

Independent reviewing officers: taking up the challenge?

This report evaluates the effectiveness of independent reviewing officers in discharging their responsibilities towards looked after children. Inspectors visited a sample of 10 local authority areas. The report draws on evidence from 111 cases, the views of children and young people, carers, and professionals from the local authorities and from partner agencies.

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Executive summary

The core purpose of the independent reviewing officer (IRO) role is to ensure that the care plan for the child fully reflects the child's needs and to ensure that each child's wishes and feelings are given full and due consideration.¹ The appointment by local authorities of an IRO is a legal requirement.²

The Children and Young Person's Act 2008, followed by revised care planning regulations and guidance which came into force in April 2011, strengthened the role of the IRO who is not only responsible for chairing statutory reviews but also for monitoring cases on an ongoing basis.³ Concerns had arisen over time that IROs did not sufficiently challenge local authority decisions when practice was poor and not in children's best interests.

The IRO also has a duty to monitor the local authority's overall performance as a corporate parent and to bring any areas of poor practice in the care and planning for looked after children to the attention of senior managers.⁴

This report evaluates the effectiveness of IROs in discharging their responsibilities towards looked after children. Inspectors visited 10 local authority areas. The report draws on evidence from 111 cases and from the views of children and young people, carers, and professionals from the local authority and from partner agencies.

The pace of progress in IROs taking on the full scope of their enhanced responsibilities as outlined in the revised regulations was too slow in most authorities visited by inspectors. IRO oversight of care plans was not consistently robust. IROs did not sufficiently challenge delays in the making of permanent plans for children's futures. The views of children were not always taken into full account. The IRO role in monitoring and challenging local authorities' overall performance as corporate parents was underdeveloped.

In only two local authorities visited were recommendations arising from children's reviews consistently good enough to drive forward plans for children's futures. There was a clear link between weak recommendations and inadequate monitoring of

¹ IRO handbook: statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children, Department for Children, Schools and Families (DCSF), 2010 (pp 9–12); www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065612/independent-reviewing-officers-iros.

² Adoption and Children Act 2002, section 118; www.education.gov.uk/childrenandyoungpeople/families/adoption/b0067811/adoption-legislation/adoption-and-children-act-2002

³ The care planning, placement and case review (England) regulations, Department for Children, Schools and Families, 2010; www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00185-2010.

⁴ As corporate parents, all those who are responsible for looked after children should act for the children as a responsible and conscientious parent would act for their own children.

progress. This led sometimes to delays for children. Similarly, IROs were much less likely to challenge poor practice if earlier review recommendations and ongoing monitoring of plans were not sufficiently strong.

Statutory guidance stipulates that each local authority should establish a formal process, usually known as a dispute resolution protocol, for the IRO to raise concerns with managers. Formal protocols were in place in nearly all local authorities. Several protocols were well established and promoted informal resolution of disagreements, but these processes were not consistently understood or applied. In most local authorities visited, outcomes of disagreements were not used to inform organisational learning.

Inspectors did see some sensitive work by IROs to engage with children. IROs generally met with children prior to review meetings when possible, although excessive workloads in several local authorities affected their capacity to meet with children more often between reviews. When IROs were able to spend more time with children, their wishes and feelings were more likely to be fully understood and taken into account in reviews and in care planning.

In most local authorities visited, caseloads for IROs were higher than recommended in statutory guidance. This seriously reduced their capacity to undertake their roles effectively. Difficulties were exacerbated in most areas by a variety of additional responsibilities for the IRO. Although a lower caseload was not a guarantee of high-quality work, IRO input was likely to be more effective where caseloads were manageable; review recommendations were generally sharper, monitoring of cases was tighter and IROs' relationships with corporate parents were more assertive and challenging. IROs were better equipped to ensure that children were involved effectively in care planning.

Inspectors found that senior leaders valued the quality assurance role of the IRO. Nearly all said that they would generally welcome more consistent, and stronger, challenge from IROs. Improvement is needed, however, to ensure that IROs are sufficiently supported and challenged by leaders to undertake their role in driving effective improvement in services for looked after children. Senior managers must regularly evaluate the value added by IROs and the extent to which plans and outcomes for looked after children improve as a result of their input.

The Children and Young Person's Act 2008 does make provision for IROs to be employed by a body outside the local authority, but this provision has not yet been used. Inspectors saw some evidence that IROs were able to provide suitably independent challenge on behalf of children when employed by, and based within, local authorities.

The report suggests that the effectiveness of IROs would not be easily improved by removing them from the employment of local authorities. In most local authorities visited, there remained considerable scope for improvement under the current arrangements.

Key findings

- The pace of progress in IROs taking on the full scope of their enhanced responsibilities has been too slow in most local authorities.
- The effectiveness of IRO oversight of individual looked after children's care plans was not consistently good enough.
- Excessive workloads for IROs in most authorities visited had an adverse impact on their ability to carry out their role effectively, particularly in ensuring that children's voices influence planning for their future care.
- In nearly all authorities, review recommendations and the subsequent monitoring of progress by IROs were not consistently rigorous, leading to poor planning for children's futures and unnecessary delay in some children's cases.
- Children and young people were not always properly consulted on the venues for reviews and about which adults they would like to attend.
- Social workers and IROs communicated regularly with each other between reviews, although the purpose and impact of this was not always evident.
- The quality of IRO annual reports, where they existed, was not consistently good enough. Nearly all reports that were produced were not accessible to children, young people, carers and families, or to the wider public.
- IROs in most areas visited had not forged strong links with the corporate parenting board or the Children in Care Council. They were not sufficiently integrated into senior leadership discussions or strategic reviews of the progress and experiences of looked after children and young people.
- Formal dispute resolution processes were in place, but were not always well understood or used when required.
- Generally, the involvement of IROs in cases during care proceedings was underdeveloped, although there were signs of improving liaison with the Children and Family Court Advisory and Support Service (Cafcass) in several authorities.
- Oversight of IROs' work by their line managers was not sufficiently rigorous in most local authorities visited.
- The independent challenge that can be provided by IROs was encouraged and welcomed by senior managers as a lever for improvement.

Recommendations

Local authorities should:

- Take urgent action to implement in full the revised IRO guidance and ensure that:
 - IROs have the required skills, training, knowledge and time to undertake all elements of their role effectively, including ensuring that children's wishes and feelings properly influence the plans for their future

- management oversight of IROs is sufficiently robust, which must include formal and rigorous challenge where there is delay in making permanent plans for their future; senior managers must assure themselves of the quality of the IRO service and manage its performance effectively; line managers must take prompt action to rectify poor IRO performance
 - an annual report is produced by the IRO service in line with statutory guidance, setting out the quality of corporate parenting and care for looked after children; it should be publicly accessible and include information on IRO caseloads
- seek regular feedback from children, young people, families, carers and professionals about the difference the IRO has made to the lives of the children with whom they work. This evidence should be collated by the local authority and used to drive improvement
 - prioritise and implement strategies that enable the most vulnerable looked after children, such as children with additional communication needs and children living away from their home local authority, to participate as fully as possible in the planning and reviews of their care.

Local authorities and Cafcass should:

- ensure that IROs and Children’s Guardians develop productive working relationships, both during care proceedings and when seeking to resolve a dispute on behalf of children.

Government should:

- collate, analyse and report on the information from IRO annual reports so that the findings inform policy and improve the quality of care for children and young people.

Introduction

1. The core purpose of the IRO role is to ensure that the care plan for the child fully reflects the child’s needs and to ensure that each child’s wishes and feelings are given full and due consideration. Local authorities are required by law to appoint an IRO.⁵
2. A House of Lords judgement in 2002 recognised that some children with no adult to act on their behalf may not be able to challenge a local authority that was failing in its duties to looked after children. In 2004, the government made it a legal requirement for an IRO to be appointed for each looked after child, to

⁵ Adoption and Children Act 2002, section 118;
www.education.gov.uk/childrenandyoungpeople/families/adoption/b0067811/adoption-legislation/adoption-and-children-act-2002.

participate in case reviews, monitor the local authority's performance in respect of reviews, and to consider whether it would be appropriate to refer cases to Cafcass. Later, Cafcass's powers were enhanced so that, following a referral from an IRO, they could consider initiating proceedings for breaches of the child's human rights.⁶

3. However, *Care matters: transforming the lives of children and young people in care* reflected concerns that IROs were not sufficiently challenging of local authority's decisions in all authorities, even where practice was poor and not in a child's best interests.⁷ Not all reviews enabled rigorous analysis of need. Insufficient weight was given to the views of children, parents, carers and key professionals.
4. The number of formal referrals to Cafcass has been very low. Only eight referrals were made by IROs to Cafcass between 2004 and June 2011. Informal advice from Cafcass has been sought more regularly by IROs.
5. In explaining the lack of referrals to Cafcass, the 2009 Children, Schools and Families Select Committee report on Looked after Children questioned whether IROs were sufficiently independent of their employing local authority. The Children and Young Person's Act 2008 does make the provision for IROs to be employed by a body outside the local authority, but this provision has not yet been used. *Care matters: time for change* concluded that, on balance, it would be premature to pursue the option of externalising IRO services as the disruption that this might cause to children in care services in the short term could outweigh potential longer-term benefits.⁸
6. The Children and Young Person's Act 2008, followed by revised care planning regulations and guidance which came into force in April 2011, strengthened the role of the IRO, such that:⁹
 - local authorities must appoint a named IRO for each child
 - the IRO must monitor each case and the child's wishes and feelings must be given due consideration
 - the IRO must speak with each child privately before each review

⁶ For more details of the legal context, see IRO handbook: statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children, DCSF, 2010;

www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065612/independent-reviewing-officers-iros.

⁷ *Care matters: transforming the lives of children and young people in care*, DCSF, 2006; www.education.gov.uk/publications/standard/publicationDetail/Page1/CM%206932.

⁸ *Care matters: time for change*, DCSF, 2007; www.education.gov.uk/publications/standard/publicationdetail/page1/DFES-00541-2007.

⁹ The care planning, placement and case review (England) regulations, DCSF, 2010; www.education.gov.uk/publications/standard/publicationDetail/Page1/DCSF-00185-2010.

- the IRO will be able to refer cases to Cafcass at any time, and not necessarily as a last resort
 - recommendations made at a child’s review become decisions and must be implemented within a week, unless challenged by the local authority.
- 7. The IRO handbook sets out how IROs should discharge their distinct responsibilities for looked after children. It also provides guidance to local authorities on their strategic and managerial responsibilities to establish an effective IRO service.¹⁰
- 8. The Family Justice Review noted that there needed to be effective links between the courts and IROs and that the working relationship between the court-appointed Children’s Guardian and the IRO needed to be stronger.¹¹ The review made a number of relevant recommendations, including the IRO submitting regular reports to senior managers and lead members on work undertaken, and the need for IROs to have manageable caseloads. The review stated that priority should be given to increasing the effectiveness of IROs rather than focusing on creating an independent body external to the local authority. Indeed, citing the Children’s Rights Director’s report, *Children’s views on IROs*, it notes that children said they would prefer IROs to be employed by the local authority.¹²
- 9. In the same report, there was a general lack of awareness reported by children of the specific tasks that should be undertaken by IROs. A sizeable majority felt that big decisions were not taken at reviews. Overall, however, there was strong support from young people for the job that IROs were doing and close to half of respondents had only ever had one IRO.
- 10. In June 2012, in a case brought by two teenage brothers who had been in care since early childhood, it was judged that Lancashire council and an IRO had breached the boys’ human rights.¹³ The children had experienced frequent moves and abuse by foster carers. Although they had been freed for adoption, adopters were never identified and the freeing orders remained in place for 11 years. Links to the boys’ families were severed. The IRO was held personally responsible as he had not challenged the authority’s failure to implement its

¹⁰ IRO handbook: statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children , DCSF, 2010; www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065612/independent-reviewing-officers-iros.

¹¹ *Family Justice Review: final report*, Ministry of Justice, Department for Education and the Welsh Government, 2011;

www.education.gov.uk/childrenandyoungpeople/families/familylaw/a00200548/family-justice-review.

¹² *Children’s views on IROs: a report of children’s views by the Children’s Rights Director for England*, Ofsted, 2011;

www.ofsted.gov.uk/resources/100207.

¹³ *A and S v Lancs CC* [2012] EWHC 1689 (Fam); www.familylawweek.co.uk/site.aspx?i=ed98855.

care plans and review decisions. The case, and the ensuing judgement, raised wider questions about the professional status of IROs, caseloads, training and access to independent legal advice.

11. Other issues that have influenced local authority care planning for looked after children since 2004 include:
 - the Linked Care and Placement Order Updated Guidance, which clarified that court papers should be made available to the IRO during care proceedings and links established between the IRO and the Children’s Guardian
 - the Cafcass practice note (Cafcass, 2007), which included Cafcass’s expectations for communication by the Guardian with the IRO in care proceedings.
12. In 2005, a study commissioned by the government on the placement of looked after children, found that the effective operation of the council’s IRO service was an important factor in enabling local managers to maintain an overview of the planning processes for the children in their care, increasing the likelihood that their placements would be stable.¹⁴
13. In 2009 a review of IRO services in Wales was undertaken and it was found that the IRO role in safeguarding the human rights of children was not fully understood in all authorities.¹⁵ IROs were not always informed of significant changes to care plans and they were not always rigorous enough when progressing the implementation of care plans. Escalation processes were in place but not consistently used when necessary to resolve disagreements.
14. In Her Majesty’s Chief Inspector’s Annual Report 2010–11, it was reported that looked after children have generally reported to Ofsted inspectors that they are engaged well in contributing to the planning for their care. Most were satisfied with how they were engaged in their care plan and supported to contribute to their reviews.¹⁶ Independent reviewing officers were often cited during inspections as being central to helping young people contribute to plans about their futures.
15. More recently, in February 2013, the House of Lords Committee on Adoption Legislation recommended that robust action should be taken to reduce IRO caseloads. Reflecting their concerns that IROs were not sufficiently independent, the committee also recommended that the government should

¹⁴ J Held, *Qualitative study : the placement stability of looked after children*, Department for Education and Skills, 2005; www.scie-socialcareonline.org.uk/profile.asp?guid=8e874056-c581-4816-a9c5-5fcc89820d6f.

¹⁵ *National review of IRO services 2008–09*, Care and Social Services Inspectorate Wales, 2009; www.wales.gov.uk/cssiwswebsite/newcssiw/publications/ourfindings/allwales/2009/nirorpt/?lang=en.

¹⁶ The Annual Report of Her Majesty’s Chief Inspector of Education, Children’s Services and Skills, 2010/11, Ofsted, 2011, p 148; www.ofsted.gov.uk/resources/annualreport1011.

implement Section 11 of the Children and Young Persons Act 2008, which enables IROs to be employed outside the local authority.¹⁷

16. The proposals within the Children and Families Bill that courts should reduce their focus on the detail of care plans is likely to lead to an increased significance of the role of the IRO during and after childcare proceedings.¹⁸
17. Further completed research into the effectiveness of IROs is limited, although several projects are under way, including work by the National Children's Bureau Research Centre and the University of East Anglia, due to report in 2013 and 2014, respectively.^{19,20}

Methodology of thematic inspection

18. This report summarises the findings from visits by inspectors to 10 local authority areas between November 2012 and February 2013. The visits explored the effectiveness of IROs in discharging their responsibilities towards looked after children. The local authorities varied in size and geographical context and included metropolitan areas, London boroughs and counties of varying size, with a combination of rural and urban features.
19. The local authorities reflected a range of performance in recent relevant inspection outcomes. Of the 10 authorities visited, six had received a judgement of good for the overall effectiveness of looked after children services in their most recent safeguarding and looked after children inspection. Three had been judged as adequate, and one had been judged as outstanding.
20. Inspectors sought to address the following overarching questions.
 - How does the work of IROs contribute to improved outcomes for looked after children?
 - Do IROs act in accordance with current guidance, including revised care planning regulations and the IRO handbook?
 - Are IROs supported effectively by senior managers?

¹⁷ *Select Committee on Adoption Legislation – second report*, House of Lords Select Committee on Adoption Legislation, HMSO, 2013;

www.publications.parliament.uk/pa/ld201213/ldselect/ldadopt/127/12702.htm.

¹⁸ Children and Families Bill (HC Bill 131), clause 15;

www.publications.parliament.uk/pa/bills/cbill/2012-2013/0131/cbill_2012-20130131_en_1.htm.

¹⁹ *The role of the independent reviewing officer in improving care planning for looked after children*; National Children's Bureau Research Centre; publication forthcoming in 2013

²⁰ J Dickens, G Schofield, C Beckett, J Young and G Philip, *Care planning and the role of the independent reviewing officer* (funded by the Economic and Social Research Council, 2012–14), University of East Anglia; publication forthcoming in 2014.

- How do caseloads and any additional responsibilities affect the effectiveness of IROs?
 - Do IROs liaise with courts and Cafcass when necessary?
 - Is relevant and sufficient training available?
 - How does IRO status and position in relation to the local authority structure affect their ability to act with the necessary independent challenge on behalf of looked after children?
21. On each visit, two inspectors tracked six looked after children's cases via electronic caseloads. This was supported by meetings with IROs and other involved professionals such as social workers, and access to case records. Inspectors also examined a randomly selected sample of cases. Sixty cases were tracked. A further 51 cases were randomly sampled.
22. The report draws on evidence from discussions with looked after children and with parents of looked after children in each area.
23. Interviews were also held in each local authority area with:
- senior managers with overall responsibility for looked after children
 - a group of IROs
 - a group of social workers
 - a group of foster carers
 - a representative from Cafcass.
24. Good practice examples are highlighted in this report to illustrate aspects of good work in a particular area and are not intended to suggest that practice in that area was exemplary in every aspect.

Driving progress for children

25. IROs are responsible for monitoring children's progress on an ongoing basis as well as reviewing their care plan at regular intervals. In this thematic inspection, inspectors were looking for evidence that IROs ensured that:
- the identified needs of children and the planned outcomes were reviewed regularly and continued to be in the child's best interests
 - review recommendations were suitably robust and addressed key issues in a child's life, including plans for returning home or permanent alternatives
 - accountabilities and timescales for agreed actions were clear.
26. Furthermore, evidence was sought to show that IROs tracked progress of agreed actions to address children's needs between reviews when necessary and that any shortfalls were challenged appropriately and escalated when necessary to senior managers.

27. Overall, the level of challenge to poor practice on behalf of children was not strong enough. Lack of challenge was exacerbated by vague review recommendations and superficial monitoring of care plans. Insufficient challenge was seen in at least one tracked case in nearly all local authorities visited by inspectors. Manageable caseloads were not a guarantee of rigorous challenge to poor practice, although IROs demonstrating effective challenge were more likely to have lower than average caseloads.
28. In some cases, inspectors saw that IROs had taken a key role in avoiding unnecessary drift and delay for children. In one case, for example, correspondence from an IRO to legal advisers and senior managers emphasised the urgency of resolving concerns about a child's legal status and her parent's accommodation issues as swiftly as possible in order to achieve permanence for the child. Elsewhere, the evident 'grip' that the IRO had on a case that had suffered in the past from planning drift led to the establishment of a revised long-term care plan that took full account of the child's wishes and feelings.
29. In another case, an IRO challenged the details of an adoption plan by highlighting the implications for a child of severing ties with his birth family before a match had been identified. The fieldwork team accepted the IRO's view and the plans were accordingly amended to ensure that family contact was not ended prematurely.
30. In another authority, it took an intervention from an IRO to ensure that family-finding commenced promptly. In other cases, IRO interventions contributed to actions that addressed issues such as children's contact arrangements, referrals to support agencies and delayed assessments.
31. IROs did not, however, always drive plans for children strongly enough. In one case, where the plan to apply for a special guardianship order had been instigated by the carer, the IRO was overly reactive to developments and had not taken a lead role in ensuring that a suitable permanence option was secured for the child as quickly as possible. In another case, a review did not set clear timescales for permanent future plans and the IRO did not seek to move the plan forward with the necessary urgency.
32. Effective challenge was not always sustained. In a small number of cases, timescales that had been set were not tracked robustly, such as in one case where there was no evidence that an IRO had checked on the completion of some actions with tight timescales required to progress pathway planning. In another case, the establishment of a tight plan to ensure effective parallel planning was not followed by strong monitoring of progress, leading to further delay.
33. Occasionally, IRO empathy with the demands placed upon social workers led them to collude with weak practice. For example, IROs often turned a blind eye to the common late production of social work reports – 'I know how difficult it

is to be a social worker,' said one IRO – although this regularly undermined effective preparation for children and families.

34. In one local authority, social workers had replaced an unsatisfactory electronic template with their own document. However, a standard replacement template had not been agreed and the lack of some important information, such as the dates and frequency of statutory visits to children, was inadequately challenged by IROs.
35. In several cases seen by inspectors, incomplete actions were not sufficiently challenged at subsequent review. In several cases, recommendations were merely repeated at the next review. The review record sometimes focused on compliance with previous recommendations and did not always detail the outcomes from actions taken or address possible barriers to progress. In one case, a social worker had repeatedly been asked to submit a criminal compensation application on behalf of a child. The social worker acknowledged that she had not completed this as she had not known the process to follow, but this had not emerged at several reviews, or elsewhere.

Review records

36. The quality of the review records, that is the minutes of review discussions, including recommendations, was generally not good enough. The review records of cases tracked by inspectors were consistently good in only three local authorities. Inspectors saw at least one example of good review records in the remaining seven authorities, but the overall quality was inconsistent.
37. In the better examples of review records, the important issues in a child's life were set out clearly and covered in appropriate detail. Reasons for decisions were thoughtfully explained. The views of all relevant people, especially the child who was the subject of the review, were conveyed strongly. Recommendations followed logically from the record of discussion.
38. As an example, in one case, serious child protection issues were addressed fully, including the actions taken to assess and manage the risks of sexual exploitation. In another case, a comprehensive review record clearly conveyed the views of a young person regarding a potential move to live with a family member, and summarised effectively the actions required to progress a significant change of plan. In a case in a different local authority, the most recent review record was sufficiently detailed to ensure that the child's experience could be understood without reference to case records elsewhere.
39. The consistently good quality of review records in one authority had been supported by a dedicated minute-taking service, which was very much welcomed by the IROs.
40. More than half of the tracked cases, however, were characterised by review records that were not good enough. Some records were sparse and did not address key issues with enough rigour or challenge. For example, the concerns

raised by a social work report for the review about a child's negative view of their ethnicity were not addressed at the review meeting itself and no relevant actions ensued.

41. The lack of detail in review records sometimes led to an incomplete picture of recent events or the reasons for making decisions, which was particularly significant for children returning to view their records or for an adult trying to understand the child's experience. Several IROs acknowledged that records did not always include information that they assumed was already known by those involved.
42. In several cases, education issues were not covered in sufficient detail. Often, the completion (or otherwise) of the personal education plan was recorded but issues that had been raised during the process were not addressed. In one authority, an IRO acknowledged that she tended to address educational matters in more detail if there were concerns or shortfalls in performance. This left inspectors concerned that children who appeared to be reaching an acceptable standard of education were not stretched as much as they should be. In such cases, IROs were not acting as sufficiently strong independent advocates for looked after children in an area of their life that had serious implications for their life chances.

Review recommendations

43. Only two local authorities visited demonstrated consistently robust recommendations arising from children's reviews. In the majority of local authorities visited, recommendations were too vague. Overall, recommendations were consistently rigorous in less than half of the cases tracked by inspectors. Sampled cases showed similar shortfalls.
44. Too many cases suffered from review recommendations that lacked specific timescales, such as actions that should be completed 'as soon as possible'. Some recommendations were not exact enough about the required actions, which meant that professionals, including the IRO, were not clear what needed to be done to progress the care plan. For example, agencies were often asked 'to monitor' a broad issue on an 'ongoing' basis.
45. One case exemplified several common flaws in recommendations seen in records of review discussions. There were many long and complicated recommendations, some of which lacked timescales for completion. Some, such as a restating of the carers' responsibilities, were likely to be repeated at each subsequent review. It was difficult in this case to identify the most crucial actions required to progress the care plan.
46. The standing agenda for reviews in one authority did not systematically address the recommendations from the previous review, which contributed in some cases to weak and incomplete tracking of progress.

47. In several cases, while the stated recommendations were sufficiently specific and timely, they did not always cover the most crucial areas of discussion. For example, in one case, although it had been identified that a personal education plan was 'still being written up' in the record of discussion, no recommendation for completion ensued. Elsewhere, a review failed to address the young person's evident emotional difficulties and relationship problems with other young people.
48. In another case seen by inspectors, a review raised key concerns about the suitability of a placement to meet a young person's cultural and identity needs and to address her vulnerability to sexual exploitation. The recommendations did not resolve these serious deficits. The local authority had taken appropriate action since the review, but nevertheless inspectors were at the time concerned about the quality of care and planning for this child.
49. Many reviews for children in a long-term placement led persistently and routinely to recommendations that a child should remain where they were living. This recommendation was not only superfluous, as it did not change the existing care plan, but raising the issue at each review was potentially unsettling for a child who was settled with long-term carers. In such cases, IROs had not made sufficient adjustments in their approach towards children in permanent placements.
50. The best examples of recommendations were not only robust, and in the child's immediate and longer-term best interests, but were also written in a style and format that could be easily understood and followed by all relevant parties, including children.
51. A small number of local authorities used prescribed templates for recording review discussions that required timescales and accountabilities to be clearly stated. This led to an improvement in quality, although the overall quality of recommendations remained dependent upon how well IROs ensured that they addressed all issues raised during the review.
52. There was a link between weak recommendations and inadequate monitoring of progress. Tracking the progress of recommendations was much more likely to be robust in those cases where recommendations were consistently strong.
53. Similarly, IROs were much less likely to provide robust challenge to practice shortfalls if earlier recommendations and ongoing monitoring were not strong enough. Insufficient challenge of poor practice, leading to delays for children, was much more likely to be seen by inspectors in cases where decision-making at reviews had been weak than in those that had benefited from strong and relevant recommendations.

Monitoring of progress between reviews

54. In the majority of cases seen by inspectors, social workers and IROs communicated routinely between reviews, which led to IROs having a good

understanding of a child's day-to-day life, although tracking of progress was not always sufficiently effective or well recorded. Social workers informed IROs appropriately of significant events affecting a child's life and, therefore, the plans for their future.

55. IROs used a variety of means to enable stringent tracking of progress, such as accessing case notes; emails and telephone calls to social workers or managers; and face-to-face contact when necessary. IROs in some local authorities routinely contacted the social worker several weeks prior to a statutory review to check on progress.
56. In one local authority, the statutory reviewing system was complemented by multi-agency placement support meetings, chaired by IROs and convened quickly when there was a risk of placement breakdown for young people in care. The majority of young people who had been subjects of the meetings had remained in the same placement, although where that was not possible or appropriate, the meetings provided an effective forum for planning and managing the child's move to a new placement. The meetings benefited from the IRO knowledge of the child's history, care plan and placement. IRO independence from operational constraints promoted a needs-led focus on intervention and support.
57. Close and thoughtful collaboration by social workers and IROs between reviews could lead to some appropriate and effective decision-making. In one authority, the IRO had liaised closely with the social worker following the death of a close relative during the Christmas holidays and took an active part in discussing and planning the support provided to that child. However, in some cases monitoring was not purposeful or effective. Discussions between social workers and IROs were often not fully evidenced in case records. Two local authorities routinely held additional 'midway' reviews but actions arising from these meetings were not always evident.

Formal dispute resolution

58. Formal dispute resolution protocols (DRPs) were in place in nearly all local authorities, although these processes were not consistently understood or applied. Several protocols were well established and promoted informal early resolution. In one authority, for example, a staged process was in place to ensure that issues were addressed initially at the lowest level possible. This included a pre-quality assurance stage and a quality assurance stage (both 'informal'). The more formal DRP, involving senior managers, was used rarely.
59. One local authority had no established DRP, although a draft had been produced. The absence of a formal protocol and the overall lack of challenge from IROs reflected what a senior manager described as a 'high tolerance culture' regarding poor performance. This tolerance was seen in other local authorities, where the response to disputes tended to be to review procedures

rather than addressing individual poor performance through line management. Another local authority acknowledged that its protocol was not easily accessible and most social work teams were unaware of its existence.

60. Inspectors did see evidence of IROs raising concerns appropriately at a more senior level. An IRO had recently raised concerns about the risks involved with a proposed placement move and had taken the issue to a more senior level of management, having sought unsuccessfully to resolve the disagreement informally at a lower level. Elsewhere, an IRO had resolved an issue of delay in instigating care proceedings at service manager level. Funding difficulties were regularly addressed by IROs with senior managers, with evidence of positive outcomes for children.
61. However, inspectors did not see evidence of a DRP being invoked formally in any tracked cases. A small number of cases should have been referred to the DRP, for example to address issues such as a change of placement that was made without notifying the IRO. In one case, the IRO's failure to trigger the DRP was one of many omissions in a case characterised by poor practice and appropriately subject to management review by the local authority. In another, an IRO had not raised the failure of police to attend and contribute to strategy meetings for a looked after child who was persistently running away from home. This demonstrated that DRPs were used typically to address internal disagreements rather than the practice of external agencies.
62. The lessons from formal disputes raised by IROs had been analysed in a small number of authorities and had informed service planning accordingly. For example, in one local authority, a dispute had led to earlier assessments for children with disabilities who might require the support of adult services. One authority used regular low-level 'alerts' from IROs to inform managers of shortfalls in performance. Common themes were identified from these alerts, such as delay in the transfer of cases to the leaving care team and some significant delay in adoption plans, allowing corrective action to be taken. In most authorities, however, inspectors saw no evidence that outcomes from disputes informed strategic service planning.
63. No IRO in any local authority visited by inspectors had exercised their right to refer a case to Cafcass, reflecting the very low numbers of referrals on behalf of looked after children nationally. Inspectors did not see any evidence in any cases to suggest that they should have done so.

Access to independent legal advice

64. IROs had no significant problems in accessing independent legal advice in any of the local authorities visited by inspectors. Nearly all had clear arrangements in place that were well understood by IROs, who had confidence that, if required, independent advice would be readily accessible, although the need rarely arose in any of the local authorities.

65. Two local authorities reported that there were currently no formal arrangements in place, although they were both considering establishing reciprocal arrangements with neighbouring local authorities, whereby IROs could contact that authority's childcare solicitors for advice if necessary. Several local authorities had put in place similar arrangements, but the infrequency of their application meant that the independence of the advice had yet to be fully tested. Others were able to spot-purchase advice from local solicitors.
66. Some IROs expressed their view that they were comfortable with consulting in-house legal advisers for support, while retaining the right to access legal advice if they felt it necessary and if there was a potential conflict of interest. In-house legal advisers in one local authority sometimes assisted IROs to formulate appropriate questions for independent legal advice. In another, IROs could access specialist in-house advice where the solicitor was not involved in the care case, but the IRO service had access to external independent legal advice if required. In-house senior lawyers gave advice about suitably specialist lawyers.
67. Inspectors did not encounter any resistance from senior managers to the principle that IROs should be able to access timely, independent legal advice.

Complaints

68. IROs did not consistently carry out their duty to ensure that children, their parents and their carers knew of their right to make a complaint, and how to do so. Evidence was seen, via signed consultation forms and review records, that some IROs routinely and regularly reminded children of the complaints mechanism. In most cases, IROs expressed the reasonable view that they should be able to use their discretion about how often to raise the matter. As one IRO pointed out, children often complained about being told about the complaints procedure so often.
69. In several cases and in several local authorities, however, IROs were unclear when children and others had been told about how to complain. Some were confident that children were kept well informed by children's rights advocates, while several said they believed that children and their parents were given such information when children first entered care. In these cases, a much more robust approach to informing children and families of their right to complain was required and this often reflected a general lack of rigour in the level of challenge shown by the IRO to the local authority.

Involving children

70. One IRO reflected the common view among IROs seen by inspectors when he said that the overriding question that all IROs should ask themselves was:

'Are we able to listen to children properly so that we can help them?'

71. The IRO handbook makes it clear that the IRO must ensure that a child's wishes and feelings are taken into full consideration in the care planning and review process. In practice, however, the quality of IROs' engagement with children seen by inspectors varied. In more than a quarter of tracked cases, inspectors did not see clear evidence of consistently effective engagement of children in care planning.
72. When engagement with a child had led to their active participation in reviews, this was not always fully reflected in the records of discussion, which in some cases did not adequately report the child's views.
73. IROs generally met with children prior to review meetings when possible. However, high workloads in several local authorities affected their capacity to meet with children more often between reviews.
74. Occasionally a low-key approach was appropriate and in line with the IRO handbook guidance, which suggests that there may be no need for contact between reviews if the care plan is continuing to meet a child's needs.²¹ In one case, for example, an IRO who had known a 17-year-old young person for some years no longer considered visits between reviews necessary. The young person contributed effectively to reviews and was settled at home. The IRO knew the needs of the young person, who in turn was able to contact the IRO if necessary.
75. Strategies to manage the demand for contact, however, differed across these authorities and were not always based on need. In one local authority, a group of IROs said that they tried to focus on children in less stable placements; in another, IROs had prioritised on the basis of age. When IROs were only able to meet children immediately prior to the review, their opportunities to prepare children sufficiently for the meeting were limited and, generally, children's wishes and feelings were less likely to be fully understood and taken into account.
76. Inspectors did see some sensitive work by IROs to engage with children. For example, in one case an IRO built a strong understanding of a seven-year-old child's interests and needs by visiting her regularly between reviews, spending time interacting with her, including playing games with her, and talking to her carers. Communication between the IRO and the social worker was good; the differences in their roles were made clear to the carers and the child, who participated appropriately and effectively in her review meetings.
77. Elsewhere, an IRO took appropriate advice from involved professionals about how to engage with a child with specific emotional needs. The IRO took time to

²¹ IRO handbook: statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children, DCSF, 2010, p 30; www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065612/independent-reviewing-officers-iros.

explain her role clearly to the child, who had been initially resistant to attending his review but now contributed confidently throughout the meetings.

78. However, the purpose of IROs' visits were not always clear. For example, one young person spoken to by inspectors complained that the IRO inspected her bedroom when she visited. The young person felt that this duplicated her social worker's role and was unnecessarily intrusive.

79. Continuity of IRO was important to children seen by inspectors and stability of the IRO workforce was identified as a strength by inspectors in six of the authorities visited, contributing to generally good participation by children in their care planning and reviews.

80. The vast majority of young people spoken to by inspectors said that it was important to get to know their IRO and welcomed visits from them. One child said:

'She is the only person who has stuck around. She is also the IRO for my brother and sister and it's good because she knows my family.'

81. Another said that speaking to her IRO before reviews meant:

'You know what is going to come up in the discussion. There are no surprises.'

82. Indeed, most children spoken to by inspectors were very positive about their IROs. One complimented the IRO's ability to manage disagreements and remain neutral:

'He takes both sides, like he will listen to what the school says about me behaving and what I say, and just draws into one conclusion.'

83. Several agreed that it was important for IROs to be straightforward and honest when discussing difficult issues, although a small number of children said that this was not always forthcoming – 'sometimes it's hard to understand what they're trying to tell me' – and not all found reviews to be conducive to their effective participation:

'Reviews are boring, they just ask you the same thing.'

84. Consultation forms were routinely used in all local authorities as a vehicle for children to contribute their views to reviews. These could be of particular help in giving the views of those children who did not wish to attend reviews or were unable to do so. However, several authorities acknowledged that the consultation documents themselves required improvement. One child had a number of complaints about the consultation documents in his local authority:

'The consultation booklets are pathetic... the wording is just like from 1934... they put graffiti writing into the booklets, it's just like they want to get down with the kids... there's only one booklet, it's useless if you've got dyslexia... my brother has special needs and he doesn't understand it.'

85. A social worker in a different authority voiced similar concerns:

'Consultation forms for young people are shocking, not child-friendly at all, they have not been updated and some young people won't fill them in.'

86. Inspectors saw a small number of cases where IROs had made good efforts to engage children with communication difficulties and learning difficulties, but nearly all local authorities identified this as an area requiring improvement. Some local authorities had decided to identify one IRO to act as a lead in this specialism, to share best practice and provide support to colleagues, but these initiatives were not yet fully established.

87. Several IROs expressed the concern that between reviews it was particularly difficult to find the time to visit children placed away from the local authority area. Furthermore, the IRO (and, indeed, the allocated social worker) was likely to have less knowledge of available resources for the child.

88. Some IROs had begun to support children to chair their own reviews, but this practice was not widely seen across the local authorities visited. In some authorities there were no firm plans to increase such opportunities for children to take a more active role in leading discussions about their care plans. Where it did take place, IROs were clear that children should retain a choice:

'We have to make sure that when young people are chairing, it's because they want to do it, not because it's expected.'

89. In one local authority, children as young as six had chaired their own reviews. Approximately half of young people able to chair their reviews had done so. The initiative had impressed upon IROs the need to use plain language and to ensure that recommended actions were clear and concise. Feedback from young people had been positive; one young person had said that it enabled their reviews to be 'relaxed and not just an adult meeting'. Young people who were well prepared by IROs to lead the meetings reported that chairing their reviews felt empowering and gave them increased ownership of their care plans.

Parents and carers

90. In cases examined by inspectors, parents participated appropriately in reviews and those that inspectors spoke to were generally positive about the support they received from IROs. Most were satisfied with the time that IROs took to explain the process of reviews and felt that their views were taken into account. One parent told inspectors that the IRO had explained carefully the reason for a

decision arising from the review that conflicted with her views. With only a small number of exceptions, parents valued highly the independent role of the IRO in holding social workers and other professionals to account for carrying out agreed plans, reflecting one parent's view that the IRO was 'a very important person in my child's life'.

91. Parents too valued the continuity provided by having the same IRO for a considerable length of time, and this was contrasted on several occasions with the changes of social worker experienced by some families.
92. Some parents, however, did not completely understand the role of the IRO and would have welcomed more information, especially when their children first became looked after. The most common complaint from parents was the late distribution of invitations and review minutes to help them contribute and respond to reviews.
93. Foster carers expressed similar views to parents and, similarly, were engaged effectively in the review process in those cases that were tracked by inspectors. Foster carers in some local authorities also complained that review minutes took too long to distribute. Several considered that children should be consulted more often about who they would like to attend reviews and where they would like the review to be held. However, foster carers in several authorities felt that not all IROs consulted with children in a sensitive manner – for instance, they sometimes asked them sensitive questions in front of adults who might influence the answer, knowingly or otherwise. Several foster carers thought that IROs needed to see children more often between reviews.
94. Foster carers, like most parents, valued the 'clout' that IROs could sometimes bring to decision-making for children that they were looking after:

'I have two boys with me... they had previously missed a lot of schooling. The contact arrangements meant that even though they had settled in school, they had to be taken out of school. The IRO put a stop to it straight away. He said, "It stops now."'
95. IROs in one local authority had raised awareness of their role by attending foster carer group meetings. Carers discussed with IROs how they could contribute to ensuring that reviews were as positive and purposeful as possible for children and were encouraged to contact IROs directly between reviews if they felt it was necessary.

Timing, attendance and location of reviews

96. Statutory reviews for looked after children should be held within one month of a child becoming looked after. The second review should be held within three months of the first review and at least every six months thereafter, although an earlier review should be convened if a child's circumstances required it.

97. Generally, reviews of children's care plans were held in a timely manner. Inspectors saw cases where reviews were held early if necessary in response to significant events. For example in one case, when a child's review was poorly attended by relevant professionals, the review was reconvened to ensure that the meeting was more productive. Elsewhere, a meeting was delayed for a fortnight to ensure good attendance; the meeting was still held within the six-month timescale, as the IRO service systematically built in contingency measures for such circumstances.
98. Professionals spoken to by inspectors were united in their view that children should be consulted about where they would like the reviews to be held, and that reviews should result in minimal disruption to a child's education. In most cases, venues were appropriate and child-centred. Children were generally consulted about who should attend their reviews, although this was not always clearly evidenced in case records.
99. There were exceptions, however. In one authority, reviews were regularly held in schools, usually to enable school attendance at the reviews. Children were sometimes taken out of class to attend their meetings, which meant that they missed lessons and their looked after status was unnecessarily highlighted to other students, a particular concern of some children spoken to by inspectors. A small number of similar examples were found in other authorities.
100. The perception of professionals that children were routinely consulted about the venue of the review and who should attend did not match the views of children who spoke to inspectors. Generally, children were less positive. Children in several authorities complained, with reason, that they were not routinely given a choice about location. One child, for example, complained about a lack of privacy when reviews were held at school and a lack of sensitivity when teachers asked her in front of her peers to come out of class to attend the meeting. Other children were happy that the meetings were not held at their foster home as that raised other issues such as discomfort for their parents and other family members.
101. Some children had similar concerns about the degree of choice they were given about who could attend their meeting. Several children in different local authorities were unhappy about schoolteachers attending their review, particularly when the meeting was held at home. One child asked:

'Why can't they send a report?'
102. In one case seen by inspectors a child had expressed her anxiety when three teachers arrived unexpectedly for her review at home; the IRO swiftly and sensitively asked the teachers to leave before the review began. Effective preparation and consultation with all concerned with the review process were key factors in maintaining a sensitive balance between ensuring that a review was child-centered and that it was attended by the right people.

IRO involvement in care proceedings

103. IRO impact on care proceedings varied in the 10 local authorities. Practice was stronger where links to Cafcass and the courts were well established and working protocols were well understood by all relevant parties, including IROs, social workers and children's Guardians. However, two authorities had not established formal joint working protocols with Cafcass. A further six had only recently done so, or were about to launch a draft protocol. In these eight authorities, communication between IROs and children's Guardians was likely to be inconsistent and more dependent on relationships at casework level between individual IROs and Guardians.
104. The two local authority areas where joint protocols were well embedded ensured that children's Guardians were provided with the details of the child's IRO at an early stage of care proceedings. The development of protocols had led to an increased and mutual understanding of roles and IROs had begun to play a more significant part in care proceedings. Judges were more likely to ask for the view of the IRO as cases progressed through care proceedings. Guardians received regular invitations to reviews and attended the meetings whenever possible. There were clear arrangements for establishing an appropriate level of contact between the IRO and the Guardian, including introductory discussions and hand-over meetings at the end of care proceedings. IROs were routinely provided with the necessary court documentation.
105. Social workers valued the IRO involvement. One said that it was often easy to lose focus on the needs of the child during complex and demanding proceedings; the IRO had challenged her to 'step back' and allowed her to reflect on and renew that focus. Another social worker said:
- 'I've seen IROs standing up really well to solicitors. That's really helpful sometimes!'
106. Some local authorities strengthened the protocols by increased liaison between key partners. For example, in one local authority there were regular liaison meetings between senior managers. In another, an IRO who had a lead role to promote joint working had focused on implementing a communication protocol and improving links between the IRO service and Cafcass. Elsewhere, a joint training event for children's Guardians and IROs focused on shared areas of interest, such as their contribution to achieving targets for the completion of childcare proceedings. IROs in one local authority had made a well-received presentation to the local court users' group on the role of the IRO and the importance of effective liaison between the IRO and the children's Guardian.
107. Cafcass representatives had a mixed view overall on the effectiveness of IROs. In some local authorities, Guardians were not routinely invited to reviews. Several felt that IROs were too passive during care proceedings. Although

inspectors heard examples of some effective challenge to care plans, some Cafcass representatives spoken to by inspectors expressed concern that IROs did not exert rigorous challenge consistently, particularly when there was delay in achieving permanence for children.

Training

108. IROs in most local authorities told inspectors that they struggled to identify relevant training and development opportunities that were relevant to their role and effectiveness. All had access to training provided by the Local Safeguarding Children Board and by the local authority, but this training was often felt to be too generic, and sometimes too basic.
109. Several had welcomed training in respect of the Family Justice Review and chairing meetings. Some had attended 'Total Respect' training which aimed to promote increased participation of looked after children within local authorities.
110. Nearly all had received recent training on the revised regulations and guidance. Team meetings and area meetings (in the larger local authorities) provided good opportunities for self-directed learning. In one authority, for example, a recent IRO development day had explored the new duties of IROs, appropriate venues for reviews, and improved communication with looked after children. Other local authorities held similar practice workshops for IROs (and colleagues).
111. Generally, local authorities had good links with regional IRO networks and these were valued forums where good practice could be shared and learning from high-profile cases, such as those in Rochdale and Lancashire, could be absorbed.
112. In some local authorities, IROs had identified the need to raise the awareness of social workers and carers of IRO responsibilities. Inspectors heard of several examples where IROs had provided well-received training that had led to an increased understanding of their role and improved working relationships.
113. However, training plans were not all specific enough to address an identified need to increase skills and expertise in certain fields, such as in youth justice or, most often, in working with children with additional communication needs. Plans to address such identified skills gaps were generally not well advanced.

Feedback from children, families and professionals

114. All services suffered from a lack of feedback from service users, including looked after children, to help them improve their understanding of the strengths and weaknesses of the IRO service and to help drive improvement. Examples of consultation with looked after children were directed mostly at the Children in Care Council, but the outcomes of these consultations were not always clear.

115. For example, children in one local authority had been asked about their level of satisfaction with the IRO service. Responses were largely positive but further analysis of the findings was limited and there was no evidence that the children's views had systematically informed changes or plans for improvement. In other local authorities, some consultation about children's awareness of how to contact their IRO and on the nature of reviews had taken place – several children said that they found their reviews 'boring' – but generally consultation was not routine. One authority reported that it had asked looked after children about the content of consultation booklets, but children told inspectors that the response to their answers had been slow.
116. There was no evidence of IRO services seeking the views of social workers, carers, family members, or other agencies. This overall lack of consultation with those who came into contact with IROs was a significant gap in IRO understanding of their own effectiveness.

Driving overall improvement

117. IROs had not fully developed their role in driving overall service improvement in the areas visited by inspectors, although there were pockets of good practice and in some areas this aspect of their work was improving. Reports that highlighted gaps in compliance had led to some improvement in some local authority areas. Some IROs met regularly with senior operational managers where they could provide feedback on key issues. However, IRO knowledge of individual cases did not sufficiently inform organisational learning.
118. Nearly all groups of IROs identified the need to raise their profile in monitoring the effectiveness of corporate parents. As one IRO told an inspector:
- 'We are in a good position to spot themes but are not necessarily good at raising them at the right level. IROs need to develop an ability to be heard on a wider stage.'
119. IROs in one local authority raised concerns that the standard of accommodation and support for care leavers was not consistently good enough. This led to the establishment of an annual audit programme to assess the quality of provision, although it was too early to assess its impact. A timetable of visits was also in place for senior managers, the lead member and the Director of Children's Services. The Children in Care Council had been closely involved in developing the response to the overall concerns.
120. Most groups of IROs, however, said that their links to corporate parenting boards were underdeveloped, although several IRO managers were members of such boards. Similarly, links to Children in Care Councils were not consistently strong although inspectors saw examples of some effective liaison. Children in Care Council members in several local authorities told inspectors that IROs had a low profile. One young person said:

'They need to come out of the woodwork and let us know who they are.'

121. IRO annual reports that should be provided by IRO managers varied in quality. In two local authorities, an annual report had not been produced since 2011. Where they did exist, too many were over-descriptive, concentrating on activity data, and did not focus sufficiently on the progress that children make. They also lacked specific recommendations to the local authority in its role as a corporate parent.
122. One report provided unclear data, lacked analysis and concluded with vague, unchallenging recommendations. Another covered the relevant areas, but the report's analysis did not lead to the identification of key priorities for the IRO service or any recommendations to corporate parents. In another local authority a report established key priorities for the IRO service more clearly. The report was presented to the Corporate Parenting Board and was endorsed by the lead elected member for children's services. However, it failed to make any specific recommendations for consideration by the wider service. Nearly all annual reports seen by inspectors would have been improved by a clearer analysis of challenges facing the services for looked after children, and more explicit recommendations to improve children's outcomes.
123. One effective annual report provided a clear description of the context in which IROs worked and highlighted the impact that IROs had made in the previous 12 months; areas of development were identified for the next year. The report demonstrated how the IRO service priorities linked to the needs of the looked after children locally.
124. Statutory guidance makes it clear that the IRO report should be a public document and suggests that enabling access to the report on the local authority website would be good practice. However, only one local authority had placed the report on the website, although most had discussed it both at the corporate parenting board and with the Children in Care Council. This lack of transparency does not provide assurance about the independence of the reviewing function, the effectiveness of their work or the difference they make to the lives of children and young people.
125. Generally, the IRO annual report was a missed opportunity for IRO services to harness their knowledge about what is happening for looked after children to influence policy and challenge the local authority as corporate parent. Senior managers or IRO managers were generally unable to provide examples of the annual report's impact on service improvement.

Caseloads

126. The IRO handbook estimates that a caseload of between 50 and 70 children for a full-time equivalent IRO would represent good practice and allow IROs to undertake the full range of their functions.

127. The average caseloads of IROs fell within this recommended range in only four of the 10 local authorities visited by inspectors. This adversely affected their capacity to undertake their roles effectively and was exacerbated in most areas by additional responsibilities that they were required to undertake.
128. Average caseloads ranged from 50 to 112, although inspectors found evidence of individual caseloads as high as 120. The average caseload across all authorities was slightly above 80, although this does not take into account the additional responsibilities that IROs were required to undertake.
129. IROs in four authorities also chaired child protection conferences as part of their day-to-day responsibilities, but there was no consistent link between this and an increased workload. Rather, the ability to manage these two distinct roles depended on effective case weighting and close supervision. Most IROs who undertook both roles did not perceive this as a key contributing factor to excessive workloads.
130. The nature of other additional responsibilities varied between local authorities, but included:
- attending additional care planning meetings
 - providing training
 - undertaking case file audits
 - investigating complaints
 - chairing foster carer reviews
 - membership of the fostering and private fostering panels
 - undertaking Regulation 33 visits to children's homes.²²
131. The increased time burden placed on IROs by these tasks varied, but additional duties meant that IRO caseloads were accepted as consistently manageable by senior managers in only one authority, even though numbers of cases might lie within recommended levels. Even in the sole local authority where caseloads were commensurate with the breadth of their responsibilities, IROs took the view that capacity would be quickly overstretched, should the numbers of looked after children increase.
132. IROs in the other nine local authorities all saw high caseloads as a barrier to carrying out their work effectively, and in particular to fully embracing their enhanced role. IROs were particularly concerned that their ability to meet

²² Regulation 33 visitors are not involved in the daily conduct of the home and provide an independent report to those running the home following their visit, usually monthly.
www.education.gov.uk/childrenandyoungpeople/families/childrenincare/childrenshomes/a00191997/childrens-homes-regulations-guidance-and-national-minimum-standards.

children before and after review meetings was undermined by a lack of capacity. In several cases tracked by inspectors a lack of time was given as a reason by IROs for not seeing children between reviews. Evidence suggested that high caseloads also affected IROs' capacity to identify overall patterns and themes emerging from their work and to take a more active role on behalf of children during care proceedings.

133. An additional challenge for IROs in effectively managing their time was ensuring a good service for children who were placed some distance away from the local authority. For IROs working in larger local authority areas, the amount of time spent travelling to reviews and to see children within the authority was a routine additional burden on their workload.
134. Capacity was stretched further if administrative support was not adequate. In a small number of authorities, social workers retained responsibility for most administrative tasks relating to the management of reviews, including distribution of reports and minutes and for sending invitations to meetings. Where such arrangements were in place, timeliness of the distribution of relevant paperwork was likely to be poor. No local authorities identified these arrangements as ideal.
135. Generally, local authorities sought to identify dedicated administrative support for the IRO service and where this was in place, timely completion and distribution of relevant paperwork promoted good preparation for reviews.
136. Inspectors found that the rigour of IRO work was likely to be stronger where caseloads were more manageable and enabled them to focus clearly on their responsibilities to looked after children. Review recommendations were generally sharper and monitoring of cases was tighter, which led to swifter progress for looked after children. IRO relationships with the local authority were more assertive. In particular, IROs were better equipped to ensure that children's views influenced the content of their care plans.

Management oversight

137. All those who directly managed IROs in the local authorities visited by inspectors were qualified social workers, as required by regulation and guidance. However, the level of scrutiny of IRO performance by line managers was not sufficiently rigorous in several local authorities.
138. In a small number of authorities, inspectors found a wide range of mechanisms used by IRO managers to reassure themselves that the quality of IRO work was good. These included regular one-to-one supervision, sampling of review records and the scrutiny of electronic case records. Data relating to timeliness of reviews were provided regularly. IRO managers periodically observed reviews. This enabled them to provide constructive feedback to address individual shortfalls, promote a standardised service quality and reach a good understanding of the IROs' strengths and weaknesses.

139. In one local authority the IRO manager routinely audited the quality of a sample of review reports against an agreed set of standards. When children did not participate in their review, the IRO manager sought reasons for this and for details of the efforts that had been taken to engage the child more successfully. Elsewhere, case file audits had identified shortfalls in reviews, such as the lack of health assessments.
140. One local authority visited had developed a practice observation tool which was used by IRO managers as part of the performance review and appraisal processes. Direct observation of practice had facilitated discussions within supervision and appraisal meetings, leading to specific support and increased challenge for the IROs. Practice observation had also led to identification and delivery of specific training needs for the entire service.
141. In most local authorities, however, oversight of IRO performance by managers was less rigorous. Managers did not carry out observation of reviews at all in some local authorities, although several IRO managers told inspectors that there were plans to do so. Review records were not sampled routinely to assess quality, although where sampling had been undertaken, some common gaps in reviews had been identified and this had led to improvement.
142. Some IRO managers told inspectors that they received feedback from other managers about the individual performance of IROs, but this was informal and opportunistic rather than part of a coherent IRO performance management framework for IROs.
143. Inspectors saw examples of IRO service plans in nearly all local authorities, although the plans were of variable quality. Some lacked clear timescales, accountabilities and targets and did not always reflect the services' priorities articulated elsewhere. A small number of service plans were suitably challenging and ambitious, focusing on areas of improvement for IROs as well as the wider service. They included identified priorities that could drive improvement, such as the development of recording exemplars and a clear response to the likely demands of the Legal Aid, Sentencing and Punishment of Offenders (LASPO) Act.²³ This provides that a child who is remanded to youth detention accommodation will be treated as looked after by a designated local authority.
144. Senior managers had a sound understanding of the roles and responsibilities of IROs as expected by regulations and guidance, but their overview of how well the IRO service undertook those responsibilities was not consistently well informed. Some were kept up to date with key issues by regular meetings with IRO managers, supported by regular performance reports which included some

²³ The LASPO Act 2012;
www.legislation.gov.uk/ukpga/2012/10/contents/enacted

data on IRO and review performance; but there was a tendency for managers to focus more sharply on output data, such as timeliness of reviews and distribution of minutes, than on more qualitative issues.

145. In nearly all local authorities visited, inspectors found considerable shortfalls in key management responsibilities as outlined by the IRO handbook.²⁴ For example, quality assurance arrangements, including feedback from children and families and direct observation of IRO practice, were not robust enough. IRO annual reports did not consistently display the necessary quality. There was a patchy approach to IRO training and development. IRO caseloads were too high in most authorities.
146. This lack of sufficient management rigour and oversight suggested low ambition for looked after children. For IROs to undertake effectively their central role in ensuring that the local authority acts as a responsible and committed corporate parent, all responsible managers must provide the necessary support and challenge that was lacking in too many local authorities visited by inspectors.

The independence of IROs

147. All 10 local authorities visited by inspectors provided an in-house IRO service. IROs were employed by the local authorities, although a small number of temporary IROs were in post to cover sickness and vacancies. IRO services were based within discrete non-operational services, most typically within quality assurance teams. Only one IRO service manager had some operational management responsibility and this was under review. All arrangements met the prescribed minimum levels of independence specified by the regulations.²⁵
148. There were some concerns, expressed by a very small number of IROs and some Cafcass representatives, that IROs might be perceived as not sufficiently independent of the local authority as long as it remained their employer. Inspectors, however, did not find firm evidence, whether from case examples or from individual and group testimonies, that IRO independence was directly compromised by their employment by the local authority.
149. With only a very few exceptions, IROs considered that their position within the local authority enabled them not only to exert the necessary independence, but also to provide a vantage point from which to have the most impact. IROs in most authorities valued the organisational knowledge afforded by their position; variously described as 'insider knowledge', 'soft information' or an 'insight into

²⁴ IRO handbook: statutory guidance for independent reviewing officers and local authorities on their functions in relation to case management and review for looked after children, DCSF, 2010; www.education.gov.uk/childrenandyoungpeople/families/childrenincare/a0065612/independent-reviewing-officers-iros.

²⁵ The Care Planning, Placement and Case Review (England) Regulations 2010, section 46; www.legislation.gov.uk/ukxi/2010/959/contents/made.

the culture' of services for looked after children. This, most IROs believed, enabled them to act more sensitively, swiftly and flexibly than if they were employed outside the local authority.

150. Indeed, the examples seen by inspectors of informal dispute resolution were often underpinned by constructive relationships between social work teams and IROs, which had been developed through proximity and timely sharing of information. Social workers generally saw the 'critical friend' role of the IRO as beneficial and supportive overall. One IRO expressed a common concern:

'If we became fully independent [of the local authority], we would lose our relationships and it would feel much more adversarial.'

151. The appropriate balance between challenge and support was not easy to maintain, however. While some IROs welcomed the access to social workers provided by co-location, they also recognised the inherent risks that relationships could become too close. In one smaller local authority, an IRO manager identified a potential drawback in working within an authority with less staff:

'Everyone knows everyone. This can impact on our ability to provide the level of challenge necessary.'

152. Co-location presented some logistical problems that affected IRO independence:

'We have made the transition to an open plan office. You can't make phone calls without being heard. It's not conducive to the role. Other teams being there challenges our independence.'

153. In some local authorities, co-location did blur the boundary between the independent review mechanism and operational management. The informal nature of many interactions with practitioners meant that IRO involvement in care planning was not always recorded.

154. IROs whose duties included the chairing of child protection conferences felt that this could provide valuable continuity for families, if the IRO for a looked after child had previously chaired conferences when the same child was subject to a child protection plan. However, one IRO had experience of acting as chair of both child protection conferences and looked after children reviews in one local authority and, in another, acting only as an IRO for looked after children. This IRO believed that combining the two roles undermined the perceived independence of IROs:

'The IRO goes from a lead role in constructing a [child protection] plan as a representative of the local authority to one that is meant to challenge and be independent from line management. It's confusing for families.'

155. It was not clear in those local authorities where the roles were combined how they had sought to resolve the potential conflict of interest that might affect families' perception of the IRO's independence.
156. Senior managers spoken to by inspectors valued the IRO's quality assurance role highly. Indeed, recognising the key quality assurance role that IROs should play, nearly all senior managers said that they would generally welcome more consistent, and stronger, challenge from IROs. Inspectors found little, if any, evidence of resistance within local authorities to the principle that IROs should offer independent challenge that is uncompromised, within reason, by overall resource considerations.
157. Inspectors did not find that the position of IROs within the local authority threatened their level of independence. Rigorous and consistent independent challenge on behalf of children by IROs within local authorities was evident in some cases seen, but was more likely if:
- IROs and their managers were independent of operational services within the structure of the local authority
 - IRO independence was not compromised by conflicting additional responsibilities and their independent role was fully understood by all staff, and particularly by children and their families
 - the physical location of IROs promoted independence, confidentiality and clarity of role.
158. Inspectors saw evidence that IROs had a positive impact upon outcomes for children when they were employed by the local authority. Advantages to those arrangements included:
- increased knowledge of organisational and resource issues that affected children's outcomes
 - access to shared data systems
 - established links between operational teams and IROs that promoted effective communication and early resolution of disputes.
159. Inspectors' findings suggest that shortcomings in IRO performance, including the variable level of challenge, would not be easily resolved by removing them from the employment of local authorities; in most local authorities there remained considerable scope for improvement under the current arrangements.

Conclusions

160. The pace of progress towards IROs taking on the full scope of their enhanced responsibilities as outlined in the revised regulations was too slow in most authorities visited by inspectors. IRO oversight of care plans was not consistently robust. IROs did not always challenge drift or delay with rigour. The views of children were not always taken into full account. IROs did not

gather feedback from children, families and other professionals to inform the development of their own services. The IRO role in monitoring the local authority's overall performance as corporate parent was underdeveloped.

161. Excessively high caseloads were seen in nearly all local authorities. This was the most significant factor that hindered IROs in carrying out their role effectively. They were not always fully supported or challenged by managers. As a starting point, IRO workloads must be manageable. Leaders must ensure that IROs can prioritise their core tasks, including developing positive relationships over time with children for whom they are responsible. IROs must be held accountable for poor practice by strong line management.
162. Senior managers must urgently review the arrangements for monitoring the effectiveness of this service and take the necessary steps to ensure that care planning for children's futures receives the degree of independent challenge that it merits.
163. Suitably skilled and assertive IROs were seen more often where:
 - caseloads were manageable and enabled IROs to focus on the needs of looked after children
 - line managers of IROs had the necessary expertise and provided robust line management and supervision
 - IROs' professional development was prioritised
 - there was a culture of robust performance management about the progress of looked after children across wider children's services
 - IRO independence was protected and highly valued by leaders within local authorities who, as corporate parents, should have the same high aspirations for looked after children as they would for their own children.

Further information

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Further reading

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The Children, Schools and Families Select Committee report on looked after children, 2009;
www.publications.parliament.uk/pa/cm200809/cmselect/cmchilsch/111/11102.htm

National review of IRO services 2008–09, Care and Social Services Inspectorate Wales, 2009;
www.wales.gov.uk/cssiwebsite/newcssiw/publications/ourfindings/allwales/2009/nirorpt/?lang=en

Annex A: Providers visited

Local authorities

Bath and North East Somerset Council

Durham County Council

East Riding of Yorkshire Council

Leeds City Council

Leicester City Council

London Borough of Lambeth

London Borough of Harrow

Portsmouth City Council

Stoke-on-Trent City Council

Wirral Council.