**Individual Management Reviews**

1. **Introduction:**

Individual Management Reviews are commissioned to Derbyshire’s Children’s Services department to support Child Safeguarding Practice Reviews and Domestic Homicide Reviews. (Appendix 1 Derbyshire CS IMR Guidance)

All requests are received into CS.Safeguarding@derbyshire.gov.uk and the IMR workflow (Appendix 2) is then initiated to support the completion of the IMR work.

1. **Principles:**
* All IMR’s are allocated and tracked by the Child Protection and IRO Business Services Team CS.Safeguarding@derbyshire.gov.uk using the IMR Workflow (Appendix 2)
* Allocated report authors are independent of the case and are children’s services managers.
* Report authors are allocated a quality assurance head of service to support them in the completion of the work.
* Each IMR has a uniquely defined timescale to complete the work. This period of time includes an internal quality assurance framework for senior management. authorisation for the submission of the report.
* Each IMR requires the submission of both a chronology and a report.
* Reports commissioned by the Derby and Derbyshire Children’s safeguarding Board require the following templates to be used: (Appendix 3 CSPR CS chronology template) and (Appendix 4 CSPR IMR template)
* IMR’s in relation to Domestic Homicides are commissioned by Community Safety and templates for these reports are provided by Community Safety upon commission.

**Appendix 1**

**DERBYSHIRE CHILDREN’S SERVICES**

**GUIDANCE FOR INDIVIDUAL MANAGEMENT REVIEWS (IMR)**

**Chronology**

The review should include a comprehensive chronology that charts the involvement of children’s services with the child and their family over the period of time set out in the review’s Terms of Reference. It should summarise the events that occurred; the intelligence and information known to children’s services; the decisions reached and the services offered and provided to the child and their family.

**Analysis of involvement**

The review should consider the events that occurred, the decisions made and the actions taken or not taken. Where judgements were made or actions taken that indicate that practice or management could be improved, the review should consider not only what happened but why. Each significant incident may have specific issues that need to be explored and each review should consider carefully the individual case and how best to structure the review in light of the particular circumstances. The following are examples of the areas that will need to be considered:

* Were practitioners sensitive to the needs of the child and family, knowledgeable about potential indicators of harm and aware of what to do if they had concerns about the child? Was it reasonable to expect them, given their level of training and knowledge, to fulfil these expectations?

* Was the service provided compliant with the relevant policies and procedures in place? Was there compliance to information sharing protocols?
* What were the key points or opportunities for assessment and decision making in this case? Do assessments and decisions appear to have been reached in an informed way, i.e. were decisions evidence based?

* Were actions/risk management plans aligned with the assessment and decisions made? Were appropriate services offered or provided, or relevant enquiries made in the light of the assessments, given what was known or what should have been known at the time?

* When, and in what way, were the child’s wishes and feelings ascertained and considered?
* When, and in what way, were the views of relevant family members ascertained and considered?
* Was information recorded and shared appropriately?

* Was practice sensitive to the ethnic, cultural, linguistic and religious identity of the child and family? Was practice considerate to protected characteristics?

* Were senior managers or other agencies and professionals involved at the appropriate points? How accessible were the services for the child and family?
* Were the services provided impactful?
* Are there ways of working effectively that could be passed on to other organisations or individuals?

* Are there lessons to be learned from this case relating to the way in which the organisation safeguards children and promotes their welfare, or the way it identifies, assesses and manages identified risks? Where can practice be improved? Are there implications for ways of working, training, management and supervision, working in partnership with other agencies and resources?

**Appendix 2**

IMR workflow

(Day 1) Request received from DDSCP CS Safeguarding (Childrens Services) CS.Safeguarding@derbyshire.gov.uk cc to and Head of CP and IRO’s

B/S unit commence tracker

(Days 1-4) Head of CP and IRO allocates report author and QA senior lead. Escalation to be made to Service Directors for support should problems occur in sourcing of an author from within the pool.

A meeting is arranged between the allocated QA senior lead for the case, the report author and author’s line manager

(Day 4) - Joint meeting takes place between QA senior lead, report author and author’s line manager to scope work and ensure allotted time available for completion. Specific timescales for the work are agreed.

(Day 15) - Midway Review meeting between report author, author’s line manager and QA senior lead for the case

(Day 25) – report author submits report to QA senior lead

(Days 25-30) QA senior lead to quality assures report and any proposed amendments are completed by report author as required. A meeting between the QA lead and report author maybe helpful during this time.

(Days 30-35) Service Director for Early Help and Safeguarding, cc Service Director for Quality, Partnerships and Performance and any proposed amendments are completed by report author as required

(Day 35) Submission to the DDSCP

\*The above proposed timetable is based on an average working day timescale for IMR’s, each case will require a bespoke agreement with the DDSCP in relation to the overall timescale due to the scale of the work required in each case.

**Appendix 3**

RESTRICTEDDerbyshire Children’s Services – Individual Management Review ref: Date

| **Date** | **Source of Information/Event** | **Activity** | **Response or Outcome of Activity** |
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Key to Initials Used:

**Appendix 4**

**Child Safeguarding Practice Review**

**Ref:**

**INDIVIDUAL MANAGEMENT REVIEW**

**(Derbyshire Children’s Services)**

**Author:**

**Date:**

**INDIVIDUAL MANAGEMENT REVIEW TEMPLATE**

**1 INTRODUCTION**

*Name, job title and e-mail address of person completing this IMR (include confirmation regarding independence from the line management of the case).*

1. **TERMS OF REFERENCE**

**Family composition (including genogram)**

**Background and reason for undertaking DHR**

*As set out in the terms of reference*

**Scope of the review**

*Confirm the report will include any significant events between the periods set out in the terms of reference. Any significant/relevant events outside of these timeframes should be included IMR’s and Chronologies.*

**Issues to be addressed**

*Refer to the agreed terms of reference for clarity as to the issues to be addressed within this IMR*

Consider if there any specific considerations around equality and diversity issues such as age, disability (including learning disabilities), gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation that may require special consideration?

**3 METHODOLOGY**

*Record the methodology used including extent of document review and interviews undertaken*.

**6 SUMMARY OF AGENCY INVOLVEMENT**

*Construct a chronology using the specified template (APPENDIX A), to be filed and read in conjunction with this report.*

*In this section summarise the overview of children’s services involvement, draw together any primary observations and detail key points of interest as you see them.*

*Using the grid below, clarify the details of the professionals from within your agency who were involved with the child and family and whether they were interviewed or not for the purposes of this IMR.*

|  |  |
| --- | --- |
| **Name and Role of Professional** | **Period of involvement** |
| *e.g. Joe Bloggs – Social Worker* | *e.g. 15/12/2015 - 12/02/2016* |
|  |  |
|  |  |

**7 ANALYSIS OF INVOLVEMENT**

*Consider the events that occurred, the decisions made, and the actions taken or not. Assess practice against guidance and relevant legislation.*

*Address the key lines of enquiry as set out in the terms of reference and confirmed in section 2 of this report.*

*Consider further analysis in respect of key critical factors, which are not otherwise covered by the sections above.*

**8 EFFECTIVE PRACTICE/LESSONS LEARNT**

*Summarise concisely, and with evidence, the effective practice that you have identified and any lessons that can be learnt*

**9 RECOMMENDATIONS**

*Recommendations should be focussed on the key findings of the IMR and be specific about the outcome which they are seeking.*

Signed (author):

Date: