

**North Yorkshire LSCB
Serious Case Reviews**

**Individual Management
Review Handbook**

Contents

1	Introduction	2
2	What is a Serious Case Review (SCR)?	2
3	The LSCB Serious Case Review Sub Group	3
4	Stages of the SCR (includes Timetable)	4
5	Individual Management Review (IMR) Format and Guidance Front Sheet Agency Sign Off Statement of Independence Key Acronyms List Genogram Terms of Reference The Reason for the Review What was our involvement with the child and family? Analysis of Involvement Lessons Learned from the IMR Recommendations References Check List for IMR Writers Tasks to be undertaken by the IMR Writer	6
6	Guidance on Chronologies	15
7	Making Recommendations	20
8	Appendix A: Audit Tool	21
9	Appendix B: Example of a Terms of Reference	29
10	Appendix C: Flowchart	34
11	Appendix D: Ofsted Grade Descriptors	35

1. Introduction

Welcome to the North Yorkshire Serious Case Review Handbook. All agencies of the LSCB have agreed the content of this document, which aims to assist Individual Management Review (IMR) authors in preparing reports of an acceptable standard.

If you are reading this document, you are likely to be working in an organisation where you could be asked to contribute an IMR for a Serious Case Review. Furthermore, it is likely that you will have been nominated to be a potential author of IMRs for your organisation.

This handbook has been created to provide guidance and support to all staff who are asked to write an IMR on behalf of their agency. This is an important role that should only be delegated to experienced and skilled staff with significant knowledge about the subject of safeguarding children, relevant policies, procedures and roles and responsibilities within their own organisation and multi-agency working to safeguard children. It has been agreed by the LSCB that only those who have completed a suitable multi-agency IMR course such as the one run by North Yorkshire LSCB can be put forward to complete an IMR.

Before we go any further, it would be wise to check whether you are the right person to be producing an IMR. Please consider the following questions:

1. Are you a manager or a person in a position of seniority who has not line managed/supervised any of the staff involved in the case?
2. Do you have the level of experience and knowledge to be able to critically analyse the work, systems, policies and procedures of your agency in relation to safeguarding children?
3. Are you fully independent of the staff or services involved in the case?
4. Have you completed a suitable IMR course?

If you can answer “yes” to these questions, you meet the criteria set by the North Yorkshire LSCB, and can author an IMR. If the answer to any of these questions is “no” or if you have any other concerns about your suitability to author an IMR for a Serious Case Review, please speak to your own line manager, or seek advice from the LSCB Manager.

2. What is a Serious Case Review?

As a nominated IMR author, you may well already be familiar with the process of a Serious Case Review (SCR). If not, we would ask that you read Chapter 8 of Working Together to Safeguard Children, 2010 and Chapter 6 in the North Yorkshire LSCB Procedures. These documents give a clear explanation of the circumstances in which a LSCB is required to undertake, or consider, a Serious Case Review, and how the process should be managed.

In brief, a LSCB **must** undertake a SCR whenever a child dies, and where abuse or neglect are known, or suspected to be, a factor in the death.

LSCBs are also required to consider, and may choose to undertake a SCR in circumstances where a child is seriously injured as a result of abuse or neglect (which includes suicide), or a parent has been murdered and a domestic homicide review is being initiated under the Domestic Violence Act 2004; **and** where the case gives rise to concerns about the way in which local professionals or agencies worked together to safeguard and promote the welfare of the child (Working Together 2010).

The purpose of a SCR is to enable the work of agencies to be scrutinised and analysed, in order to establish whether there are lessons to be learned from the case about the way in which local professionals or agencies worked together to safeguard and promote the welfare of the child. If the SCR does identify lessons to be learned, there is a requirement to implement plans in order to act on these lessons in order to safeguard children more effectively in the future.

Although a SCR is not an exercise in apportioning blame the process can identify failings of individual staff as well as systems, procedures and organisations. Therefore, there can sometimes be implications for individuals, and it is not unknown, although relatively rare, for the SCR process to influence processes such as disciplinary or capability. Therefore as an IMR author, you need to be aware of this and discuss any such issues that arise with your organisation's most senior lead for safeguarding children and young people.

The purpose of an IMR is to enable an agency's work with the child or family to be comprehensively described and analysed. For this reason, as well as the impact on individual staff, there is a potential impact on the agency, particularly as the Overview Report and Executive Summary of the SCR will be published and may attract attention from the media.

The LSCB understands that preparing an IMR is a significant task. It therefore expects that authors will be given sufficient time and support by their employers to enable them to complete the task within the given timescale (usually six to eight weeks) and to an acceptable standard. In addition, at the start of the process, all IMR authors will be invited to attend a briefing session held by the LSCB, which will provide them with information about the case, as well as about the process of preparing an IMR. As the review progresses you will be expected to attend at least one, and possibly more than one, session with the Overview Report Writer to receive feedback in order for you to improve your report and/or answer questions on the IMR.

During the process, you will be able to receive support from the LSCB Manager and the Safeguarding Unit as well as relevant staff within your own organisation.

Please note that it is not the responsibility of the LSCB Administrator to check for grammar, spelling, punctuation or typographical errors. Please make sure this task is undertaken before the IMR is presented, or it may have to be returned.

3. The LSCB Serious Case Review Sub Group

North Yorkshire LSCB has a standing SCR Sub Group. The membership is taken from the LSCB and is comprised of professionals with specific expertise and seniority around safeguarding and child protection. There are representatives from NYCC Legal Services, Police, the commissioning arm of the PCT, Education and Children's Social Care. It is their

responsibility to advise the Chairperson of the LSCB when the criteria is met to undertake an SCR.

Only the Chairperson of the LSCB can agree a Serious Case Review.

Where a new SCR is to be started, the SCR Sub Group will put together the Terms of Reference and identify the members of the Individual Panel for that SCR. Members will be responsible, where possible, for ensuring that their agency identifies the most suitable person to complete the IMR. In the Health Service the Designated Nurse and Designated Doctor will be responsible for liaising with the different Health Trusts and completing the Health Overview Report/Commissioners IMR.

The LSCB Manager will be responsible for securing the services of an Independent Chairperson and Overview Report Writer for the SCR.

4. Stages of the Serious Case Review

The following needs to take place within the first four weeks:

- The LSCB Manager is informed of a serious child care incident or a child death (the LSCB procedures outline the processes for professionals to inform the Safeguarding Unit of any child death or serious child care incident)
- The LSCB Manager reviews the information against the criteria in Working Together 2010
- Integrated Children System (ICS) checked by the Safeguarding Unit to see if the child is known or has been known to Children's Social Care
- Agency Checks undertaken by the Safeguarding Unit
- LSCB Manager informs the Sub Group members, including the Designated Nurse
- All SCR Sub Group members and the Designated Nurse are asked to provide a brief written report of their agency's involvement with relevant family members to the SCR Sub Group Meeting
- SCR Sub Group decides on the basis of the information provided, if the child care incident/death meets the criteria for holding an SCR
- SCR Sub Group makes the recommendation for an SCR to the Chairperson of the LSCB
- Chairperson agrees whether criteria is met to commence an SCR
- Terms of Reference drawn together by the SCR Sub Group
- Decision taken as to membership of the Individual Panel

- IMR report writers identified from each agency
- Overview Report writer/Chairperson of the SCR commissioned
- Ofsted (and Strategic Health Authority and Care Quality Commission) informed
- LSCB Manager writes to the Chief Executive of each agency and the LSCB Executive Group to inform them of an SCR.

Once the above has been completed a date is set to meet with the Individual Panel, the Overview Report Writer and the Chairperson. This meeting may last a full day and takes place in two parts. The first part is where the Individual Panel meets with the Overview Report Writer/Chairperson and discusses the Terms of Reference. At this stage amendments may be made to the Terms of Reference. The second part of the meeting is where you, as one of the IMR writers, meet the Chairperson/Overview Report Writer and the Individual Panel. It is at this meeting you will be given the IMR Pack and the timetable.

Next Steps:

- First Meeting of the Individual Panel with the Overview Report Writer and Chairperson
- Timetable set
- Terms of Reference discussed and amended
- Chairperson and Individual Panel meet with the IMR writers
- IMR writers given the IMR pack which includes the IMR template, booklet, "ChronoLator" and acronyms to be used in reports.

4.1 Timetable

The timetable is usually supplied with all proposed dates at the first Individual Panel meeting. SCRs are required to be completed within six months. If an extension is required the LSCB Manager will need to negotiate with Ofsted. Any extension will be commented on by the Ofsted Evaluation and may contribute to the overall assessment.

The following is subject to change:

- IMR writers given 4 weeks to complete the single agency chronology (note that within the Health Service, this must be approved by the Designated Nurse and Designated Doctor for Child Protection/Safeguarding Children before being sent to the LSCB Administrator)
- IMR writer to send single agency chronology to LSCB Administrator
- LSCB Administrator will compile the multi-agency chronology
- IMR report writers are given a further 4 weeks (making a total of 8 weeks) to complete their report and the Action Plan. Within Health Services, the IMR writers are given a further 2 weeks to complete IMR and agency Action Plan to be submitted to

Designated Nurse Safeguarding Children, to enable the Commissioners IMR/Health Overview Report to be written)

- All IMR writers are invited to a meeting with the Overview Report Writer approximately 10 weeks after the start of the process for feedback on the IMR and Action Plan
- IMR writers given a further 2 weeks to make amendments to IMR and Single Agency Action Plan
- The Panel will meet between 3-4 times to view the multi-agency Chronology. IMR writers must be available to attend meetings, make changes or clarify issues in the chronology
- The Designated Nurse and Designated Doctor for Safeguarding Children/Child Protection will complete a Commissioners IMR/Health Overview Report and Action Plan which will contribute to the SCR Overview Report
- Overview Report Writer will complete a draft Overview Report and present it to the Individual Panel for comments
- Individual Panel to put together the LSCB Action Plan
- Full Overview Report, Executive Summary and Action Plan to be presented to the SCR Sub Group for comment
- Overview Report, Action Plan and Executive Summary to be presented to the LSCB Executive Group
- Full SCR including multi-agency Chronology, all IMRs, Action Plans, Executive Summary and LSCB Action Plan to be sent to Ofsted for evaluation.

5. IMR Format and Guidance

This guidance **must** be followed for all IMRs provided to the North Yorkshire LSCB as part of a SCR. Any reports submitted to the LSCB that do not comply with the guidance will be returned for amendment.

The document should be used in conjunction with the Quality Assurance Tool (Appendix A) which provides more detailed information about the expected content of IMRs.

IMR reports and chronologies should always be presented in Arial font, size 12, unless otherwise agreed by the SCR Sub Group

Format for IMRs

All IMR reports should contain the following:

1. Short paragraph of independence, setting out author's experience and qualifications
2. Remit (Provided by the LSCB)
3. Genogram (Provided by the LSCB)
4. Reason for the Review (Provided by the LSCB)
5. Narrative of what happened covering the remit dates
6. Analysis
7. Lessons learned
8. Recommendations
9. Action Plan

An electronic front sheet and agency sign off sheet will be provided by the LSCB.

All IMRs should be accompanied by a chronology. See Guidance on Chronologies.

5.1 Front Sheet

At the start of a SCR, IMR authors will be issued with an electronic version of a standardised LSCB front sheet that should be used for all IMR reports.

This will clearly identify:

- the agency that has provided the IMR
- the subject of the SCR (using agreed anonymity measures)
- the author (name and job title) of the IMR
- The date of commissioning the IMR (ie date of SCR Sub Group decision) and the date of completion

- Draft version number. (If you provide more than one version it is your responsibility to change the version number on the front sheet.)

5.2 Agency Sign Off

When an IMR is completed, a designated senior decision-maker in the agency is required to approve the IMR for submission to the LSCB. The second page of the IMR should include a statement, signed and dated by this designated officer, indicating that the IMR has been approved for submission to the LSCB.

The agency “sign off” should be included in the IMR, at the end of the document, on a separate page as follows:

Countersigned on behalf of (name of organisation)

Name:

Signature:

Designation:

Date:

5.3 Statement of Independence

The statement of Independence should contain the following information:

- Qualifications
- Experience
- Role in the agency
- Independence of the case

It should provide information about the author (name, job title etc) and **must** provide a clear statement that illustrates their level of independence from the line-management of, and supervision of staff involved in the case.

It should clearly describe the sources of information used to prepare the IMR (eg analysis of case records, interviews with staff etc) and when and by whom these were secured.

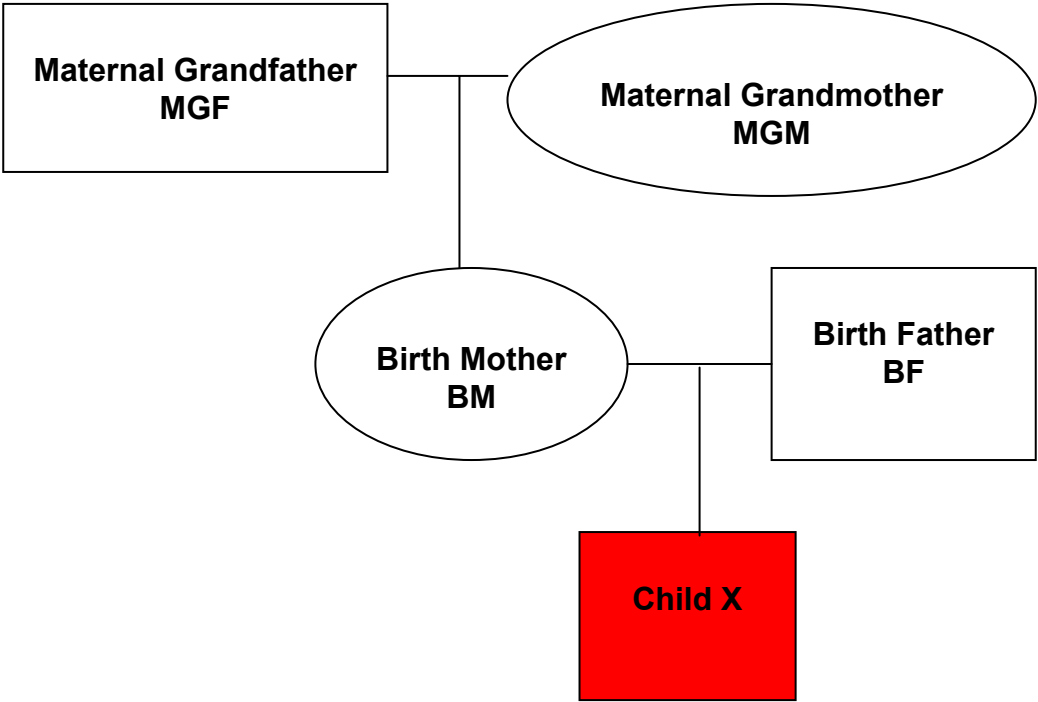
5.4 Key Acronyms List

Within IMRs, the confidentiality of both staff and service users should be respected and maintained. At the beginning of each review the SCR Panel will try to identify the key players. These will include family and staff. The LSCB Administrator will allocate an acronym to each participant which will be sent out to all IMR authors with the IMR template. It is more than likely that the list of participants will grow as the SCR continues. It is the **responsibility of the IMR author to contact the LSCB Administrator** and ask for a new acronym if they come across a professional or family member who they are going to refer to in the IMR if this person is not on the Acronym List. The LSCB Administrator needs the person's name, job title, and organisation. This also applies to names of places, organisations, schools etc. If in

any doubt, please contact the LSCB Administrator for advice. Any breaches will result in the IMR being returned to the author by the Individual Panel. All IMRs should contain a key that enables the reader to quickly refer to and understand which family members and professionals the report is referring to at specific points.

5.5 Genogram

The LSCB will provide the Genogram for each review.



5.6 Terms of Reference

The Terms of Reference for the SCR will have been drawn together by the SCR Sub Group and will contain information about the scope of the SCR. Appendix B gives an example of what Terms of Reference should contain. This is usually a set of questions specific to the case. Also the following, from Working Together 2010, will be part of the Terms of Reference.

- Were practitioners aware of and sensitive to the needs of the children in their work and knowledgeable both about potential indicators of abuse or neglect and what to do if they had concerns about a child's welfare?
- When, and in what ways were the child/ren's wishes ascertained and taken account of when making decisions about the provision of children's services? Was this information recorded?
- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?

- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made, in the light of assessments?
- 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?
- Where relevant, were appropriate child protection or care plans in place and child protection and/or looked after reviewing processes complied with?
- Was practice sensitive to the racial, cultural, linguistic and religious identity and any issues of disability of the child and family, and were they explored and recorded?
- Were Senior Managers or other organisations and professionals involved at points in the case where they should have been?
- Was the work in the case consistent with each organisation's and the LSCB's policies and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?
- Were there organisational difficulties within or between agencies? Were these due to lack of capacity in one or more organisation? Was there an adequate number of staff in post? Did any resourcing issue such as vacant posts or staff on sick leave have an impact on the case?
- Was there sufficient management accountability for decision making?

Working Together 2010, Chapter 8.

At the first meeting with the Individual Panel and the Overview Writer and Chairperson the IMR authors will be given the Terms of Reference. It will also be sent out electronically. There is no need to reproduce it at the beginning of your IMR as the LSCB Administrators will do this for you.

In complicated reviews it is not uncommon for the Terms of Reference to be modified or further information requested.

5.7 The Reason for the Review

A short paragraph will be inserted into each IMR by the LSCB Administrator stating the reason for the Review. The introduction should contain enough information to enable a reader to understand why a SCR was commissioned.

5.8 What was our involvement with this child and family?

IMRs should include a clear narrative and description of the agency's involvement. This should usually be provided in chronological order. However, information may come available during your research that you feel should be included despite it falling outside of the Terms of Reference. Please consult your agency lead for Safeguarding Children and/or the LSCB Manager before you include such information. If it is historic information it should be placed at the beginning of the narrative with a short explanation as to why it has been included.

As the report will be read by people from different disciplines who are not familiar with the case, the reader should be able to gain a clear understanding of the chronological narrative of the agency's involvement with the family. Do not make assumptions about the professional knowledge base of the reader.

During your development of the narrative you do not analyse practice, but merely describe it.

5.9 Analysis of Involvement

Analysis and evaluation are of equal, possibly greater, importance as description, and are areas that Ofsted will focus on when evaluating the quality of the IMR.

Within an IMR, analysis needs to be clear and clearly linked/evidenced to events described in the previous section.

It is expected that IMR authors will not only describe what happened, but will identify **why** something happened. This can be difficult, and explains why it is expected that whenever possible authors will interview staff to establish why they acted in a particular way. In addition, issues such as agency context, availability of procedures at the time etc will all be crucial in helping to establish why events occurred. It is important to ascertain why particular decisions were made or actions taken, and where it is not possible to ascertain why, this should be mentioned within the analysis.

Where judgements were made, or actions taken, which indicate that practice or management could be improved, try to get an understanding not only of what happened but why something did or did not happen.

The Terms of Reference will have set out a series of questions that are relevant to that particular case. All the questions must be analysed and evaluated, including the questions from Working Together to Safeguard Children 2010 as outlined in section 4 above. It may be that your agency has no information regarding a particular question. In that case the author should state that this question does not apply to their agency or that it does apply but that there is no available information relating to that question.

Questions to keep in mind when completing the IMR:

- Keep asking why something did or did not happen
- Use the evidence within records and from interviews with staff involved
- Use published research
- Use of agency procedures, protocols etc
- Use hindsight – eg was this acceptable/standard practice at the time? Would it be acceptable practice now?
- Continually refer back to the Terms of Reference.

Analysis should be based on the evidence that has been found during the review and it would be helpful if it was backed by research (which must be quoted and referenced). Hindsight should be used to learn where things went wrong, in order to try and prevent similar mistakes being made in the future. However, agencies and individuals should not be criticised for not taking into account information that was not available to them at the time. A re-occurring question would be whether your agency followed LSCB policies and procedures. Also question whether the people performing the tasks had sufficient knowledge, skills or training to undertake the task?

- Keep facts, narrative and analysis separate
- Show what evidence you have collected to back up your analysis
- Do not speculate, which is different from providing a hypothesis
- Break down analysis chronologically, and if appropriate into themes.

5.10 Lessons Learned from the IMR

This is the section that should identify any conclusions drawn from the analysis of the agency's involvement, eg are there lessons that can be learned for the way in which the agency works to safeguard children? Is there good practice to highlight, as well as ways in which practice can be improved?

5.11 Recommendations

In most cases, your IMR will identify areas where the agency's practice can be improved upon. If this is the case, the report also needs to make recommendations as to how the agency can achieve these improvements.

All recommendations for your agency should be clearly held within a separate section of the IMR and each recommendation should be clearly linked to the analysis, which in turn should be clearly linked to events in the narrative.

Each recommendation should have a clear intended outcome and a way of measuring that outcome. An example is:

Recommendation:

The LSCB should ensure that multi-agency programmes meet the need for those working in adult mental health services to understand the impact of parental mental ill health on parenting and children's well being.

Intended Outcome:

The impact of mental ill-health on parenting capacity in its broadest sense is understood and addressed in assessment and intervention.

Measure:

Audit of staff take up of training, analysis of feedback from training courses, audits of supervision records and personal development plans.

There should be no recommendations in the IMR that do not arise as a direct result of the analysis of the practice in the case.

Authors should note that there is a difference between making recommendations for an agency within an IMR, and producing an Action Plan. The Action Plan is a **separate** document that translates the recommendations from the IMR into clear actions, and which provides more detail and clarity as to how the agency will achieve the recommendations made in the IMR.

Recommendations in an IMR must be SMART (specific, measurable, achievable, realistic, and within a specific timescale) to enable an Action Plan to be derived from them.

If recommendations are not specific, or unrealistic, the agency will be unable to develop a suitable Action Plan and this will impact on the agency and the SCR as a whole.

In making recommendations it is important to remember that the recommendations must actually reflect the identified shortfall in practice and must therefore be aimed at addressing this shortfall in the future.

It is essential to ensure that every recommendation has a stated intended outcome and a method of audit to enable compliance to be tested in the future.

It is acknowledged that writing SMART recommendations is a challenge, particularly as once submitted, the agency will be tied to the actions that arise from them until completion. Each agency's own quality assurance or "sign off" mechanisms will undoubtedly assist in the refining of recommendations and resultant Action Plans, and this will be further supported by the SCR Sub Group which has a quality assurance role later in the process. You will be able to seek advice from your agency lead for safeguarding children.

Action Plans

An Action Plan template will be provided by the LSCB. Please do not use names of professionals in the Lead Officer column as there may be staff changes. Therefore it is advisable to use job titles.

5.12 References

It is good practice for IMR authors to refer to research or texts within their report where applicable. If so, clear references should be included at the end of the report that adheres to the Harvard system. It is particularly relevant to refer to published enquiries or reports, or previous published SCRs or their Executive Summaries where necessary.

5.13 Check List for IMR Writers

The following bullet points might help IMR writers when completing IMRs. They are provided to give IMR writers an idea as to what is organisational and time constraint issues need to be considered when undertaking an IMR.

Carrying out an IMR:

- Planning overarching issues
 - Access to records
 - Interviewing people
 - Writing the report

- Contribution to the Overview Panel
- Time to amend your IMR.

Please note, undertaking an IMR is time consuming. It is important that you leave adequate time in your diary to complete all the commitments. It might be that due to unforeseen circumstances you are asked at short notice to attend a meeting or provide further information. Please remember you have been put forward by your own agency. If you have problems completing any of the tasks you must contact both your own Manager and the LSCB Manager. Holidays, weddings, sick leave etc are not excuses that Ofsted recognise.

5.14 Tasks to be Undertaken by the IMR Writer

- Read the Terms of Reference
- Be clear regarding the dates of analysis of involvement - these will be found on the Terms of Reference
- Secure the records within the timeline on the Terms of Reference
- Read the records
- Complete the Chronology using “ChronoLator”, the Terms of Reference and the Acronyms List
- Make sure that if you come across a name not on the list you contact the LSCB Administrator
- Send the completed Chronology to the LSCB Administrator (after approval by your agency lead for safeguarding children)
- Decide who, if anybody, you are going to interview or consult
- If you interview a member of staff make sure that you have clear questions (written down) that you want to address during the interview, take accurate notes and give the interviewee a copy of those notes. The interviewee should sign both your and their copy to state that this is an accurate record of the interview. (Make sure that all staff interviewed have had access to the LSCB leaflet on staff involvement in SCRs; these are available from the LSCB Administrator)
- Complete first draft of IMR using the template and advice given in the booklet about format and font
- Do not forget the front page
- Do not forget to number pages
- Do not forget to put on the draft version number and date
- Do not forget to number individual paragraphs

- Make sure this has been shared and agreed with the appropriate line manager(s)/ safeguarding children lead within your organisation
- Complete the recommendations and Action Plan using the Action Plan template. Make sure this has been shared and agreed with the appropriate line manager(s)/ safeguarding children lead within your organisation
- Send completed IMR and Action plan to the LSCB Administrator
- Attend feedback meeting with the Overview Report Writer (sometimes the Overview Report Writer will send comments by email to facilitate changes before the above meeting)
- Amend IMR/Action Plan as necessary and again get this approved by the relevant managers/leads for safeguarding children within your agency
- Go through the audit tool to make sure you have completed everything required
- Sign off by appropriate Senior Manager
- Send to LSCB Administrator

Once the Overview Report Writer and Panel have accepted the IMR it is the responsibility of the IMR writer to feed back to those who were involved in the case within their agency on the lessons learned from their agency perspective. However, this needs to be tempered with the understanding that the Overview Report Writer may have a different perspective or make further or different recommendations for change.

6. Guidance on Chronologies

General Guidance

Each agency is required to put together a chronology of involvement between the dates specified in the Terms of Reference. Each single agency chronology is amalgamated into a multi-agency chronology by the LSCB Administrator. This allows the Overview Report Writer and Individual Panel members to view events from all the agencies' perspectives. North Yorkshire uses ChronoLator to put together the multi-agency chronology. The Chronology will have a number of headings. These headings might change over time. However, Date and Time usually remain the same. If you can not put in a time please be aware that ChronoLator can not distinguish the sequence of events. If you have a number of entries for a specific date please put the one that occurs first. **Do not worry, the LSCB Administrator will talk you through how to use the tool.**

Usually one of the headings will be **Type of Event or Document Source**. In this column please state where the document or information comes from. For example: Strategy Meeting Minutes, LAC Care Plan, GP notes, Police Log. A further standard heading is the **Initials of family member/Person involved**. In this column you need to put which family member you are referring to (as per the Acronym List supplied by the LSCB Administrator) regarding the event you have put into the previous column.

The **Summary of key information** is exactly that - a summary. However, in order to complete the column properly and help the Overview Report Writer and Individual Panel you must read the Terms of Reference. Do not leave out key information because you feel that you are giving too much information or you feel that you want to cut down on the information provided. It might be that a full set of minutes are produced in this column because a decision taken hangs on exactly what was said rather than a possible interpretation. However, this should be rare. **Do not cut and paste information from a case file or electronic files.**

In the **Decisions and Actions column** put in what decisions were taken and by whom. If you are referring to a Strategy Meeting put in the actions and decisions from the meeting, with time frames and those responsible for completion of that decision.

If there is a column for **Issues for review/Comment**, it is here that you point out what should have happened or did not happen. For example, did not follow LSCB Procedures, No Child In Need meeting.

Guidance on Abbreviations and Anonymity

It is important to ensure that this chronology protects the identity of both family members and professionals involved in the case. Therefore, suitable acronyms should be used when referring to them. These must be agreed with the LSCB Administrator.

In the case of family members, they should always be referred to by using the initials specified within the Terms of Reference for the SCR. This will enable consistency.

In relation to professionals, they should be referred to by using acronyms that will be agreed at the SCR Sub Group and stated clearly in the Terms of Reference for the SCR. Deviation from this will result in the need to re-submit your chronology. If you come across a professional, family member, school etc that has no acronym you must contact the LSCB Administrator who will give you one.

Each IMR report writer will be supplied with the chronology electronic template by the LSCB Administrator at or soon after the first meeting. IMR report writers must use this template. Any chronologies not completed on the template will be returned.

The Acronym list must be used; names, places etc must each have an acronym. These acronyms must be used in the chronologies. If the Acronyms List is not used the IMR will be returned to the author for modification.

Presentation

To enable a consistent composite chronology to be produced by the Safeguarding Children Board, agencies should not amend the format of the template.

In addition, it is expected that agencies will use Arial size 12 font. ChronoLator will recognise and accept various formats for dates and times; for example 01.01.2004 or 22.05.04, and 01:00 or 0100. A booklet "Using ChronoLator Documents" will be sent to all IMR writers by the LSCB Administrator, who will give any further advice requested.

Chronologies that deviate from the recommended formats will be returned to the agency for amendment.

7. Making Recommendations

For many IMR authors, the most challenging part of the process is the making of recommendations about how the organisation should address any failings in practice. The following guidance is designed to assist authors in making recommendations that will enable the organisation to develop an Action Plan. Each IMR must have a list of Recommendations. This list will usually be at the back of the IMR before the agency sign off. An Action plan must be provided that addresses the recommendations. The template for Action Plans will be provided by the LSCB Administrator. The Action Plan is a separate document. If an IMR does not have an attached Action Plan it will be sent back to the author.

Key Questions:

There are a number of key questions to ask when looking to make a recommendation.

- Did staff in each agency follow relevant single and multi-agency policies and procedures?
- Were the adult's experience of being parented and the likely impact of this on their parenting capacity known, acknowledged and analysed?
- Did agencies appropriately recognise that adult issues of anger, mental health problems, substance misuse and domestic abuse could place children at risk?
- Did agencies appropriately assess the needs of the children and provide services accordingly?
- Was the child (ren) seen and their wishes and feelings ascertained?

What is the purpose of making recommendations?

- To allow appropriate action to be taken
- To improve practice
- To better protect children.

In order to serve their purpose recommendations must be:

- Relevant and of the right type (see below)
- SMART
- Ofsted have found that recommendations are commonly too focused on policies and procedures as opposed to actual practice.

- Need to be clear what type of recommendation is appropriate.

There are different types of recommendations:

- Resources

Usually require the production of a policy, procedure or protocol. These types of recommendations are easy to write and audit. However, they very rarely address the root cause of something that has gone wrong.

- Professional Action

This requires someone to do something, rather than produce something. For example they may be about someone attending training or writing a specific report. These recommendations may or may not be easy to audit depending on the complexity of the task.

- Professional Knowledge and Skills

They require individuals and groups to acquire or improve their professional knowledge and skills. Two good examples are: i) The Chief Constable will ensure that an email is sent to all Police officers to remind them of the procedures to be followed when they attend an incident of domestic abuse and a child is present; or ii) the Chief Constable will ensure that all Police officers are aware of and understand the procedure to be followed when they attend an incident of domestic violence and a child is present.

SMART Recommendations

Recommendations made within an IMR should always be SMART:

- Specific

It should always be very clear exactly what action is to be taken. In cases where the same action is required of different people, or different parts of the organisation, it will help to actually provide separate recommendations, enabling progress to be monitored more easily.

- Measurable

It should be possible for the organisation to be able to identify when a recommendation has been carried out and what effect it has had.

- Achievable

All recommendations should be within the power of the organisation to carry them out.

- Realistic

All recommendations should be realistic, based on organisational context, financial or staffing constraints etc.

- Timed

The IMR should provide a timescale for each recommendation that should be realistic and achievable, but also avoid delay in implementation.

Some general advice:

- **Focus recommendations on a small number of key areas**

Avoid providing too many recommendations, or ones that do not clearly arise as a result of this SCR.

- **Give yourself time**

Recommendations are often left to the end of the process. However it is helpful to keep a running log of issues which may need recommendations as you work through the IMR.

- **Consult**

It is important to consult with the people who will be responsible for implementing recommendations, to assist in determining whether they are achievable, realistic etc and in deciding on timescale. It is essential to have senior management agreement to the recommendations.

- **Separate recommendation for each change/action needed**

Recommendations will be easier to read and understand, and also to monitor, if they are not combined.

- **Don't re-state existing policies**

A common mistake is to recommend amending a policy or procedure, when the actual failing was in relation to compliance with a procedure.

- **Be clear, evidence based and useful**
- **Develop a consistent style that works for you**
- **Consider how you would put it into action**
- **Apply the 6 Ws:**
 - **What** needs to be done?
 - **Why** does it need to be done?
 - **Where** does it need to be done?
 - **When** does it need to be done?

- How is it to be done?
- **Who is to do it?**

- **Once a SCR has been signed off and sent to the Local Safeguarding Children Board and the agencies involved are committed to implementing all the recommendations, progress will be monitored by the Government. Therefore it is important to get them right before submission. However, if because of specific changes (eg agency reorganisation) a recommendation cannot subsequently be carried out, this MUST be discussed both with the person (or their equivalent) to whom the recommendation has been made, and with the LSCB Manager.**

- Every recommendation must appear on the Action Plan

- Action Plan should state:
 - How the recommendations are going to be implemented
 - Who is responsible for the different tasks required for implementation
 - When these parts will be completed.

- Action planning is much easier when recommendations are already SMART

An Action Plan template will be supplied to you by the LSCB Administrator

North Yorkshire Safeguarding Children Board

Serious Case Review Procedure

LSCB Procedures: Section 13

www.safeguardingchildren.co.uk

Appendix A

IMR AUDIT TOOL

Introduction

This tool has been created to assist IMR authors in the quality assurance of their own IMR reports, prior to submission to their senior decision-makers for “sign off”. It has been completed using information found in Working Together to Safeguard Children, as well as information provided by Ofsted on the SCR evaluation process.

The tool represents the first stage in quality assurance for IMRs, and is intended to assist authors and agencies in self-assessing the content of their reports. However, if they choose to do so, the agency representatives with the authority to “sign off” the IMR can also use the tool to satisfy themselves that the report is of suitable quality for submission to the Safeguarding Children Board.

Effective use of this Audit Tool may reduce the risk of delays to the SCR process that can arise when the Individual Panel request improvements to the reports that have been submitted.

In addition, if the tool is used as a guide to the content and structure of IMRs (alongside the IMR Format document) this may impact favourably on the evaluation of the SCR by Ofsted.

Once the IMR has been approved within your agency, it will be submitted to the Overview Report Writer, Chairperson and Individual Panel via the LSCB Administrator, who will provide further quality assurance. To avoid the possibility of the report being returned to the author for further work, IMR authors should ensure that their reports comply with all parts of the tool.

1. Securing of Case Files

Have relevant case files been secured?

In paragraph 8.21 Working Together to Safeguard Children clearly states that this should take place, to guard against loss or interference.

Author's Notes

2. Independence of Author

Is it clear within the report that the IMR has been authored by somebody who was not “directly concerned with the child or family, or the immediate line-manager of the practitioners involved”?
(Paragraph 8.20 Working Together to Safeguard Children).

Is the name and position (job title) of the author clearly recorded?

Author's Notes

3. IMR Format

Is the IMR prepared in the agreed format? (If not, it will be returned to the author by the Overview Panel)

Author's Notes:

4. Presentation

Is the IMR report presented in a professional manner (does it use a legible and clear typeface, is formatting and spelling acceptable etc)? If not, the report will be returned to the author for amendment.

Jargon should not be used. Specific professional terms (ie those not in plain English such as CAT scan must be explained).

Is the chronology prepared on the agreed North Yorkshire Safeguarding Children Board template (which will be distributed electronically to all IMR authors)? If not, it will not be accepted by the Safeguarding Children Board.

Author's Notes:

5. Staff Interviews

Have key staff members been interviewed in the preparation of the report, and is this clearly recorded in the IMR (see IMR Format document)?

It is expected that where possible, staff will have been interviewed by the IMR author. If this has not been possible, the IMR should include a clear explanation of the reason for this.

Is there a clear record of the interview that has been signed as being accurate by both interviewer and interviewee?

Author's Notes

6. Confidentiality

Is the IMR properly anonymised?

All abbreviations used in the report **MUST** be consistent with those specified in the Terms of Reference to ensure consistency between reports.

Does the IMR include a key for abbreviations/ acronyms used to refer to both family members and professionals?

NB Professionals should not be identified personally, and should be referred to by the acronym assigned to them by the LSCB Administrator.

Author's Notes:

7. IMR Content

Does the IMR fully address the Terms of Reference and the following questions taken from Working Together to Safeguard Children 2010.

What was our involvement with this child and family?

The IMR should be accompanied by a comprehensive chronology of involvement by the organisation and/or professional(s) in contact with the child and family over the period of time set out in the review's Terms of Reference.

Does the body of the IMR contain a clear, chronological narrative description of the work undertaken by professionals within the agency, and clearly summarise decisions reached, the services offered and/or and any other action taken.

Author's Notes

Analysis of involvement

Does the IMR consider the events that occurred, the decisions made, and the actions taken or not taken?

Where judgements were made, or actions taken, which indicate that practice or management could be improved, does the IMR try to get an understanding not only of what happened but why it happened?

Inter-agency or inter-disciplinary power or authority issues may also need to be explored within the analysis section of the IMR.

Does the IMR consider specifically the following?

- Were practitioners sensitive to the needs of the children in their work, knowledgeable about potential indicators of abuse or neglect, and about what to do if they had concerns about a child?

- Did the organisation have in place policies and procedures for safeguarding and promoting the welfare of children and acting on concerns about their welfare?
- What were the key relevant points/opportunities for assessment and decision making in this case in relation to the child and family? Do assessments and decisions appear to have been reached in an informed and professional way?
- Did actions accord with assessments and decisions made? Were appropriate services offered or provided, or relevant enquiries made, in the light of assessments?
- Where relevant, were appropriate child protection or care plans in place, and child protection and/or looked after reviewing processes complied with?
- When, and in what way, were the child(ren)'s wishes and feelings ascertained and taken account of when making revisions about children's services. Was this information recorded?
- Was practice sensitive to the racial, cultural, linguistic and religious identity of the child and family?
- Were more senior managers or other organisations and professionals involved at points where they should have been?
- Was the work in this case consistent with each organisation's and the LSCB's policies and procedures for safeguarding and promoting the welfare of children, and with wider professional standards?

Author's Notes:

What do we learn from this case?

Does the IMR clearly identify lessons from this case for the way in which the organisation works to safeguard and promote the welfare of children?

Does the IMR clearly highlight good practice, as well as ways in which practice can be improved?

Does the IMR identify implications for ways of working; training (single- and multi-agency); management and supervision; working in partnership with other organisations; resources etc?

Author's Notes:

Recommendations for action

Are all failings in practice linked to an appropriate recommendation? NB: where practice has changed since a particular failing occurred, rendering a recommendation unnecessary, this should be stated.

Are all recommendations clearly linked to a conclusion reached within the IMR?

Does the IMR identify what outcomes any recommendations should achieve?

Are all recommendations SMART?

Author's Notes:

8. Issues Related to Diversity

The IMR must refer to the ethnicity of the family, and any gender, ethnic, cultural, disability, health, religious/spiritual or other diversity issues must be explored.

If there are no relevant issues, the IMR must state this and the reason for arriving at this view.

Author's Notes:

9. Compliance with Terms of Reference

Does the IMR fully and accurately reflect the Terms of Reference for the SCR?

Author's Notes:

10. Gaps in Information

Are there any gaps in the report that will lead the Overview Report Writer and Individual Panel to request more information? If so, this will delay the completion of the SCR.

Any gaps in the information must be unavoidable, and should be fully explained by the IMR author.

Author's Notes:

11. Provision of Feedback to Staff

Have arrangements been made for the provision of feedback to professionals who are referred to in the IMR?

Author's Notes:

12. Governance and Agency “Sign-Off”

Has the designated senior officer in your organisation reviewed the IMR and has the report been signed off by them?

The signature of the relevant senior officer should be clearly included at the end of the IMR report (see IMR Format document).

Author’s Notes:

13. Chronology

Does the chronology use the agreed North Yorkshire Safeguarding Children Board template, and comply with the Guidance on Chronologies chapter of this handbook?

Author’s Notes:

Appendix B

EXAMPLE OF A TERMS OF REFERENCE



SERIOUS CASE REVIEW

Terms of Reference for Child X

Remit

The purpose of the review is to improve inter agency working to better safeguard and promote the welfare of children, by seeking to establish what, if any, lessons are to be learnt from the way local professionals and agencies worked together to safeguard and promote the welfare of Child X, date of birth xxxx

This review has been initiated under paragraph 8.5 of *Working Together to Safeguard Children* (2006):

A LSCB should always undertake a serious case review when a Child dies (including death by suicide), and abuse or neglect is known or suspected to be a factor in the child's death. This is irrespective of whether LA children's social care is or has been involved with the child or family.

The review should identify clearly and make appropriate recommendations as to:

1. what those lessons are;
2. how they will be acted upon;
3. what is expected to change as a result and
4. the acceptable timescale for implementation.

Subject of the Review

Initials	Date of Birth/ Date of Death	Relationship
Child X		Subject

The review of the case is to include the following family members:

Initials	Date of Birth	Relationship to Child X

The Start and End Date of the Review

Issues identified by the SCR Sub Group as of particular relevance

- 1
- 2
- 3
- 4

Obviously, other issues may come to light when the chronology is available and the individual management reports are prepared. If Sub Group members become aware of any further issues, and in particular if those issues relate to a time outside the existing remit of the Review, the Independent Chairperson should be informed and they will be considered and a decision made as to whether the remit should be extended.

Further, IMR writers may find that other issues come to light relating to a time outside of the remit that would contribute to the understanding of the issues. These should be included in the IMR.

The IMR and Overview Report Writers should take into account any available research, including the Biennial Overview Reports of SCRs¹ and recommendations from previous SCRs undertaken by North Yorkshire Safeguarding Children Board (or its predecessor the Area Child Protection Committee). Copies of the previous recommendations will be supplied to the Overview Report Writer.

Any unusual features of the Case

- 1
- 2
- 3
- 4

¹ The Biennial Review (Brandon et al (2009) *Understanding Serious Case Reviews and their Impact* DCSF p27, contains potentially useful material in relation to disability.

Overview Author and Composition of the Panel

It is a requirement that the roles of the Overview Report Writer and Panel Chairperson should be undertaken by individuals who:

- are Independent of North Yorkshire Safeguarding Board and its member agencies;
- are highly experienced at a practitioner level in multi-agency safeguarding work and preferably, in this case, in a disability context;
- have experience as a senior manager in a safeguarding context, ideally in a disability context;
- have investigation and report-writing skills;
- have experience and a good track record of similar work in relation to other reviews.

The appointed Independent Overview Author is xxxx and the Independent Chairperson is xxxx. They were each identified by the LSCB Manager, in consultation with the Independent Chairperson of the Board, as having all of the above qualities.

The Panel will comprise the following:

- ◆
- ◆
- ◆
- ◆

At this stage, the Panel are not proposing to bring in any outside experts, because the issues to be addressed appear to be within the expertise of the group. If during the course of the Review it is considered that particular expertise should be brought in it will be decided in conjunction with the Panel members, Overview Report Writer and Chairperson.

Agencies Involved

The following organisations are known to have been dealing with this child and family and have been asked to compile Individual Management Reports:

- ◆ North Yorkshire Children & Young People's Service – Children's Social Care
- ◆ North Yorkshire Children and Young People's Service – Education
- ◆ North Yorkshire Police
- ◆ General Practitioner
- ◆ NSPCC

It may transpire that during the course of the Review other family members, professionals or agencies are identified as being important to the outcome of the Review. This will be dealt with by the Panel in conjunction with the Overview Report Writer and Chairperson.

All of the agencies involved have been reminded of their responsibilities in relation to SCRs. If any of the IMR authors and/or the overview report author encounters difficulty in securing the cooperation of agencies or professionals, or in securing access to information, they should inform the Independent Chairperson, who will liaise with the LSCB Manager and/or Independent Chairperson of the LSCB, who will be able to take legal advice if necessary.

Involvement of Family Members

At the conclusion of the review, the family will be offered an opportunity to meet with the Overview Report writer to inform them of the outcome of the review.

Concurrent Investigations

Cross Boundary Issues

So far as we are aware, there are no organisations based wholly outside North Yorkshire that would need to be brought into this Review. There will therefore not be any other LSCBs involved in this Review.

Issues of Ethnicity, Culture etc

Anonymisation and Publicity

The IMR authors, Overview Report Writer and Chairperson are being provided with a schedule of anonymisation for family members and professionals. Any media approaches or freedom of information requests should be passed to the Safeguarding Board Manager. In due course, the Police will deal with any issues of publicity arising from the criminal proceedings. An Executive Summary of the Overview Report will be prepared by the Overview Report Writer and placed on the Safeguarding Board website.

Legal Advice

We do not believe that we require independent legal advice at this stage, but this will be kept under review by the Panel.

Format and Timescale for the Report

The IMR authors and Overview Report Writer have been given a template for their reports. These follow the formats contained in Chapter 8 of Working Together. However, the Report Writers are free to supplement these templates if they consider that including additional information would add to learning.

North Yorkshire Safeguarding Children Board has purchased the 'ChronoLator' software for preparing multi agency chronologies, and will be using it in relation to this Review.

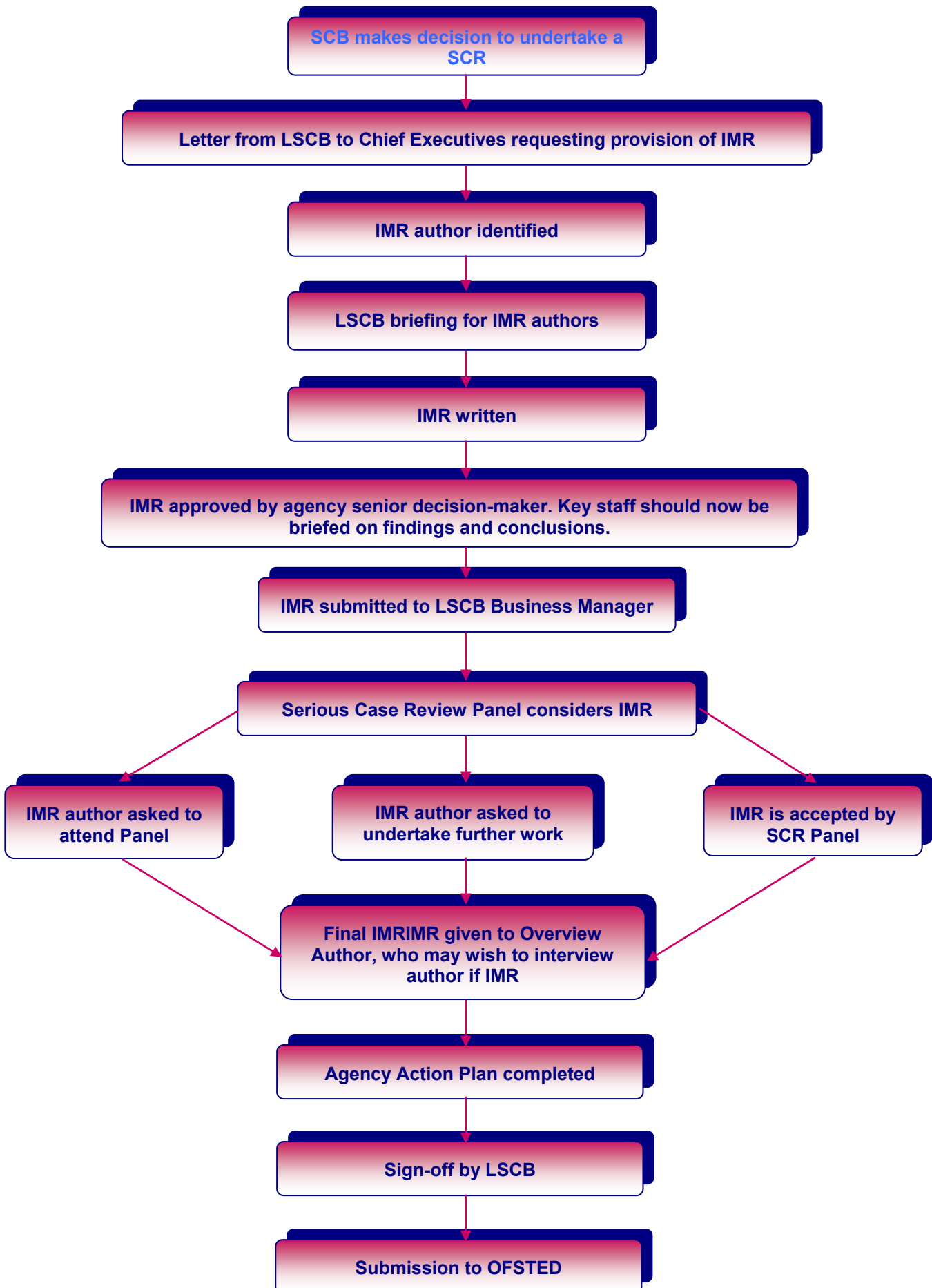
With regard to the timetable for the process, the Panel has decided the following in conjunction with the Overview Report Writer:

1. Agency chronology to be prepared by 2 April 2004.
2. Composite chronology by 16 April 2004.
3. Individual Management Reports to be submitted by 24 May 2004 at 5 pm.
4. Single agency Action Plans to be submitted by 24 May 2004 at 5 pm.
5. Meeting with IMR writers and Panel on 10 June 2004 at 10 am.
6. SCR Overview Panel meetings on 17 June 2004 at 10 am and 24 June 2004 at 10 am.
7. Meeting to consider draft Overview Report on 15 July 2004 at 10 am.
8. Sub Group meeting to accept report and confirm inter agency Action Plan on 5 August 2004 at 1.30 pm.
9. LSCB meeting to consider Report and Action Plan on 19 August 2004.
10. Submission to Ofsted no later than 2 September 2004.

LSCB Manager
on behalf of the SCR Panel
North Yorkshire Safeguarding Children Board
14 March 2004

Appendix C

IMR FLOWCHART



Appendix D

Ofsted Descriptors for the Evaluation of Serious Case Reviews

All SCRs, including their component IMRs, are reviewed and evaluated by Ofsted. The Ofsted descriptors are provided here as an appendix for your information.

Judgements will be made by Ofsted in the following areas:

- Depth of learning
- Quality of recommendations and action plan
- Quality of review process
- Overall effectiveness.

The evaluation will weigh up the evidence in each area and come to a judgment based on 'best fit' with the grade descriptors.

As a guide to proportions, the term 'majority' in this schedule means 50% or more; the term 'a large majority' means 65% to 79%; and 'most' means 80% or more.

Depth of learning

The inspectors will evaluate the extent to which:

- the IMRs identify the key lessons learned for practice, training, management, organisation and resources in the individual agency responsible
- the overview report brings together the findings from the IMRs into a coherent narrative which identifies the key lessons learned and areas for interagency learning and action
- the conclusions drawn by the overview report and the IMRs flow clearly from the analysis
- the executive summary of the overview report and action plan contains a clear presentation of the issues arising from the case, and the lessons learned
- the review has involved the child and all relevant family members and significant others in the review process and their voices have been heard
- the learning includes consideration of needs and issues relating to the ethnic, cultural, linguistic, and religious background of the child and family, and the effectiveness of services' response to those needs
- the learning includes consideration of needs and issues relating to the disability of the child and/or other parties, and the effectiveness of services' response to those needs

- research and findings from previous SCRs are used to inform learning
- Learning from the SCR is considered in the context of safeguarding arrangements both locally and nationally.

Depth of learning: Grade Descriptors	
Outstanding	Systematic attention is given to all dimensions of learning, including practice, training, management, professional supervision where applicable, organisation and resources, and inter-agency working. There is comprehensive identification of lessons to be learned and these flow directly from the analysis and conclusions of the review. The voice of the child and of relevant family members has been heard and taken into account fully. There is comprehensive consideration of needs and issues arising from the ethnic, cultural, linguistic, and religious background of the child and family, and those relating to the disability of the child and/or other parties, and of the effectiveness of services' response to those needs. The IMRs identify, where appropriate, the lessons to be learned for individual agency practice and organisation. The overview report brings together the findings from the IMRs into a coherent narrative which identifies the key lessons learned and areas for interagency learning and action. The executive summary contains a clear presentation of the issues arising from the case, and the lessons learned. Systematic use is made of research and / or the findings from previous SCRs. Lessons to be learned are identified on both the local and the national levels, where appropriate.
Good	Attention is given to most dimensions of learning. Lessons to be learned are clearly identified and derive from the analysis and conclusions of the review. The voice of the child and family members has been heard and taken into account. Consideration is given to needs and issues arising from the ethnic, cultural, linguistic, and religious background of the child and family, and those relating to the disability of the child and/or other parties, and the effectiveness of services' response to those needs is examined. The IMRs identify, where appropriate, the lessons to be learned for individual agency practice and organisation. The overview report brings together the findings from the IMRs into a coherent narrative which identifies the key lessons learned and areas for interagency learning and action. The executive summary contains a clear presentation of the issues arising from the case, and the lessons learned. Effective use is made of research and / or the findings from previous SCRs.
Satisfactory	Key lessons to be learned are identified and are informed by the analysis and conclusions of the review. There is evidence of efforts made to consider the views of relevant family members. Consideration is given to needs and issues arising from the ethnic, cultural, linguistic, and religious background of the child and family, and those relating to the disability of the child and/or other parties. The IMRs identify, where appropriate, the lessons to be learned for individual agency practice and organisation. The overview report draws out the lessons to be learned for both intra- and inter-agency practice. The executive summary contains a clear presentation of most of the issues from the case, and the lessons learned.

Inadequate	Key lessons to be learned are missed or not clearly identified; some that are identified do not always flow from the analysis and conclusions of the review. Significant dimensions of learning are not addressed. The voice of the child and family members has not been heard and/or taken into account. There is limited or no consideration of needs and issues arising from the ethnic, cultural, linguistic, and religious background of the child and family, and of those relating to the disability of the child and/or other parties. The IMRs do not identify, where appropriate, the lessons to be learned for individual agency practice and organisation. The overview report fails to coherently draw together the analysis and conclusions of the IMRs. The executive summary is not fully clear about the issues arising from the case, and the lessons learned.
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Quality of recommendations and action plan

Inspectors will evaluate the extent to which:

- recommendations and action plans, in both the IMRs and the overview report, are clearly focused on improving the safeguarding of children
- the recommendations of the IMRs and of the overview report flow clearly from the analysis and the lessons learned
- the action plans address all the recommendations
- the recommendations and action plans are specific, measurable, achievable, relevant and timely
- they are clear about the changes required and the intended outcomes, timescales and accountability for implementation, and arrangements for evaluation of achievement
- recommendations and urgent actions have already been implemented

Quality of recommendations and action plan: Grade Descriptors	
Outstanding	All or most IMRs set out a robust action plan to translate into practice the lessons learned for the individual agency. In the overview report, the key lessons learned are translated into clear and relevant recommendations which are likely to have a major impact on improving the quality of safeguarding of children. The recommendations flow clearly from the analysis. All or most of the recommendations and action plans are specific, measurable, achievable and timely. There are clear timescales and accountabilities for the all or most of the recommendations. A significant number of recommendations have already been implemented.
Good	The IMRs set out a robust action plan to translate into practice the lessons learned for the individual agency. The key lessons learned are translated into clear and relevant recommendations which are likely to have a demonstrable impact on improving the quality of safeguarding of children. The recommendations flow clearly from the analysis. The large majority of the recommendations and action plans are specific, measurable, achievable and timely. There are

	clear timescales and accountabilities for the large majority of recommendations. Some recommendations have already been implemented.
Satisfactory	The IMRs set out a robust action plan to translate into practice the lessons learned for the individual agency. The key lessons learned are translated into clear and relevant recommendations which have a clear focus on improving the quality of safeguarding of children. The recommendations flow clearly from the analysis. The majority of the recommendations and action plans are specific, measurable, achievable and timely. There are clear timescales and accountabilities for the majority of recommendations. Urgent recommendations have already been implemented.
Inadequate	It is not clear how the review will contribute to improving the safeguarding of children in the area. Few of the lessons learned are translated into convincing recommendations for improving the safeguarding of children. The IMRs do not set out a robust action plan to translate into practice the lessons learned for the individual agency. The key lessons learned are not all translated into clear and relevant recommendations which have a clear focus on improving the quality of safeguarding of children. It is not clear how the recommendations derive from the analysis. The majority of recommendations do not have clear timescales and accountabilities for. No recommendations have yet been implemented, or urgent recommendations have not yet been implemented.

Quality of review process

Inspectors will evaluate the extent to which:

- IMRs and the overview report are consistently focused on the experiences, perspectives, wishes and feelings of the child
- the review process has appropriately engaged all the relevant members of the family, including children and young people where appropriate
- the decision to instigate the review is timely and the SCR is completed within *Working Together to Safeguard Children* timescales
- appropriate and robust independence is demonstrated at all stages and at all levels of the review process
- the Terms of Reference provide a clear framework and direction to enable agencies to identify areas of learning
- IMRs are commissioned from, and provided by, all relevant agencies
- the scope and format of each IMR comply with *Working Together to Safeguard Children* guidance
- IMRs and recommendations are signed off by an appropriate senior officer on behalf of the agency
- the scope and format of the overview report comply with *Working Together to Safeguard Children* guidance

- the effectiveness of the IMRs is critically evaluated by the overview report and the overview addresses any shortfalls
- the executive summary includes clear and appropriate information about the review process, key issues arising, the recommendations and the action plan
- The executive summary is suitably anonymised.

Quality of review process: Grade Descriptors	
Outstanding	In the IMRs there is a consistent focus on the experiences, perspectives, wishes and feelings of the child. Relevant members of the family, including children and young people where appropriate, have been engaged in the review, and there is evidence that their perspectives have been taken fully into account. There is compliance with <i>Working Together to Safeguard Children</i> timescales. Appropriate and robust independence is demonstrated at all stages and at all levels of the review process. The Terms of Reference are comprehensive and effectively focus attention on areas of learning. All relevant agencies have produced IMRs. The scope and format of IMRs and the overview report comply with <i>Working Together to Safeguard Children</i> guidance. The effectiveness of the IMRs is critically evaluated by the overview report and the overview addresses any shortfalls. The executive summary provides clear and appropriate information about the review process, key issues arising, the recommendations and action plan, and is suitably anonymised.
Good	In the f IMRs there is a consistent focus on the experiences, perspectives, wishes and feelings of the child. Relevant members of the family, including children and young people where appropriate, have been engaged in the review. There is compliance with <i>Working Together to Safeguard Children</i> timescales. The SCR panel Chairperson, and the overview report writer, meet the criteria for independence set down by <i>Working Together to Safeguard Children</i> . Most IMRs are conducted by suitably experienced and senior people, who have had no involvement in or responsibility for the matters under review. The Terms of Reference effectively focus attention on areas of learning. All relevant agencies have produced IMRs. The scope and format of IMRs and the overview report comply with <i>Working Together to Safeguard Children</i> guidance. The executive summary provides clear and appropriate information about the review process, key issues arising, the recommendations and action plan, and is suitably anonymised.
Satisfactory	In the IMRs there is a clear focus on the experiences, perspectives, wishes and feelings of the child. There is a record of consideration given to engaging relevant members of the family, including children and young people where appropriate. There is compliance with <i>Working Together to Safeguard Children</i> timescales. The SCR panel Chairperson, and the overview report writer, meet the criteria for independence set down by <i>Working Together to Safeguard Children</i> . The Terms of Reference are clear and cover the main areas which the review needs to focus on. All agencies with a significant involvement in the case have produced IMRs. The

	scope and format of IMRs and the overview report broadly comply with <i>Working Together to Safeguard Children</i> guidance. The executive summary accurately summarises the main issues and recommendations, and is suitably anonymised.
Inadequate	There is insufficient focus on the experiences, perspectives, wishes and feelings of the child. There is limited evidence of consideration given to engaging relevant members of the family, including children and young people where appropriate. <i>Working Together to Safeguard Children</i> timescales have not been complied with. There is insufficient independence in the process. The IMRs are not conducted by suitably experienced and senior people or they have had involvement in or responsibility for the matters under review. The Terms of Reference are not clear and do not appear to identify some of the key issues to be covered. One or more agencies with a significant involvement in the case have failed to produce an IMR. The scope and format of IMRs depart significantly from <i>Working Together to Safeguard Children</i> guidance. The executive summary does not sufficiently summarise the main issues and recommendations. It is not suitably anonymised.

Overall effectiveness

In reaching a judgement on overall effectiveness, the evaluation will weigh the balance of evidence across the three domains of depth of learning, quality of recommendations and action plan, and quality of the review process, and the strength of the evidence within each domain. If the judgment of either the depth of learning or the quality of the recommendations and action plan is inadequate, it is likely that the overall effectiveness will also be inadequate.

If you would like this information in another language or format such as Braille, large print or audio, please ask us.

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