



Policy and Procedure for the conduct of Serious Case Reviews

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1. Establishment of Local Safeguarding Children Boards

The Children Act 2004 (the Act) has required all children's services authorities to establish a Local Safeguarding Children Board (LSCB) to replace the non-statutory Area Child Protection Committees (ACPCs) introduced as part of the child protection system set up following the inquiry into the death of Maria Colwell in 1974.

Tameside Safeguarding Children Board (the Board/TSCB) was established with effect from 1st September 2005 in accordance with section 13(1) of the Act and the Local Safeguarding Children Board Regulations 2005.

Although the Board's core functions are based on the child protection functions of the ACPCs, the LSCBs have a wider remit for safeguarding children. This involves being more pro-active as well as co-ordinating and monitoring responses by agencies that work with children and families on a broader range of issues that impact on the safety and welfare of children and young people.

LSCBs are subject to the guidance in *Working Together to Safeguard Children* (2006) and to regulation in the form of the *Local Safeguarding Children Boards Regulations 2006*

2. Function of Tameside Safeguarding Children Board

The primary function of Tameside Safeguarding Children Board (the Board) is to co-ordinate and ensure the effectiveness of the activities of all Board member agencies for the purpose of safeguarding and promoting the welfare of children in its area.

In practice the Board will evaluate how each member agency fulfils its responsibility to safeguard and promote the welfare of children and will ensure that the safeguarding work of each Board member is effective.

The Board is not accountable for the operational work of member agencies or other members of the Board. Responsibility for safeguarding and promoting the welfare of children rests with each agency and indeed with everyone living or working in Tameside.

Individual members of the Board have a duty to contribute to the effective work of the Board in making the Board's assessment of performance as objective as possible and in recommending action to address any problems. This role will, if necessary, take precedence over their role as representative of their organisation.

3. Local Safeguarding Children Boards Regulations 2006

One of the functions of LSCBs (as set out in Regulation 5) is to undertake reviews of serious cases and advise the local authority and Board partners on lessons to be learned.

For the purposes of paragraph (1)(e) a serious case is one where—

(a) abuse or neglect of a child is known or suspected; and

(b) either—

(i) the child has died; or

(ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child.

Also from 1st April 2008 each LSCB shall, in addition to the functions referred to in regulation 5, have the following functions in relation to the deaths of children normally resident in the area of the authority—

(a) collecting and analysing information about each death with a view to identifying—

(i) any case giving rise to the need for a review mentioned in regulation 5(1)(e);

(ii) any matters of concern affecting the safety and welfare of children in the area of the authority; and

(iii) any wider public health or safety concerns arising from a particular death or from a pattern of deaths in that area; and

(b) putting in place procedures for ensuring that there is a co-ordinated response by the authority, their Board partners and other relevant persons to an unexpected death.

One of the most important functions of LSCBs is to undertake reviews of serious cases and to advise the local authority and its LSCB members on lessons to be learned (Regulation 5(e)).

4. What is a Serious Case Review? – The Purpose for Conducting a Serious Case Review

The prime purpose of a Serious Case Review (SCR) is for agencies and individuals to learn lessons to improve the way in which they work both individually and collectively to safeguard and promote the welfare of

children. As part of this prime purpose the aims of the Serious Case Review are to:

- establish what lessons are to be learned from the case about the way in which local professionals and organisations work individually and together to safeguard and promote the welfare of children
- 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
- improve intra- and inter-agency working and better safeguard and promote the welfare of children.

In carrying out reviews it is essential that the following principles are applied:

- The lessons learned should be disseminated effectively, and the recommendations should be implemented in a timely manner so that the changes required result, wherever possible, in children being protected from suffering or being likely to suffer harm in the future.
- It is essential, to maximise the quality of learning, that the child's daily life experiences and an understanding of his or her welfare, wishes and feelings are at the centre of the SCR, irrespective of whether the child died or was seriously harmed. This perspective should inform the scope and terms of reference of the SCR as well as the ways in which the information is presented and addressed at all stages of the process, including the conclusions and recommendations.
- Reviews vary in their breadth and complexity but, in all cases, where possible lessons should be acted upon quickly without necessarily waiting for the SCR to be completed.

The purpose of a Serious Case Review is **not**:-

- a judicial inquiry – there is no hearing of oral evidence and no testing of that evidence e.g. by cross-examination;
- an inquiry into how a child died (that is for the Coroners Court to decide)
- an inquiry into who is to responsible (that is for the Criminal Court to decide) or
- an inquiry into professional negligence (that is a matter for disciplinary procedures within the relevant service or organization to decide).

Therefore the focus of the review is upon the way in which local practitioners, managers and services work together to safeguard and promote the welfare

of children. It will scrutinise the actions of individual agencies with a view to learning lessons for the future locally, regionally and nationally.

5. When should the TSCB undertake a Serious Case Review?

When a child dies (including death by suspected suicide) **and** abuse or neglect is known or suspected to be a factor in the death, the LSCB should **always** conduct a SCR into the involvement of organisations and professionals in the lives of the child and family. This is irrespective of whether local authority children's social care is, or has been, involved with the child or family.

These SCRs should include situations where a child has been killed by a parent, carer or close relative with a mental illness, known to misuse substances or to perpetrate domestic abuse.

In addition, a SCR should always be carried out when a child dies in custody, either in police custody, on remand or following sentencing, in a Youth Offending Institution (YOI) or a Secure Training Centre (STC), or where the child was detained under the Mental Health Act 2005.

LSCBs should **consider whether** to conduct a SCR whenever a child has been seriously harmed in the following situations:

- a child sustains a potentially life-threatening injury or serious and permanent impairment of physical and/or mental health and development through abuse or neglect
- a child has been seriously harmed as a result of being subjected to sexual abuse
- a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004
- a child has been seriously harmed following a violent assault perpetrated by another child or an adult;

and the case gives rise to concerns about the way in which local professionals and services worked together to safeguard and promote the welfare of children. This includes inter-agency and/or inter-disciplinary working.

The following questions may also help in deciding whether a case should be the subject of a SCR. The answer 'yes' to one or more of these questions is likely to indicate that a SCR could yield useful lessons:

- Was there clear evidence of a child having suffered, or been likely to suffer, significant harm that was:— not recognised by organisations or professionals in contact with the child or perpetrator **or**— not shared with others **or**— not acted on appropriately?

- Was the child abused or neglected in an institutional setting (for example, school, nursery, children's or family centre, YOI, STC, immigration removal centre, mother and baby unit in a prison, children's home or Armed Services training establishment)?
- Was the child abused or neglected while being looked after by the local authority?
- Was the child a member of a family that has recently moved to the UK, for example as asylum seekers or temporary workers?
- Did the child suffer harm during an unauthorised absence from an institution, or having run away from home or other care setting?
- Does one or more agency or professional consider that its concerns about a child's welfare were not taken sufficiently seriously, or acted on appropriately, by another?
- Does the case indicate that there may be failings in one or more aspects of the local operation of formal safeguarding children procedures which go beyond the handling of this case?
- Was the child the subject of a child protection plan at the time of the incident, or had they previously been the subject of a plan or on the child protection register?
- Does the case appear to have implications for a range of agencies and/or professionals?
- Does the case suggest that the LSCB may need to change its local protocols or procedures, or that protocols and procedures are not being adequately promulgated, understood or acted on?
- Are there any indications that the circumstances of the case may have national implications for systems or processes, or that it is in the public interest to undertake a SCR?

6. Initiating a Serious Case Review

The TSCB Chair should consider whether a case might meet the criteria for a SCR, applying the criteria in sections 3 and 5 above. In doing this the TSCB chair will be assisted by the Chair of the TSCB Overview Panel. Responsibility for conducting Serious Case Reviews in Tameside is delegated to the Overview Panel although the final report must be agreed by the Board and signed of by the TSCB Chair. The Overview Panel will convene a Serious Case

Review Panel to manage and oversee the entire Serious Case Review process.

Immediately after notification of the death of a child and where any member of the TSCB considers that there is reason to believe the death may meet the criteria for being considered a 'serious case' (see above) the Chair of the Overview panel will inform the TSCB Chair who will decide if the criteria is met. Where the TSCB Chair considers, in a particular case, that the criteria for a SCR may be met, the TSCB chair will request the TSCB Overview Panel Chair to convene a Serious Case Review Panel to consider whether a SCR should take place.

In some cases, it may be valuable to conduct a single Individual Management Review (IMR) rather than a full SCR, for example where there are lessons to be learned about the way in which staff worked within one agency rather than about how agencies worked together, or a smaller scale audit of an individual case that gives rise to concern but does not meet the criteria for a SCR.

Methodologies such as those developed by SCIE or root cause analysis used in the health service may be useful here. In such cases, arrangements should be made to share relevant findings with the SCR sub-committee or SCR Panel. If the SCR Panel recommends that a SCR be undertaken, they should also recommend the scope and terms of reference for the review. These recommendations should be forwarded to the Chair of the TSCB, who has ultimate responsibility for deciding whether to conduct a SCR.

The TSCB Chair will ensure that the following people and agencies are notified about the decision whether or not to convene a Serious Case Review:

- Ofsted will be notified of the outcome of this decision as soon as it has been made. Ofsted will then pass this information to the relevant Government Office (GO) and the Department for Children, Schools and Families (DCSF).
- PCT commissioners should notify the Strategic Health Authority (SHA) and the Care Quality Commission (CQC).
- The police should also notify Her Majesty's Inspectorate of Constabulary (HMIC).
- The National Offender Management Service should notify Her Majesty's Inspectorate of Prisons (HMIP) and Her Majesty's Inspectorate of Probation (HMI Probation).
- All members of the Board. This will be done by the Chair of the Serious Case Review Panel.
- All members of the Overview Panel.

- Chief Executive officers of each TSCB member agency.
- Other agencies where considered appropriate to the individual case. Representatives of all agencies on the Serious Case Review Panel will report the decision to their agency.
- The Coroner's Office. If the Case involves the death of a child the Chair of the Serious Case Review Panel will contact the Coroner to inform him/her that a Serious Case Review is being carried out.
- The Parents or carers of the child. Consideration will be given as to how the family or carers of the child are told, and by whom, that a Serious Case Review is to be undertaken. This will be determined on a case-by-case basis. Practitioners who are still working with the family will be invited to advise on how best to approach this.
- It may be necessary to speak to the child if the Review concerns an injury or event which the child survived. Before contact is made with either the family or a child a decision will be made as to whether they will be interviewed as contributors to the review or simply to be informed that review has commenced. Any statements made by family members will be recorded and a copy given to them.

At this point the TSCB will identify and commission a suitably qualified and experienced person to chair the Serious Case Review (SCR) Panel. This person will be independent of the TSCB and will not have worked in a Tameside agency that delivers services to children and families for a period of at least 2 years prior to taking up the role of Independent Chair of the SCR Panel.

The membership of the Serious Case Review will be determined on a case by case basis (appropriate to the conduct of the review) and will form part of the recommended terms of reference that the chair of the Board will consider in making a decision about commissioning the Serious Case Review.

7. Terms of Reference

The SCR Panel should consider, in the light of current information known in each case, the scope of the SCR and draw up clear terms of reference. The TSCB Chair should ensure that the terms of reference address the key issues in the case and approve them.

The Government Office North West Safeguarding Advisers will assist the TSCB where policy advice on undertaking a SCR is required. Where necessary the TSCB will seek legal advice.

Relevant issues to consider in drafting the Terms of Reference include the following:

- What appear to be the most important issues to address in identifying the learning from this specific case? How can the relevant information best be obtained and analysed, including, for instance, information on the mental health of relevant adults?
- When should the SCR start, and by what date should it be completed, bearing in mind the timescales for completion set out below? Are there any relevant court cases or investigations pending which could influence progress or the timing of the publication of the executive summary?
- Over what time period should events in the child's life be reviewed, i.e. how far back should enquiries extend and what is the cut-off point? What family history/background information will help better to understand the recent past and the present?
- How should the child (where the review does not involve a death), surviving siblings, parents or other family members contribute to the SCR, and who should be responsible for facilitating their involvement? How will they be involved and contribute throughout the overall process?
- Are there any specific considerations around ethnicity, religion, diversity or equalities issues that may require special consideration?
- Did the family's immigration status have an impact on the child/children or on the parents' capacities to meet their needs?
- Which organisations and professionals should be asked to submit reports or otherwise contribute to the SCR including, where appropriate, for example, the proprietor of an independent school or a playgroup leader?
- Who will make the link with relevant interests outside the main statutory organisations, for example independent professionals, independent schools, independent healthcare providers or voluntary organisations?
- Is there a need to involve organisations/professionals working in other LSCB areas (see paragraph 8.13), and what should be the respective roles and responsibilities of the different LSCBs with an interest?
- Will the LSCB need to obtain independent legal advice about any aspect of the proposed SCR?

- Who should be appointed as the independent author for the overview report (bearing in mind that this person will not be the Chair of the TSCB, the SCR sub-committee or the SCR Panel – see section 9)?
- Might it help the SCR Panel to bring in an outside expert at any stage, to help understand crucial aspects of the case?
- Will the case give rise to other parallel investigations of practice, for example, into the health or adult social care provided or multi-disciplinary suicide reviews, a domestic homicide review where a parent has been killed, a Prisons and Probation Ombudsman (PPO) Fatal Incidents Investigation where the child has died in a custodial setting or a Serious Further Offence (SFO) or MAPPA Serious Case Review (MSCR) process where offenders are charged with serious further offences whilst subject to statutory supervision? And if so, how can a co-ordinated or jointly commissioned review process address all the relevant questions that need to be asked in the most effective way and with minimal delay? Arrangements should be agreed locally on how a NHS Serious Untoward Incident investigation into the provision of healthcare should be co-ordinated with a SCR.
- How will the SCR terms of reference and processes fit in with those for other types of reviews – for example, for homicide, mental health or prisons?
- How should the review process take account of a coroner's inquiry, any criminal investigations (if relevant), family or other civil court proceedings related to the case? How will it be best to liaise with the coroner and/or the Crown Prosecution Service (CPS) and to ensure that relevant information can be shared without incurring significant delay in the review process?
- How should the review process take account of relevant lessons learned from research (including the biennial overview reports of SCRs) and from SCRs which have been undertaken by the LSCB?
- How should any family, public and media interest be managed before, during and after the SCR? In particular, how should surviving children (where appropriate given their age and understanding) and family members be informed of the findings of the SCR?

8. Timescales for undertaking a Serious Case Review

Reviews vary widely in their breadth and complexity but, in all cases, where lessons are able to be identified they should be acted upon as quickly as possible without necessarily waiting for the SCR to be completed.

Within one month of a case coming to the attention of the TSCB Chair, the TSCB Chair should decide, following a recommendation from the SCR Panel, whether a review should take place. An initial decision may need to be revisited if further information comes to light, for example through a criminal investigation or a child death review in accordance with Chapter 7 of Working Together (2006). Ofsted and other inspectorates should be notified accordingly.

Within six months from the date of the decision to proceed, the Serious Case Review should be completed. Sometimes the complexity of a case does not become apparent until the SCR is in progress. If it emerges that a SCR cannot be completed within six months of the LSCB Chair's decision to initiate it (perhaps because of judicial proceedings), the LSCB should revise its timetable and immediately consult the relevant GO in their capacity to provide advice, support and challenge.

Where an extension **beyond the six month timeframe** is necessary, an update on progress and a revised project plan should be produced quickly for Government Office North West (GONW) to consider. This update should include recommendations for action where these are not dependent on the SCR being concluded until after other proceedings have ended. It should also include actions taken to date and an explanation for the extension to the timescale, including the revised completion date.

Where a decision to extend the period for completion is made, this information will be passed to Ofsted by GONW. The TSCB will be proactive in keeping GONW fully apprised of timing expectations, of risks of delay and of interdependencies with other parallel or related processes.

In some cases, criminal proceedings may follow the death or serious injury of a child. The Chair of the SCR Panel should discuss with the relevant criminal justice agencies such as the police and the CPS, at an early stage, how the review process should take account of such proceedings. For example, how does this affect timing and the way in which the SCR is conducted (including any interviews of relevant personnel), what is its potential impact on criminal investigations, and who should contribute at what stage?

Much useful work to understand and learn from the case can often proceed without risk of contamination of witnesses in criminal proceedings. In some cases it may not be possible to finalise the IMRs and the overview report or to finalise and publish an executive summary until after coronial or criminal proceedings have been concluded, but this should not prevent early lessons learned from being acted upon.

SCRs should not be delayed as a matter of course because of outstanding family, civil or administrative court cases. The LSCB Chair should make these decisions on a case by case basis based on advice from the Chair of the SCR Panel and having consulted with the local authority where there are pending family cases. The LSCB Chair may also need to seek legal advice to assist in deciding how to proceed.

The final SCR report, including the executive summary, should take full account of salient, new information which becomes available during the course of these proceedings and the facts, conclusions and recommendations should be revised accordingly.

9. Responsibilities of those involved in the Serious Case Review

The role of the Serious Case Review Panel

The Chair of the Serious Case Review Panel will:-

- take overall responsibility for the conduct of the Serious Case Review, including compliance with the Terms of Reference
- report regularly to the Board on the activity of the Serious Case Review Panel and on the progress of any Action Plans initiated during the SCR process
- liaise directly with the TSCB Chair and the TSCB Overview Panel Chair to ensure that they are aware of any issues for action at any point in the SCR process
- maintain communication, where required with Government Office North West (GONW) and Ofsted throughout the review and
- be responsible for negotiating any change of timescale on behalf of the Board
- Ensure that the SCR Panel gives sufficient consideration to making recommendations about implementing early identified lessons, including those that impact on training and supervision of staff
- advise the TSCB chair on the how the action plans should be monitored
- Prepare the Multi-agency Consolidated Action Plan.
- Set out recommendations for dissemination of learning from the SCR.

Responsibility of Members of the Serious Case Review Panel

Individual members of the Serious Case Review Panel are responsible for maintaining timely communication with their own agency staff, senior managers, legal advisers, Communications/press officers and others identified as needing to know about the progress of the Serious Case Review.

This will include giving consideration in their respective agencies to the needs of staff for support through the SCR process. Where staff have been directly

involved with the families of the child that is the subject of the SCR, there can be a level of stress and anxiety both as a legacy of working with the child and the family and as a result of the SCR itself.

Members of the SCR panel will scrutinise any reports produced in respect of the Serious Case Review, offering challenge and support to the authors and representatives of the agencies that have commissioned the reports. Members of the SCR Panel will support the chair of the SCR Panel in ensuring that the terms of reference of the SCR are complied with.

Scoping the involvement of agencies and services

The initial scoping of the SCR should identify those who should contribute, although it may emerge, as further information becomes available, that the involvement of others, such as those providing specialist adult services, would be useful.

The Terms of Reference of the Serious Case Review will set out which agencies are requested to contribute to the Serious Case Review, for example by the conducting of Individual Management Reviews (IMRs).

Each relevant service should undertake an IMR of its involvement with the child and family. This should begin as soon as a decision is taken to proceed with a SCR, and even sooner if a case gives rise to concerns within the individual organisation. Relevant independent professionals should contribute reports of their involvement.

Where Cafcass contributes to a review, the prior agreement of the courts should be sought so that the duty of confidentiality which the children's guardian has under the court rules can be waived to the degree necessary.

Designated safeguarding health professionals, on behalf of the PCT(s) as commissioners, should review and evaluate the practice of all involved health professionals, including GPs and providers commissioned by the PCT area. This may involve reviewing the involvement of individual practitioners and NHS Trusts, and advising named professionals and managers who are compiling reports for the review.

The designated doctor and designated nurse should produce an integrated health chronology and a health overview report focusing on how health organisations have interacted together. This may generate additional recommendations for health organisations. The health overview report will constitute the IMR for the PCTs as commissioners.

The SCR Overview Report Author

The SCR Panel, on behalf of the TSCB, should commission an overview report that brings together and analyses the findings of the various IMRs from organisations and others, and that makes recommendations for future action. It is crucial that the SCR Panel and the overview report author have access to all relevant documentation and where necessary individual professionals to enable both to undertake effectively their respective SCR functions.

The overview report will be commissioned from a person who is independent of all the local agencies and professionals involved and of the LSCB(s). The overview report author will not be the chair of the LSCB, the SCR sub-committee or the SCR Panel.

The Overview Report author will also draft the Executive summary for approval by the board and signing off by the TSCB Chair.

The Overview Report Author will produce all reports in accordance with the guidance set out in this policy, in the current version of *Working Together to Safeguard Children* and in compliance with any other relevant guidance from GONW, Ofsted or the DCSF.

Responsibility of Individual Agencies Contributing to the Individual Management Review (IMR) Process

Individual agencies have the following responsibilities:-

- Appoint a person to write the Individual Management Review Report within **two months** of being requested to do so;
- Once it is known that a case is being considered for review, each organisation should secure records relating to the case to guard against loss or interference.
- The aim of the IMR should be to look openly and critically at individual and organisational practice to see whether the case indicates that changes could and should be made and, if so, to identify how those changes will be brought about.
- Those conducting management reviews of individual services should not have been directly concerned with the child or family, or have been the immediate line manager of the practitioner(s) involved.
- The findings from the IMR reports should be signed off by the senior officer in the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted on.
- On completion of each IMR report, there should be a process for feedback and debriefing for staff involved, in advance of completion of the overview report by the TSCB. There may also be a need for a follow-up feedback session if the TSCB overview report raises new issues for the organisation and staff members.
- Serious case reviews are not a part of any disciplinary enquiry or process, but information that emerges in the course of reviews may indicate that disciplinary action should be taken under established procedures. Alternatively, reviews may be conducted concurrently with disciplinary action. In some cases

(e.g. alleged institutional abuse) disciplinary action may be needed urgently to safeguard and promote the welfare of other children.

- Where staff or others are interviewed by those preparing IMRs, a written record of such interviews should be made and this should be shared with the relevant interviewee.

10. TSCB action on receiving the Serious Case Review Report

The SCR Panel, on behalf of the TSCB, should quality assure the final SCR – that is, the IMR reports, the overview report, the executive summary and the action plan.

The TSCB should approve the final SCR and

- provide an anonymised copy of the IMRs, overview report, executive summary and the individual and multi-agency consolidated action plans and chronologies to Ofsted, the relevant GO Children and Learners Team, the SHA and DCSF. All personal information relating to children, family members and professionals involved in the case (with the exception of the names of the LSCB and SCR Panel chairs and the overview report author) should be anonymised in all the SCR documentation submitted to Ofsted and GONW. If the child died in a custodial setting, copies of the anonymised SCR should be made available to the YJB and copies of the executive summary should be provided to the PPO
- make arrangements to provide feedback and debriefing to staff and the media as appropriate
- disseminate the executive summary and key findings to relevant interested parties
- publish only the SCR executive summary once the SCR has been completed
- implement those actions for which the TSCB has lead responsibility and monitor the timely implementation of the SCR action plan
- on receipt of the evaluation letter from Ofsted, take action as necessary to amend the action plan and/or the SCR report if the SCR executive summary has been published before receiving Ofsted's feedback
- formally conclude the review process when the action plan has been implemented and inform GONW of this decision.

The TSCB should decide on a case by case basis when to publish the executive summary. This decision should take account of the timing of the conclusion of relevant parallel processes such as inquests or criminal proceedings. The TSCB, on advice from the SCR Panel and where relevant the CPS, the police or its lawyers, should decide whether new information may become available from these other processes which is likely to have an impact on the lessons to be learnt from the SCR. If the findings are not likely to have an impact, then there should be no delay in publishing the SCR Executive summary. On the other hand, in some cases it may be best to undertake the IMRs and finalise them and the SCR overview report in the light of this new information or findings before publication of the SCR executive summary.

In addition, the TSCB may decide to take account of any points raised in Ofsted's evaluation of the SCR before publishing the SCR executive summary but, depending on circumstances, it may be necessary for the TSCB to publish it prior to the completion of an evaluation by Ofsted.

All SCRs are evaluated by Ofsted and, in line with the arrangements agreed between inspectorates, the evaluation may involve other inspectorates notably the CQC and HMIC. The evaluation will be shared with the TSCB and, together with the published executive summary, with partner inspectorates and government.

Where a SCR has been evaluated as 'inadequate' the TSCB should convene a SCR Panel, to be chaired by an independent person, to reconsider the review. The TSCB is then required to submit to Ofsted, within three months, an action plan that addresses the inadequacies of the SCR.

11. Individual Management Review Reports

Once it is known that a case is being considered for review, each service or organisation that has had contact with the family should secure its records relating to the case to guard against loss or interference. Once it is decided that a SCR will be undertaken, individual organisations, having secured their case records promptly, should begin quickly to draw up a chronology of their involvement with the child and family.

The aim of IMRs is to look openly and critically at individual and organisational practice and at the context within which people were working to see whether the case indicates that improvements could and should be made and, if so, to identify how those changes can be brought about.

The IMR reports should be quality assured by the senior officer in the organisation which has commissioned the report. The senior officer is responsible for signing off the report when they are satisfied the findings. This senior officer will be responsible also for ensuring that the recommendations of the IMR, the action plan and, where appropriate, the overview report are acted on.

The IMR report will be produced in the format set out in the separate guidance produced by the TSCB, *Practice Guidance and Template for the authors of Individual Management Review Reports*.

Those writing the Individual Management Review reports will not have been directly concerned with the child or family, or be the immediate line manager of the person(s) involved. Each report author will be given professional and managerial support from a Report Supervisor within the commissioning agency for the period of time spent preparing the report.

All relevant records will be read and a list of staff to be interviewed will be drawn up. Staff will be supported throughout this process. Notes will be taken during the interview of the questions asked and the responses received. A copy will be given to the interviewee who will have the opportunity to verify them.

There should also be a follow-up feedback session with these staff once the SCR report has been completed and before the executive summary is published. It is important that the SCR process supports an open, just and learning culture and is not perceived as a disciplinary-type hearing which may intimidate and undermine the confidence of staff. The purpose of the Individual Management Review is to examine practice, not to invoke disciplinary action. If issues arise which may lead to disciplinary action this will be reported to the appropriate person within the agency.

The Serious Case Review Panel will scrutinise and discuss all Individual Management Review Reports seeking clarification and making suggestions for amendments as appropriate. This will be a quality assurance process with the aim of ensuring that the IMR adequately addresses the terms of reference of the SCR. This process will not seek to influence the recommendations of the IMR but does have scope to challenge whether sufficient enquiries have taken place and questions asked in order to reach the findings that underpin the recommendations.

The IMR Report recommendations will be translated into an Action Plan with details of timescales for the actions to be implemented for consideration and approval by the Serious Case Review Panel. This should not prevent early lessons from being implemented by the individual services or organizations which have contributed to the review.

12. Serious Case Review Overview Report

The Serious Case Review Panel will commission an independent person to write an Overview Report to bring together and draw overall conclusions from the information and analysis contained in each of the IMR Reports.

The SCR overview report should bring together, and draw overall conclusions from, the information and analysis contained in the IMRs, information from the child death review processes, where relevant, and reports commissioned from any other relevant interests. Overview reports should be produced according to the format set out in Appendix B. However, as with IMRs, the

precise format will depend on the features of the case. This outline is most applicable to abuse or neglect that has taken place in a family setting. In certain circumstances, for example abuse in institutional settings or complex situations, the reviews are likely to be more complex.

The report will be completed within the timescales set by the SCR Terms of Reference. If additional time is required this will be negotiated by the Chair of the Serious Case Review Panel and Government Office North West.

The Overview Report will make recommendations which include the recommendations made in the IMR Reports from each service or organization as well as recommendations made by the Serious Case Review Panel itself.

The report author will be invited to attend every meeting of the Serious Case Review Panel at which the report is to be considered.

Once agreed by the Serious Case Review Panel the Overview Report will be submitted to the Board for approval. On receiving the Overview Report for approval the Board will ask the Chair of the Serious Case Review Panel to:-

- confirm that contributing organisations and individuals are satisfied that their information is fully and fairly represented in the Overview Report;
- translate all the recommendations in the Overview Report into a Multi Agency Consolidated Action Plan (see below) and ensure that this is signed up to at a senior level by each of the organisations that need to be involved;
- bring forward proposals as to whom the Overview Report, or any part of it, should be made available;
- make recommendations for the dissemination of the key findings in the Overview Report to such audiences/interests as may be agreed by the Board

Once agreed by the Board, the Overview Report and the Multi Agency Consolidated Action Plan together with all IMR Reports will be submitted to Ofsted and the DCSF.

13. Executive Summary

In all cases, the SCR overview report and the IMRs should be used to produce an executive summary that should be made public and which accurately reflects the full overview report. It will include, as a minimum:-

- information about the review process
- key issues arising from the case and

- the recommendations which have been made i.e. recommendations from the IMR Reports and any further recommendations made by the author of the Overview Report, the Serious Case Review Panel or Tameside Safeguarding Children Board
- the action plan (including any actions that have been completed)

The content of the Executive Summary will need to be suitably anonymised in order to protect the identity of children, relevant family members and others and to comply with the Data Protection Act 1998. The executive summary should, however, include the names of the TSCB Chair, SCR Panel Chair, the overview report author, and the job titles and employing organisations of all the SCR Panel members.

The Executive Summary will usually be published after the conclusion of all legal proceedings whether civil or criminal.

Any delay in publishing the Executive Summary pending the outcome of any legal proceedings or for any other reason should not prevent early lessons from being implemented by the TSCB and the individual service or organisations which have contributed to the review.

The Serious Case Review Panel will make recommendations to the Board as to how the Executive Summary shall be made public.

14. Multi-Agency Consolidated Action Plan

On completion of these reports the Serious Case Review Panel will translate the recommendations in the Overview Report for all the services or organisations into a Multi Agency Consolidated Action Plan in the format set out in Appendix D.

This will be signed up to by an authorised officer at a senior level from each of the services or organisations involved.

The plan will set out:-

- who will do what, by when, and with what intended outcome and
- by what means improvements in practice/systems will be monitored and reviewed by the Board

The Multi Agency Consolidated Action Plan will be submitted to the Board for approval. It will be regularly monitored by the Serious Case Review Panel on behalf of the Board and progress reports will be submitted to the Board on a quarterly basis until all the objectives have been achieved. The Board will then sign off the Multi Agency Action Plan and Ofsted will be informed.

Tameside Safeguarding Children Board will receive feedback on SCR reports and action plans from Ofsted and will use this feedback to inform improvements to the process of conducting SCRs and to review actions arising from the relevant SCR.

TSCB will continue to monitor compliance with policy and practice issues raised in the course of the Serious Case Review, reporting to the Board when there are concerns. This monitoring function will initially be the responsibility of the Overview Panel via the SCR Panel but, within an agreed timescale, this responsibility will be transferred to the TSCB Performance Monitoring sub-committee.

The TSCB Development Manager will be responsible for the regular review and updating of TSCB policies or procedures arising from Serious Case Reviews to ensure that all agencies remain fully informed of the requirements for safeguarding children.

The TSCB Training Organiser will be responsible for the regular review and updating of TSCB training programmes and courses in the light of lessons learnt from Serious Case Reviews.

15. Parallel Processes

Criminal investigations and legal proceedings may run concurrently with the SCR. The Serious Case Review Panel will be kept fully informed of such processes and will ensure that the timing of the publication of the Executive Summary is sensitive to the timing of the court processes and any external or media interest.

Disciplinary action is not a central concern of the SCR process but where issues are identified these will be referred to the relevant agency managers at any point in the review process. The inquiries undertaken as part of the IMR process may help to inform any decision about disciplinary action.

The Serious Case Review Panel will be informed of any disciplinary proceedings but it will not be involved or kept informed of their content or outcomes.

Changes in practice or procedure may be identified as being necessary at any point in the review process and may be made immediately either because of their urgency or because they are straightforward to implement without waiting for the finalisation of the Action Plan.

Serious Case Reviews should not be delayed as a matter of course because of outstanding coroner or criminal proceedings or an outstanding decision on whether or not to prosecute.

If inquests or criminal proceedings follow the death or serious injury of a child the Chair of the Serious Case Review Panel will liaise with the Coroner, Police

and Crown Prosecution Service as appropriate to agree how the Serious Case Review will take account of those proceedings e.g.

- the timing of the review
- the way in which the review is conducted
- the potential contamination of witnesses
- who should contribute to the review and at what stage

The Serious Case Review Panel will also consider whether publication of the Executive Summary should be delayed until the outcome of any inquest or criminal proceedings (including sentencing but not including any appeal). If publication of the Executive Summary is to be delayed this will not prevent early lessons from being implemented by the individual services or organisations as identified in the review.

16. Information issues and the Serious Case Review

Accountability and disclosure

The TSCB will consider carefully who might have an interest in the SCR – for example, elected and appointed members of authorities, staff, the child who was seriously harmed and the subject of the SCR, members of the child's family, the public, the media – and what information should be made available to each of these interests.

There are difficult interests to balance, including:

- the need to maintain confidentiality in respect of personal information contained within reports on the child, family members and others
- the accountability of public services and the importance of maintaining public confidence in the process of internal review
- the need to secure full and open participation from the different agencies and professionals involved
- the responsibility to provide relevant information to those with a legitimate interest
- constraints on public information sharing when criminal proceedings are ongoing, in that providing access to information may not be within the control of the TSCB.

It is important to anticipate requests for information and plan in advance how they should be met. For example, a lead agency may take responsibility for discussing the process and outcome of the SCR with the child (where the SCR was undertaken in respect of a child who has not died) and family members,

or for responding to media interest about a case, in liaison with contributing agencies and professionals.

The publication of the executive summary needs to be timed in accordance with the conclusion of any related criminal court proceedings. Neither the SCR overview report nor the IMRs should be made publicly available.

The TSCB will ensure that GONW, Ofsted and all other relevant bodies including the SHA, the CQC, HMIC, HMIP and HMI Probation are appropriately briefed in advance about the publication of the executive summary. Where a child has died in a custodial setting, this briefing should include the YJB and the PPO. The SHA should brief the Department of Health.

Accessing health-related information

Designated safeguarding health professionals have an important role in providing guidance on how to balance confidentiality and disclosure issues to ensure an objective, just and thorough approach to identifying lessons in the IMR. If the designated health professional(s) have been clinically involved with the case the PCT should seek advice and help from another PCT designated professional as necessary.

The process of conducting an IMR requires access to records relevant to the child such as those from health bodies. The public interest served by this process warrants full disclosure of all relevant information within the child's own records.

In some circumstances the person conducting the IMR may require access to information about third parties (for example, members of the child's immediate family or carers) that is either contained within the child's health records or in the health records of another person. While in most cases there will be a public interest in disclosing this information, the record holder(s) should ensure that any information they disclose about a third party is both necessary and proportionate.

All disclosures of information about third parties need to be considered on a case by case basis, and the reasoning for either disclosure or non-disclosure should be fully documented. This applies to all records of NHS-commissioned care, whether provided under the NHS or in the independent or voluntary sector.

Dissemination of Information from the SCR

It is acknowledged by the Board that various groups of people will have a legitimate interest in Serious Case Reviews and their outcome. The publication of an Executive Summary of an Overview Report will address as far as possible public interest issues of accountability and transparency without compromising the confidentiality of the review itself. The publication of a Multi Agency Consolidated Action Plan will address the concerns identified in the Executive Summary. Organisations that have contributed to the review may publish their own Action Plans subject to consultation with the Chair of the Board.

The dissemination of information will include:-

- the proactive promotion of the work of the Board and awareness raising activities concerning safeguarding issues;
- responding to public and media enquiries about the work of the Board and
- responding to or ensuring that the relevant organisation responds to public and media enquiries concerning individual cases.

The TSCB has a separate document *Promoting a Positive Approach to Communicating the Safeguarding Agenda – TSCB Guidance* which deals in more detail with how the relevant information from the Serious Case Review will be disseminated.

This guidance sets out that there should be a Single Point of Contact (SPOC) for any media enquiries in respect of the SCR.

Disclosure Issues in respect of Specific SCR Documents

Executive Summary

See section 13 above.

Overview Report

By its very nature the Overview Report will contain some confidential details about family members and information by which it may be possible for individuals, although not named, to be identified.

No disclosure will be made without first taking legal advice from the legal adviser to the Board who will, if appropriate, consult with the legal advisers to the agencies that have contributed Single Agency Review Reports to the Serious Case Review. This is essential because consideration has to be given to whether disclosure of information may be in breach of the data protection legislation or the European Convention of Human Rights.

Provided the recommendations in the Overview Report do not contain confidential details about individuals or information by which individuals can be identified, they will be published as part of the Executive Summary.

The Overview Report will be anonymised subject to a coding schedule produced as part of the SCR Panel's Terms of Reference. This coding Schedule will also be used to anonymise all other SCR documents.

Individual Management Review Reports

As with the Overview Report these reports will contain some confidential details and information by which individuals, although not named, can be identified. Consideration has to be given to whether disclosure of information may be in breach of the data protection legislation or the European Convention of Human Rights.

No disclosure will be made without first taking legal advice from the legal adviser to the Board and/or the legal adviser to the organisation concerned. Provided the Action Plans drafted in response to these Reports do not contain confidential details about individuals or information by which individuals can be identified the Action Plans may be published at the discretion of individual agencies.

If an organisation that has contributed to a Serious Case Review proposes to publish an Action Plan in response to the recommendations in its Single Agency Report, it will first notify the Chair of the Board that the Action Plan is to be published and will discuss with the Chair the timing of the proposed publication. The Chair will disseminate that information to the other members of the Board.

A report will be submitted to the next meeting of the Board by the representative of the organisation setting out details of what has been published, when it was published and to whom.

Multi Agency Consolidated Action Plan

A Multi Agency Action Plan will be published on the Board's website www.tameside.gov.uk/childprotection provided it does not contain confidential information about individuals or information by which individuals can be identified. It will set out:-

- the recommendations for action by each individual agency that has contributed a IMR Report;
- the person within that agency who is responsible for the implementation of the proposed actions;
- the date by which the proposed action will be implemented and
- if the recommended action has not been implemented by the proposed date, the progress which has been made towards implementation and the revised date by which the action will be implemented.

Freedom of Information Act 2000

The Freedom of Information Act 2000 provides the public with a general right of access to information held by public authorities. Public authorities include local government, the police, the NHS and state schools.

This general right of access to information held by public authorities is subject to a number of exemptions. **Personal information must not be disclosed if its disclosure would breach the data protection principles.** Information provided in confidence may be withheld if its release would constitute an actionable breach. There is also an exemption relating to information the disclosure of which would be prejudicial to the effective conduct of public affairs, although this is subject to the public interest test (see below).

Every request for information which is not the subject of section 9 of this Policy must be considered on its merits. There can be no automatic refusal of the disclosure of certain types of documents e.g. Single Agency Reports or Overview Reports. The Freedom of Information Act 2000 does not allow this. Nothing in this Policy can override the legislation.

The Information Commissioner has a general role (not specific to Tameside) to decide whether a request for information made to a public authority has been dealt with in accordance with the requirements of Part 1 of the Freedom of Information Act 2000. The Information Commissioner in 2006 made a decision that a full report of a Serious Case Review is exempt under section 36, Freedom of Information Act 2000 and that disclosure would be prejudicial to the conduct of public affairs. Furthermore substantial parts of the report were also deemed to constitute exempt information under section 40 – personal information and section 41 – information provided in confidence.

Although a Serious Case Review is commissioned and “owned” by the members of the Board working in partnership with each other, a response to a Freedom of information request must come from the organisation to which the request is made.

If a member organisation receives a Freedom of Information request which relates to a Serious Case Review commissioned by the Board it will draft a response based on the advice of its own legal adviser, who will liaise with other legal advisers as appropriate.

The request and the response will be copied to the Chair and all members of the Board for their information.

If a request for information under the Freedom of Information Act 2000 (the Act) is refused then the complainant has a right of appeal to the Information Commissioner. The Commissioner’s role is to decide whether a request for information made to a public authority has been dealt with in accordance with the requirements of the Act.

Document Management and Security

Serious Case Review documentation must be treated as highly sensitive and confidential, and stored securely by all agencies. Secure sharing, retention and storage of IMR Reports and accompanying documents, such as records of staff interviews, is the responsibility of the originating agency and may be used as part of parallel or subsequent processes such as disciplinary or insurance activity.

One master copy of each agency’s IMR Report will be retained with the Serious Case Review Report by the TSCB Administrator.

During the review process, secure sharing, retention and storage of master copies of the Single Agency Reports, the Overview Report, the Executive Summary, the Multi Agency Consolidated Action Plan and any relevant accompanying documents, will be the responsibility of the TSCB Administrator and *subject to restricted access to authorised persons only*. These master

copies will be retained by the Administrator in secure conditions throughout the period of the review process.

Authorised persons will only be allowed access to SCR-related documents in order to legitimately progress the due process of the Serious Case Review. Access requests from authorised persons which are agreed will be recorded. Authorised persons will be senior representatives of member agencies of the TSCB and members of the SCR Panel.

Hard copies of the Serious Case Review Report will be limited in number and stored securely. Each copy will be numbered, and a signing-out procedure used when a copy is issued. Hard copies will be provided for Ofsted, the local authority's Head of Legal Services, and the Executive Director of Children's Services.

Authorised persons wishing to access hard copies of the Serious Case Review Report will sign for the copy, leaving contact details to ensure swift retrieval if required. During the period that the hard copy is signed out, the person receiving it is responsible at all times for its security and confidentiality.

Requests for electronic or hard copies of the Executive Summary will be collated and responded to by the TSCB Administrator subject to the protocol set out here. The TSCB Administrator will record all such requests and the reasons given for making them. This information will be passed to the Overview Panel for information at the conclusion of the review in order to aid understanding of the level and type of external interest in the review.

After the conclusion of the Serious Case Review process the master copies of all documents will be stored securely and all other hard copies destroyed. These documents will be retained for the period set down for the retention of children's records.

17. Learning Lessons

As the purpose of SCRs is to learn lessons for improving both individual agency and inter-agency working, they will be of little value unless the lessons are acted upon. This means that at least as much effort should be spent on implementing the recommendations as on conducting the review. The following may help in getting maximum benefit from the review process:

- as far as possible, conduct the review in such a way that the process is a learning exercise in itself for all those who have been involved in the case
- consider what type and level of information needs to be disseminated, how and to whom, in the light of a SCR. Be prepared to communicate both examples of good practice and areas where change is required, as well as to integrate this information with that from other serious case reviews or other local reviews

- incorporate the learning into local training programmes
- focus recommendations on a small number of key areas, with **Specific, Measurable, Achievable, Relevant and Timely** proposals for change and intended outcomes
- the TSCB will put in place a means of monitoring and auditing the actions of all agencies against recommendations and intended outcomes
- utilise feedback on SCR reports and the implementation of the findings from Ofsted and GONW. The role of GONW in relation to safeguarding includes giving support and challenge to LSCBs and to Children's Trusts in relation to SCR and Child Death Overview Panel activity and implementation
- PCTs should seek feedback from SHAs who should use it to inform their performance management role, and the CQC may use the findings of SCRs to inform its processes for regulating NHS and independent sector provider organisations. PCTs will monitor the implementation of the recommendations by provider organisations.

Day-to-day good practice can help ensure that reviews are conducted successfully and in a way most likely to maximise learning

- establish a culture of audit and review. Make sure that tragedies are not the only reason inter-agency work is reviewed
- have in place clear, systematic case-recording and record-keeping systems
- develop good communication and mutual understanding between different disciplines and different LSCB members
- communicate with the local community and media to raise awareness of the positive and 'helping' work of statutory services with children, so that attention is not focused disproportionately on tragedies
- make sure staff and their representatives understand what can be expected in the event of a child death/SCR.

The TSCB will draw on the information from the Serious Case Review when publishing the TSCB annual report. Appropriate care will be taken to ensure confidentiality of personal information and sensitivity to the families whose child is the subject of a SCR.

The TSCB annual report will support the driving forward of measures to prevent child deaths and serious harm where abuse and neglect have been factors and to safeguard and promote the welfare of children.

Taken together, child death and SCRs are an important source of information to inform national policy and practice. The DCSF is responsible for identifying and disseminating common themes and trends across review reports, and acting on lessons for policy and practice. The DCSF commissions regular reports, drawing out key findings of SCRs and their implications for policy and practice to assist the process of learning lessons. In the future relevant findings from the work of the local child death overview teams will be integrated into these reports.

Appendix A - overview report format

1. INTRODUCTION

- Summarise the circumstances that led to a review being undertaken in this case.
- State the terms of reference of the review.
- List agencies or types of contributors to the review and the nature of their contributions (for example, IMR by local authority, report through the PCT as commissioner from adult mental health service). List the names and roles/positions/job titles of the LSCB Chair, SCR Panel Chair, the author of the overview report and the job titles and employing organisations of all the SCR Panel members.
- List external investigations, if any, that are being conducted (for example the PPO investigation following the death of a child in custody a Prisons and Probation Ombudsman (PPO), a Fatal Incidents Investigation where the child has died in a custodial setting or a Serious Further Offence (SFO), MAPPA or a mental health inquiry).

2. THE FACTS

- Prepare an anonymised genogram showing membership of family, extended family and household.
- Compile an integrated chronology of involvement with the child and family on the part of all relevant organisations, practitioners and others who have contributed to the review process. Note specifically in the chronology each occasion on which the child was seen, if the child was seen alone and the child's wishes and feeling sought or expressed.
- Consider explicitly any relevant ethnic, cultural or other equalities issues and whether these are relevant to the behaviours and approach taken by the organisations and professionals involved.
- Summarise the relevant information that was known to the agencies and professionals involved about the parents/carers, any perpetrator and the home circumstances of the children.

3. ANALYSIS

It is important that this is objective and open, being clear where systems, policy and practice could be improved. The findings from the SCR should be

considered alongside learning from previous SCRs undertaken by the TSCB, by other LSCBs and findings from relevant research.

- Consider and reach a judgement about how and why events occurred
- Consider and reach a judgement about how and why decisions were made
- Consider and reach a judgement about how and why actions were taken or not taken
- Consider and reach a judgement about whether with the benefit of hindsight different decisions or actions may have led to an alternative course of events
- Highlight any examples of good practice.

4. CONCLUSIONS AND RECOMMENDATIONS

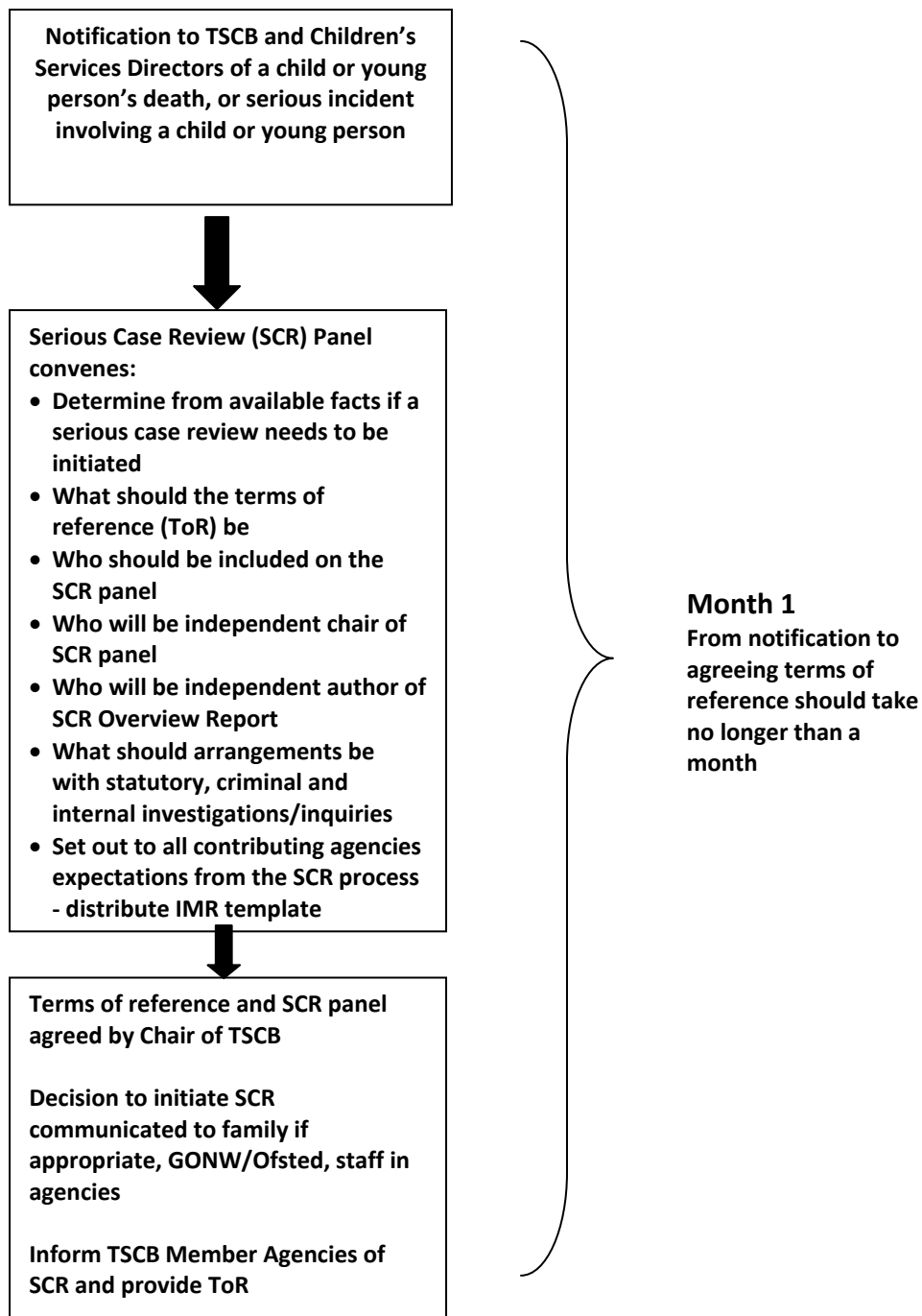
This part of the report should summarise what lessons are to be drawn from the case, and how those lessons should be translated into recommendations for action, and to what timescales.

- List the recommendations made in individual reports from each organisation
- List the recommendations of the Overview report author
- List any additional recommendations of the Serious Case Review Panel
- Ensure that the recommendations are
 - few in number
 - focused
 - specific
 - capable of being implemented
- It can also be helpful to think in terms of framing recommendations according to the SMART principle, namely:
 - **S**pecific
 - **M**easurable
 - **A**chievable
 - **R**ealistic
 - **T**imely.
- If there are lessons for national as well as local policy and practice, these should also be highlighted and the information sent to the relevant government department.

Appendix B – Multi-Agency Consolidated Action Plan Format

Recommendation	Outcome	Action	Target Date	Person Responsible	Evidence of Progress	Cross Reference

Appendix C – Flowchart of SCR Process



Month 1 & 2: All agencies involved with child(ren) and family initiate Individual Management Reviews (IMRs) including interviewing staff where appropriate -

Individual agencies begin learning from case and implementing actions identified in IMRs – begin the feedback to staff

Agencies submit chronologies to SCR Panel and identify key themes so that terms of reference are defined

Finalise SCR Panel members, authors and any independent expert

Month 3:

- SCR Panel begins to combine individual chronologies
- Agree on what the major issues are in the case
- Amend terms of reference if required
- IMRs presented to Panel for scrutiny and challenge – QA Role
- Request additional IMRs from agencies whose involvement has come to light following the analysis of IMRs, or where initial IMRs do not sufficiently cover the terms of reference
- Finalise and seek senior officer approval on IMRs
- Independent author of Overview Report begins reviewing ToR, chronologies, IMRs and minutes of Panel meetings with Independent Chair of Panel
- Begin compiling Overview Report
- Make arrangements for interviewing families where appropriate
- Request from agencies additional material required to enable critical analysis and strong evaluation – national research, professional standards and clarifications of policies and procedures

Month 4:

- Complete interviews
- Further analysis and agreement of issues
- Analysis and commentary on the quality of IMRs
- Begin drawing conclusions and what lessons to be learnt
- Begin producing the recommendations and negotiating with agencies timeframes for their implementation
- First draft of Overview Report – discuss with Panel

Month 5:

- First draft of Overview Report, Action Plan and Executive Summary sent to the TSCB and, where necessary, out of Borough LSCBs for pre publication checks and approval
- Senior representatives of all agencies at TSCB ensure that information in Overview Report is fully and fairly represented
- Produce a final Action Plan ensuring actions are 'SMART' (specific, measurable, achievable, realistic and time related)
- Produce final drafts of Overview Report and Executive Summary
- Disseminate key findings from the Overview Report and action areas to staff in affected agencies to continue implementing actions and learning lessons
- TSCB chair to approve final drafts of all documents
- Submit IMRs, Overview Report, Executive Summary and Action Plan to Ofsted and Government Office North West

Month 6 and onwards:

- Where Ofsted evaluate a SCR as 'inadequate', re-convene panel, nominate new chair and author to rectify sections judged as 'inadequate' – meet with inspectors where this is offered and obtain the evaluation report written on SCR by Ofsted. To appeal against any evaluations, use the regional quality assurance process and then the National Consistency Panel process.
- Once final Ofsted judgement is received, make Executive Summary available on website and provide briefings for family, staff, members and media
- Monitor implementation of Action Plan quarterly through SCR Committee and by LSCB Chairs Group
- Regular case file audits include checking that recommendations/actions from SCRs are being implemented