Stockport Safeguarding Children Partnership (SSCP) and Safeguarding Adults Board (SSAB)

Combined Safeguarding Children Practice Review/Safeguarding Adults Review Protocol

Interim Guidance

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1. Introduction

This document sets out the arrangements by which Stockport Safeguarding Children Partnership (SSCP) and the Safeguarding Adults Board (SSAB) will conduct its case reviews. It highlights its statutory duties, overall process for running a Child Safeguarding Practice Review (CSPR) or a Safeguarding Adult Review (SAR), and how both Safeguarding Partnerships will commission such work.

The core process that SSCP and SSAB will utilise for all case reviews is set out in the attached document.

It should also be noted that both Safeguarding Partnerships are concerned with reviews of significant cases, some of which will become CSPRs/SARs and others may become reviews that will not meet the threshold but will be commissioned by the Executive/Board when considered necessary.

The key aim of any review remains as set out in the following legislation:

- Working Together to Safeguard Children (2018)
- Care Act 2014.
- Domestic Violence, Crime and Victims Act (2004)

A CSPR or SAR should be conducted in a way which:

- Recognises the complex circumstances in which practitioners work together to safeguard children/adults;
- Seeks to understand precisely who did what and the underlying reasons that led individuals and organisations to act as they did;
- Seeks to understand practice from the viewpoint of the individuals and organisations involved at the time rather than using hindsight;
- Is transparent about the way data is collected and analysed and
- Makes use of relevant research and case evidence to inform the findings.

Deciding whether to convene a CSPR/SAR

Each Safeguarding screening panel is made up of representatives from either SSCP and/or SSAB partner agencies. There is an expectation that all screening panel members will ensure that they attend the meeting to share initial information and to assist in the shared decision making.

It is the responsibility of the screening panel members to consider whether the presenting information meets the criteria for CSPR/SAR as set out in Working Together 2018 and the Care Act 2014.

In the case of a child safeguarding referral, the Business Manager with the oversight of the Practice Improvement Partnership (PIP) will determine the most appropriate pathway for the referral. The pathways are, a Rapid Review, a Practice Review or Case Escalation. A virtual panel, consisting of the three statutory partners, will consider a referral and if serious harm has occurred and abuse or neglect is suspected, then the case must be notified to the

National Panel *(The Local Authority is the only partner able to do this)* and consideration given as to whether a local review is required. If the criteria is met for a Rapid Review this will be conducted as outlined in the Rapid Review guidance and The National Panel notified of the outcome. The outcome may be to conduct a Local Child Safeguarding Practice Review (CSPR) or other alternative process. The National Panel considers all Rapid Reviews and will make a recommendation back to the three statutory partners and the Independent Chair. For more details please see SSCP Review Process.

As for a Safeguarding Adult review (SAR) the final decision on whether to conduct a SAR is made by the Independent Chair of the Adults Board considering the rational and recommendations of the SAR panel.

2. Types of Case Reviews

Safeguarding Adult Reviews – Section 44 of **The Care Act 2014** sets out the explanation of the circumstances in which Safeguarding Adults Boards are required to undertake a Safeguarding Adults Review.

Safeguarding Children Practice Review - Working Together 2018 identifies that where a case is a "serious child safeguarding case" then partners must make arrangements to identify, commission and oversee arrangements for that review process. For further information on the arrangements by which Stockport Safeguarding Children Partnership (SSCP) will determine when to trigger a Rapid Review process or another appropriate alternative case review process. More details can be found in the SSCP Review Process available in the link above.

Domestic Homicide Reviews – were established on a statutory basis under Section 9 of the **Domestic Violence, Crime and Victims Act (2004)**

3. The purpose of a Review

The purpose of having a CSPR/SAR is not to reinvestigate or to apportion blame, it is to establish whether there are any lessons to be learnt from the circumstances of the case, about the way in which local practitioners and agencies work together to safeguard children and/or adults.

CSPRs/SARs are not disciplinary proceedings, and should be conducted in a manner, which facilitates learning, and appropriate arrangements must be made to support staff.

SARs are not enquiries into why an adult has died (or been significantly injured), or who is culpable. These are matters for criminal courts and coroner's courts.

4. Notification of a serious safeguarding incident

The Safeguarding Adults Board is the only body that can undertake a Safeguarding Adult Review.

- Any practitioner can make a referral for a Safeguarding Adult Review.
- Staff will usually find it helpful to discuss their concerns with their organisation's safeguarding lead prior to making a referral. Using the referral checklist (Appendix 1).
- Referrals are made via secure email.

- Discussions regarding the appropriateness of referring a case are welcomed by the Safeguarding Adults Board Business Manager.

SSAB - SAR referral form can be found here and returned to email lsb@stockport.gov.uk

SSCP – CSPR Referral form can be found here and returned to email lsb@stockport.gov.uk

Appendix 1 shows a flowchart of SAR referral process.
Referrals should be made via secure email to the Safeguarding single point of contact (SPOC) as soon as possible after the incident via email at: lsb@stockport.gov.uk

SPOC to notify Stockport's Safeguarding Board Business Manager who will ensure that the Chair of the Safeguarding Board is briefed on the circumstances.

5. Procedure for a SAR

Once a referral is received, the Board Business Manager will ensure sufficient information regarding the case is included to demonstrate how SAR criteria is met. This may involve referees being asked to provide additional information. Where referrals do not appear to evidence the SAR criteria the three statutory partners will be asked to consider the appropriate next steps. There may be occasions where alternative pathways are more appropriate, such as the escalation pathway. To ensure absolute transparency is in place, all SAR referrals are reported on a quarterly basis to both the Practice Improvement Partnership and the Safeguarding Adults Board. This will allow scrutiny and challenge of all decision making.

Where the SAR referral is considered to be sufficient to screen, a panel will be scheduled and the Chair of the safeguarding screening panel, supported by the Safeguarding Partnership Lead/Board Business Manager, will discuss with members of the panel to consider whether the criteria is met.

Agencies can be asked for additional information by the Business Manager to inform a decision as to whether a review should take place. The Chair of the Safeguarding Adults Board is responsible for deciding whether to undertake a review or not, based on the recommendations of the safeguarding screening panel.

The methodology for undertaking a SAR will be discussed and agreed by the safeguarding screening panel and the Chair of the Safeguarding Adult Board.

The Safeguarding Adults Board Business Manager on behalf of the SAB will inform the lead representative of the referring agency of the decision.

If the decision is to undertake a SAR, the Board will arrange to notify the individual, their family, friends or carers (where appropriate), of the outcome of the decision.

5.1 Recommending the Overall Approach to the CSPR or SAR

The safeguarding screening panel will recommend:

- Which agencies should be asked to participate in the CSPR/SAR.

- Whether the agencies concerned are required to secure their files.
- Which methodology should be used to facilitate learning in the case.
- The Terms of Reference for the CSPR/SAR.
- The required output from the CSPR/SAR (e.g. a report).
- Recommendations relating to an independent facilitator/chair.
- Recommendations relating to the commissioning of an independent author.
- The timescales for completion of the CSPR/SAR. (The expectation of the SSCP/SSAB is that the report and learning is available no later than 6 months after the decision to initiate a review is made.

6. Links with other reviews and investigations

There are separate statutory requirements for CSPR/SAR. However, the same process is applied when a referral has been received for either a child and/or adult of a CSPR/SAR.

When running an CSPR or SAR all relevant areas that need to be addressed should be established at the outset to reduce potential for duplication for families and staff.

Any CSPR/SAR will need to take account of a coroner's inquiry, and, or, any criminal investigation related to the case, including disclosure issues, to ensure that relevant information can be shared without incurring significant delay in the review process.

A CSPR/SAR should also take account of any other review process e.g. NHS serious incident investigations and should inform the development of the Terms of Reference.

The SAR process will be flexible depending on the nature and complexity of a case, and the same processes will apply for any recommendation received by Community Safety Partnership (CSP) in relation to a Domestic Homicide Review (DHR).

7. Coroners

Coroners are independent judicial office holders who are responsible for investigating violent, unnatural deaths or deaths of unknown cause, and deaths in custody, or otherwise in state detention, which are reported to them. The Coroner may have specific questions arising from the death of a child/and or adult at risk. These are likely to fall within one of the following categories:

- Where there is an obvious and serious failing by one or more organisations.
- Where there are no obvious failings, but the actions taken by organisations require further exploration/explanation.
- Where a death has occurred and there are concerns for others in the same household or other setting (such as a care home).
- The Coroner or his or her officers identify deaths that fall outside the requirement to hold an inquest but follow-up enquiries/actions.

In the above situations, the Safeguarding Executive and the Safeguarding Adults Board should consider instigating a CSPR/SAR.

The final overview report for the Safeguarding Adult Review (or equivalent) will be shared with the Senior Coroner only once this has been completed and signed off by the Safeguarding Executive and/or the Safeguarding Adults Board.

The Coroner may also request additional information pertaining to the review, such like IMRs and chronologies and if so, it would be necessary for the Safeguarding Executive or the Safeguarding Adults Board to seek to facilitate information requests to the relevant partners in a timely manner.

8. Screening of referrals

The Business Unit will inform Board members of the arrangements for case screening and request information/agency contact forms to be submitted in advance of screening meeting.

A screening meeting is held, and it will make a recommendation to the Independent Chair of the Safeguarding Executive/Board as to the need for a review (or not) and recommend an appropriate learning model to be used if required.

Membership of screening panel:

- Head of Safeguarding and Learning (Chair)
- Safeguarding Board Business Manager
- Agency representative on case by case basis
- Minutes of the meeting will be recorded by the Business Unit

Within 5 working days the Independent Chair of the Safeguarding Adults Board will consider the case and forward the decision to the Business Unit. The Business Unit will then inform Executive/Board members.

The screening meeting allows:

- To share historical and current agency information known about the victim / perpetrator / family / household members or known significant others.
- To share information about the events surrounding the death of the victim.
- To identify any parallel review processes which may be planned or underway in relation to the incident, and the implications of these for CSPR/SAR arrangements.
- To advise the Independent Chair of the Safeguarding Executive and or the Safeguarding Adults Board on whether the statutory criteria for undertaking a CSPR/SAR have been met and accordingly whether a review should be commissioned.
- To identify those best placed to sit on the Safeguarding screening panel (where applicable) and its terms of reference.

Where the Safeguarding screening panel agrees that a situation does not meet the criteria for a CSPR/SAR, but agencies will benefit from a review of actions, other methodologies can be considered.

These include:

- **Single Agency Review:** A review by an individual organisation in relation to their understanding and management of a safeguarding issue.

- **Reflective Practice Session:** The original participants in the case may review identified aspects of the case as part a reflective practice session chaired by the Safeguarding Lead or other such suitable person, including an independent facilitator.
- **A practice review** - will be considered by the PIP when Rapid Review criteria is not met. They will review the referral to identify if there is multi-agency or single agency learning. If they identify the potential for lessons about how we work together locally then they will identify a lead to take forward a practice review.

9. Responsibilities of the Safeguarding Adult Review Panel

The role of the Review Panel is to agree the terms of reference, review the progress of enquiries, consider all data being submitted before the Panel, give consideration to the findings and conclusions and make recommendations in relation to what action is required to address the learning identified.

The Review Panel must be independent from the case, so to ensure autonomy it is important the Panel is in a position of seniority who have the right level of experience to provide respectful critical challenge. Therefore, its important to establish at the initial stage of the review process that the review panel is fully represented by each organisation and any disclosures of involvement with the subject of the review and/or family members is settled at the start.

It is expected that all Review Panel members will attend each Panel meeting. Each Review Panel member has a key role and practitioner responsibility within the Safeguarding Adult Review process. Agencies must be robust in selecting their nominated panel member and be clear on time commitment for the panel meetings and involvement in the review including preparation between, and for panel meetings. It is imperative to the integrity of the safeguarding adult review process to ensure it is quorate at each meeting of the Review Panel meeting and that there is continuity.

Once the Review Panel is established, nomination of any deputy panel member is only permitted under exceptional circumstances. It is a requirement for the panel members to prepare for each panel meeting thoroughly and input in other ways that the Review Panel Chair/Report Author may require.

10. Membership

The Review Panel will be quorate when the police, health and local authority representatives are present, together with the Review Panel Chair/Report Author and will meet on average between 3 and 6 times during the course of the review.

Membership of the Review Panel:

- Review Panel Chair/Report Author.
- Head of Safeguarding and Learning (Chair).
- Safeguarding Board Business Manager.
- Stockport Local Authority including Safeguarding Adults and Children.
- Greater Manchester Police (GMP).
- Stockport Clinical Commissioning Group.

Any other local or national agency, which had or may have been involved with the victim, perpetrator or their families and households, should also be invited to contribute to and attend the CSPR/SAR panel meeting. The following examples of those who should be considered are not exhaustive:

- Stockport NHS Foundation Trust.
- Pennine Care NHS Foundation Trust.
- Registered providers i.e. Housing Associations and Social Landlords.
- HM Prison Service.
- National Probation Services.
- Independent Health practitioners, e.g. GPs and Dentists.
- Schools.
- Crown Prosecution Service.
- The Police Family Liaison Officer.
- Representatives of the Voluntary and Community Sector (VCS) with expertise in domestic violence and abuse.

Servicing the meeting

The Head of Safeguarding and Learning will chair the Safeguarding screening panel meeting.

The Council's Safeguarding Business Unit will service the meetings. Papers will be provided at the meeting to allow panel members to be fully informed and enough time will be allowed to read all the relevant information.

The safeguarding business unit will:

- Notify core members that a Safeguarding screening panel is to take place and members will save the date in their calendar.
- Send invitations to the Screening panel members and all other known agencies, which had been involved with the victim, perpetrator or their families and households to attend the Safeguarding screening meeting.
- Compile a summary for the Chair of each case in preparation for the meeting.
- Ensure that the Chair and the screening panel members who will be attending have copies at the meeting.
- Prepare the agenda.
- Attend the meeting and take minutes and record decisions.
- If a decision is taken to conduct a CSPR/SAR, and the decision is approved by the Independent Chair of the Board, then the Safeguarding Business unit will send out the chronology template to agencies identified as being involved.

11. Timescales

SARs - All requests to hold a SAR will be dealt with in accordance with the decision-making process set out in paragraph 5.1. The meeting to discuss the SAR Referral will be established within 15 working days of the request being received.

The conclusions of the meeting and the SSAB's recommendations should be provided in writing within 5 working days of the meeting to the Independent Chair of the Safeguarding

Adults Board, who will make the decision on whether there should be a SAR within 5 working days.

CSPRs - If the Virtual Panel determine that a Rapid Review is required, then the safeguarding partners should promptly undertake a Rapid Review of the case. This will be for those cases which meet the threshold of a Notifiable Serious Incident or the virtual panel has taken a decision that a Rapid Review is the most appropriate way forward. Timescales for this process can be found on page 9 of the SSCP Review Process.

Stockport's Safeguarding Partnership/Board Manager, on behalf of the Independent Chair, must inform the victim's family, in writing, of the Safeguarding Executive/Boards position regarding whether a CSPR/SAR will be conducted. There may be occasions where there are already practitioners involved with family members and where appropriate these existing relationships will be utilised to ensure clear and prompt communication of decisions takes place.

Once the decision to undertake a CSPR/SAR has been made, it is good practice for it to be completed within six months.

It is acknowledged that where there are dual processes or reviews that are complex, these may require more time. Any urgent issues, which emerge from the review and need to be considered immediately, should be brought to the attention of the Executive/Board.

12. Conducting the review

Once a decision has been made to conduct a review, the Chair and members of the Safeguarding screening panel will be responsible for preparing draft Terms of Reference, which are proportionate to the circumstances of the case.

13. Appointment and Role of the Review Panel Chair/Report Author

The Review Panel Chair/Report Author should be an experienced individual who is not directly associated with any of the agencies involved in the Review.

The Review Panel Chair/Report Author will be responsible for effectively leading and coordinating the Review Panel and for quality assurance of the final Report based on the Individual Management Reviews (IMRs – see below) and any other evidence the Safeguarding screening panel decides is relevant.

Consideration should be given to the skills and expertise required to effectively Chair a CSPR/SAR. They should have the appropriate core skills including:

- Strong leadership and ability to motivate others.
- Expert facilitation skills and ability to handle multiple perspectives and potentially sensitive and complex group dynamics.
- Collaborative problem-solving experience and knowledge of participative approaches.
- Ability to find and evaluate best practice.
- Good analytical skills and ability to manage quantitative and qualitative data.
- Knowledge of safeguarding adults.

- Ability to write for a wide audience.
- An understanding of the complexity of the health and social care arrangements and an awareness of issues which are complex or of national importance such that a national review may be appropriate.

The Review Panel Chair/Report Author is responsible for the final decision on the suitability of the CSPR/SAR terms of reference and they are to be agreed at the first meeting of the Panel.

The Terms of Reference may, however, need to be revisited as the Review progresses and as new information is identified. The Review Panel Chair/Report Author will agree any amendments to the Terms of Reference with the Review Panel.

The Review Panel Chair/Report Author will establish an agreed timetable of Review Panel meetings in accordance with the required timescales of the Review and set specific parameters, including timescales, for the completion of IMRs.

As part of the terms of reference, the Review Panel Chair/Report Author should appoint lead individuals or agencies who will act as a:

- Designated advocate for engaging with family members and friends.
- Contact point for responding to media interest about the Review in conjunction with Stockport Council's corporate communications team.

The Review Panel Chair/Report Author should as far as possible, ensure that the review process is a learning exercise for all those involved in the case.

The Review Panel Chair/Report Author will regularly update the Independent Chair of the SSCP and, or the SSAB on progress with the CSPR/SAR.

The Review Panel Chair/Report Author will maintain contact with the Safeguarding Partnership/Board Manager of all parallel review or investigation processes and to ensure that any coordination and joint commissioning arrangements are effective.

The Chair of the Review Panel/Report Author should ensure that regular updates are obtained regarding services being provided by any agency to meet the safeguarding or other needs of individuals who are subject of the Review.

Where there is an on-going criminal investigation the Review Panel Chair/Report Author will ensure that early and regular contact is made with the Senior Investigating Officer to ensure no conflict exists between the two processes. This relates particularly to any planned interviews with family members, practitioners and managers and must take into account that any one of these people may be potential witnesses or even defendants in a future criminal trial.

14. Methodology

CSPRs/SARs can be conducted in a variety of ways. Traditional methods involve analysis of the involvement of agencies, led by an independent overview report author. With this

method, individual agencies are asked to review the practice within their organisation through Individual Management Reviews (IMR) and Chronologies, which then form part of an Overview Report. Using this approach, agencies are asked to produce a chronology and an IMR ensure that their IMRs have been formally quality assured and signed off through their individual organisations governance processes before being submitted.

The chronology and IMR are a vital part of the review process and therefore it is essential that authors are supported by their agencies in carrying out this function.

At the first panel meeting, the Review Panel will discuss and go through the process and expectations of the IMRs. IMR submissions and deadlines will be agreed and the Review Panel Chair/Report Author will propose a preferred method to obtain any additional information or feedback to IMR authors.

At the second panel meeting the Review Panel will ask IMR authors to present their reports and chronologies at the panel which provides an opportunity for scrutiny and challenge from the panel and each agency to explain their report.

Other methods considered are:

- Action Learning Approach.
- Peer review approach.
- Thematic Reviews.
- Single Agency Review.
- Desk top Review.

Stockport Safeguarding Executive/Board will endorse the approach best suited to the circumstances of each individual case, and the Safeguarding screening panel will decide on the most appropriate method.

15. Involvement of Family Members, Friends, and other Support Networks

Family members can offer a unique perspective into how the delivery of services and involvement of agencies were viewed and responded to. It is essential that the Review Panel have opportunities to listen to family experiences and perspectives and that these contribute meaningfully to the final report.

Family members can include:

- Siblings.
- Parents.
- Carers.
- Grandparents.
- Other significant family members identified from the Family Association Network/ Genogram.

As a minimum, family members should:

- Be notified of the review process, what that means for them and how they can access support – including impact of media coverage.
- Agree the level and frequency of contact with family members to ensure they are kept informed.

- Supported to contribute to the review process – either in writing, by meeting with the review panel, sharing views via a third party or by other means identified by the Review Panel.
- Included in feedback about the learning identified by the Review Panel.
- Informed and prepared for the publication of the report in a timely manner – again including the likelihood of media interest.
- Provided with a read only copy of the report which family members can review and comment on prior to publication but not retain; where possible any relevant comments should be incorporated into the final version – a 'hard' copy of the report should not be provided until the report is in the public domain.

16. The Final Overview Report

The CSPR/SAR overview report brings together the learning, themes identified from the review and will analyse and comment on the effectiveness of practice, and the systems used to safeguard and promote the welfare of the child/and or adult.

The Chair of the Review panel has responsibility for collating the report and the report should:

- Provide a summary of the circumstances that led to the review.
- Briefly outline the review process and methodology, including how the views and participation of key stakeholders as achieved.
- Be written in a succinct and focused manner with the emphasis on recognising and sustaining good practice as well as identifying how and where practice can be improved in the future.
- Identify action that agencies or services have already undertaken in response to learning.
- Form a conclusion as to the effectiveness of local practice to safeguard and promote the welfare of the child/and or adult.

The CSPR/SAR overview report should firstly be presented to the Safeguarding screening panel. This provides an opportunity for the Chair of the review panel along with the screening panel to quality assure the document, reference the identified learning and to ensure an opportunity for the findings to be challenged where necessary.

Once agreed the Chair of the review panel should present the report to the Safeguarding Executive/Board, supported by the Safeguarding screening panel Chair.

It will be the responsibility of the Safeguarding Executive/Board and its Independent Chair to identify and agree how practice challenges or recommendations from the CSPR/SAR Report will be responded to and what action is needed by individual agencies or from a multi-agency perspective.

17. Action plans

A clear CSPR/SAR action plan should be developed by the Stockport Safeguarding Executive /Board with a focus on improving outcomes for children/ and or adults at risk. Following the

presentation of the report at the Board, the SAR panel members will meet to finalise the action plan and sign off by panel members before being circulated to partner agencies.

The following should be included in the Action Plan as standard:

- A timeline for publication of the report should be developed and where possible a date identified.
- Action is taken by the Stockport Safeguarding Executive/Board to share the findings of the report with the practitioners who contributed to the Learning Event and with family members.
- Stockport Safeguarding Executive/Board will identify how it will share the lessons learned, and practice impact with the wilder workforce in the Stockport area.
- When looking to develop an action plan the SAR panel should consider previous reviews when looking to turn the recommendations into achievable actions.

Once the CSPR/SAR report and action plan have been agreed, the report will be endorsed and signed off by the Safeguarding Executive/Board and copies to be available on the children or adult safeguarding website.

The action plan will be regularly reviewed, and its impact evaluated using existing local Safeguarding Executive/Board processes.

18. Findings from CSPRs/SARs

The findings from any CSPR/SAR should be reported in the Stockport Safeguarding Annual Report and what actions it has taken or intends to take in relation to those findings. Where the Safeguarding Executive/Board decides not to implement an action, then the Annual report must state the reason for that decision.

19. Media Strategy

The Chair of the Safeguarding screening panel, in consultation with the Independent Chair, will consider appropriate publication of the report on a case-by-case basis. Discussions about publication will be held with the individual(s), their family or carers (where appropriate).

Since the Local Authority is, the lead agency, media and communication issues will usually be co-ordinated by the council's Communications Team. This will be done in collaboration with the communications teams of the other agencies involved, alongside agreed representatives of the Board.

All CSPR/SAR reports will be considered for publication on the website of the relevant Safeguarding Executive/Board. In the case of publication, the Independent Chair of the Safeguarding Executive/Board will release a statement where appropriate.

20. Learning from CSPR/SAR

The value of CSPR/SARs is in the learning derived from them. As much effort should be spent on acting on recommendations as on conducting the actual Review. Recommendations should be SMART: Specific, Measurable, Achievable, Realistic, and Timed.

The following should help to secure maximum benefit from the review:

- Conduct the review in such a way that the process is a learning exercise.
- Consider what information needs to be disseminated, how, and to whom, in the light of a review.
- Be prepared to communicate both examples of good practice and areas where change to practice is required.
- Focus recommendations on a small number of key areas with specific and achievable proposals for change and intended outcomes;
- Ensure robust monitoring of the resultant action plan to ensure identified changes/improvements are implemented and embedded.
- Communicate with the local community and media to raise awareness of the positive work of services working with adults.
- Make sure staff and their representatives understand what can be expected in the event of a CSPR/SAR.

21. Complaints & Escalation procedure

If a member of the public or an organisation has a complaint about the decision on whether to conduct a Review, or the process in the way in which the Review has been carried out or the outcomes of the Review, then they should raise this in the first instance with the Safeguarding Business Unit (lsb@stockport.gov.uk). The Manager of the Safeguarding Business Unit will review the complaint and liaise, in consultation with the relevant Head of Service, with a written response within 28 days of receipt.

If the complainant is unsatisfied with the response, they should contact the Board Business Manager who will arrange for their complaint to be considered by the Independent Chair.

The Independent Chair will provide a further written response within 28 days of the complainant contacting the Board Business Manager. All written complaint responses will include details of how to contact the Local Government Ombudsman.

The Board Business Manager will ensure that a record is kept of complaints received, responded to and those referred to partner agencies. Complaints and copies of responses will be securely retained in accordance with the principles of data protection legislation.

Appendix 1 – Flow Chart

Review Decision making process

Domestic Homicide

Notified by GMP to Head of Safeguarding and Learning

Case moves Straight to Review process

Unexpected child death, serious incident or safeguarding adult incident occurs

Head of Safeguarding and Learning and Business Manager to be notified within 1 working day)

Safeguarding Investigation would refer to Safeguarding Children Practice Review panel for consideration

Head of Safeguarding and Learning consults with:

- Service Director Children Social Care – Stockport MBC
- Head of Safeguarding Quality and Workforce – Adult Social Care
- Inspector Public Protection Unit – GMP
- Safeguarding/Designated Nurse Safeguarding Children/Adults – Stockport CCG

Consultation and agreement to take place within 2 working days of the incident

Does a Consideration Meeting need to be convened?

A date for the Consideration meeting is arranged and all agencies are contacted and requested to complete an Agency Contact report

Agency contact form requires completion and returning to SSCP or SSAB within 8 working days of request being made

Consideration Meeting takes place:

All agency information is reviewed, and consideration is given as to whether the incident meets the threshold for a CSPR/SAR

The Consideration Meeting decision is referred to the Independent Chair of SSCP or SSAB for final decision review

See Appendix B of Process Overview in the SSCP Review Process.

Decision to hold CSPR	Decision to hold Independent Learning Review	Decision to hold SAR	No further action

Proceed to Review

See separate review process/task list

Appendix 2

Appendix 2
Communication strategy re: SAR/CSPR publication
All responsibilities for the Safeguarding Executive/Board business manager unless otherwise stated
On completion of SAR/CSPR

- In Final Panel meeting have a discussion with partners about Communication and agree what information needs to be communicated and to who.

In preparation for inquest

- Head of Safeguarding and/or Safeguarding Executive/Board Business manager will liaise with Communication re statements in relation to inquest - prepare statement in advance. Director of People will make a statement on behalf of Stockport Council as and when required.
- Head of Safeguarding and/or Safeguarding Executive/Board Business manager to write Communication statement in co-operation with Communication and provide this to Panel members.
- Communication to provide statement from Press on request.

In preparation for publication of SAR

- Agree a date for publication.
- Ensure Panel have had final version of Overview report
- For CSPR's send copies of overview reports to National panel and Ofsted with proposed publication date two weeks in advance of publication.
- Send finalised report to SAR repository and/or NSPCC and National Association of LSCPs
- Agree publication style - pro-active press statements or publish on website.
- Liaise with Council Communication about potential for press interest re publication.
- Inform family by letter.
- Inform independent reviewer.
- Inform lead member and Chief Executive. Consider if an elected members brief is required
- Notify Website team of intention to publish on Stockport Safeguarding Boards website.
- Liaise with Panel members so that their Communication departments can be alerted - panel members to provide communication lead from their respective organisation.
    - Final version of reports to be circulated to Communication reps as required
    - Partners need to have their own statements ready and liaison should take place with Stockport Council Communication about prepared statements.
    - If partners have media, queries they **must** liaise with Stockport Council Communication link person before making a response so that the level of exposure and risk can be assessed.
- Inform Safeguarding Executive/Board partners of intention to publish any reports on either of the Stockport safeguarding websites, and what information will be provided

alongside with the report. Usually this will be 7-minute briefing, but it may include a summary of the changes that have taken place because of the SAR/CSPR and an explanation about delays in publication.

- Report onto website - circulate link to partners

Appendix 3: Stockport Safeguarding Partnerships Review Protocol

Stockport Safeguarding Children Partnership/Adults Board has produced a protocol that demonstrates the management arrangements of their Safeguarding learning reviews once completed. The primary purpose of this process is to ensure the learning from reviews is embedded into practice.

Clarification of the process is provided in the stages described below:

Stage 1
A Safeguarding Review has been undertaken and approved by the Review Panel. At this stage the overview report along with recommendations have been endorsed by the Safeguarding Executive/Board.

Stage 2
The Review Panel produce an action plan based on the recommendation agreed in the overview report. The agreed action plan is then shared with the Practice Improvement Partnership who has the responsibility to oversee the delivery of the action plan. Lessons learnt from learning reviews are disseminated through safeguarding 7-minute briefing papers and the Practice Improvement Partnership has the responsibility to sign off such papers to assist in the sharing of key messages.

Stage 3
Practice Improvement Partnership will manage the performance and progress of an action plan, this will be conducted through discussion at each partnership meeting for updates/evidence on the actions. The partnership will continue to monitor the work until members are fully satisfied that all actions within the plan have been met. At this point, the action plan is signed off by the partnership and shared with the Quality Assurance Partnership for oversight.

Stage 4
On receipt of the action plan, the Quality Assurance partnership will arrange a multi-agency moderation meeting to scrutinise evidence provided and verify that each action has been met and implemented; and there is evidence as to how the impact will be measured. Once assurance is gained the action plan is signed off and reported back through to the Safeguarding Executive/Board in the QAP standard report to the Safeguarding Executive/Board. The QAP will also consider how any of the impact of learning can be tested from a partnership perspective i.e. completion of single agency audits/multi agency audits/inclusion in the dataset.