Individual Management Reviews structure

This document is intended to provide an IMR of the decisions, actions taken and services provided to the adult.

The aim of the IMR 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.

The findings from the IMR report should be endorsed by the senior officer within the organisation who has commissioned the report and who will be responsible for ensuring that recommendations are acted upon.

Name of Agency:	
Name of Adult(s):	
DOB:	
Name, agency and contact details of author:	
Date of Completion of IMR:	

SUMMARY

Provide a brief factual and contextual summary of your agency's involvement with the adult for the time period identified for this safeguarding adult review. Provide reference for the source of factual information.

CHRONOLOGY OF AGENCY INVOLVEMENT
(To be completed on template provided).

Provide 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. Please avoid abbreviation.

ANALYSIS OF INVOLVEMENT

The report author is expected to analyse the involvement of their agency. Consider the events that occurred, the decisions made, and the actions taken or not. It is important to get an understanding not only of what happened, but why, with the context of practice, the environment, leadership, commissioning models etc. The Terms of Reference should be referred to as headings to analyse practice against.

Consider specifically:

- Were practitioners sensitive to the needs of the adult at risk in their work, knowledgeable about the potential indicators of abuse or neglect, and about what to do if they had a concern about an adult at risk of abuse or neglect?

- Did the agency have policies and procedures for safeguarding adults at risk and acting on concerns about abuse or neglect?

- What were the key relevant points/opportunities for assessment and decision making in the case in relation to the adult? Do assessments and decisions appear to have been reached in an informed and professional way?

- Did action accord with assessments and decisions made? Were appropriate services offered/provided or relevant enquiries made in the light of assessments?

- Where relevant were appropriate care plans in place, reviewing processes complied with and how did they involve relevant risk assessment in protecting the adult?

- Were more senior managers or other agencies and professionals, involved at points they should have been?

- Was the work in this case consistent with agency policy and procedures for safeguarding adults at risk, and wider professional standards?

- Was mental capacity adequately assessed and recorded where appropriate?

- Was practice sensitive to any protected characteristics and identity of the adult?

- Are there any particular features of this case, or issues surrounding the death or injury of the adult(s), that you consider require further comment in respect of your agency's involvement?

LEARNING

- Is there good practice to highlight, as well as ways in which practice can be improved?
- Are there lessons from this case for the way in which this agency works to safeguard adults?
- Are there implications for ways of working?
- Are there implications for management and/or supervision?
- Are there implications for training (single or multi-agency)?

RECOMMENDATIONS FOR ACTION

Recommendations should be few in number, focused and specific, and capable of being implemented. Consideration should be given to the resources required to implementing the recommendations such as cost.