

**WORCESTERSHIRE SAFEGUARDING ADULTS BOARD**

# SAFEGUARDING ADULT REVIEW

# INDIVIDUAL MANAGEMENT REVIEW

**COMPLETED BY**

**NAME OF AGENCY**

**NAME OF INDIVIDUAL**

**D.O.B: XXX**

**INDIVIDUAL MANAGEMENT REVIEWS**

## 1. Introduction

* 1. This document is intended to provide an individual management review of the decisions, actions taken and services provided to XXX (deceased)who is subject of a Safeguarding Adults Review instigated by the Worcestershire Safeguarding Adults Board relating to (add information from the referral). The Safeguarding Adult Review is reviewing how agencies worked together during this period.

1.2 The aim of the individual management review is 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.

1.3 The findings from the individual management review report should be quality assured and approved by the senior officer within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.

1.4 The individual management review provides a chronology of agency involvement and brings together, and draws overall conclusions from, the involvement of the agency with the adult with care and support needs.

1.5 The IMR author should have access to supervision and be able to evidence, if requested, relevant training or experience to support their role as the IMR author. They should be able to;

* gather and analyse information,
* clearly describe what happened, commenting on the quality of practice
* provide explanations for why it happened
* clearly show how the conclusions relate to the individual case as well as the wider safeguarding practice within the organisation.

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## 1. SAFEGUARDING ADULTS REVIEW TERMS OF REFERENCE

Enter Section 6 from Terms of Reference

## 2. METHODOLOGY

List the sources of information that your agency has used to compile your report. This might include paper records, IT systems searched, computer records, supervision notes etc. It should also include some details about staff that have been interviewed as part of this review, or if not why not. Please say if files could not be found and why.

## 3. FAMILY COMPOSITION as known to the agency

Please use this section for the family details as known to your agency (**As per the example below**, please delete and retype your information). If your agency is not aware of any of the information below please specify as ‘not known’. Please add additional people to list below as needed using the reference names provided.

| **Anonymised Name** | **Relationship to subject (if applicable)** | **Date of Birth** | **Date of Death**  **(Or Serious Incident)** | **Full Address** | **Ethnicity or diversity needs** |
| --- | --- | --- | --- | --- | --- |
| *Adult 1* | *Father* | *01/01/1978* | *17/11/09* | *123 Wall Street, Town, County, Postcode* | *White British* |
| *Adult 2* | *Sister* | *01/02/1981* | *n/a* | *123 Wall Street, Town, County, Postcode* | *White British* |
| *Mrs A* | *Mother* | *03/03/1954* | *n/a* | *123 Wall Street, Town, County, Postcode* | *White British* |
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## 4. CHRONOLOGY OF AGENCY INVOLVEMENT

**This will need to be completed on the chronology template provided in the excel spreadsheet**

***What was your agency’s involvement with this adult with care and support needs***

You are required to construct a comprehensive chronology of involvement by your agency and/or professional(s) in contact with the adult(s) over the period of time set out in the review’s terms of reference.

Where abbreviations are used, please provide a glossary at the back of this document to explain them.

## 5. NARRATIVE ON THE CHRONOLOGY

The previous section asks for hard facts and dates. This section allows you to now reflect on that information and provide an analysis of the involvement of your agency with the adult with care and support needs.

This section should bring the chronology to life and tell the story of the adult/ family involvement with your agency. This section will also include a description of the key events, highlighting concerns, omissions and good practice. It is important throughout this section to reflect on the experience of the adult during your agency’s involvement.

You may find the 13 trigger questions attached helpful in framing your response. However, it is not expected that you methodically answer every question. Use it as a guide.

These questions are attached as appendix 1.

## 6. CRITICAL ANALYSIS

In this section the IMR author must answer the questions below which are taken directly from the Terms of Reference. Take time to reflect on the information you have provided in the chronology and the narrative. The information provided and the analysis should be appropriately evidenced explained fully.

Please ensure to clearly specify if any of the questions are not relevant to your agency and/or service and the reasons why. If a question is left blank it will be queried by the SAR Author.

|  |
| --- |
| **Insert question 1 from Section 1** |
| **Insert question 2 from Section 1** |
| **Insert question 3 from Section 1** |
| **Insert question 4 from Section 1** |
| **Insert question 5 from Section 1** |
| **Insert question 6 from Section 1** |
| **Insert question 7 from Section 1** |

**It is just as important to highlight good practice within organisations as this offers the opportunities to learn from what works well. Are there any aspects of how your agency worked that should be highlighted as such?**

## 7. WHAT DO WE LEARN FROM THIS CASE?

Following on from the critical analysis section previously, the IMR author should identify specific lessons which his/her agency can learn from the case. These can include areas of good or poor practice identified, as well as ways in which practice can be improved.

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## 8. RECOMMENDATIONS FOR ACTION AND SINGLE AGENCY ACTION PLAN

Recommendations for your single agency action plan (SAAP) must flow from section 7.

Any recommendation about improving or developing new procedures should be specified in terms of the expected practice outcomes . Actions contained in this IMR report will be considered by the SAR Panel for inclusion in the SAR Report. The SAR Panel may also recommend further actions for your agency to be included in the SAR Report. You should add as many actions for your agency as is necessary.

Recommendations for action must be included in the Single-agency Action Plan Template and the Template needs to be fully completed in order to be clear about;

* What action should be taken, by whom and by when?
* What outcomes should these actions bring about and how will the organisation evaluate whether they have been achieved

It should be noted that WSAB will require updates on any actions identified. This process will continue until all actions are completed.

## Action Plan

Please complete the attached Excel file below



## SECTION 9

**INDIVIDUAL MANAGEMENT REVIEW**

**QUALITY ASSURANCE FORM**

**This section must be completed fully prior to the IMRs submission.**

| **Criteria** | **Yes** | **No** | **Comments** |
| --- | --- | --- | --- |
| Author was independent |  |  |  |
| Access to legal advice available where appropriate |  |  |  |
| Report is completed within agreed timescale |  |  |  |
| Report includes chronology of involvement for identified time period |  |  |  |
| Report takes account of the individual needs of the adult(s) and family members |  |  |  |
| Report is sensitive to the racial, cultural and linguistic identity of the adult (s) and family members |  |  |  |
| Report reflects a critical examination of the facts and provides a credible explanation for actions/ decisions that were/ were not taken |  |  |  |
| Practice at individual and organisational level is analysed openly and critically against local and national requirements, professional standards and local procedural guidance |  |  |  |
| Good practice is highlighted beyond expected minimum practice |  |  |  |
| Report contains an action plan with measurable and relevant recommendations for improvement and a timescale for implementation. |  |  |  |
| Action plan has been agreed with relevant senior management groups |  |  |  |

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| --- | --- |
| **Author of IMR Signed:** |  |
| **Job Title** |  |
| **Quality Assured and Approved by:** |  |
| **Job Title** |  |
| **Date of Submission** |  |

**Glossary of Personnel involved**

| **Name** | **Job Role** | **Identification in report** |
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## APPENDIX 1

1. Were practitioners aware of and sensitive to the needs of the adult in their work, and knowledgeable both about potential indicators of abuse or neglect and about what to do if they had concerns about an adult with care and support needs’ welfare?
2. When, and in what way, were the adult's wishes and feelings ascertained and taken account of when making decisions about the provision of the adult's services? Was this information recorded?
3. Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of adults with care and support needs and acting on concerns about their welfare?
4. What were the key relevant points/opportunities for assessment and decision-making in this case in relation to the adult and their family? Do assessments and decisions appear to have been reached in an informed and professional way?
5. Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
6. Were there any issues, in communication, information sharing or service

delivery, between those with responsibilities for work during normal office

hours and others providing out of hours services?

1. Where relevant, were appropriate Safeguarding Adult’s or care plans in place, and the reviewing processes complied with?
2. Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the adult and their family, and were they explored and recorded?
3. Were senior managers or other organisations and professionals involved at points in the case where they should have been?
4. Was the work in this case consistent with each organisation’s and the WSAB’s policy and procedures for safeguarding and promoting the welfare of adults with care and support needs, and with wider professional standards?
5. Were there organisational difficulties being experienced within or between

agencies? Were these due to a lack of capacity in one or more organisations?

1. Was there an adequate number of staff in post? Did any resourcing issues such as vacant posts or staff on sick leave have an impact on the case?
2. Was there sufficient management accountability for decision making?