

WORKING PRINCIPLES TO BE USED WHEN CARRYING OUT A SAFEGUARDING REVIEW (CHILDREN OR ADULTS) OR DOMESTIC HOMICIDE REVIEW



Working principles agreed between the Yorkshire & Humber SABs, LSCPs, CSPs and Humberside Police

To be used when managing a Safeguarding Adults Review (SAR), Child Safeguarding Practice Review (CSPR) or a Domestic Homicide Review (DHR) alongside a police investigation by Humberside Police.

Background

It is accepted that there is a need to work in parallel processes when there is either a children's or adults review or a domestic homicide review which meets any review criteria, and the Police also need to investigate the crime. These are two entirely different functions; the review to determine what learning there is to support practitioners and the police investigation to determine whether a crime has been committed and if so who is culpable.

Points to consider at an early stage in decision making

There are some fundamental points to consider when deciding how to proceed:

- How can the review progress in a timely way to ensure there is immediate learning without jeopardising the police investigation?
- What material will need disclosing ie will any information assist the defence or similarly will any information undermine the prosecution?
- There is no legal reason why the police (or any other agency) can stop a review.
- It is key to get the right people round the table from the onset and for these people then to commit throughout, wherever possible. This supports our principles of local partnership working.
- Always comply with defensible decision making.

Local working principles

These principles have been developed to enable both processes to run concurrently, and to support a timely response to both, and are to be used in conjunction with National guidance which. Links to national guidance are included at the end of this document.

- We will always adhere to national policy and legislation.
- Where a case meets more than one criteria it is discussed at the next meeting of whichever partnership panel is scheduled to meet first. The Chairs and/or additional representative of the other partnership panel are invited to attend the meeting, to contribute to the discussion and to ultimately agree where is the best place for maximum learning.
- A confidential email should be sent to **YH.PersonalAssistant@cps.gov.uk** which will include some basic details of the case and request a relevant CPS colleague to attend the first panel meeting. This can be done by whoever is arranging the initial panel meeting.
- The Terms of Reference will be agreed at the first panel meeting and these should make it clear what actions can and cannot progress where a crime is also being investigated. Terms of Reference may require review as information evolves, as guided by CPS
- When a review has commenced and after further information gathering it is felt that the case should be following another review process, the chair of the original group sends a

formal email to the chair of the alternative review group, explaining their decision and rationale for the possible transfer to a different review process.

- At the first panel meeting, and for consistency thereafter, there is an agreement as to who should be the relevant agency(s) representative and this remains the case for the duration of the review. Specifically for the Police there is agreement as to whether this is the Officer In Case (OIC) or the Senior Investigating Officer (SIO), with the most likely being the OIC.
- At the point when terms of reference are being set, the focus must be on high impact learning. There is no aspect of learning in either a police or coronial investigation.
- If there is a challenge about any review which means the panels are not able commence in a timely manner, the issue of concern is escalated to the relevant partnership Chair for resolution and a solution.

Additional considerations

- Is there any information which has been shared as part of the MAPPA process (if relevant) which needs considering as part of the review? The Police representative will identify if this is the case.
- Has there already been any other type of review such as a NHS Serious Incident (SI)? If so would this negate the need for any further review? The CCG would be able to identify if this is the case.
- Does/did the individual have a learning disability and if deceased was there a LeDeR review? The CCG would be able to identify if this is the case.
- Is there an Independent Investigation being considered/held where a case pertains to a mental health in-patient? Humber FT would be able to identify if this is the case.

Supplementary guidance to be used to support the process

National Panel review on non-accidental injury to children under one (awaiting publication)

Children's safeguarding guidance

<https://www.gov.uk/government/publications/working-together-to-safeguard-children--2>

<https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-practice-guidance>

North Lincolnshire Multi Agency Resilience & Safeguarding (MARS) Local Arrangements

<https://www.northlincscmars.co.uk/policies-procedures-and-guidance/>

See Improving Child Protection and Safeguarding Practice Policy and Procedure under statutory documents specifically Appendix 3: Interface between safeguarding partners and those responsible for other review processes.

Child and Vulnerable Adult Case Reviews – Crown Prosecution Service Guidance

[Child and Vulnerable Adult Case Reviews | The Crown Prosecution Service \(cps.gov.uk\)](https://www.cps.gov.uk/child-and-vulnerable-adult-case-reviews)

Domestic homicide reviews: statutory guidance

[Domestic homicide reviews: statutory guidance - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/guidance/domestic-homicide-reviews)

NHS Serious Incident Policy

<https://www.england.nhs.uk/patient-safety/serious-incident-framework/>