Interface between the Child & Adult Practice Review Process and Domestic Homicide Reviews in Mid and West Wales.

The Mid & West Wales Safeguarding Children and Adults Boards and the respective Community Safety Partnerships within the region have committed to strengthen communication and information sharing in the process for undertaking Child and Adult Practice Reviews and Domestic Homicide Reviews. Statutory guidance in respect of Child and Adult Practice Reviews is issued under the *Social Services and Well-Being Act (Wales) 2014*, and supplementary guidance contained within *Working Together to Safeguard People Volumes 2 and 3*.

Formal governance and reporting for Practice Reviews is to the Mid & West Wales Safeguarding Executive Board and Child and Adult Practice Review Sub Groups. Local Operational Groups also play an important role in the process of identifying and determining cases that may be suitable for Child and Adult Practice Reviews.

Child Practice Reviews

According to *Working Together to Safeguard People – Volume 2 – Child Practice Reviews*, the criteria for undertaking Child Practice Reviews is:

A Safeguarding Board **must** undertake a **Concise Child Practice Review** in any of the following cases where, within the board area, abuse or neglect of a child is known or suspected and the child has;

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of health or development; **and**

The child was neither on the child protection register nor a looked after child in the 6 months preceding-

- The date of the event referred to above; or
- The date on which the local authority or relevant partner* identifies that a child has sustained serious and permanent impairment of health or development.

**Local authority or relevant partner means a person referred to in s28 of the Children Act 2004 or body mentioned in s 175 Education Act 2002.*

The criteria for undertaking an **Extended Child Practice Review** is the same as above the only difference being:

The child was on the child protection register and/or was a looked after child (including a person who has turned 18 years of age, but who was a looked after child) on any date during the 6 months preceding.

Adult Practice Reviews

According to *Working together to Safeguard People – Volume 3 – Adult Practice Reviews*, the criteria for undertaking Adult Practice Reviews is:

A Safeguarding Board **must** commission a **Concise Adult Practice Review** where an adult at risk who has **not**, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority, and has

- Died; or
- Sustained potentially life threatening injury; or
- Sustained serious and permanent impairment of health.

The criteria for undertaking an **Extended Adult Practice Review** is the same as for a concise review the only difference being that:

Where an adult at risk, who **has**, on any date during the 6 months preceding the date of the event, been a person in respect of whom a local authority has determined to take action to protect them from abuse or neglect following an enquiry by a local authority

Statutory responsibility and governance within a national context for Practice Reviews is devolved to Welsh Government.

Domestic Homicide Reviews

Domestic Homicide reviews are a statutory requirement as outlined in the *Domestic Violence, Crime and Victims Act 2004* and the underpinning *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Dec 2016)*. Responsibility, reporting and governance for undertaking DHRs are with local Community Safety

Partnerships within each of the four Local Authorities across the region. Overarching national responsibility is with the Home Office and UK Government, and unlike Practice Reviews, powers are not devolved to Welsh Government.

According to *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Dec 2016)*, the criteria for undertaking a **Domestic Homicide Review** is:

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 personal relationship, or
(b) A member of the same household as himself

Statutory Guidance, as referenced above, supports collaborative working, particularly in situations where the identified learning is relevant to both staff and agencies who work within both the Practice Review and DHR frameworks and where the criteria for undertaking reviews overlap. Examples of such a situation could be a young person aged 16 or 17 who is the victim of a domestic homicide or alternatively, an adult victim of domestic homicide who has previously been assessed as being an adult at risk and having care and support needs. Technically both these situations could meet the criteria for a DHR and a Child or Adult Practice Review. When such situations occur it is important close liaison and communication takes place between the Regional Safeguarding Board and Local Community Safety Partnerships and DHR panels. This will help ensure any potential for joint learning and collaborative working is identified at the earliest opportunity and will enable appropriate arrangements to be put in place.

When the criteria to undertake a DHR have been met it is very unlikely an Adult Practice Review would also be undertaken and the DHR in most cases will be identified as the lead review process. However, it is important the regional Practice Review Sub Group is sighted on progress and any relevant learning themes are captured and disseminated to relevant staff. Likewise undertaking a collaborative DHR and/or APR/CPR would only be considered in exceptional circumstances when it is agreed undertaking two separate review processes would create significant unnecessary duplication and would not be in the best interests of family members. Any decision to undertake a joint review would need to be carefully considered and agreed by the Safeguarding Board Chair and the Chair of the respective Community Safety Partnership.

Parallel Reviews of Practice

Working Together to Safeguard People – Volume 2 - CPRs states:

6.7 There are a number of statutory responsibilities to review deaths and serious incidents. These include, domestic homicide reviews, the provision of mental health services by Healthcare Inspectorate Wales following a homicide, a Youth Justice Board Serious Incident Review, or a Prisons and Probation Ombudsman investigation where a child has died in a custodial setting.

6.8 Where the case gives rise to other parallel reviews of practice:-
The Review Sub Group should:

- consider the opportunities and potential arrangements for coordinating with those other bodies involved;
- discuss with those bodies and agree how a coordinated or jointly commissioned review process best addresses the outcomes that need to be delivered, in the most effective way and with minimal delay;
- consider a joint review or adding additional questions to the review's terms of reference;
- ensure the children's interests are always appropriately represented in other investigations of practice where, for example the focus is upon the adult;

Working together to Safeguard People – Volume 3 gives similar guidance in respect of Adult Practice Reviews.

In a similar context and ethos *Multi-Agency Statutory Guidance for the Conduct of Domestic Homicide Reviews (Dec 2016)* states:

23. It should be noted that, when victims of domestic homicide are aged between 16 and 18, there are separate requirements in statutory guidance for child Serious Case Reviews, Safeguarding Adults Review and a Domestic Homicide Review. Consideration should be given to how these reviews can be managed in parallel in the most effective manner possible so that organisations and professionals can learn from the case – for example, considering whether some or all aspects of the reviews can be commissioned jointly so as to reduce duplication of work for the organisations involved and provide an improved experience for families, subject to the final shape of the review meeting the requirements of both as set out in the statutory guidance.

In ensuring lessons are learned, DHR Guidance also states:

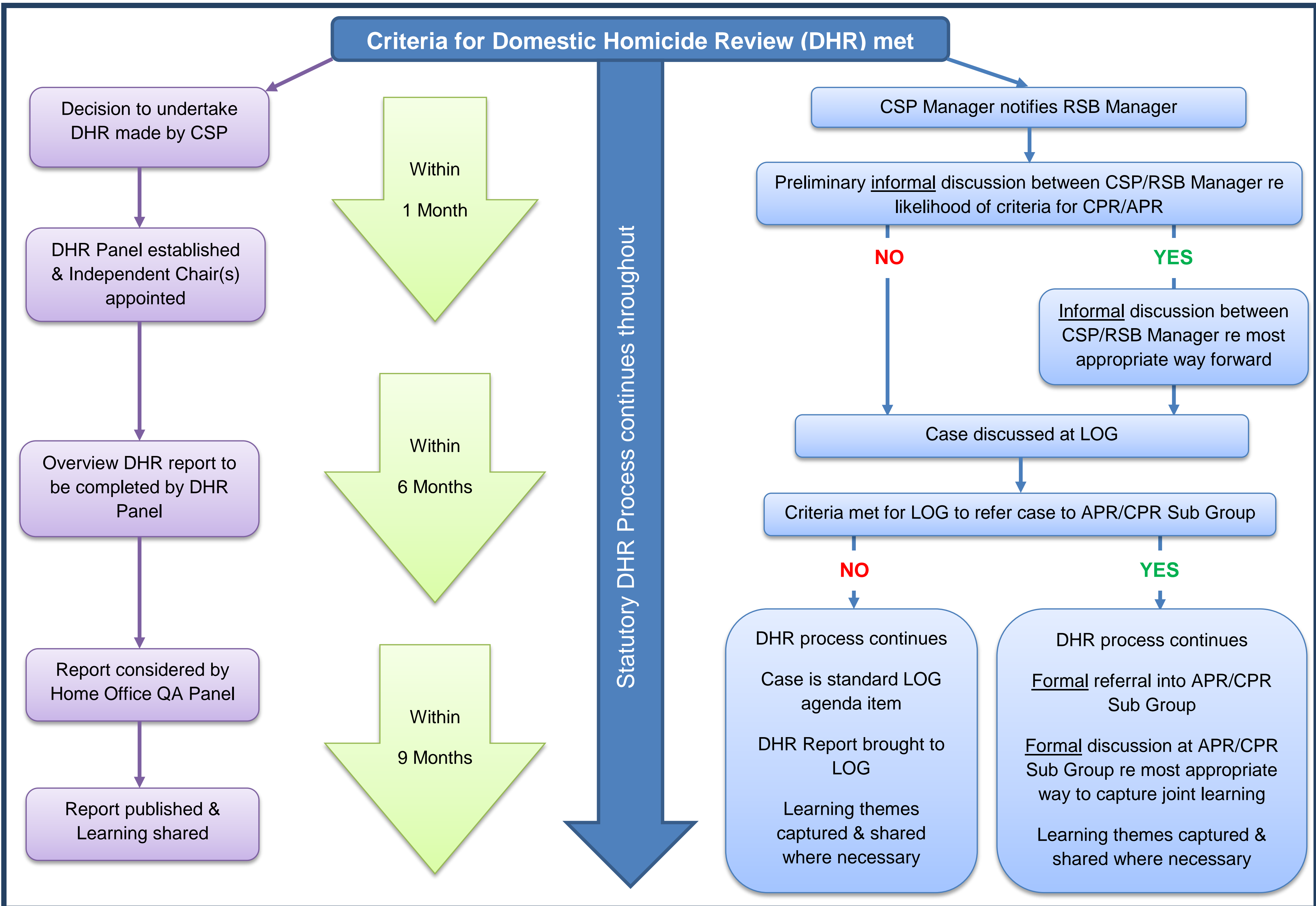
110. c) Subsequent learning should be disseminated to the local MARAC, other multi-agency fora, the Safeguarding Adults Board, the Local Safeguarding Children Board and commissioners of services.

d) Share and incorporate the learning (including any national lessons learnt) across the strands of adult and children safeguarding and utilise into local and regional training programmes for frontline staff.

The above frameworks provide the Mid & West Wales region with opportunity to:

- Strengthen communication between the Practice Review and DHR processes
- Be creative in the regional approach to reviews
- Support collaborative and joint working, where sensible and practical to do so
- Establish robust and clear communication between the Regional Safeguarding Board and Community Safety Partnership and DHR Review Panels
- Help avoid unnecessary duplication and ensure any lessons learned are shared widely across muliti-agency partnerships and respective review processes

The follow process has been agreed and established between the Mid & West wales Safeguarding Board and local Community Safety Partnerships to support the above.


Criteria for Domestic Homicide Review (DHR) met
Decision to undertake DHR made by CSP
DHR Panel established & Independent Chair(s) appointed
Overview DHR report to be completed by DHR Panel
Report considered by Home Office QA Panel
Report published & Learning shared
Within 1 Month
Within 6 Months
Within 9 Months
Statutory DHR Process continues throughout
CSP Manager notifies RSB Manager
Preliminary informal discussion between CSP/RSB Manager re likelihood of criteria for CPR/APR
NO
YES
Informal discussion between CSP/RSB Manager re most appropriate way forward
Case discussed at LOG
Criteria met for LOG to refer case to APR/CPR Sub Group
NO
YES
DHR process continues
Case is standard LOG agenda item
DHR Report brought to LOG
Learning themes captured & shared where necessary
DHR process continues
Formal referral into APR/CPR Sub Group
Formal discussion at APR/CPR Sub Group re most appropriate way to capture joint learning
Learning themes captured & shared where necessary