewer to comply with the expectations and terms of the DHR contract will result in escalation by the SAR/DHR sub-group to the KCOMS Board, or KBSP Independent Chair, and if relevant their independent management.

Scoping of review

Once appointed, a 'scoping' meeting will be held between the lead reviewer(s), SAR/DHR sub-group Chair, KBSP Statutory Review Officer, KBSP Business Manager and KBSP Legal Advisor to discuss the agreed arrangements for the review process and a draft Terms of Reference for the group.

Plans should be made to contact the family to provide an opportunity to engage with the review. All due consideration should be given to identify the most appropriate contact for the family, this may be a Family Liaison Officer, or practitioner with an existing relationship.

Agency Reports and member expectations

Any reports produced by organisations solely for use as part of a DHR methodology are the property of the KBSP.

Any request to share Independent Management Reports/Reviews (IMRs) or other information with external parties should be made in writing to the KBSP Business Manager. Requests will be considered, and a response provided. Information pertaining to reviews should not be shared unless agreement from the KCOMS Chair is obtained.

Agencies

Agencies that have, or ought to have had significant involvement in the case are required to appoint an appropriate person of sufficient experience in safeguarding who will be a member of the Review Panel.

Member Expectations

Review Panel members are expected to:

- Be independent of the case, and independent of any line management of staff involved in the case.
- Be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
- Share any relevant records pertaining to the subject of the review.
- Advise on matters of practice.
- Be consistent throughout the process and attend all review meetings. Where this is not possible, panel members should send an appropriate

delegate who has been briefed on the role. Persistent non-attendance will be escalated to KCOMS Board.

- Understand the relevant legislation Domestic Violence, Crime and Victims Act 2004.
- Be aware of the highly sensitive nature of the subject discussed and ensure their communications and data storage is secure.
- Undertake attributed work and actions as appropriate to their roles to support the review, this includes submitting a chronology and IMR on behalf of your organisation.
- Review and provide feedback on all versions of draft reports.
- Ensure that the report is factually accurate and that - agency specific and partnership - recommendations are SMART.
- Read all papers shared in advance of the meeting and have sought clarification where required.
- Report back to their line managers on any issues pertaining to their agency that arise during the review.

See appendix 2 for KBSP Member Roles and Responsibilities.

Information sharing within the DHR process

Agencies should be assured that information requested by the KBSP for the purposes of DHR is proportionate and relevant.

Section 10 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews states that information must be provided to Community Safety Partnerships to enable or to assist the board to exercise its functions, including undertaking DHRs.

In instances of challenge regarding information sharing, advice should be sought from Caldicott Guardians and the KBSP legal advisor.

DHR Meetings

The first meeting of the Review panel should:

- Confirm the members of the panel, identifying where there may be gaps in representation or submitted information.
- Confirm the terms of reference / research questions for the review.
- Discuss and analyse the submitted information to identify areas for exploration during the review.
- Identify any other agencies that may have specific expertise in an area that can support the review process.
- If applicable, invite the SIO to attend the first panel meeting to brief on the investigation and for the SIO to be party to the setting of the Terms of Reference.

Practitioner Group

In certain methodologies, frontline practitioners who had direct involvement with the adult and/or their family are asked for information. They may meet for practitioner event(s) to explore key episodes or hold one to one conversations with the independent reviewer or members of the review team.

Once the review has sufficiently progressed to produce findings, the practitioners will be provided with an opportunity to provide feedback and comment on these findings.

See appendix 2 for KBSP Member Roles and Responsibilities.

Involvement of Family, Friends and Other Support Networks

The family/ carers / friends or other support networks of the subject under review should be contacted by the KBSP at the earliest opportunity. This will be done via letter and the DHR information for families' / friends / employers' leaflet included. Every effort should be made to ensure that the family/ carers / friends or other support networks is fully briefed on the purpose of a DHR, the methodology, and timeframes.

Every effort should be made to support any support network wishing to engage with the review process through facilitating conversations and arranging interviews at their convenience. It is entirely the individual's decision whether they wish to do this.

An agreement should be made regarding who should be the main point of contact for the family/ carers / friends or other support networks, and how regularly they will be updated, and a record kept of contacts made. Consideration should be given to whether this first contact should be supported by an appropriate professional who may have already established a working relationship (such as their existing Social Worker, or Family Liaison Officer).

The family and other support networks involved in the review will be provided an opportunity to review the final report after it has been approved by the KBSP at least one week prior to publication. The practical arrangements for sharing the report pre-publication should be considered on a case-by-case basis, taking into account the needs of the family member/individual. A face-to-face meeting is preferable. If a face-to-face meeting is not possible and the report needs to be sent by post or email, a confidentiality agreement must be signed and returned before releasing the report.

Should the family or other support networks wish to comment on the report the KBSP may consider publishing their response alongside the final report.

It must be recognised that the context in which a DHR is held is likely to have been distressing for those involved, and where appropriate the family should be signposted to relevant support services.

The family or other support networks may wish to engage their own legal representation. In this instance, all communication should be directed in conjunction with the KBSP legal advisor.

Section 6 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews sets out further information and guidance on the involvement of family, friends and other support networks.

Quality Assurance and Approval

Once the reviewer has drafted the full Overview Report and Executive Summary, the Review Panel must formally approve its contents and recommendations at a meeting or via email.

The final draft Overview Report and Executive Summary will also be sent to the KBSP Statutory Review Officer and KBSP Business Manager to ensure that the report has met the required criteria agreed at the scoping meeting and that the recommendations are achievable.

The Review Panel must work with the KBSP Business Unit to create an action plan based on the findings from the DHR.

SAR/DHR sub-group quality assurance meeting

The KBSP Statutory Review Officer will attend the meeting to present the report, recommendations and action plan. The sub-group will quality assure the report and ensure that any draft recommendations are suitable to be accepted by the KBSP KCOMS Board.

Guidance and Report templates can be found at: DHR-Statutory-Guidance-161206.pdf

The SAR/DHR sub-group must be quorate with representation from the local authority, police, and Integrated Care Board. Full agency representation is strongly encouraged.

SAR/DHR sub-group members should come to the meeting:

- Prepared to represent their agency views.
- Having read the review thoroughly, highlighting any factual or typographical errors they may have identified.
- Having fully considered whether they are prepared to approve the DHR, and what amendments may be needed if they are not.
- Challenge the reviewers and discuss the draft recommendations.
- Ensure the accepted recommendations are accompanied by SMART actions for their service.

The Overview Report, Executive Summary and Action Plan will be circulated to the attendees in advance, clearly labelled to indicate that the report is confidential and only for the use of the SAR/DHR sub-group members. It should be noted that a DHR is the product of and owned by the KBSP and therefore should not be shared any wider without consent of the KBSP Business Manager or KCOMS Chair.

At the conclusion of the meeting the SAR/DHR sub-group members will agree to approve the draft report for onward submission to the KCOMS Board, or request that

further amendments are made to the document. In these circumstances' amendments should be made in a timely manner and subsequently approved via an additional meeting or virtually circulated for approval before submission to the KCOMS Board.

Keeping Communities Safe Board acceptance meeting

Once the SAR/DHR Sub-Group has conducted quality assurance of the DHR it must be formally accepted by the Keeping Communities Safe Board. The reviewer/s will then be invited to a KCOM meeting to provide a short presentation of the review findings, recommendations and action plan.

The report will be circulated to attendees in advance, clearly labelled to indicate that the report is confidential and only for the use of the KCOMS members. All members must attend having read the draft document thoroughly.

If a KCOMS member is unable to attend, they must ensure a deputy attends and receives a copy of the report. Full agency representation is strongly encouraged.

KCOMS members should come to the meeting having read through the report thoroughly and be prepared to discuss and accept the recommendations and action plan that has been developed following the DHR.

It is essential that if an agency has significant concerns about the content of the report, then they must share this with the KCOMS Board to ensure that members are aware of their concerns.

In the event of the above the KCOMS Chair may consider whether the report should return to the SAR/DHR sub-group or Review Panel, or whether the reviewers could incorporate the feedback into a re-drafted version of the report without the need for further quality assurance.

No new suggested amendments will be accepted once a decision has been reached at the KCOMS. Agencies must be assured of their position prior to the meeting and ensure that any relevant input via their agencies has already been sought.

Outcomes of DHR presentation to the Keeping Communities Safe Board

At the conclusion of the meeting, the KCOMS Board will agree on an outcome; approval to be sent to the Home Office Quality Assurance Panel, minor amendment, resubmission following significant amendment or rejection.

In the unlikely event that a DHR and recommendations are not accepted by the KCOMS Board all efforts will be made to bring resolution. Failure to resolve issues will result in the escalation to the KBSP Steering Group.

The decision made by the KBSP in respect of a DHR is subject to KBSP Members' liabilities as set out in the KBSP Constitution.

Home Office Quality Assurance Panel

On acceptance of the Overview Report, Executive Summary and Action Plan, and the Home Office data collection form will be sent to the Home Office Quality Assurance Panel using the secure email address:

DHRENQUIRIES@homeoffice.gsi.gov.uk and will be assessed against the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews.

The Quality Assurance Panel will review the DHR and write back to the KBSP recommending areas for change or agreeing that the report is fit for publication. This process can take up to 6 – 12 months.

The Home Office Quality Assurance Panel's feedback will be shared with the author/chair of the DHR to make any necessary changes and to help inform future DHRs which they may be commissioned to undertake.

The SAR and DHR process flowchart can be found in appendix 3.

Action Plans

Action plans based on the findings of the DHR should be developed by the Review Panel who may seek assistance from the SAR/DHR sub-group or KCOMS Board if required in conjunction with the report sign off.

Action plans will specify how recommendations will be delivered, the individual or agency leading on that action, and a timescale for completion.

The KBSP Action Plan Template can be found in appendix 4.

The Statutory Review Officer on behalf of the SAR/DHR sub-group will report progress of the action plans to the KCOMS Board. Lack of progress will be escalated to the KCOMS Board, and where necessary to the KBSP Steering Group.

Publication

It is a requirement of the Home Office that DHR Overview Reports, including the DHR Action Plan and the Executive Summary are suitably anonymised and made publicly available. The DHR Reports will be published on the Keeping Bristol Safe Partnership and Bristol City Council website. A learning brief for the KBSP workforce will also be created to help embed learning from the review process.

All Overview Reports and Executive Summaries should be published unless there are compelling reasons relating to a person's welfare. The reasons for not publishing a DHR should be communicated to the Home Office Quality Assurance Panel.

The publication of a DHR needs to be timed in accordance with the conclusion of any related court proceedings or other review process[7].

There is not a one size fits all for publishing a DHR, and all approaches to publication should be considered on a case-by-case basis. The KBSP Business Unit will meet with Press and Communication leads for the KBSP and BCC on a quarterly basis to review potential upcoming publications. The Press and Communication

[7] Section 8 – Publication of the Overview Report: DHR-Statutory-Guidance-161206.pdf

leads for Bristol City Council will manage any political engagement and brief the relevant elected members and/or committee chairs prior to publication.

Typically, three media strategies are used which the Press and Communication leads will advise on:

- **Bronze:** Standard publication on KBSP website, no joint statement and no proactive promotion.
- **Silver:** Bronze approach with an opportunity for agencies to produce their own statements alongside Board publication.
- **Gold:** A bespoke communications approach that meets the level of public interested in the case. A communications plan will be developed in collaboration across relevant agency partners to meet the needs of the situation**.** (This may include, for example, a press release or press briefing if appropriate).

Plans for publication will be made ensuring the family are fully informed and involved as relevant.

Once the Home Office Quality Assurance Panel and KCOMS Chair has formally approved a DHR, a publication planning meeting should be arranged as soon as possible. Attendees should include:

- DHR sub-group Chair
- Legal Advisor to the Board
- KBSP Representatives of the three core partners; BCC, BNSSG ICB and Avon & Somerset Police
- Press and Communications leads for the three core partners

Press and Communications representatives for the Local Authority and KBSP are only required to attend the multi-agency meeting if the publication approach has previously been agreed as Gold.

Safeguarding representatives from any agencies involved in the DHR and their Press and Communication leads will be given the option to attend should they wish to engage.

The meeting agenda will cover two core items:

1. Whether the DHR can be published in full.
2. The media strategy for publication (this would be led by the KBSP communication representatives).

Attendees at the publication planning meeting should consider the following:

- If publication would lead to any breach of confidentiality
- If any redaction is required in the light of the Data Protection Act, and other relevant legislation
- If an Executive Summary or other briefing document would be more appropriate
- The production of individual agency responses
- The most appropriate course of notifying the media (‘publish’ vs ‘publicise’)

- A plan for informing key people, including family members and front-line professionals, and who is best placed to do this
- Agreeing a reasonable timescale for publication

Learning Dissemination

On publication of a DHR, the following individuals/organisations will be notified:

- The DHR family, friends or other support networks involved in the review.
- The DHR Review Panel and Independent Review Author.
- The SAR/DHR sub-group.
- The KCOMS Board and Chair.
- Bristol City Council – Committee Chairs with responsibility for Public Health and Communities.
- Multi-agency Domestic Abuse and Sexual Violence Board (MADASV)
- The local Police and Crime Commissioner
- Domestic Abuse Commissioner for England and Wales
- The Home Office Quality Assurance Panel

The KBSP Business Unit will also produce a learning briefing and disseminate this across the KBSP network to ensure that key messages and learning reaches and is embedded within workforces across Bristol. Further opportunities to promote the learning from DHRs should include targeted learning events, conferences and via the KBSP newsletter, with the uploading of briefings and other relevant learning materials onto the KBSP website.

All agencies and practitioners who work with adults and children should actively engage with the learning opportunities provided by case reviews. All agencies should take responsibility for ensuring learning is shared with relevant staff. Practitioners are responsible for ensuring that they are equipped with the necessary skills and training to perform their role by:

- reading case review publications
- attending appropriate single and multi-agency training
- using learning from case reviews to inform to staff and team meetings/supervision
- Supporting colleagues and staff in other agencies in implementing the learning from case reviews

The KBSP will include the findings from any DHR in its annual report and what actions it has taken/ intends to take in relation to those findings. Where the partnership decides not to implement an action from the findings it must state the reason for that decision in the annual report.

Costs

All DHR related costs are to be divided equally between the three core partners of Bristol City Council, Avon & Somerset Constabulary and Bristol, North Somerset, and South Gloucestershire Integrated Care Board.

Disclosure of information with external parties

Section 9 of the Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews sets out expectations in relation to information sharing with external parties.

There may be a request to disclose (as opposed to share) information with external parties such as the Coroner; the Police; legal representation of the family or subject(s).

It is established in guidance and case law that in order for there to be openness and candour within the DHR process, it is necessary to protect confidentiality particularly in relation to related agency reports. This must be balanced with general principles of openness and transparency applicable to public process, and compliance with relevant legislation in relation to disclosure of information.

Disclosure to the Coroner is based on the public interest in a fair hearing as well as the need to the court to have all relevant information before it. This is balanced by the public interest in agencies being able to learn from incidents that have happened. It is recognised this may require that information is not disclosed in some circumstances.

Good practice provides the Coroner should be informed that the KBSP has commissioned a DHR.

If the Coroner requests disclosure of information, case law dictates what should be disclosed, and legal advice should be sought before a response is made. The KCOMS Chair will decide in consultation with the core partners to do this.

Decisions regarding disclosure of information to the family or other interested third parties will vary according to the timing of any requests and the stage reached within the DHR process. Legal advice should always be sought.

Single agencies will be required to make their own decision regarding information disclosure to third parties who approach them directly external to the DHR process, but this should be done in consultation with the KCOMS Chair.

Other than the final report, documentation will not be disclosed to the family or other individuals external to the DHR process prior to the completion of the report save where ordered to do so. Any request for access to documents will be considered in accordance with the principles of the Freedom of Information Act 2000 and the Data Protection Act 2018. Decisions will be made by the KCOMS Chair in relation to requests for disclosure of documents.

Safeguarding Adult Reviews

Criteria for a Safeguarding Adults Review

Section 44 of the Care Act 2014 and Care and support statutory guidance require Safeguarding Adult Boards (SAB) to conduct Safeguarding Adult Reviews (SAR) in certain circumstances. The Keeping Bristol Safe Partnership (KBSP) is constituted to perform the function of the Safeguarding Adult Board via the Keeping Adults Safe (KAS) Board in Bristol.

The KBSP must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if—

a) there is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult, and
b) condition 1 or 2 is met.

Condition 1 is met if—

a) the adult has died, and
b) the SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died).

Condition 2 is met if—

a) the adult is still alive, and
b) the SAB knows or suspects that the adult has experienced serious abuse or neglect.

The SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs).

Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to—

a) identifying the lessons to be learnt from the adult's case, and
b) applying those lessons to future cases[8].

In the context of SARs, something can be considered serious abuse or neglect where, for example the individual would have been likely to have died but for an intervention or has suffered permanent harm or has reduced capacity or quality of life (whether because of physical or psychological effects) as a result of the abuse or neglect.

The KBSP should be primarily concerned with weighing up what type of review process will promote effective learning and improvement action to prevent future

[8] Care Act 2014

deaths or serious harm occurring again. This may be where a case can provide useful insights into the way organisations are working together to prevent and reduce abuse and neglect of adults.

The KBSP are free to arrange for a SAR in any other situations involving an adult in its area with needs for care and support if the KBSP determine that it would be effective in identifying and promoting learning for the partnership. This will be called a 'discretionary SAR'.

SARs may also be used to explore examples of good practice where this is likely to identify lessons that can be applied to future cases.

SARs should seek to understand what actions were taken by the relevant agencies involved in the case and the systems in which they worked together and determine what might have been done differently that could have prevented harm or death. This is so that lessons can be learned from the case and those lessons applied to future cases to prevent similar harm occurring again.

The purpose of the SAR is not to hold any individual or organisation to account. Other processes exist for that, including criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation, such as Care Quality Commission and the Nursing and Midwifery Council, the Health and Care Professions Council, and the General Medical Council.

It is vital, if individuals and organisations are to be able to learn lessons from the past, that reviews are trusted and safe experiences that encourage honesty, transparency and sharing of information.

Principles of Adult Safeguarding

The 6 key principles of adult safeguarding should apply to SAR activity, namely:

- Empowerment
- Prevention
- Proportionality
- Protection
- Partnership
- Accountability

To apply these principles to the SAR process the KBSP will expect that:

- There is a culture of continuous learning and improvement across the organisations that work together to safeguard and protect adults by identifying opportunities to draw on what works, promote good practice and seek to make improvements in order to prevent future harm.
- The approach taken to reviews will be proportionate according to the scale and level of complexity of the issues being examined.
- Reviews of serious cases will be led by individuals who are independent of the case and organisations under review and have sufficient experience

and training to undertake the role effectively in order to ensure that those agencies can be challenged and held to account.

- Professionals will be involved fully in reviews and invited to contribute their perspectives in the spirit of partnership improvement, without fear of being blamed for actions they took in good faith.
- Adults at risk will be empowered to contribute to SARs about their experience if they so wish. If they have any significant difficulty in being involved, an independent advocate will be commissioned to support them to be as involved as possible throughout the process.
- Families will be invited to contribute to SARs. They should understand how they are going to be involved and their expectations should be managed appropriately and sensitively.

Referrals

Making a referral

Any individual, professional or agency can refer a case to the KBSP, requesting that consideration be given to convening a SAR. The request is made by submitting the KBSP SAR referral form, available online at www.bristolsafeguarding.org/adults/safeguarding-adult-reviews/. Once completed, this should be sent via secure email to the KBSP Business Unit at KBSP.statutoryreviews@bristol.gov.uk.

As referrals can and should be made by anyone, there may be instances in which a referral is made by a professional unfamiliar with the purpose and criteria for a SAR. The referral form contains direction on how and when a referral is appropriate, this should be carefully considered when completing the form.

Staff members in partner agencies are advised to discuss the case with their agency representative on the KBSP SAR/DHR sub-group before submitting a referral. If the agency does not have a representative, they can discuss the case with their adult safeguarding lead in the organisation. The KBSP Business Unit can also be contacted for advice about the process.

Referral quality

The KBSP Business Unit will examine each referral to ensure that the referrer has provided sufficient evidence to set out why they believe the criteria has been met; this is not to consider whether the criteria are met, but to ensure that sufficient information to make that decision has been provided. Where this evidence is not present it will be requested from the referrer before progressing.

It is essential that the referrer should consider and explicitly answer the following questions when making a referral:

- Does the referral state explicitly which of the statutory criteria the case has met?
- A brief description of the circumstances of the case. For example, details of the adults' care and support needs, the allegation(s) of abuse or

neglect, a list of known agencies that should hold relevant information on the adult, key decisions made, and any safeguarding procedures.

- Has the adult died or suffered significant harm? Is there suspicion or evidence that abuse or neglect contributed to the adult's death or significant harm?
- What evidence of concern is there about how agencies worked together to safeguard the adult, or what evidence is there that one or more agencies involved did not support joint agency working?
- Does the case provide an opportunity to learn from local practice that could prevent abuse or neglect from occurring?
- Are explanations provided for any delays in the referral?
- Details of any additional reviews or other processes that this case is subject to.

The SAR/DHR sub-groups role is not to resolve differences between agencies about action taken or through which to escalate concerns about a case. Any case that has been subject to case resolution and required resolution at senior levels in more than two organisations *may* warrant a review to examine further issues and disseminate any learning. If a case is being referred to the SAR/DHR sub-group for this reason, please state this clearly.

Receipt of referral

The majority of cases referred are considered by the SAR/DHR sub-group, however if the decision is that it will not progress, then the KBSP Business Unit will contact the referrer with a clear rationale.

Once a completed referral is received, the KBSP Business Unit will convene a meeting for the SAR/DHR sub-group to consider the referral. This will be arranged to take place within one month.

Prior to the meeting, SAR/DHR sub-group members will review records held by their respective agencies and complete a brief agency involvement form to assist decision making.

SAR sub-group referral consideration

It is the role of the SAR/DHR sub-group to consider each referral against the criteria for commissioning, as outlined in the Care Act 2014.

At the meeting, the sub-group will make a recommendation as to whether the criteria for a SAR has been met. The sub-group may ask for further information to be gathered in an effort to assist them in deciding whether the threshold has been met: the outcome may be a statutory SAR, a discretionary (non-statutory) review, a single agency action in relation to practice in the case, or no further action to be taken by the SAR/DHR sub-group.

The SAR/DHR sub-group should refer to the SAR referral decision making flowchart in appendix 5.

Once a decision has been made, the SAR/DHR sub-group will make a recommendation to the KAS Chair (also known as the SAB Chair) for their final decision.

If the KAS Chair agrees a SAR should be undertaken, it should be initiated immediately.

If the KAS Chair disagrees with the recommendation, this will be fed back to the SAR/DHR sub-group and the referral will be closed.

The decision and the rationale will be fed back to the referrer and to agencies who provided information to support the consideration of the case.

Consideration of other processes

Where multiple local authorities are involved, a joint SAR should be considered. If the SAR/DHR sub-group believes this to be appropriate, contact with the other relevant local authority should be made as soon as possible. Methodology and governance should be agreed jointly.

Where there are possible grounds for a Safeguarding Adult Review, Domestic Homicide Review, Child Safeguarding Practice Review or other formal review process then a decision should be made at the outset as to which process is to lead and who is to chair with a final joint report being taken to the necessary commissioning bodies.

It should be recognised that running dual or multiple agency processes can be overly burdensome or distressing for professionals and family members involved; delay publication; and limit learning. The principle of proportionality should always be considered.

Deciding whether to commission a SAR

The recommendation about whether to undertake a statutory or non-statutory SAR is made by the SAR/DHR sub-group, who have the delegated authority to make a recommendation about whether the criteria has been met which is then signed off as set out above.

Not all cases considered by the SAR/DHR sub-group will meet the criteria for a SAR. The following will be considered when deciding whether to complete a review:

- whether there are concerns about the care/protection of the person who died/was injured by more than one agency; how local professionals and organisations have worked both individually and together to safeguard those involved
- whether a review of the case will provide new learning
- whether a case highlights good practice
- for cases that involve adverse incidents and near misses, whether there is multi-agency learning to be gained
- whether there has already been a review of the case (for example single agency internal review)

- any other multi-agency review processes that have taken place (for example, if a review or Learning Disabilities Mortality Review (LeDeR) are already taking place) and are assessed to be sufficient to generate learning
- any substantial work that has been done by single agencies to review the case (for example Root Cause Analyses etc) which have already identified learning
- if the case is historic, and evidence demonstrates that practice has changed so substantially since the harm occurred that the review would fail to identify relevant learning
- if the case is similar enough to another case already reviewed by the partnership that learning is considered to have already been established.

Convening a SAR

Methodologies

The process for undertaking SARs should be determined locally according to the specific circumstances of individual circumstances. No one model will be applicable for all cases. The principle of proportionality must always be considered to learn lessons as quickly as possible and to ensure the process is an effective use of resources.

Accredited methodologies include SCIE Learning Together and SILP which both use a systems learning approach. A bespoke or hybrid approach may also be undertaken.

All SAR methodologies should demonstrate a commitment to:

- engagement with family and carers
- engagement with frontline practitioners
- taking a 'no blame' and systems learning approach
- being conducted in accordance with the SCIE Quality Markers
- aim to be completed within a reasonable timeframe

Optional models and methodologies for SARs can be found in appendix 6.

Notification of SAR to agencies

SAR/DHR sub-group partner agencies should be given as much notice as possible that a SAR has been agreed. Requests for review team members and agency chronologies should be made along with an agreed scope and methodology with the reviewer(s). The KBSP will ask for information from agencies by issuing SAR notification to partners' letter.

Appointment and expectations of lead reviewers

All SARs must be led by an independent reviewer.

The KBSP Business Unit holds a database of potential SAR reviewers. The Business Unit will write to potential reviewers, and request they express an interest

in undertaking the review on behalf of the partnership. The KBSP Business Unit will request the following:

- A letter expressing interest
- A CV
- References from other SABs, and links to any published reports.

It is expected that those who submit an expression of interest will include relevant experience in the following:

- Strong leadership and ability to motivate others
- expert facilitation skills and experience of sensitive and complex group dynamics
- collaborative problem-solving experience and knowledge of participative approaches
- analytic skills and ability to manage qualitative data
- safeguarding knowledge
- promote an open, reflective learning culture

The potential reviewer should specify a daily rate, and the expectations of the work to be provided. Where amendments to the report are required due to issues of quality, these amendments must be undertaken at the lead reviewer's expense.

The KBSP Business Unit will meet with the statutory safeguarding partner representatives from the SAR sub-group to make the appointment to conduct the SAR.

Failure for the lead reviewer to comply with the expectations and terms of the SAR contract will result in escalation by the SAR/DHR sub-group to the KAS Board, or KBSP Independent Chair, and if relevant their independent management.

Scoping of review

Once appointed, a 'scoping' meeting will be held between the lead reviewer(s), SAR/DHR sub-group Chair, KBSP Statutory Review Officer, KBSP Business Manager and KBSP Legal Advisor to discuss the agreed arrangements for the review process and a draft Terms of Reference for the group.

Plans should be made to contact the family (or surviving subject of the review) to provide an opportunity to engage with the review. All due consideration should be given to identify the most appropriate contact for the family, this may be a Family Liaison Officer, or practitioner with an existing relationship.

Agency Reports and member expectations

Any reports produced by organisations solely for use as part of a SAR methodology are the property of the KBSP.

Any request to share Independent Management Reports/Reviews (IMRs) or other information with external parties should be made in writing to the KBSP Business Manager. Requests will be considered, and a response provided. Information pertaining to reviews should not be shared unless agreement from the KAS Chair is obtained.

Agencies

Agencies that have had significant involvement in the case are required to appoint an appropriate person of sufficient experience in safeguarding who will be a member of the Review Panel.

Member Expectations

Review Panel members are expected to:

- Be independent of the case, and independent of any line management of staff involved in the case.
- Be sufficiently senior to have the authority to commit on behalf of their agency to decisions made during a panel meeting.
- Share any relevant records pertaining to the subject of the review.
- Advise on matters of practice.
- Be consistent throughout the process and attend all review meetings. Where this is not possible, panel members should send an appropriate delegate who has been briefed on the role. Persistent non-attendance will be escalated to KAS Board.
- Understand the relevant legislation Care Act 2014.
- Be aware of the highly sensitive nature of the subject discussed and ensure their communications and data storage is secure.
- Undertake attributed work and actions as appropriate to their roles to support the review, this includes submitting a chronology and IMR on behalf of your organisation.
- Review and provide feedback on all versions of draft reports.
- Ensure that the report is factually accurate and that - agency specific and partnership - recommendations are SMART.
- Read all papers shared in advance of the meeting and have sought clarification where required.
- Report back to their line managers on any issues pertaining to their agency that arise during the review.

See appendix 2 for KBSP Member Roles and Responsibilities.

Information sharing within the SAR process

Agencies should be assured that information requested by the KBSP for the purposes of SAR is proportionate and relevant.

Section 45 of the Care Act and section 14.186 of the Care and Support Statutory Guidance states that information must be provided to Safeguarding Adult Boards to enable or to assist the board to exercise its functions, including undertaking SARs.

There may be occasions in which information is requested regarding individuals who are not subjects of the review, for example, the perpetrator of a homicide if they were in receipt of care and support services. This information can be shared with the KBSP in line with Section 45 of The Care Act and Care and Support Statutory guidance.

In instances of challenge regarding information sharing, advice should be sought from Caldicott Guardians and the KBSP legal advisor.

SAR Meetings

The first meeting of the Review panel should:

- Confirm the members of the panel, identifying where there may be gaps in representation or submitted information.
- Confirm the terms of reference / research questions for the review.
- Discuss and analyse the submitted information to identify areas for exploration during the review.
- Identify any other agencies that may have specific expertise in an area that can support the review process.

Practitioner Group

In certain methodologies, frontline practitioners who had direct involvement with the adult and/or their family are asked for information. They may meet for practitioner event(s) to explore key episodes or hold one to one conversations with the independent reviewer or members of the review team.

Once the review has sufficiently progressed to produce findings, the practitioners will be provided with an opportunity to provide feedback and comment on these findings.

See appendix 2 for KBSP Member Roles and Responsibilities.

Family engagement

Where the subject(s) of a SAR can contribute to the review they should be given the opportunity to do so, and independent advocate should be arranged to support the adult to participate, if required.

The family/ carers of the subject(s) of the review should be contacted by the KBSP at the earliest opportunity. This will be done via letter and the SAR information for families' leaflet included. Every effort should be made to ensure that the family / carers or subject(s) is fully briefed on the purpose of a SAR, the methodology, and timeframes.

Every effort should be made to support the family / carers or the subject(s) to engage with the review process through facilitating conversations and arranging interviews at their convenience. It is entirely the family / carers or the subject(s) decision whether they wish to do this.

An agreement should be made regarding who should be the main point of contact for the family / carers or subject(s), and how regularly they will be updated, and a record kept of contacts made. Consideration should be given to whether this first contact should be supported by an appropriate professional who may have already

established a working relationship (such as their existing Social Worker, or Family Liaison Officer).

The family / carers or subject(s) will be provided an opportunity to review the final report after it has been approved by the KBSP at least one week prior to publication. The practical arrangements for sharing the report pre-publication should be considered on a case-by-case basis, taking into account the needs of the family member/ carer. A face-to-face meeting is preferable. If a face-to-face meeting is not possible and the report needs to be sent by post or email, a confidentiality agreement must be signed and returned before releasing the report.

Should the family / carers or subject(s) wish to comment on the report the KBSP may consider publishing their response alongside the final report.

It must be recognised that the context in which a SAR is held is likely to have been distressing for those involved, and where appropriate the family should be signposted to relevant support services.

The family / carers or the subject(s) may wish to engage their own legal representation. In this instance, all communication should be directed in conjunction with the KBSP legal advisor.

When the subject of a SAR is alive and has capacity to make an informed decision, engagement with family members or carers will be determined by the consent given by the adult.

Quality Assurance and Approval Process

Once the reviewer has drafted the full Overview Report the Review Panel must formally approve its contents and recommendations at a meeting or via email.

The final draft Overview Report will also be sent to the KBSP Statutory Review Officer and KBSP Business Manager to ensure that the report has met the required criteria agreed at the scoping meeting and that the recommendations are achievable.

The Review Ranel must work with the KBSP Business Unit to create an action plan based on the findings from the SAR.

SAR/DHR sub-group quality assurance meeting

The KBSP Statutory Review Officer will attend the meeting to present the report, recommendations and action plan. The SAR/DHR sub-group will quality assure the report and ensure that any draft recommendations are suitable to be accepted by the KBSP KAS Board.

Guidance and SAR Quality Assurance Markers can be found at: Safeguarding Adults Review Quality Markers - SCIE

The SAR/DHR sub-group must be quorate with representation from the local authority, police, and Integrated Care Board. Full agency representation is strongly encouraged.

SAR/DHR sub-group members should come to the meeting:

- Prepared to represent their agency views.
- Having read the review thoroughly, highlighting any factual or typographical errors they may have identified.
- Having fully considered whether they are prepared to approve the SAR, and what amendments may be needed if they are not.
- Challenge the reviewers and discuss the draft recommendations.

The draft report will be circulated to the attendees in advance, clearly labelled to indicate that the report is confidential and only for the use of the SAR/DHR sub-group members. It should be noted that a SAR is the product of and owned by the KBSP and therefore should not be shared any wider without consent of the KBSP Business Manager or KAS Chair.

At the conclusion of the meeting the SAR/DHR sub-group members will agree to approve the draft report for onward submission to the KAS Board, or request that further amendments are made to the document. In these circumstances' amendments should be made in a timely manner and subsequently approved via an additional meeting or virtually circulated for approval before submission to the KAS Board.

Keeping Adult Safe Board acceptance meeting

Once the SAR/DHR Sub-Group has conducted quality assurance of the SAR it must be formally accepted by the Keeping Adults Safe Board. The reviewer/s will then be invited to a KAS meeting to provide a short presentation of the review findings, recommendations and action plan.

The report will be circulated to attendees in advance, clearly labelled to indicate that the report is confidential and only for the use of the KAS members. All members must attend having read the draft document thoroughly.

If a KAS member is unable to attend, they must ensure a deputy attends and receives a copy of the report. Full agency representation is strongly encouraged.

KAS members should come to the meeting having read through the report thoroughly and be prepared to discuss and accept the recommendations and action plan that has been developed following the SAR.

It is essential that if an agency has significant concerns about the content of the report, then they must share this with the KAS Board to ensure that members are aware of their concerns.

In the event of the above the KAS Chair may consider whether the report should return to the SAR/DHR sub-group or Review Panel, or whether the reviewers could incorporate the feedback into a re-drafted version of the report without the need for further quality assurance.

No new suggested amendments will be accepted once a decision has been reached at the KAS. Agencies must be assured of their position prior to the meeting and ensure that any relevant input via their agencies has already been sought.

Outcomes of SAR presentation to the Keeping Adults Safe Board

At the conclusion of the meeting, the KAS Board will agree on an outcome; approval for publication, minor amendment, resubmission following significant amendment or rejection.

In the unlikely event that a SAR and recommendations are not accepted by the KAS Board all efforts will be made to bring resolution. Failure to resolve issues will result in the escalation to the KBSP Steering Group.

The decision made by the KBSP in respect of a SAR is subject to KBSP Members' liabilities as set out in the KBSP Constitution.

The SAR and DHR process flowchart can be found in appendix 3.

Action Plans

Action plans based on the findings of the SAR should be developed by the Review Panel who may seek assistance from the SAR/DHR sub-group or KAS Board if required in conjunction with the report sign off.

Action plans will specify how recommendations will be delivered, the individual or agency leading on that action, and a timescale for completion.

The KBSP Action Plan Template can be found in appendix 4.

The Statutory Review Officer on behalf of the SAR/DHR sub-group will report progress of the action plans to KAS. Lack of progress will be escalated to the KAS Board, and where necessary to the KBSP Steering Group.

Publication

There is no obligation to publish a SAR other than to include the detailed findings in the annual report. However, it is good practice to do so and the KBSP is committed to publishing its SARs and making them available online via the KBSP website. A learning brief for the KBSP workforce will also be created to help embed learning from the review process.

There is not a one size fits all for publishing a SAR, and all approaches to publication should be considered on a case-by-case basis. The KBSP Business Unit will meet with Press and Communication leads for the KBSP and BCC on a quarterly basis to review potential upcoming publications. The Press and Communication leads for Bristol City Council will manage any political engagement and brief the relevant elected members and/or committee chairs prior to publication.

Typically, three media strategies are used which the Press and Communication leads will advise on:

- **Bronze:** Standard publication on KBSP website, no joint statement and no proactive promotion.

- **Silver:** Bronze approach with an opportunity for agencies to produce their own statements alongside Board publication.
- **Gold:** A bespoke communications approach that meets the level of public interested in the case. A communications plan will be developed in collaboration across relevant agency partners to meet the needs of the situation**.** (This may include, for example, a press release or press briefing if appropriate).

Plans for publication will be made ensuring the family are fully informed and involved as relevant.

Once the KAS Board has formally approved a SAR, a publication planning meeting should be arranged as soon as possible. Attendees should include:

- SAR Sub-group Chair
- Legal Advisor to the Board
- KBSP Representatives of the three core partners; BCC, BNSSG ICB and Avon & Somerset Police
- Press and Communications leads for the three core partners

Press and Communications representatives for the Local Authority and KBSP are only required to attend the multi-agency meeting if the publication approach has previously been agreed as Gold.

Safeguarding representatives from any agencies involved in the SAR and their Press and Communication leads will be given the option to attend should they wish to engage.

The meeting agenda will cover two core items:

1. Whether the SAR can be published in full.
2. The media strategy for publication (this would be led by the KBSP communication representatives).

Attendees at the publication planning meeting should consider the following:

- If publication would lead to any breach of confidentiality
- If any redaction is required in the light of the Data Protection Act, and other relevant legislation
- If an Executive Summary or other briefing document would be more appropriate
- The production of individual agency responses
- The most appropriate course of notifying the media (‘publish’ vs ‘publicise’)
- A plan for informing key people, including family members and front-line professionals, and who is best placed to do this
- Agreeing a reasonable timescale for publication

Learning Dissemination

On publication of a SAR, the following individuals/organisations will be notified:

- The SAR subject and / or family or carers involved in the review.
- The SAR Review Panel and Independent Review Author.
- The SAR/DHR sub-group.
- The KAS Board and Chair.
- Bristol City Council – Committee Chair with responsibility for Adult Social Care.

The KBSP Business Unit will also produce a learning briefing and disseminate this across the KBSP network to ensure that key messages and learning reaches and is embedded within workforces across Bristol. Further opportunities to promote the learning from SARs should include targeted learning events, conferences and via the KBSP newsletter, with the uploading of briefings and other relevant learning materials onto the KBSP website.

The KBSP may question single agencies on the SAR progress and how they are embedding learnings from SARs as part of their KBSP Quality Assurance Framework (QAF) for Adults activity. This may include Single Agency Audits and the Adult Self-Assessment Process which will be reported to the KBSP, on request.

All agencies and practitioners who work with adults and children should actively engage with the learning opportunities provided by case reviews. All agencies should take responsibility for ensuring learning is shared with relevant staff. Practitioners are responsible for ensuring that they are equipped with the necessary skills and training to perform their role by:

- reading case review publications
- attending appropriate single and multi-agency training
- using learning from case reviews to inform to staff and team meetings/supervision
- Supporting colleagues and staff in other agencies in implementing the learning from case reviews

The KBSP will include the findings from any SAR in its annual report and what actions it has taken/ intends to take in relation to those findings. Where the partnership decides not to implement an action from the findings it must state the reason for that decision in the annual report.

Costs

All SAR related costs are to be divided equally between the three core partners of Bristol City Council, Avon & Somerset Constabulary and Bristol, North Somerset, and South Gloucestershire Integrated Care Board.

Disclosure of information with external parties

Chapter 14 of the Care and Support Guidance sets out expectations in relation to information sharing between agencies and Safeguarding Partnerships in relation to

SARs, including an expectation that information must be shared to enable a Safeguarding Partnership to do its job.

There may be a request to disclose (as opposed to share) information with external parties such as the Coroner; the Police; legal representation of the family or subject(s).

It is established in guidance and case law that in order for there to be openness and candour within the SAR process, it is necessary to protect confidentiality particularly in relation to related agency reports. This must be balanced with general principles of openness and transparency applicable to public process, and compliance with relevant legislation in relation to disclosure of information.

Disclosure to the Coroner is based on the public interest in a fair hearing as well as the need to the court to have all relevant information before it. This is balanced by the public interest in agencies being able to learn from incidents that have happened. It is recognised this may require that information is not disclosed in some circumstances.

Good practice provides the Coroner should be informed that the KBSP has commissioned a SAR.

If the Coroner requests disclosure of information, case law dictates what should be disclosed, and legal advice should be sought before a response is made. The KAS Chair will decide in consultation with the core partners to do this.

Decisions regarding disclosure of information to the family or other interested third parties will vary according to the timing of any requests and the stage reached within the SAR process. Legal advice should always be sought.

Single agencies will be required to make their own decision regarding information disclosure to third parties who approach them directly external to the SAR process, but this should be done in consultation with the KAS Chair.

Other than the final report, documentation will not be disclosed to the family or other individuals external to the SAR process prior to the completion of the report save where ordered to do so. Any request for access to documents will be considered in accordance with the principles of the Freedom of Information Act 2000 and the Data Protection Act 2018. Decisions will be made by the KAS Chair in relation to requests for disclosure of documents.

Annex A: Compliance with Human Rights and Equalities Legislation

This can include, but is not limited to:

- United Nations Convention on the Rights of the Child
- European Convention on Human Rights
- Human Rights Act 1998
- Equality Act 2010

The KBSP has responsibilities to adhere to the Human Rights Act 1998. The specific convention rights applying to this work are:

- Article 6: Right to a fair trial
- Article 8: Respect for your private and family life, home and correspondence
- Article 9: Freedom of thought, belief and religion
- Article 10: Freedom of expression
- Article 14: Protection from discrimination in respect of these rights and freedoms

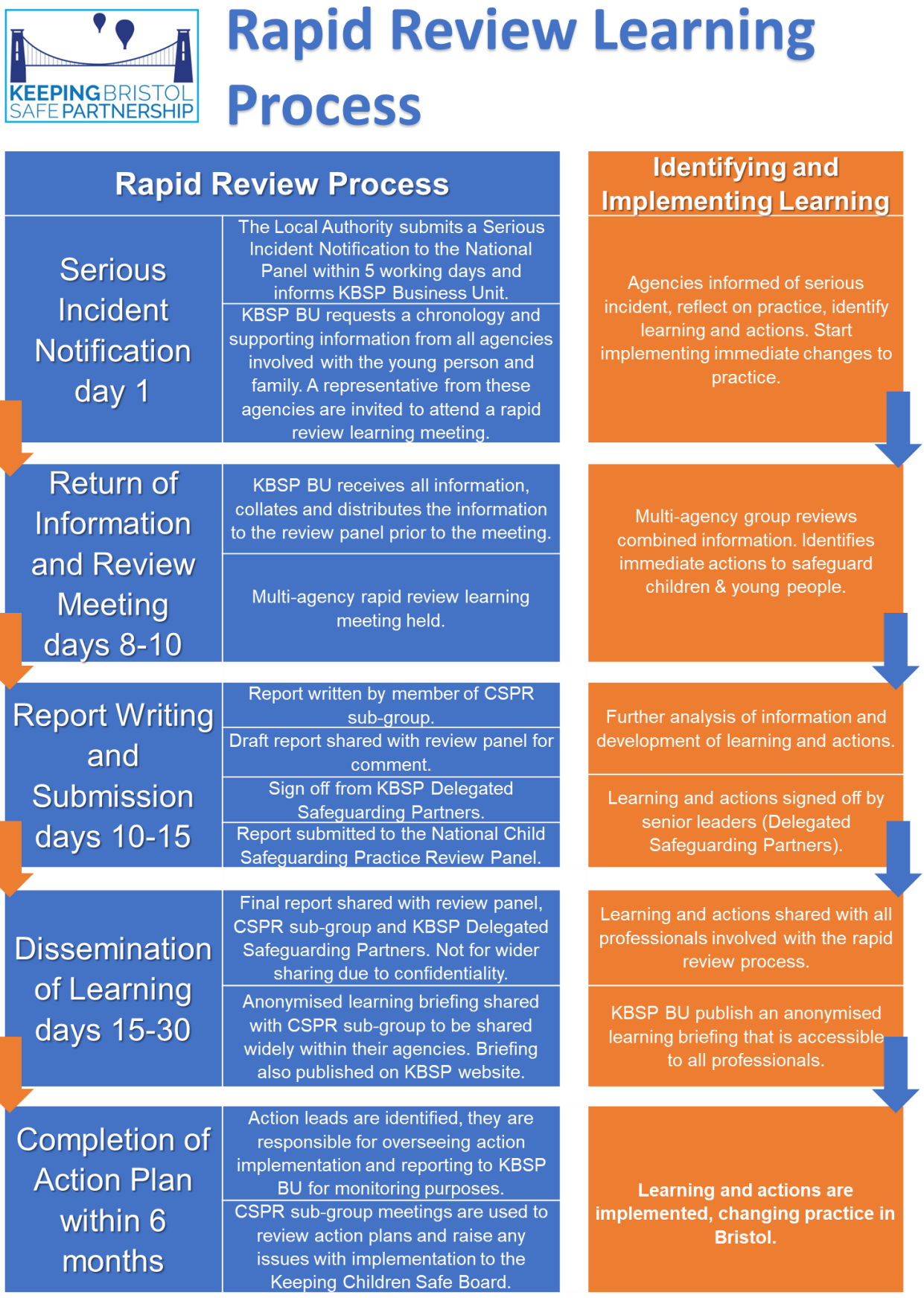
The KBSP has responsibilities to adhere to the Equality Act 2010, included in this is our public sector equality duty. General duties include:

1. Eliminate discrimination, harassment, victimisation, and other conduct that is prohibited by the Equality Act 2010.
2. Advance equality of opportunity between people who share a protected characteristic and people who do not share it.
3. Foster good relations across all protected characteristics between people who share a protected characteristic and people who do not share it.

The KBSP will be mindful to:

- Ensure they are compliant with the above legislation when carrying out their functions as set out in this document.
- Ensure they consider anti-oppressive and anti-discriminatory practice when they carry out reviews.

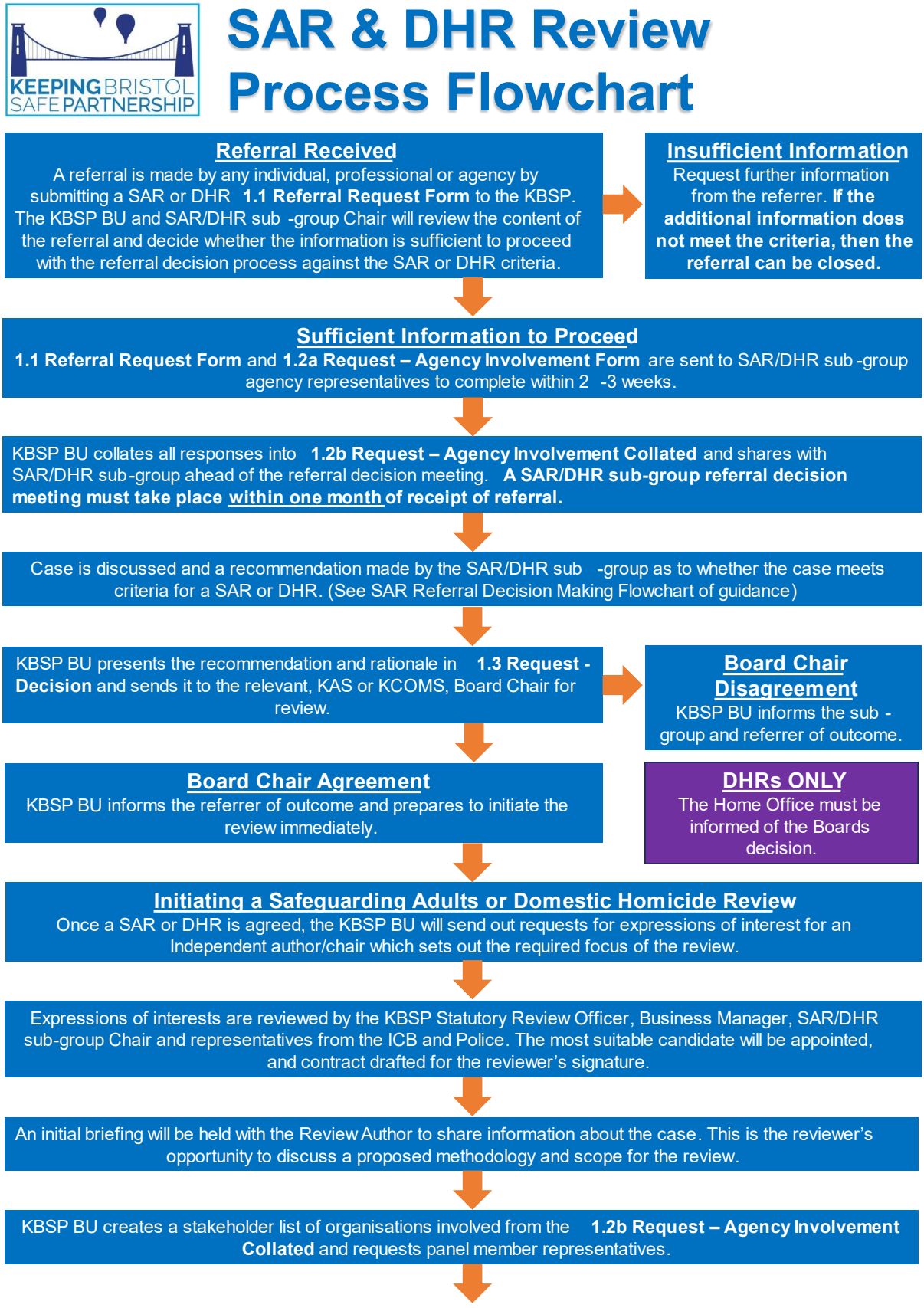
Appendix 1: Rapid Review Process Flowchart



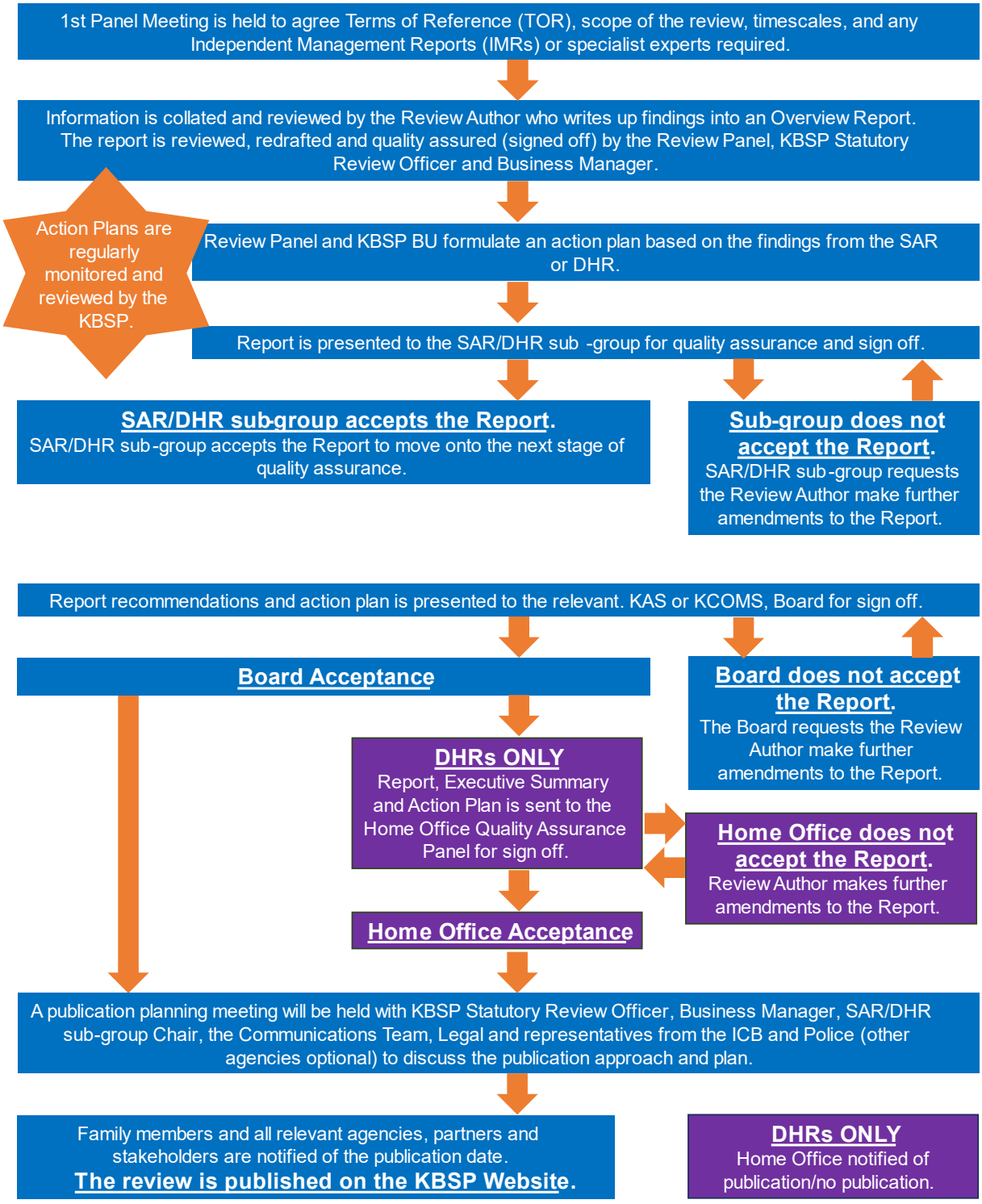
Appendix 2: KBSP Member Roles and Responsibilities

KBSP Roles and Responsibilities.pdf

Appendix 3: KBSP SAR and DHR Process Flowchart



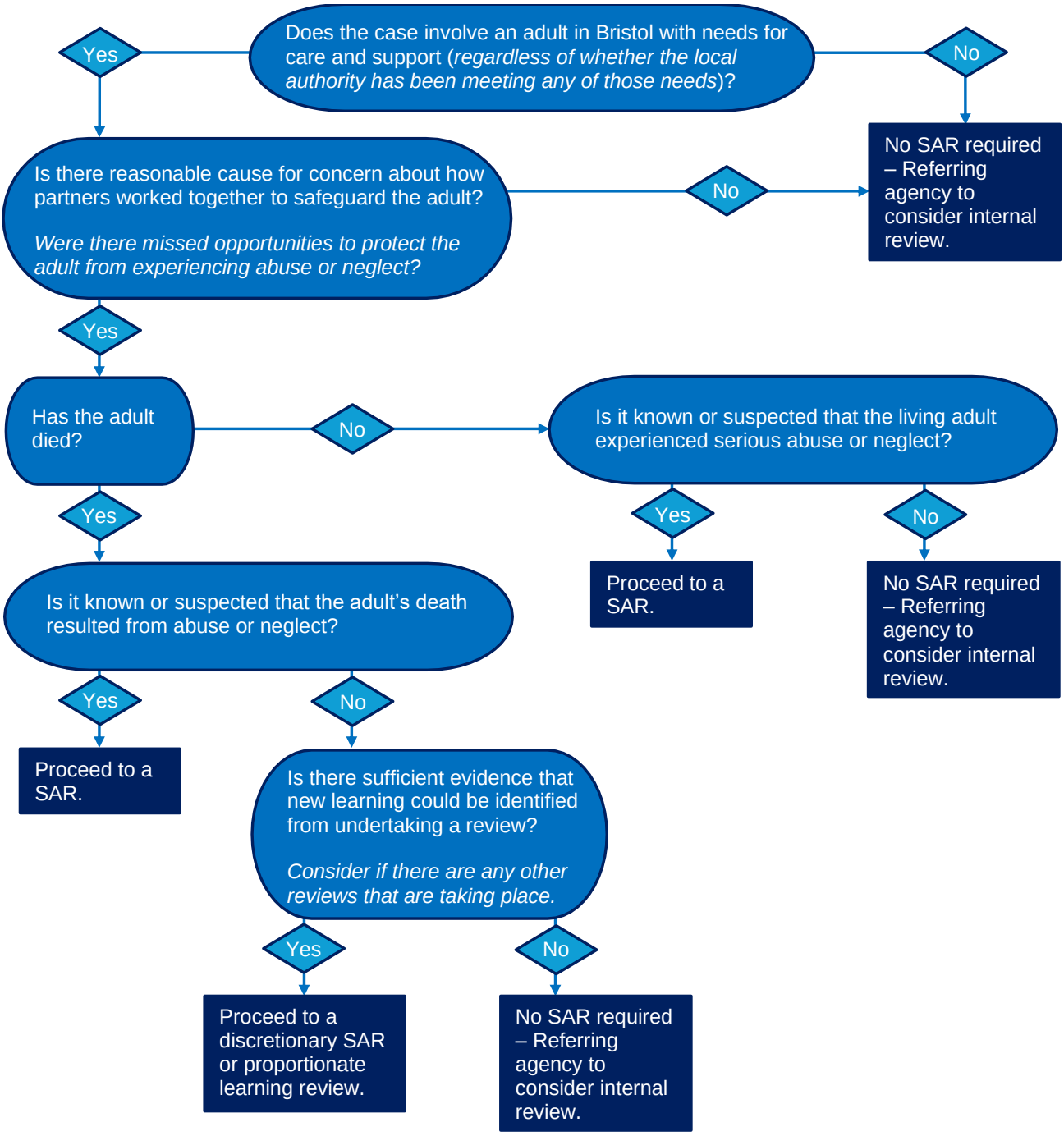
SAR & DHR Review Process Flowchart continued…



Appendix 4: KBSP Statutory Review Action Plan Template

Recommendation	**Scope of recommendation** Local/ Regional/ National	**Action to take** *What specific actions will be taken to fulfil this recommendation? Ensure the actions are SMART: Specific, Measurable, Achievable, Realistic, and Timely*	**Lead Agency**	**Key milestones achieved in enacting recommendation** *What are the key milestones within the plan for completing these actions which can be measured for progress reporting?*	**Target Date** *When will these actions be completed?*	**Date of completion and Outcome** *To be completed upon completion of actions.*
		.				

Appendix 5: KBSP SAR Referral Decision Making Flowchart



Definitions:

- **Needs for care and support:** refer to the requirements that an individual has due to physical or mental impairments, or illnesses, that impact their ability to achieve two or more outcomes and has a significant impact on their wellbeing (The Care and Support (Eligibility Criteria) Regulations 2014).
- **Abuse or neglect:** refer to situations where an adult with care and support needs is experiencing, or at risk of abuse or neglect, and as a result of those needs, is unable to protect themselves from abuse or neglect or the risk of it (Care Act 2014).

Appendix 6: Optional Models and Methodologies for SARs

There is no evidence that one approach or model is superior to another, investigators must have a 'toolbox' of approaches which should be differentially applied depending on the type of incident and the stage of investigation (Woloshynowych, Rogers et al., 2005).

The below is a non-exhaustive list of methodologies for SARs and the advantages and disadvantages associated with each approach. These methods may also be used for other types of review where appropriate. Methods 1-6 are included in the paper written for London SABs (Sue Bestjan, 2012).

1. Review by Independent Author and the production of an overview report
2. Action Learning
3. Peer Review
4. Significant Event Analysis
5. Multi-Agency Combined Chronology
6. Single Agency Review
7. Case File Audit
8. Reflective Learning Workshop
9. Systems Analysis
10. SAR in rapid time

1. Review by Independent Author and the production of an overview report

This broadly follows a traditional model:

- Appointment of a SAR panel, including chair and core membership which oversees progress
- Appointment of an independent overview report author
- Chronologies of events
- Production of a report outlining involvement and key issues
- Overview report with analysis, lessons learnt and recommendations
- Production of action plan
- Formal reporting and ongoing monitoring by SAB

This methodology is more likely to be applicable where there are demonstrably serious concerns about the conduct of several agencies or inter-agency working and the case is likely to highlight national lessons about safeguarding practice.

Advantages	Disadvantages
More familiar to SAB partners	Overly bureaucratic and protracted, there is potential that lessons learnt will not be responsive to time considerations

Tried and tested process which is familiar to public/politicians giving confidence in the approach	Can preclude direct contact with the frontline practitioners and when they are seen is done in a single agency format missing opportunities to maximise learning
Works well for complex and serious incidents or high-profile cases	Costly – costs may not justify the outcomes
Methodology is similar to that used in Children SCRs and Domestic Homicide Reviews	Can be perceived as punitive, attributing blame

2. Action Learning

Action learning is characterised by reflective/action learning approaches which do not seek to place blame but identify examples of good practices and areas for improvement. This requires close collaborative partnership working, including those involved, in the joint identification and deconstruction of the incident, contextual factors and recommended development.

This involves:

- Appointment of a facilitator and overview report author
- Production of relevant evidence, the procedural guidance and a chronology
- Material circulated to attendees of the learning event which is to include members of the SAB, frontline staff and managers, experts where necessary and the facilitator or overview author
- Learning event to consider what happened and why, areas of good practice areas for improvement and lessons learnt.
- Consolidation into an overview report including analysis and recommendations
- Event to consider first draft of the overview report and action plan
- Overview report presented to SAB to agree dissemination of learning and response to recommendations
- SAB ongoing monitoring of action plan progress

The exact nature of this methodology can be adapted depending upon the individual circumstances, case complexity, requirements and preferences of the partnership, giving flexibility over the scale and costs.

There are a number of individuals and agencies who have developed specific versions of action learning models, including:

- Social Care Institute for Excellence (SCIE Learning Together Model)
- Significant Incident Learning Process (SILP)
- Root Cause Analysis/Systems Analysis – Supplementary information available in appendix

Advantages	Disadvantages

Evidence indicates this approach is much more efficient	Methodology is much less familiar to many
Swiftness of conclusion and embedding the learning	Complexity of process management with large numbers of practitioners involved
Considerable reduction in overall costs compared to more traditional approaches	Wide practitioner involvement may not suit cases where criminal proceedings are ongoing and practitioners are witnesses
Action learning enhances partnership working and understanding of each other's roles and perspectives	Costs associated with training in-house reviewers or commissioning external reviewers
Collaborative problem solving	Associated costs of practitioners spending large amounts of time in meetings
Frontline engagement and perspective of systems	
Identification of strengths	
Learning takes place in real time	

3. Peer Review

This approach encompasses a review by one or more people who know the area of business. It accords with self-regulation and sector-led reviews of practice. This can either be peers from within the same partnership or outside the partnership but within a specified region. Peer review methods are used to maintain standards of quality, improve performance and provide credibility.

Advantages	Disadvantages
Objective, independent perspective, but with some local knowledge	Capacity issues may restrict availability and responsiveness
Usually trusted sources sharing common experiences	Potential to view peer reviews from SAB members as not sufficiently independent, especially in high profile cases
Arrangements can be reciprocal	Potential skills and experience issues
Very cost effective	

4. Significant Event Analysis

This approach brings together managers and/or practitioners to consider significant events within a case and collaboratively analyse what went well and what could have been done differently, producing a joint action plan with recommendations for learning and development. Significant Event Analysis has been used for many years in the health service to analyse a significant event in a detailed and systematic way to ascertain learning from the overall quality of care and to identify changes which might lead to future improvements. Significant Event Analysis does not involve the

adult or their family however, the findings may lead to further review which should involve them.

A Significant Event Analysis approach involves:

- Information gathering – collation of as much information as possible from a broad range of sources
- Facilitated workshop to analyse the event. It is crucial that this workshop is operated fairly, openly and in a non-threatening environment
- Analysis of the significant event

The key questions to be considered in a Significant Event Analysis are:

- How could things have been different?
- What can be learnt from what happened?
- What has been learned?
- What has been changed or auctioned?

5. Multi-Agency Combine/Integrated Chronology

Developing a chronology of events is a useful way of achieving an overview of a case and considering the areas for development. With a combined chronology and multi-agency participation, perspective is greatly enhanced and enables not only the identification of gaps in service provision or practice but also missed opportunities for communication between agencies. Lead practitioners and managers can use a combined chronology to analyse and reflect on a case within a facilitated workshop setting as part of a desk-based review or a multi-agency panel and develop timely recommendations for change.

For more details on how to complete a combined/integrated chronology click here

6. Single Agency Review

Single agency reviews may be conducted where agencies from the local partnership undertake their own reviews, e.g. Serious Incident Reviews conducted by health partners. KBSP (via the SAR/DHR sub-group) may task an agency to undertake a Single Agency Review to support them in strengthening internal arrangements where there is a safeguarding element but no concerns regarding involvement of other agencies, e.g. an emerging pattern of issues/concerns or even where serious harm or abuse had been prevented by good practice.

Any agency undertaking a Single Agency Review with a safeguarding element will be expected to inform KBSP in order for the Board to consider transferable learning across the partnership.

Advantages	Disadvantages

An opportunity for detailed internal scrutiny of practice by single agency	Restricts scope and doesn't embody a wider perspective of other partners
Opportunity to identify areas for improved practice	Can be viewed as outside the SAR purpose of multi-agency learning
Assists a 'Duty of Candour'	

7. Case File Audit

The case file audit can include all contributing agencies specific to the case, or just a few who will be identified at the scoping meeting.

A case file audit involves a 'walk through' of the case within the time parameters set by the scoping panel meeting. It is usual for the audit to be undertaken chronologically with agencies sharing information and pausing to explore opportunities for learning as necessary.

Advantages	Disadvantages
Opportunity for a very swift response to lessons learnt - actions can be agreed on the day	No interaction with frontline staff, the information tends to be shared by an operational head
Internal facilitator can be used as no specialist skills are required. Where outsourcing is necessary costs are minimal as it is usually only a one day commitment	Likely to take a full day to complete
No lengthy report writing - detailed minutes and agreed actions are produced	Advance preparation of a detailed chronology is required to expedite the review process
Policies and Procedures both single and inter agency are made available on the day from which to check detail	
Interactive discussion facilitated, but issues can also be paused for lengthier debate between those involved to allow momentum to be maintained	

8. Reflective Learning Workshop

Reflective learning workshops provides a respectful, positive and supportive space for frontline professionals and their line managers to consider the circumstances surrounding the case and the reasons why actions were taken. This allows the Lead Reviewer to identify important multi-agency learning.

The panel will need to ensure it has a full list of appropriate professionals and line managers to invite to the learning workshop. This will usually be requested alongside the chronology and/or information report. To maximise learning, all agencies are expected to ensure that appropriate staff attend the workshop. However, it is advised that only those who have had some form of direct operational involvement with the

individual and/or their family should attend. They can be supported by their manager or a colleague. A short briefing should be attached to any invitations explaining the purpose and importance of attending.

The structure of the Workshop will vary on a case-by-case basis, but is likely to include a discussion of:

- The information compiled about the subject of the case and their family in terms of incidents and professional interventions with opportunity to query the factual accuracy, to add information and to agree changes
- The lived experience of the adult, which enables participants to view what happened from the perspective of the person about whom the case is
- The reasons why events and practice happened the way they did, including any organisational and 'systems' factors that may have shaped behaviour (such as organisational/team aims or culture, levels of supervision, or the resources available to deliver services)
- The key themes which have emerged in the case and whether they can be transposed to working with the person about whom the case is and their families more generally
- Any examples of good practice
- The learning from the case and actions that should be taken to better safeguard people in the future.

It is essential that within these discussions all actions and decisions (or lack of them) are viewed within the context of the information available at the time and the system in which professionals involved were working. The lead reviewer is responsible for ensuring the group avoids hindsight bias when considering the events which took place.

Source: Cambridge & Peterborough Safeguarding Partnership Board

9. Systems Analysis

In any incident, there is usually a chain of events and a wide variety of contributing factors leading up to the incident. Those investigating the incident will need to identify which of these contributing factors have had the greatest impact on the incident, and most importantly, which factors have the greatest potential for causing future harm. Systems analysis describes a broad examination of all aspects of the healthcare system in question which includes the people involved across the system, how they communicate, interact, work as a team and work together to create a safe organisation.

Systems analysis emphasised the need for an open and fair culture, placing blame on particular individuals will hampers a serious and thoughtful investigation and should be separate from any disciplinary or other procedure used for dealing with persistent poor performance.

The London Protocol (2004) (updated in 2024) provides a conceptual basis for analysing adverse incidents. The inclusion of clinical and higher-level organisational

factors allows for the whole range of possible influences to be considered and can be used to guide investigation and analysis.

The process can be followed whether investigating a minor incident or a serious adverse outcome and whether there is an individual or a large team carrying out the investigation. This process in highly flexible and can be used to quickly run through the main issues in a short meeting or to carry out a full, detailed investigation over several weeks.

10. SAR in rapid time

SAR In Rapid Time is a methodology and series of tools that aim to allow learning to be turned around swiftly, with limited demand on participants' time. The model was developed by SCIE with funding from Department for Health and Social Care.

The model supports the identification of practical learning by enabling a focus on barriers and enablers to timely, effective, personalised safeguarding. The process is supported by remote meeting facilities and does not require any face-to-face contact.

The learning produced through a SAR concerns 'systems findings'. Systems findings identify social and organisational factors that make it harder or make it easier for practitioners to proactively safeguard, within and between agencies.

An outline of the process and timeline over five weeks is presented below.

Week 2	Set up meetings with leads from involved agencies and reviewers.
Week 2	Share chronology and key records with reviewers; send out invites for meetings.
Week 3	Reviewers produce Early Analysis Report.
Week 4	Structured multi-agency workshop.
Week 5	Input from agency leads to confirm systems findings.
Week 5	Reviewers produce brief systems findings report.

Bristol example of a SAR in rapid time can be found here: themat-1.pdf (bristolsafeguarding.org)