care inspectorate

Criminal Justice Social Work

Serious Incident Reviews

An overview of themes arising from notifications submitted between February 2015 and December 2017

Contents

Foreword

As well as regulating and supporting improvement in care services in Scotland, the Care Inspectorate has responsibility for scrutiny of social work services, including criminal justice social work. Where a person is on a community supervision order or licence, there is – rightly – intense public interest in how they are supervised. If things go wrong, the Care Inspectorate, alongside colleagues in the local authority, plays an important role in making sure local authorities and their partners look carefully at what happened and learn any lessons. This report provides an update on the detail and learning from serious incident reviews carried out by criminal justice social work services between 2015 and 2017.

At any point in time, social work criminal justice services supervise a large number of individuals but, fortunately, serious incidents are relatively few. Where they do occur, the responsible local authority should notify us and carry out a serious incident review in order to examine the circumstances and use the learning to improve practice and services. While not every serious incident can be prevented, a serious incident review helps improve practice by identifying and sharing the lessons learned. The Care Inspectorate reviews these serious incident reviews and work with local authorities to ensure they have been reviewed well, and the right learning has occurred. Together with Social Work Scotland and the Scottish Government, we believe this is an important way of monitoring these incidents and learning from them.

We have seen an improvement in the quality of comprehensive reviews but some initial reviews lacked necessary detail. Having to ask for more information because initial information is insufficient can prolong the time taken to get learning quickly back into the system. Nonetheless, most of the reviews we received were undertaken in a thorough and well-considered manner and demonstrated a high standard of quality assurance practice. We have again highlighted the need for more consistent reporting from some local authorities.

We found that appropriate risk assessment tools had been used in most, but not all, cases. Such tools are essential in enabling practitioners to better understand the factors that may contribute to offending behaviour and inform judgements about the likelihood of reoffending. We have seen an improvement in partnership working in reviews since our last report; this is important to ensure that any learning is shared locally across all the agencies working to support people involved with justice services and help keep communities safe.

While not all serious incidents are avoidable, undertaking serious incident reviews should be directed at maximising learning and preventing avoidable serious incidents wherever possible. Particularly welcome then, is the fact that some local authorities have invested resources in development for their staff and partner agencies to strengthen their approaches to serious incident reporting and reviewing. We encourage more local authorities and their partners to do likewise.

I hope this report is helpful to you.

Gordon Weir
Interim Chief Executive

Section 1 – Introduction

This report provides details on notifications of serious incidents made to the Care Inspectorate by local authority criminal justice social work services during the period February 2015 to December 2017. It outlines our analysis of the quality of serious incident reviews and explores what these can tell us about practice by local authority staff with responsibilities for supervising individuals on community supervision orders or subject to licence following release from prison. It also explores how well local authorities are adhering to the agreed notification process, the aim of which is to provide assurance that serious incidents are reviewed appropriately when they occur and that lessons learned from these are embedded in future practice. By engaging with criminal justice social work professionals and local authorities in relation to serious incidents and reviews of them, the serious incident review notification process is one of the ways in which the Care Inspectorate supports improvement in the quality of social work and social care services.

Section 2 – Background

Statutory supervision in Scotland

The governance arrangements for criminal justice social work services are set out in legislation, making them responsible for delivering a range of services for those involved in the criminal justice system[1]. This includes the completion of reports for courts and the Parole Board and the supervision of individuals on statutory social work orders and licences. In 2015-16, 33,045 criminal justice social work reports were prepared for courts or the Parole Board and 19,400 community payback orders were imposed. In the same period, 5,794 statutory throughcare licences were in place[2]. In 2016-17 the number of assessment reports prepared for courts or the Parole Board saw a small increase to 33,477 with 19,140 community payback orders and 5,833 statutory throughcare licences being issued[3]. In addition to the above, criminal justice social work services also have responsibility for the supervision of individuals subject to a Drug Treatment and Testing Order, extended sentence, supervised release order, short-term sex offender licence or voluntary throughcare.

Guidance on the management and supervision of these orders and licences is contained within National Outcomes and Standards[4]. We refer to and consider compliance against these standards when analysing the serious incident reviews that we receive from local authorities and assessing the quality of them.

[1] Social Work (Scotland) Act 1968, Criminal Justice (Scotland) Act 2003, Community Justice and Licensing (Scotland) Act 2010
[2] These are supervision licences put in place when an individual is released from prison and include Parole, Non-Parole and Life Licence
[3] Scottish Government: Criminal Justice Social Work Statistics 2015-16 / 2016-17
[4] National Outcomes and Standards for Social Work Services in the Criminal Justice System 2010: The Scottish Government

Defining a serious incident

A serious incident is defined as an incident involving:

> "Harmful behaviour of a violent or sexual nature, which is life threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible."[5]

Serious incident review guidance states that a serious incident review should always be carried out when:

- an individual on statutory supervision or licence is charged with, or recalled to custody on suspicion of, an offence that has resulted in the death of, or serious harm to, another person
- the incident, or accumulation of incidents, gives rise to significant concerns about professional or service involvement or lack of involvement
- an individual on supervision has died or been seriously injured in circumstances likely to generate significant public concern.

To date, serious incident notifications have related only to the first and third categories outlined above. Later in the report, we comment on where serious incident reviews have highlighted issues of professional practice and what local authorities have done to address this. Serious incident review guidance contains a detailed process for local authorities to follow and is available on our website[6]. When we refer to serious incident reviews in this report, this relates to both initial analysis reviews and comprehensive reviews unless these are named explicitly. Appendix 1 contains a flowchart which outlines the process which should be followed when a serious incident happens.

Duty to notify the Care Inspectorate

The Care Inspectorate worked in partnership with Scottish Government and Social Work Scotland[7] to develop a process that would facilitate examination of the quality of the serious incident reviews undertaken by criminal justice social work services following a serious incident. The overarching principle behind this was to support continuous improvement in this area of work. The serious incident review guidance outlines what is required of local authorities and how we will respond to notifications of serious incidents.

Local authority criminal justice social work services are required to notify us within five working days of a serious incident occurring. They then conduct an initial analysis review (IAR) of the supervision of the individual. Based on the information obtained from the IAR, local authorities will then decide whether they need to carry out a more detailed comprehensive review of circumstances or conclude that completion of the IAR was sufficient. Local authorities must submit the completed reviews to us for consideration within three months of notification of the incident.

The completion of an initial analysis review is considered sufficient when there is clear evidence that:

- risk assessments and case management plans were up to date and implemented

[5] Framework for Risk Assessment and Management Evaluation: FRAME, Scottish Government, September 2011

[6] www.careinspectorate.com/index.php/low-graphics/81-publications/professionals-registration/serious-incident-reviews/2308-serious-incident-reviews-guidance

[7] Social Work Scotland was known as the Association of Directors of Social Work until June 2014 and at the time this process was developed

- an appropriate level of contact between the supervising officer and the service user was maintained
- supervision and progress reviews were carried out in accordance with National Outcomes and Standards
- issues of non-compliance were managed appropriately.

If the initial analysis review determines that areas of sufficient concern or uncertainty remain, a comprehensive review should be completed. Comprehensive reviews should closely examine the circumstances of the supervision of the statutory order or licence and should contain an action plan which highlights areas for improvement and how these will be achieved.

We assure the quality of serious incident reviews by looking at how they have been conducted and whether they have been carried out in a robust and comprehensive manner. We then write to local authorities with our comments. This process enables us to recognise and share strengths in practice and to highlight where there is room for improvement. The aim is to provide a framework for local authorities to examine the quality of practice and adherence to legislation and guidance when a serious incident occurs, and to use the learning achieved from this to improve future practice.

Multi-Agency Public Protection Arrangements (MAPPA) and serious incident reviews

Our serious incident review guidance was developed in conjunction with MAPPA guidance[8] and is compatible with the procedures outlined within it. MAPPA guidance sets out the responsibilities of partner agencies when a relevant offender becomes involved in a serious incident and when a MAPPA significant case review (SCR) may be required. In order to streamline the process for notification of serious incidents, Section 4 of our guidance highlights that when a MAPPA significant case review initial notification report is completed for submission to the strategic oversight group, this can also be used as the notification to us. Where the strategic oversight group decides to proceed with a SCR, we have no role in the quality assurance of the resulting report. Where the strategic oversight group indicates that it does not intend to conduct a SCR and an initial case review (ICR) has not been completed, then a serious incident review should be completed by criminal justice social work services and submitted to us as outlined in our guidance. Where a MAPPA ICR is requested and completed, if suitable and appropriate, this can be submitted to us as the serious incident review report in order to avoid duplication. This ensures that a quality assurance process applies to all individuals who are under the supervision of social work services when a serious incident happens.

Section 3 - Serious incident notifications

This report focuses on the period between February 2015 and December 2017. Previous reports can be found on our website[9]. Table 1 below, provides a breakdown of the 200 serious incidents notified to us by local authorities during this period. Twenty-four of 32 local authority areas submitted at least one notification within this timeframe however; the majority of serious incident review notifications were submitted by approximately one-third of local authority areas. Eight areas have not submitted any serious incident reviews during this period. Seventeen local authorities have submitted three or fewer notifications in the past three years.

[8] Scottish Government: Multi-Agency Public Protection Arrangements (MAPPA) National Guidance 2016

[9] http://www.careinspectorate.com/index.php/publications-statistics/81-professionals-registration/serious-incident-reviews

Table 1 – Notifications submitted by local authorities

Local authority	Feb-Dec 2015	Jan-Dec 2016	Jan-Dec 2017	Total
Glasgow City	11	13	20	44
City of Edinburgh	8	9	8	25
West Lothian	7	5	11	23
North Lanarkshire	12	7	3	22
Scottish Borders	3	2	6	11
Dumfries and Galloway	4	4	2	10
North Ayrshire	2	2	5	9
South Ayrshire	3	1	2	6
Renfrewshire	3	2	1	6
Highland	0	4	1	5
East Ayrshire	5	0	0	5
Dundee City	0	1	4	5
Fife	1	2	1	4
Stirling	2	2	0	4
Aberdeen City	2	1	1	4
Inverclyde	1	0	2	3
Falkirk	0	0	3	3
West Dunbartonshire	1	1	1	3
Angus	2	0	0	2
East Dunbartonshire	0	1	1	2
South Lanarkshire	0	1	0	1
East Renfrewshire	0	1	0	1
Aberdeenshire	1	0	0	1
Orkney Islands	1	0	0	1
Clackmannanshire	0	0	0	0
Shetland	0	0	0	0
Midlothian	0	0	0	0
East Lothian	0	0	0	0
Argyll and Bute	0	0	0	0
Perth and Kinross	0	0	0	0
Moray	0	0	0	0
Eilean Siar	0	0	0	0
Total	**69**	**59**	**72**	**200**

Of the 200 notifications received, 190 progressed to a review. The 10 notifications that did not proceed to a review were withdrawn after an early exploration with the relevant criminal justice social work manager clarified that the notification criteria had not been met. The majority of notifications (135) resulted in an initial analysis review being considered sufficient while 55 resulted in a comprehensive review.

Local authorities are required to advise us of the type of serious incident that has resulted in a notification and also the type of supervision order or licence that an individual was subject to at the

time of notification. As outlined in table 2 below, the largest single number of notifications was made under the category of serious assault which accounted for 60 of 200 notifications. This is an increase since our previous report and is more in line with national crime figures.

We received 49 notifications within the category of sexual offences and 43 regarding the death of an individual subject to a statutory order or licence. Between 2016 and 2017, there was an increase from 11 to 21 notifications relating to sexual offences. In November 2015, we published a joint thematic review of the effectiveness of MAPPA in Scotland. Recommendation 10 of the review concerned the need to maximise learning and development originating from MAPPA initial case reviews and significant case reviews (SCR). This may have contributed to the increase we have seen in these notifications. The changes that we have made in order to streamline serious incident review and MAPPA SCR notification processes may also have had some bearing on this increase. While small in number, the increase is consistent with national crime figures, which highlight that there was a 5% increase in sexual crimes recorded between 2015-16 and 2016-17[10].

We have seen a reduction in notifications where an individual subject to a statutory order or licence has died. The majority of these deaths are thought to be drug-related. Notifications such as these fell from 21 in 2015 to 12 in 2017. This is in contrast to nationally-recorded drug-related deaths, which have continued to increase each year over the past decade, although the numbers are too small to be able to draw meaningful conclusions[11].

Table 2 – Type of serious incident resulting in notification

Type of serious incident	Feb-Dec 2015	Jan-Dec 2016	Jan-Dec 2017	Total
Sexual offences: these include different types of sexual offences including rape, sexual assault	17	11	21	49
Deceased: includes death by natural causes, death by accident and unexplained death (often described in reviews as potentially drug related)	21	10	12	43
Suicide	1	5	4	10
Murder (perpetrator)	2	9	5	16
Attempted murder	4	6	5	15
Murder (victim)	2	0	0	2
Serious assault: includes assault to severe injury, and assault with elements of endangerment to life, carrying offensive weapon, robbery and attempt to rob	19	18	23	60
Abduction	1	0	2	3
Possession of a firearm	1	0	0	1
Terrorism offences	1	0	0	1
Total	**69**	**59**	**72**	**200**

[10] Scottish Government: Recorded crime in Scotland 2016-2017, September 2017

[11] Scottish Government: National Records of Scotland: Drug-Related Deaths, August 2017

Table 3 below shows that 143 of 200 notifications were made in relation to individuals subject to a community payback order. This is proportionate in relation to national figures as the majority of individuals subject to statutory supervision in Scotland are on a community payback order, with a much smaller number being subject to parole, non-parole and life licence[12].

Table 3 – Type of licence or statutory supervision order at time of notification

Licence/supervision order	Feb-Dec 2015	Jan-Dec 2016	Jan-Dec 2017	Total
Community payback order	51	42	50	143
Non-parole licence	7	4	4	15
Parole licence	5	3	7	15
Supervised release order	1	7	6	14
Life licence	1	2	4	7
Extended sentence	2	1	0	3
Drug treatment and testing order	0	0	1	1
Home leave licence	1	0	0	1
Deferred sentence	1	0	0	1
Totals	**69**	**59**	**72**	**200**

Section 4 - What can notifications tell us about practice?

While the number of notifications we have received is significant, it is a very small fraction of the overall number of statutory supervision orders and licences that are imposed and issued each year. However, the level of detail contained within the serious incident reviews that we have received provides us with a useful indication of the quality of practice in this area of work. We have outlined what we have found in relation to practice under three key headings.

Risk and needs assessment, planning and reviewing

Criminal justice social workers are required to undertake risk and needs assessments when preparing reports for courts and for the Parole Board. These assessments enable practitioners to better understand and identify the factors that may contribute to offending behaviour and are used to measure relevant factors such as risk of re-offending, risk of harm to others as well as the likelihood and potential impact of offending behaviour. The information gathered from assessments is used to form case management plans and to update these when changes in risk or needs occur. A range of assessment instruments are used for this purpose including the Level of Service Case Management Inventory (LS/CMI)[13], Stable and Acute 2007 and Risk Matrix 2000, which are used to assess the risk posed by individuals convicted of sex offences, and the Spousal Assault Risk Assessment[14].

We found that appropriate reference had been made to the use of these tools in the majority of serious incident reviews we received. Almost 80% of reviews indicated that a comprehensive

[12] Scottish Government: Criminal Justice Social Work Statistics 2015-16 and 2016-17

[13] LS/CMI is the national assessment and case management instrument used by criminal justice social workers and within the Scottish Prison Service, to consider risk and needs of people who have committed offences

[14] Spousal Assault Risk Assessment is used to assess risk in respect of domestic violence convictions

assessment using LS/CMI had been carried out within 20 days of an order being imposed, as required by guidance, in order to fully inform a case management plan. This indicates an improvement in practice since our previous report. However, 20% of serious incident reviews lacked sufficient information to indicate whether or not the standard had been met.

Serious incident reviews made reference to case management plans being in place in 93% of cases. Assessments had appropriately informed the case management plan in 79% of these. This also demonstrates an improvement in practice since our previous report where only just over half of relevant serious incident reviews had a case management plan that had been suitably informed by a risk assessment.

We previously reported that LS/CMI had too often either not been completed in time for prisoner release by prison-based social work staff or had not been transferred from the prison to criminal justice social workers in the community following prisoner release. During the period covered by this report, we found a considerable improvement in previous reported practice. LS/CMI was available to community social workers in 89% of 46 relevant cases. This is an important process as it provides an opportunity for community social workers to make any amendments to the case management plan that may be necessary, based on the information contained within the LS/CMI assessment.

When supervising an individual on a statutory order or licence, progress should be reviewed by criminal justice social workers and managers at key stages, in accordance with National Outcomes and Standards. We found evidence of statutory reviews taking place in 93% of 179 relevant cases. Of these, a clear majority (84%) were undertaken within the required timescale. Of those that did not meet the required timescale, the most common reason was failure of the individual to attend the review meeting as required. It was evident from reviews that in some cases the follow-up review had not been planned within an appropriate timeframe and in a few cases there was considerable drift in review timescales being met. Poor planning decreased the likelihood of timely and effective reviews. Nonetheless, it is encouraging to note that in most of the serious incident reviews where it was recognised that the required statutory review timescales had not been met, the local authority had put an action plan in place to address the issue.

In a few instances, we found that serious incident reviews had been undertaken by the first line manager responsible for supervising the case manager and in one case the supervising officer had been involved in undertaking the review. This is not in accordance with our guidance. It is considered good practice for reviews to be undertaken by staff that did not have direct involvement in the case in order to ensure additional objectivity wherever possible.

Our guidance highlights three categories that would warrant the submission of a notification. As outlined in Section 2 of this report, all of the notifications we received related to category one, which relates to individuals being charged with a further offence and category three, which relates to the death of an individual subject to a statutory order or licence. There were no notifications made under category two, which relates to potential concerns about standards of professional practice. This suggests a need for local authorities to be more open to making notifications under category

[10] Scottish Government: Recorded crime in Scotland 2016-2017, September 2017

[11] Scottish Government: National Records of Scotland: Drug-Related Deaths, August 2017

two in appropriate circumstances. Despite this, 20% of reviews referred to concerns about practice standards. In most of these, managers undertaking reviews stated that this related to National Outcomes and Standards not being met by supervising officers. Managers noted that in some cases the required level of supervision contact had not been maintained, non-compliance had not been addressed appropriately and, in a few cases, home visits had not been undertaken in accordance with guidelines. It is encouraging to note that these issues had been identified by local authorities as a result of a thorough examination of records and interviews with relevant staff. Managers undertaking serious incident reviews provided clear performance improvement plans in order to address the issues identified and in some cases had initiated disciplinary procedures.

Compliance

In the context of statutory supervision, compliance relates to whether an individual on a statutory social work order or licence is meeting all of the requirements and conditions imposed by the court or Parole Board. This may include attending appointments with a supervising officer or other agency as instructed and remaining offence free. Individuals may also be required to complete unpaid work, undertake offence-focused work or attend drug and alcohol support services.

During this reporting period, information relating to compliance was contained within almost all of the serious incident reviews we received. This demonstrates a positive improvement since our previous report. Non-compliance by an individual subject to a statutory order or licence had been identified as an issue in 56% (106) of these reviews. This often related to missed supervision appointments or non-attendance at unpaid work, drug and alcohol services or statutory review meetings. It is encouraging to note that non-compliance had been addressed appropriately by the supervising officer in 84% of cases. However, in the remaining 16%, it was evident that non-compliance had not been managed in accordance with required standards. This issue had been identified by the majority of managers undertaking serious incident reviews and action plans had been put in place in order to address the management of non-compliance in these cases and to improve future practice.

Partnership working

In most cases where statutory orders have been imposed or when an individual has been released from prison on licence, it is necessary for supervising officers to work closely with a range of partner agencies in order to effectively manage offending behaviour and to ensure that risk and needs are addressed. In some cases, such as the supervision of individuals convicted of sex offences, it is important for supervising officers to liaise closely with the police. In others, close links should be maintained with health and addiction services, housing providers and third sector agencies. Serious incident reviews highlighted that supervising officers worked effectively with relevant partner agencies in almost three-quarters of cases. We have seen an increase in notifications of serious incidents in relation to individuals subject to MAPPA and an improvement in the quality of the information contained within the related comprehensive reviews. This is an improvement since our previous report and suggests that criminal justice social work services and partners are clearer on the expectations of the serious incident review process and have collaborated more effectively on reviews. It is clear that when close partnership working was evident, serious incident reviews reflected a more detailed

and thorough examination of circumstances and reflected real strength in partnership approaches to managing complexity and risk.

Where local authorities have engaged effectively in the serious incident review process and have submitted serious incident reviews routinely, this has resulted in higher-quality reviews that have identified helpful learning opportunities for these areas. Some local authorities have used the findings from serious incident reviews as the basis for service development days with a focus on practice and service improvement. Others have used the process to improve collaborative working with partner agencies.

> "The SIR process recognises the multi-agency approaches to risk assessment and risk management and although it does not identify development areas for other agencies, it has assisted us in developing our own practice with partner agencies such as addiction services, mental health, police and children and families."
>
> **Team manager in justice social work**

Section 5 - Embedding a learning culture

Performance and quality

Serious incident review guidance requires that we are notified within five working days of a serious incident. Fewer than one in three notifications were made within the required five working days, which meant that 71% were outside the required timescale. In the next section, we outline some of the challenges that may have resulted in local authorities not meeting required timescales more regularly. Our guidance also outlines how an initial analysis review and comprehensive review should be undertaken and what information should be included. It states who should be involved in a review and who should provide oversight and quality assurance. Once we have received a notification, local authorities have three months in which to undertake and submit a review to us. Of the 190 reviews received, 58% were completed within three months, while 42% were submitted outside the required timeframe. It is important that reviews are completed on time in order to get learning back into the system as soon as possible. We will review this with the Social Work Scotland Justice Standing Committee in order to explore potential barriers and to support improvement in this.

As previously indicated, 71% of serious incident reviews submitted to us were initial analysis reviews and 29% were comprehensive reviews. In many instances, the type of information and level of detail provided met with our guidance requirements. In a number of cases, there was insufficient detail and we were required to ask for additional information from the managers who had completed reviews. This was necessary in 30% of initial reviews and in 54% of comprehensive reviews. However, it should be noted that the vast majority of requests for additional information following a comprehensive review were made in the first year of this reporting period with only three requests being made in 2016 and 2017 respectively. This reflects a considerable improvement in the quality of comprehensive reviews submitted within this timeframe. Overall, local authorities responded to

requests for additional information within an agreed timescale. However, this process elongates the overall time taken to conclude a review and results in additional work for criminal justice managers. We will continue to liaise with criminal justice social work managers to ensure that sufficient details are provided within initial submissions in order to reduce requests for additional information wherever possible.

> "The SIR process gives us an opportunity to demonstrate our commitment to being a learning organisation that is focused on outcomes for service users and wider public protection. It facilitates meaningful review that is thoughtful and forward looking; ensuring that lessons are learned and improvements put in place when required."
>
> **Service manager in justice social work**

Our analysis of serious incident reviews found that almost all were carried out by a criminal justice manager as required and that relevant staff, including the supervising officer and first line manager, were included. Partners and other relevant colleagues, such as unpaid work supervisors and groupwork programme providers, were also consulted and included in the review when they had been involved in supervision or in the case management plan.

Under-reporting

Our previous reports highlighted concerns that there may be under-reporting of serious incidents across the country. The notification figures outlined in this report indicate that while some areas have maintained a consistent rate of notifications and compliance with the serious incident review guidance, some local authorities have never submitted a notification. While the circumstances that necessitate a notification (a serious incident) are hard to predict, we find significant differences in reporting rates across authorities, even where there are similar proportions of individuals who are subject to a community payback order. It is difficult to conclude anything other than that some areas are failing to report incidents when they should. This gives rise to two concerns – firstly, that those local authorities have not implemented a process to identify and review serious incidents in order to learn from them and secondly, that our understanding of practice across the country is incomplete. It is important to note that our priority is not to promote a rigid adherence to process but to encourage an appropriate level of notification and review of serious incidents in order to increase opportunities for learning and improvement. It is also important that we are able to build a national picture of the level of serious incidents and how these are responded to. As indicated previously in this report, we have seen evidence of robust oversight of the serious incident review process and evidence of thorough and comprehensive reviews being undertaken by some local authorities. However, if we do not receive notifications in all relevant circumstances we will be unable to know if reviews have taken place and if learning has been achieved and embedded.

We will continue to liaise with the Social Work Scotland Justice Standing Committee and with local authorities in order to encourage an increased understanding of, and engagement with, the serious incident review process in some local authority areas. Our ongoing review of serious incident review notification data and the quality of serious incident reports will also be used as part of our deliberation and decision-making regarding future criminal justice social work inspection activity.

Getting learning back into the system

The local authorities that submitted notifications to us regularly tended to submit reviews that contained evidence of a thorough review of records, assessments, plans and engagement with relevant staff. In most of these, we did not request additional information. We saw examples of some areas using the serious incident review guidance as a basis for introducing a local protocol for managing the serious incident review process. One local authority had used the learning achieved from undertaking serious incident reviews to develop and introduce a local criminal justice social work improvement plan. While we have not been able to review the impact of this, it is encouraging to note the effective use of the learning from reviews in an effort to improve the quality of services and adherence to national standards.

> "Our quality assurance has been improved significantly. We use findings from reviews to enhance employee development and the service's engagement days are taken as an opportunity to provide high-level feedback. This engagement has also helped minimise practitioner anxiety over reviews as they are now seen as an opportunity for learning and improvement."
>
> **Senior public protection manager**

Some local authorities have delivered development days for staff on the subject of serious incident reporting and undertaking reviews. One area has reviewed its quality assurance of the process in order to minimise requests for additional information and to ensure that senior managers have sufficient oversight. We have seen strong examples within comprehensive reviews of local authorities identifying areas for improvement and outlining these in detailed action plans aimed at improving practice and service delivery.

Good practice

Serious incident review guidance highlights that it would be useful for us to be informed about examples of good practice in the supervision and management of statutory orders and licences so that we can share any learning from these as appropriate. The guidance outlines criteria for good practice and states that examples of sector-leading practice that other local authorities could potentially learn and benefit from would be helpful. We also request examples of practice that demonstrate innovation and that have had a positive outcome for people who use services, and for staff and partners. While a small number of serious incident reviews referred to examples of good practice, these did not always

meet the criteria set out in our guidance. We recognise that there may be some uncertainty about what constitutes a strong example of good practice within these criteria. In some reviews, we have seen evidence of good practice that has not been recorded as such in the section provided, which may suggest a lack of confidence in identifying and promoting good practice. We will liaise with the Social Work Scotland Justice Standing Committee on this issue in order to encourage the identification of good practice that could be shared to promote continuous improvement.

We received very few serious incident reviews that outlined issues of national relevance or significance. We would encourage local authorities to give this greater consideration during their completion of reviews in order to identify issues that may improve practice or processes. This is an area we will explore further with Social Work Scotland when we next review our processes and guidance.

Section 6 - Challenges

We recognise that providing notifications within the five-day timescale outlined in guidance may be a challenge for local authorities and acknowledge that, in some instances, late notifications may be due to criminal justice social work services not being aware that a serious incident has occurred. Some reviews have highlighted that delays in receiving information from courts that an individual has appeared on charges has resulted in delayed notification. In a small number of cases where criminal justice social work services have become aware that an individual has been charged with a historical offence, this will also result in notifications being outside timescales. We have noted that changes in local management arrangements can affect the review process and have seen both an increase and decrease in notifications following changes in management.

We have examined our performance in relation to responding to local authority serious incident reports and meeting timescales to inform Scottish Government of notifications of a serious incident. We achieved this in 93% of instances, responded to 80% of reviews within agreed timescales and identified challenges that have affected this. We recognise that the demands upon strategic inspection teams of delivering national inspection programmes has resulted in delays in responding to some serious incident reviews.

We now have a designated strategic justice team that will have a focus on a range of scrutiny, inspection and improvement support activities in relation to community justice. This will include serious incident reviews. We have also adjusted our business support function to support our quality assurance work.

In late 2017, we introduced a screening process whereby a strategic inspector will consider all initial notifications to ensure that they meet our criteria. This identifies those that do not meet our criteria at an early stage in order to avoid unnecessary reviews being carried out. We intend to undertake a review of our processes and guidance in conjunction with Social Work Scotland Justice Standing Committee. This will also include new and emerging considerations such as Duty of Candour.

Section 7 - Conclusion

Notifications of serious incidents make up less than 1% of social work orders or licences, including community payback orders that are imposed in Scotland each year. However, when a serious incident occurs, it is important that every opportunity is taken to review the circumstances, the quality of supervision and the level of compliance with national standards. The completion of the serious incident review process and independent review can provide useful learning for criminal justice social work services and can reassure local authority senior managers that appropriate action has been taken in response to a serious incident.

Local authorities that have consistently submitted notifications to us have demonstrated a willingness to learn from serious incident reviews and work towards improving services and outcomes for individuals and the community. While improvement is required in meeting required notification timescales, most of the reviews we received were undertaken in a thorough and well-considered manner, and demonstrated a high standard of quality assurance practice. Under-reporting of serious incidents from some local authorities has resulted in a lack of clarity on the national picture in terms of the number of serious incidents that may have occurred and how well any learning achieved from reviewing these is embedded in practice. We have seen an improvement in the quality of comprehensive reviews but some initial analysis reviews lacked sufficient detail, which resulted in requests for additional information, which in turn elongates the process.

Section 8 – Key messages

- While several local authorities have consistently submitted good quality serious incident reviews, the lack of notifications from some local authorities has resulted in gaps in identifying the number of serious incidents that may have occurred nationally. We cannot be confident that all serious incidents are being reviewed as they should be.

  Action: It is important that those areas with low or no notifications are more proactive in considering when a serious incident meets the notification criteria and submit these accordingly.

- The quality of comprehensive reviews that we have received from local authorities that have embedded the serious incident review process into their practice has improved considerably. However, almost one-third of all initial analysis reviews lacked sufficient information.

  Action: Managers responsible for quality assurance should ensure that a robust process is in place so that reviews contain the required level of detail. This will avoid requests for further information.

- An increased number of local authorities that have completed comprehensive reviews have used the learning achieved from these to introduce plans to improve local processes, staff practice and the quality of service delivery.

- We have seen an increase in the number of serious incident reports that refer to appropriate risk assessments being completed and used effectively to inform case management plans.

- We have highlighted that a significant number of notifications were outside the required five-day timescale and that there may be barriers to achieving this in some instances.

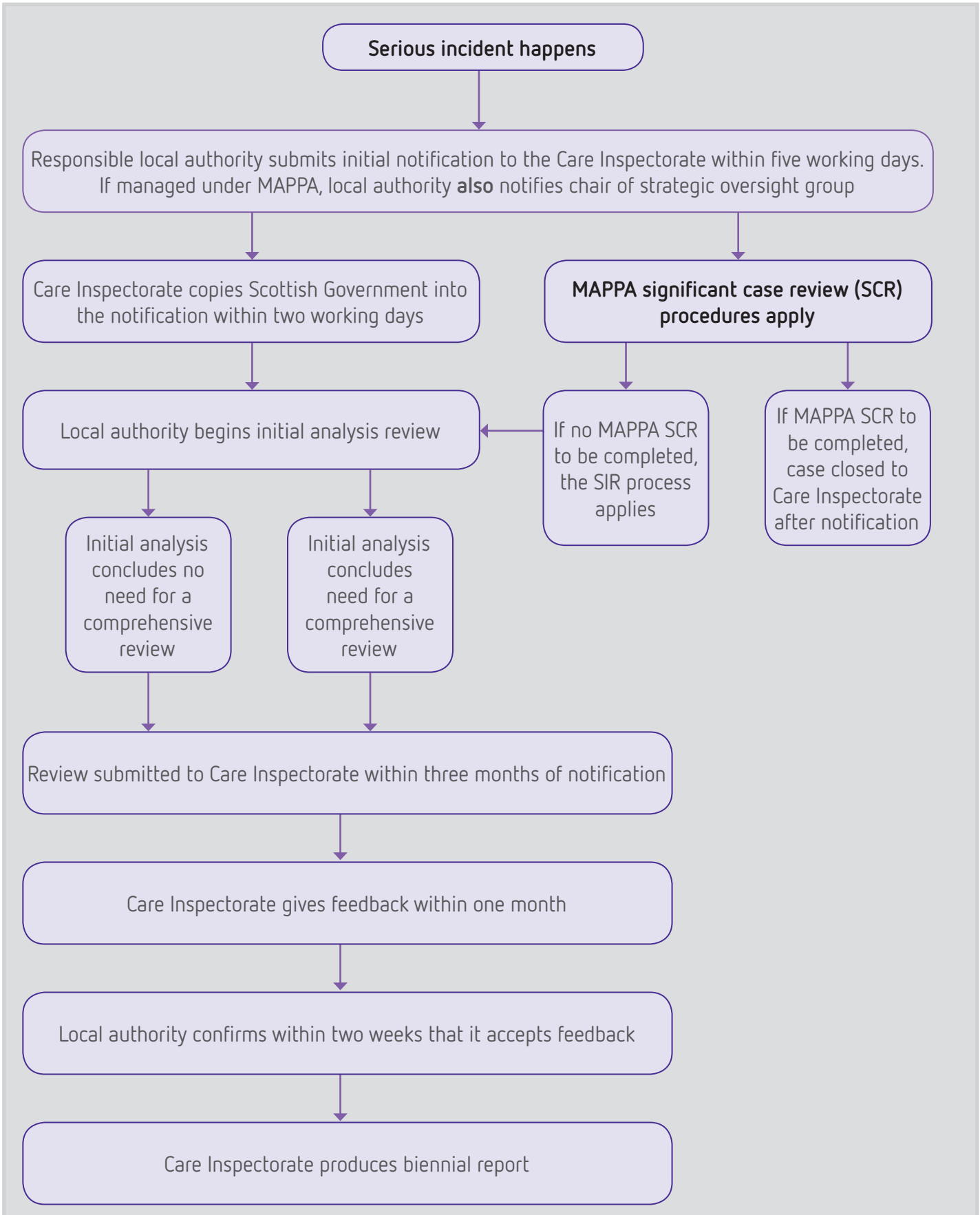
  Action: We will explore meeting the required notification timescale with the Social Work Scotland Justice Standing Committee and Scottish Government and agree further action that may be required.

- Almost half of serious incident reviews were submitted to us outside the required three-month timescale.

  Action: It is important that reviews are completed on time in order to get learning back into the system as soon as possible. We believe that improvements in local authority quality assurance processes could have a positive impact on this and will liaise with criminal justice social work managers to support improvement in this.

Appendix 1

This flowchart shows the processes to be followed when a serious incident happens



Appendix 2

Recommendations from 2015 report

1. Continuing from the recommendation made in our last Serious Incident Reviews Annual Report 2012-13, all local authorities need to ensure all relevant staff across their criminal justice service are aware of, and confident in applying, the serious incident review guidance and are applying this effectively.
2. Some senior managers and chief social work officers need to ensure there are robust quality assurance processes in place to ensure reviews sent to the Care Inspectorate are of an acceptable standard and cover all key and critical areas. This should include attention to ensuring objective measures are in place.
3. Further action needs to be taken by senior managers to ensure that LS/CMI is being completed on prisoners preparing for release and is exported to community social work staff timeously to inform planning.
4. Where staffing issues are factors in preventing the delivery of effective and efficient services in supervising offenders, managers must ensure contingency arrangements are in place.
5. Those undertaking serious incident reviews should consider and include in the review, whether the review of the licence/order in line with National Outcomes and Standards is taking place and is effective in its purpose.
6. Local authorities must improve their performance in notifying the Care Inspectorate within five working days of a serious incident occurring.

Progress made against 2015 recommendations

1. The figures in Table 1 of this report suggest that there is ongoing under-reporting of serious incidents and while some local authority areas have taken a robust approach to reporting, there remains uncertainty about the number of serious incidents occurring in areas that provide few or no notifications.
2. There has been mixed progress in this recommendation. This report shows some very positive progress in the quality of some reviews submitted to us. Comprehensive reviews in particular were more thorough and more detailed than in previous years. However, we have highlighted that there was insufficient information in a substantial number of initial assessment reports, which meant that we needed to request additional information.
3. We found that there had been a considerable improvement in LS/CMI being completed and provided to community criminal justice social workers when an individual was released from prison.
4. Notifications and reviews submitted to us within this reporting period made very little reference to staffing issues being a potential barrier to effective supervision.
5. As outlined in this report, serious incident reviews have highlighted that statutory reviews were being undertaken in the majority of cases, in accordance with National Outcomes and Standards.
6. There has been no notable improvement in notifications being submitted to us within the required timescales.

Headquarters
Care Inspectorate
Compass House
11 Riverside Drive
Dundee
DD1 4NY
Tel: 01382 207100
Fax: 01382 207289

Website: www.careinspectorate.com
Email: enquiries@careinspectorate.com
Care Inspectorate Enquiries: 0345 600 9527

Corporate member of Plain English Campaign 420
Committed to clearer communication

HAPPY TO TRANSLATE

@careinspect careinspectorate

INVESTING IN VOLUNTEERS
Healthy Working Lives Gold Award
INVESTORS IN YOUNG PEOPLE GOOD PRACTICE AWARD
CARER POSITIVE Employer in Scotland ENGAGED
We are a Living Wage Employer
LGBT CHARTER FOUNDATIONS