Learning across statutory reviews: Developing a shared agenda

Conferencing Proceedings

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Introduction

The **Learning across statutory reviews: Developing a shared agenda** conference took place at the British Library in London on Wednesday 19th March 2025.

The purpose of the event was to bring together practitioners, policy makers, and researchers to explore the intersections between different statutory reviews as a response to deaths or serious harm resulting from violence, abuse or neglect.

The key aims were:

- To identify common challenges and a potential agenda for the future
- To share examples of good practice
- To provide a space for networking and engagement.

Speakers

Professor Jill Manthorpe CBE, Kings College London
Reflections on the Age of the Inquiry 20 Years on with Q&A

Sheila Fish, Independent Consultant
Systems learning across adult and child reviews

Professor Khatidja Chantler, Manchester Metropolitan University
Learning from domestic homicide reviews: recommendations, resonances and reflections

Frank Mullane, Advocacy After Fatal Domestic Abuse
Domestic homicide / abuse-related death reviews: emerging issues affecting other enquiries

Dr Bethan Davies, Cardiff University
Lessons, learning and recommendations: a view from the Single Unified Safeguarding Review (SUSR) process

About this document

This document summarises some of the key points addressed by the speakers and from the discussions on the day. We'd like to thank all the attendees and speakers for their excellent contributions throughout the day and we hope to continue these discussions in the future.

Background

Statutory reviews as a response to deaths from violence, abuse or neglect have proliferated over the past 30 years, including in relation to child and adult safeguarding, mental health, and domestic abuse. Statutory reviews are multi-agency, multi-disciplinary tools for capturing data about different types of violence and abuse and the systems responses to it. As systems of data collection, therefore, understanding how these reviews are conducted is essential to understanding the lessons that they generate.

However, **practice, policymaking and research on statutory reviews are largely siloed**. This means that, despite sharing common aims and similar approaches, the opportunities for learning across these statutory reviews is limited.

The conference built on previous events, including the Learning across death investigations event held in Manchester, September 2024 and a symposium at the Annual VISION Conference in 2024 that led to a policy briefing titled 'Learning across statutory review practices: Origins, ambitions, and future directions'.

Notably, a key volume edited by Jill Manthorpe and Nicky Stanley – 'The Age of the Inquiry Learning and Blaming in Health and Social Care' – was published in 2004. Given just over twenty years had elapsed since publication, the conference was also an opportunity to reflect on continuities and developments since that time.

Key themes: Opportunities

What works well in and across statutory review systems?

1

Raising awareness and consciousness – Reviews can help to raise consciousness, highlight patterns of violence and abuse, including against less visible or minoritised populations, and raise questions (and answers) to improve knowledge and understanding. Sometimes, these reviews are the only opportunity to review certain deaths.

2

Potential role for advocacy, justice and accountability – When done well, reviews can be meaningful by providing recognition and offering a platform for the voice of the family and communities. In this way, reviews can be a way to facilitate conversations (and challenge) that might not have ordinarily happened. Specialist advocacy is important in this context. Increasingly, reviews are moving towards being more 'victim-centred'. As well as any changes that may come about, reviews therefore also have a symbolic element.

3

Improving processes and methodologies – Review practices - both for individuals, in panels, and for different review systems - are *developing,* with increasing guidance and research to support this. In addition, new systems are emerging (e.g., the SUSR in Wales), repositories are being launched, and thematic 'review of reviews' are being conducted. There are some examples of good communication across review systems. Having a common structure, but with room for flexibility, was also identified as potentially beneficial.

4

Impact and implementation – Reviews can improve coordinated community responses, drive practice and policy change, and also develop and foster connections and bridges between different sectors.

Key themes: Challenges

What are the challenges within and across systems?

1. **Lacking transparency, clarity, and consistency** – Despite developments, questions remain about the fundamental utility of findings and the resources or capacity to deliver them. There can be disparities in the skill base across local areas and review systems, and confusion about review panel composition and objectives. In addition, there can be inconsistency in the quality of reviews, duplication, delays, ownership, costs, and the challenges and tensions with what seem to be multi-purpose reviews (e.g., learning vs. blame vs. data collection vs. memorialisation).

2. **Duplication or invisibility?** – While there are sometimes connections between review systems, these are not always consistent, achieved, or there is variation as to whether the benefits of doing so are recognised. This is particularly problematic because of the potential for duplication of learning, which, simultaneously, is often invisible across review systems and sectors. If cross review system and sectoral working is to succeed, further alignment is needed.

3. **Further support and training required** – For all those involved in reviews systems, including commissioners, those leading individual case reviews and review panel members.

4. **Building in reflection** – Further opportunities for reflection on review practices, roles and responsibilities are required for the purposes of advocacy, justice and accountability.

5 **Ensuring meaningful engagement for families** – While the benefits of family engagement were acknowledged, these depend on *how* engagement is managed. To move toward 'victim-centred' practices, these need to be appropriately resourced and detailed. That includes access to specialist advocacy.

6 **Confusing blame with accountability** – As review systems with different purposes (and statutory requirements) interact, there can be confusion about and between the purposes of review, with stakeholders having different aspirations both within and across review systems. In addition, there is often a lack of guidance and consistency in practice about what to do in circumstances where reviews reveal information that is pertinent to another review.

7 **The potential for 'review fatigue'** – The term 'review fatigue' was identified, arising from the multiplicity of review systems and the cost and impact in participating in them.

8 **Ongoing challenges of data collection, reporting and disaggregation** – There can be an inconsistency in reporting protected characteristics in different reviews, with implications for visibility. This point was underlined by the comment that reviews were noted as a State-sponsored mechanism, and therefore had a symbolic status as public record. Given the number of review systems, there is a question about whether findings are comparable.

9 **Learning from similarities but respecting differences** – While there are important lessons to be drawn in comparing or aligning review systems, it is important to avoid being reductive by focusing solely on similarities. Sometimes, the underpinning purposes may be different for good reasons or reflect the particular forms of violence and abuse being reviewed.

Where do review systems go from here?

1. **Streamlined and rapid reviews** – These types of quick time reviews, which may precede a more in-depth review, were noted as perhaps being able to identify emerging or urgent findings sooner in the process.

2. **Accountability and monitoring** – Much greater emphasis and resources should be targeted towards monitoring and implementation. A question to be resolved is how to identify and address the lack of change that can follow repeated recommendations. There was some support for a statutory obligation for agencies to report on the implementation of recommendations.

3. **Offering further guidance about what a 'victim-centred' review entails** – Further guidance is needed on the practical considerations of how to achieve 'victim-centred' reviews. Linked to this, it is important to keep families at the centre of the review process, but build in flexibility should they wish not to be.

4. **Analyse selection and bias** – Further scrutiny is required of the types of cases and incidents that are commissioned and reviewed. Where reviews are jointly commissioned, how can we ensure that key issues (such as domestic abuse) remain central?

5. **Learning and recommendations** – Not only is further investigation needed into tracking implementation, but closer study of how to generate good quality recommendations.

5 **Recognise that reviews are just one component of learning** – As review systems develop, it is important to remember that they are just one component of learning about a death. In addition, they do not operate in a vacuum; they require regular scrutiny and reflection, particularly regarding their sustainability, as review systems and reviews continue to multiply.

6 **Understanding why as well as what** – Reviews must be able to articulate not only what happened, but why (including focusing on individual, relational and structural contexts, and taking an intersectional perspective), as this was more likely to identify pathways to change. Great emphasis was also placed on understanding what *works well* and also *barriers.*

7 **Further support and training at multiple levels** – Training needs were identified not only for panel members and those leading reviews, but also for commissioners to consider parameters, scope and composition of reviews. Training could be focused on methods (e.g., particular skills such as humility, how to identify and consult with experts, generating recommendations) *and* systems (e.g., multi-agency working, structural contexts such as misogyny, racism, homophobia, ableism, etc.).

8 **Invest in action plans** – To ensure the delivery of recommendations, action plans need costing, clearly identified responsibility, and the setting of timescales and milestones.

9 **Thinking upwards *and* across** – National and local coordination is required to ensure that different governmental bodies (e.g., Home Office, Department of Education, Department of Health and Social Care) are working collaboratively on improving both review system practices and their recommendations and cross system learning.

About the authors

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