

Sefton's Guide to STATUTORY REVIEWS

Including REFERRAL PATHWAYS

V4a

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INTRODUCTION

This guidance has been produced by a multi-agency Task and Finish Group to support cross partnership understanding of what constitutes a statutory review and provides useful links to practitioners to the relevant referral process. In the event of requiring further guidance practitioners should engage with the relevant organisational representative at Partnership Board level.

The statutory reviews referred to in this guide take place following the death of, or serious harm to, an individual which meets the criteria for a review, as detailed in relevant legislation.

The review has no power to determine civil or criminal liability, but instead, can make findings of fact and recommendations for improvement to ensure the welfare of individuals experiencing vulnerability related harm. This guide focuses on a number of different reviews related to safeguarding. Although further types of review exist, this guide focuses on those review types that occur where there has been a serious incident involving individuals who are vulnerable.

The focus of this document is on the statutory reviews system within England. In England, responsibility for each review type is governed by different bodies at a national level and locally by partnerships (all of which varies depending on the review type). In some cases, joint reviews may be conducted, for example in a domestic homicide where children have been involved both a Domestic Abuse Related Death Review and a Child Practice Review may be conducted.

The purpose of this document is to provide information about:

- the types of statutory reviews that exist which are linked to vulnerability.
- the governance related to reviews and the key agencies involved.
- guidance on the process of conducting and writing reviews.
- information about where review repositories, if available, are located.

This is not an exhaustive list but seeks to provide useful information on the most common types of statutory reviews.

The information contained in this document will be applicable to all individuals seeking more information about statutory reviews.

Sefton acknowledge the Brief Guide to Statutory Reviews authored by the National Police Chief's Council (NPCC) Vulnerability Knowledge and Practice Programme within this document.

Forms of Statutory Reviews

SAFEGUARDING ADULT REVIEW (SAR)

DOMESTIC ABUSE RELATED DEATH REVIEW (DARDR)
formerly DOMESTIC HOMICIDE REVIEW

LeDeR REVIEW

**RAPID REVIEW
AND
CHILD SAFEGUARDING PRACTICE REVIEW (CSPR)**

**OTHER TYPES OF REVIEW
AND
FORMAL REPORT**

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1.

SAFEGUARDING ADULT REVIEW

OVERVIEW

A Safeguarding Adult Review (SAR) enables partner agencies to come together to learn lessons following the death or serious harm of an adult with care and support needs.

WHAT IS A SAFEGUARDING ADULT REVIEW?

The Care Act 2014, s44 (1) (2) (3), requires a Safeguarding Adult Review (SAR) to be conducted following the death or serious harm of an adult with care and support needs as defined by the Act where:

The death or harm is suspected, or known to, result from neglect or abuse, including self-neglect; AND there is concern that agencies could have worked better to protect the adult from harm.

A discretionary SAR can also be undertaken into any incident or case involving adult(s) at risk of abuse or neglect, where the conduct of such a review is believed to be in public interest, or where it believes there will be value in doing so.

PRIMARY PURPOSE OF A SAR

To promote learning and improve practice with a focus on:

- establishing lessons to be learnt from how professionals and agencies work together.
- determining the effectiveness of safeguarding procedures and identifying good practice; and
- identifying how to improve inter-agency and individual agency practice.

THE PROCESS

Responsibility for governance of SARs on a national basis rests with the Department of Health and Social Care. Sefton has a Safeguarding Adult Partnership Board (SAPB) working together to protect adults at risk from abuse and neglect through coordinating and reviewing a multi-agency response.

One of core duties of SAPB is to undertake a SAR. They have responsibility for commissioning a SAR and following statutory guidance outlined within the [Care Act 2014](#). Any organisation that has worked with the person at the centre of the SAR at the time of the incident might be involved in the review.

SAPB consists of senior representation from multiple local authority departments – elected member, housing, adult social care and public health, Integrated Care Board, Merseyside Police, Hospital Trusts, Fire and Rescue Service, Council for Voluntary Services, Probation Services, Housing Providers and Healthwatch. Membership is regularly reviewed and invitation extended to additional organisations as considered beneficial to the people of Sefton.

There is no single methodology for undertaking a SAR and the circumstances of a case will determine the process. The approach is proportionate according to scale and level of complexity of the issues being examined.

The SAR exercise is led by an independent reviewer, with no operational role in the case being reviewed. They must have the appropriate knowledge and expertise of the adult safeguarding system to undertake the review. The methodology will set out the principles and approach to learning and should describe what was done and how. The focus within the review should be an analysis of why certain events occurred, as opposed to focusing solely on what happened.

The scope, aims, and terms of reference of the SAR will be determined by the Chair at the start, and should be specified clearly in the final report. The lived experience of an adult, and their voice, should be a key feature throughout a review, and the review should also consider the impact of the adult's identity on their lived experience and on professional decision making.

The SAR process will include the adult who is the subject of the review wherever possible, their family, and, where appropriate and helpful, with the person who initiated the abuse or neglect. Where necessary, the local authority must arrange for an independent advocate to support and represent an adult who is subject of SAR, and professionals must ensure that families are supported to engage with the review process.

The SAR process encourages honesty and transparency from individuals and organisations by ensuring they are fully involved in the process.

WRITING A SAFEGUARDING ADULT REVIEW

A SAR review and Report must reflect the six safeguarding principles as detailed within the Care Act 2014:

- empowerment,
- prevention,
- proportionality,
- protection,
- partnership, and
- accountability.

Terms of Reference are agreed at the outset by the Panel appointed to support the review process and independent reviewer and these should be published and openly available.

WHAT A GOOD SAFEGUARDING ADULT REVIEW REPORT LOOKS LIKE

- A SAR must be conscious of protected characteristics such as race, ethnicity, age, and gender and ensure that these are routinely addressed in reports and

their significance is considered.

- Provide a sound analysis written in plain English.
- The Report should clearly acknowledge any delays in producing the SAR.
- A SAR does not have to be published, but SAPBs must include details of any SARs in progress, and the findings and recommendations from completed reviews, within their annual reports.

HOW TO MAKE A SAR REFERRAL IN SEFTON

Sefton is a partner local authority area of Merseyside Safeguarding Adult Review Group along with three other Merseyside local authority areas. Business Administration for the monthly meetings of the Group is undertaken by Wirral Safeguarding Adults Partnership Business Administrator.

Where a practitioner identifies the potential of a situation to meet s44 criteria and a consideration needs to be made for referral to MSARG, they should discuss their concern with their line manager or the safeguarding lead officer for the organisation. On decision to progress to MSARG an on-line referral form can be found [here](#) and email it to both sar@wirral.gov.uk and SSAB@Sefton.gov.uk.

2.

**LEARNING FROM
LIVES AND
DEATHS REVIEW
(LeDeR)**

OVERVIEW

LeDeR is a process that is used where people with a learning disability or autism pass away and the primary aim is, as a service improvement programme to look at why people are dying and what we can do to change services locally and nationally to improve the health of people with a learning disability and reduce health inequalities. Everyone with a learning disability aged four and above who dies and every adult (aged 18 and over) with a diagnosis of autism is eligible for a LeDeR review. The child death review (CDR) process reviews the deaths of all children who are aged 4-17. This is the primary review process for children with learning disabilities and autistic children; results are shared with the LeDeR Programme.

The LeDeR programme uses the following definition of a learning disability:

Individuals with a learning disability (internationally referred to as individuals with an intellectual disability) are those who have:

- a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence) with:
- a significantly reduced ability to cope independently (impaired adaptive and/or social functioning) and:
- which is apparent before adulthood is reached and has a lasting effect on development.

Learning disability is different from a specific learning difficulty (such as dyslexia), or autism or a mental health condition. Some people have all of these and have a learning disability. A person does not necessarily need to have been on a locally held learning disability register (also sometimes called a GP quality outcomes framework [QoF] register) to be eligible for a LeDeR review.

For an autistic person to be eligible for a LeDeR review, they must have had a confirmed diagnosis of autism recorded in their clinical records prior to their death.

WHAT IS A LeDeR REVIEW?

Integrated care systems are responsible for ensuring that LeDeR reviews are completed based on the health and social care received by people with a learning disability and autistic people (aged four years and over) who have died, using the standardised review process. This enables the integrated care systems to identify good practice and what has worked well, as well as where improvements in the provision of care could be made. Local actions are taken to address the issues identified in reviews. Recurrent themes and significant issues are identified and addressed at a more systematic level, regionally and nationally.

A LeDeR review is not a mortality review. It does not restrict itself to the last episode of care before the person's death. Instead, it looks at key episodes of health and social care the person received that may have been relevant to their overall health outcomes. LeDeR reviews take account of any mortality review that may have taken place following a person's death.

LeDeR reviews are not investigations or part of a complaints process, and any serious concerns about the quality of care provided should be raised with the provider of that

service directly or with the Care Quality Commission (CQC) via their [online system](#).

Every person with a learning disability whose death is notified to LeDeR will have an initial review of the health and social care they received prior to their death. Using their professional judgement and the evidence available to them, the reviewer will determine where a focused review is required. The person's family has the right to request a focused review. Focused reviews will also be completed for every person from a minority ethnic background.

PRIMARY PURPOSE OF A LeDeR

LeDeR is a service improvement programme which aims to improve care, reduce health inequalities and prevent premature mortality of people with a learning disability and autistic people by reviewing information about the health and social care support people received.

It does this by:

- Delivering local service improvement, learning from LeDeR reviews about good quality care and areas requiring improvement.
- Driving local service improvements based on themes emerging from LeDeR reviews at a regional and national level.
- Influencing national service improvements via actions that respond to themes commonly arising from analysis of LeDeR reviews.

THE PROCESS

Responsibility for ensuring the delivery of LeDeR reviews currently lies with Integrated Care Boards (ICBs) . Each Board holds responsible for ensuring that LeDeR reviews are completed for their local area and actions are implemented to improve the quality of services for people with a learning disability and autistic people to reduce health inequalities and premature mortality.

LeDeR reviews are not investigations or part of a complaints process, and any serious concerns about the quality of care provided should be raised with the provider of that service directly or with the Care Quality Commission (CQC) via their online system.

Reviewers work in teams, with regular supervision and support including administrative support which promotes consistency in the quality of reviews. Reviewers understand how the integrated care system operates, (for example who the providers of services are and the commissioner landscape) but reviews are completed in such a way that they are still independent from the providers within the integrated care systems in which the reviewers operate.

Creation of the NHS England and NHS Improvement Autism Programme has focused attention on the need for reliable data on the health inequalities faced by autistic people. Changes to the LeDeR programme now mean that reviews of the health and social care received by autistic people who have died are included within LeDeR's remit.

NOTIFICATION OF DEATHS TO LeDeR

Notification of the deaths of people with a learning disability or autistic people to the LeDeR programme is not mandated. However, there is a strong expectation – supported by CQC – that providers of health and social care services, including GPs, will do so.

Notification of a death can be made by anyone via the LeDeR website. This includes health and social care staff, administrative staff, family members and others who knew the person.

Notification of deaths are through the LeDeR website only. Members of the LeDeR workforce complete the initial training and then undertake refresher training on an annual basis.

Every person with a learning disability whose death is notified to LeDeR has an initial review of the health and social care they received prior to their death. Using their professional judgement and the evidence available to them, the reviewer determines where a focused review is required. The person's family has the right to request a focused review.

Focused reviews are completed for every person from a Black, Asian or Minority Ethnic background. It is known that there is significant under reporting to LeDeR from Black, Asian and Minority Ethnic communities and that premature mortality in Black, Asian and Minority Ethnic communities is significantly increased therefore it is important that each of these deaths is reviewed to understand better the health inequalities faced by each of these different groups and to help tackle inequalities identified.

ICBs are expected to complete 100% of all their reviews within six months of them being notified on the LeDeR web platform unless statutory processes prevent that being possible or family members of those bereaved have asked for the review to be delayed.

To make a referral to LeDeR please use this link <https://leder.nhs.uk/report>

WHAT A GOOD LEDER REVIEW LOOKS LIKE

The initial review will include:

- a guided conversation with the family member or someone close to the person who died, this might also be someone they lived with or a carer who they were particularly close to.
- a detailed conversation with the GP or a review of the GP records
- a conversation with at least one other person involved in the care of the individual who died

A focused review will be carried out automatically if the individual is from a Black, Asian or Minority Ethnic background, a focused review will automatically be completed due to significant under reporting and increased health inequalities in these communities. (This may include, for example, and not be limited to, Romany Gypsy, Irish traveller or Jewish communities). Or a focused review will be triggered if, in the professional judgement of the reviewer, there is significant learning likely for the ICB or if there are

concerns about the quality of care provided to the person by one or more providers, or there is evidence of lack of integrated or co-ordinated care.

A family member can always ask for a focused review to be completed. If such a request is made, a conversation should take place between the family and the reviewer about the expected outcome of a LeDeR review.

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3.

**DOMESTIC ABUSE
RELATED DEATH
REVIEW
(DARDR)
(formerly DHR)**

OVERVIEW

Domestic Abuse Related Death Reviews (DARDRs) (formally Domestic Homicide Reviews) were established on a statutory basis under section nine of the [Domestic Violence, Crime and Victims Act \(2004\)](#). This provision came into force on 13th April 2011, with recent terminology changes reflected in amendments to the [Victim and Prisoners Act \(2024\)](#).

WHAT IS A DOMESTIC ABUSE RELATED DEATH REVIEW?

The Victim and Prisoners Act (2024) defines a DARDR as a review into the circumstances of the death of a person which is held:

- where the death has, or appears to have, resulted from domestic abuse towards the person, within the meaning of the Domestic Abuse Act 2021, and
- with a view to identifying the lessons to be learned from the death.

The Domestic Abuse Act (2021) defines domestic abuse as the behaviour of a person towards another person, where the two people are aged 16 or over and are personally connected to each other, and the behaviour is abusive. Abusive behaviour is defined as: physical or sexual abuse; violent or threatening behaviour; controlling or coercive behaviour; economic abuse; psychological, emotional, or other abuse.

PRIMARY PURPOSE OF A DARDR

To identify lessons to be learnt from the death, prevent domestic abuse and homicide, and improve service reviews for victims. DARDRs aim to develop a coordinated multi-agency approach to ensure abuse is identified and responded to effectively, at the earliest opportunity.

There is an emphasis on professional curiosity to determine the trail of abuse, with a focus on the past intended to increase the safety of the future.

A DARDR does not seek to apportion blame or guilt for the death. It can be held in addition to an inquest/inquiry into the death and does not replace this process.

WRITING A DOMESTIC HOMICIDE REVIEW

The review should 'articulate life through the eyes of the victim and their children' and gather information from those around the victim to help understand their reality. Guidance on writing the report can be found here: [Domestic Homicide Review Toolkit - Guide to Overview Report Writing](#).

WHAT A GOOD DOMESTIC HOMICIDE REPORT LOOKS LIKE

- Language used within the report can be clearly understood by the victim's family, friends, the perpetrator, the public, and by all agencies involved.
- Terms of Reference are clearly answered and addressed within the Report.
- There is no expression of opinion – the Report is evidence based and factual.
- The words of those involved in the review are used within the Report.
- The Report is focused on how things were viewed at the time rather than based on what is known after the event.
- Recommendations are single-topic and specific, and SMART (Specific, Measurable, Achievable, Realistic, and Timely).
- Reports are anonymised and not identifying the victim, perpetrator, or their families.

DARDR PROCESS

Any agency or individual can make a referral for case to be considered for a DARDR. This should be made in writing to the Community Safety and Engagement team in Sefton Council who coordinate the DARDR process on behalf of Safer Sefton Together.

Key agencies are then contacted to be informed of the DARDR notification and are asked to provide a summary of any information they know about the individuals involved – at this stage, this is usually the victim and the alleged perpetrator (if applicable), but it may also include other relevant individuals such as children and and/or family members.

The decision on whether to progress to a DARDR is made by Safer Sefton Together. If this is the case, an Independent Chair and Author is commissioned to undertake the review, as outlined in the Statutory Guidance.

Completed DARDRs must be submitted to the Home Office on completion for quality assurance. Once this process is complete, the reports are published on the Safer Sefton Together website unless there is agreement with the Home Office not to do so.

To make a referral please go to Sefton SST microsite and use this link [Domestic Homicide Review](#).

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4.

**RAPID REVIEW
AND
CHILD
SAFEGUARDING
PRACTICE REVIEW**

OVERVIEW

Working Together to Safeguard Children (2023) sets out the statutory requirements for rapid reviews and child safeguarding practice reviews (CSPRs).

WHAT IS A SAFEGUARDING PRACTICE REVIEW?

Serious child safeguarding cases are those in which:

Abuse or neglect of a child is known or suspected, **AND** the child has died or been seriously harmed.

A rapid review will initially be undertaken and completed. A decision will then be taken as to whether a local and/or national CSPR is required.

PRIMARY PURPOSE

To identify improvements to be made to safeguard and promote the welfare of children, at local and national level. This should happen in a way that contributes to continued systems improvement, without seeking to hold individuals, organisations, or agencies to account. Rapid reviews and CSPRs (if undertaken) further seek to prevent or reduce the risk of a similar incident recurring in the future.

THE PROCESS

At a national level, responsibility for how the system learns from serious child safeguarding incidents lies with the Child Safeguarding Practice Review Panel (the Panel). In Sefton, the responsibility lies with the safeguarding partners.

Working Together (2023) emphasises the importance of effective multi-agency work and sets out that every local authority, integrated care board, and constabulary in England must be covered by a multi-agency safeguarding arrangement (MASA). Local Child Safeguarding Partnerships publish their arrangements for commissioning and publishing CSPRs, how they will be undertaken, and the arrangements for embedding learning across organisations and agencies. An independent scrutineer or scrutiny group should also be established to provide effective support and challenge at both a strategic and operational level.

The Panel must be notified of every serious child safeguarding incident meeting the criteria for a rapid review and CSPR. The rapid review and CSPR are overseen, and the reviewer supervised by safeguarding partners.

The December 2023 update of Working Together distinguishes between Lead Safeguarding Partners (LSPs) and Delegated Safeguarding Partners (DSPs). Each statutory safeguarding partner agency should have an LSP to aid strong, joined-up

leadership and clear accountability.

The LSPs are jointly responsible for the strategic leadership of all relevant agencies, for providing shared oversight of learning, and ensuring recommendations are implemented and that a demonstrable impact on practice is evidenced in the yearly report.

The DSPs, in contrast, are responsible for leading operational delivery and conduct functions to oversee and ensure effective partnership working. They are responsible for the delivery of “high- quality” and “timely” rapid reviews, as well as CSPRs. While the DSP should be sufficiently senior to speak with authority, take decisions on behalf of the LSP, and hold their sectors to account, ultimate accountability stays with the LSP.

Local safeguarding partners (local authorities, chief officers of police, and integrated care boards) must conduct a rapid review into all incidents notified to the Panel and send a copy to the Panel. Local safeguarding partners should also notify the Panel, Ofsted, and the Department for Education (DfE) if they intend to conduct a CSPR. The final report should be published as soon as possible, and no later than six months, from the date of the decision to initiate a review.

If a case is particularly complex, or of national importance, the Panel may decide to commission a national CSPR.

HOW TO MAKE A REFERRAL IN SEFTON

When a referrer considers that the criteria for a Serious Child Safeguarding Incident may be met, or that a multi-agency reflective review may be appropriate, the Referral Form should be used.

[Sefton Safeguarding Children Partnership - Learning from Reviews](#)

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5.

**OTHER
TYPES OF REPORT
AND
FORMAL REVIEW**

REGULATION 28 REPORT

INTRODUCTION

A Coroner can issue a Regulation 28 Report (under The Coroners and Justice Act 2009) to an individual, organisation, local authority or government department and their agencies if they believe action should be taken to prevent further deaths. Regulation 28 Reports are also known as Reports to Prevent Future Deaths or Prevention of Future Death Reports.

WHAT IS A REGULATION 28 REPORT?

A Regulation 28 report sets out Coroner concerns raised from the inquest and request that action should be taken to prevent future death.

The person, body, or organisation in receipt of this request to report has 56 days to provide the Coroner with their response.

Responses need to include details of the actions taken that address the concerns raised.

MAIN PURPOSE

Reports should be intended to improve public health, welfare, and safety and should clearly state the concerns of the coroner and what action, in their opinion, should be taken to prevent future deaths.

1. MAJOR CRIME INVESTIGATION

INTRODUCTION

When a homicide or major crime occurs, the Senior Investigating Officer (SIO) is responsible for acting as the lead investigator to establish what occurred and identify the perpetrator(s). Statutory safeguarding reviews (those detailed above) will often occur at the same time as major crime investigations.

WHAT IS A MAJOR CRIME INVESTIGATION?

Investigations into homicides and major crimes, including high profile and complex investigations into serious sexual offending, acquisitive, organised, and other violent crimes.

Main Purpose

To establish the facts of what occurred and identify the perpetrator(s).

Those overseeing major crime investigations need to consider the susceptibility of victims, witnesses, and suspects to harm; ensure that safeguarding is appropriately considered;

and that relevant information is shared appropriately with partner agencies and parallel proceedings, including statutory reviews.

THE ROLE OF THE POLICE

Major crime investigations are overseen by the SIO and often run in parallel to statutory safeguarding reviews. The SIO is responsible for sharing information with the individual/agency conducting the statutory review, however, will need to balance the need to provide the reviewer with appropriate information, whilst avoiding any potential risk to the proper conduct of the criminal investigation.

SIOs need to ensure they are familiar with the local arrangements regarding statutory safeguarding reviews within their policing area and are familiar with the governance arrangements concerning these reviews. They must also ensure that there are appropriate, formal communication routes between the investigation team and those responsible for the statutory review.

Supporting Resources and Useful Reading

Safeguarding Adult Review

- A library of Safeguarding Adult Reviews can be found here: [National Network for Chairs of Adult Safeguarding Boards](#).
- Care and Support Statutory Guidance GOV.UK (www.gov.uk)
- [Analysis of Safeguarding Adult Reviews: April 2017 - March 2019 | Local Government Association](#)
- <https://www.local.gov.uk/publications/second-national-analysis-safeguarding-adult-reviews-april-2019-march-2023>

Domestic Homicide Review

- A library of domestic abuse related death reviews can be found here: [Domestic Homicide Library](#)
- The Homicide Abuse Learning Together (HALT) study, completed in 2022 and analysed all publicly available DHRs between 2011-2018. They have produced a number of briefing documents located here: [Resources and Publications](#).
- [Advocacy After Fatal Domestic Abuse \(AAFDA\)](#) are an independent organisation which offer advocacy and peer support following fatal domestic abuse.
- <https://www.gov.uk/government/collections/domestic-homicide-review>
- Professionals' Perspectives about DHRs: <https://onlinelibrary.wiley.com/doi/full/10.1111/hsc.13725>
- DHR Committees' Recommendations and Impacts: A Systematic Review: <https://journals.sagepub.com/doi/full/10.1177/10887679221081788>
- Domestic Homicide Project within the VKPP <https://www.vkpp.org.uk/vkpp-work/domestic-homicide-project/>

Child Death Review

The National Child Mortality Database holds information about all child deaths in England and shares this information through a number of annual reports. Their publications can be accessed here: [National Child Mortality Database](#).

- Child Death Review: Statutory and Operational Guidance (England): [Child Death Review Statutory and Operational Guidance \(England\) \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/90121/Child_Death_Review_Statutory_and_Operational_Guidance_England.pdf)
- A Thematic Review of Vulnerability, which increases the risk of poor outcomes, in Infants: [Vulnerability in infants: a study of sudden and unexplained deaths \(ncmd.info\)](https://ncmd.info/publications/vulnerability-in-infants-a-study-of-sudden-and-unexplained-deaths/)
- Child Mortality in England during the First Two Years of the COVID-19 Pandemic: [Child mortality in England During the Covid-19 Pandemic \(ncmd.info\)](https://ncmd.info/publications/child-mortality-in-england-during-the-covid-19-pandemic/)

RAPID REVIEW AND CHILD SAFEGUARDING PRACTICE REVIEW

- A library of CSPRs can be found here: [National review repository](https://www.gov.uk/government/collections/national-review-repository).
- Guidance on the process can be found here: [Child Safeguarding Practice Review Panel guidance for safeguarding partners \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/90121/Child_Safeguarding_Practice_Review_Panel_guidance_for_safeguarding_partners.pdf)
- [Working together to safeguard children - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/working-together-to-safeguard-children)
- [Child Safeguarding Practice Review Panel: annual report 2022 to 2023 - GOV.UK \(www.gov.uk\)](https://www.gov.uk/government/publications/child-safeguarding-practice-review-panel-annual-report-2022-to-2023)
- Case Review Process in UK Nations: NSPCC: [Case review process in each UK nation | NSPCC Learning](https://www.nspcc.org.uk/what-we-do/case-reviews/case-review-process-in-each-uk-nation/)
- Independent Scrutiny and Local Safeguarding Children Partnership Arrangements: [Full-Report-Independent-Scrutiny-August-2022.pdf \(vkpp.org.uk\)](https://www.vkpp.org.uk/wp-content/uploads/2022/08/Full-Report-Independent-Scrutiny-August-2022.pdf)

INDEPENDENT MANAGEMENT REVIEW

- Multi-agency Statutory Guidance for the Conduct of Domestic Homicide Reviews. Section Seven within this Guidance has information relating to IMRS: [DHR-Statutory-Guidance-161206.pdf \(publishing.service.gov.uk\)](https://publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/90121/DHR-Statutory-Guidance-161206.pdf)

OTHER REPORTS

- [Prevention of Future Death Reports for Suicide submitted to coroners in England and Wales: January 2021 to October 2022](https://www.gov.uk/government/publications/prevention-of-future-death-reports-for-suicide-submitted-to-coroners-in-england-and-wales)

- A Thematic Review of recent Prevention of Future Deaths Reports:
[A thematic review of recent Prevention of Future Deaths \('PFD'\) reports | Hill Dickinson](#)
- A library of Prevention of Future Deaths reports can be found here:
[Prevention of Future Death Reports.](#)