

# Criminal Justice Social Work Serious Incident Reviews

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A national report

June 2013-January 2015

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# Introduction

As well as regulating care services in Scotland, the Care Inspectorate has responsibility for scrutiny of social work services, including criminal justice social work. The purpose of this report is to update the public and professionals about serious incident reviews from June 2013 to January 2015, to inform policy and practice and to support those working in social work services. We published our first report on serious incident reviews in August 2013. You can find the recommendations and progress made against these in Appendix A of this report.

Where an offender is on licence or some form of supervision, 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 learn the right lessons.

Social work criminal justice services supervise a large number of offenders but, fortunately, serious incidents are relatively low. Where they do occur, the responsible local authority should carry out a serious incident review.

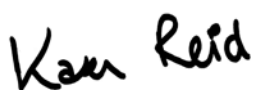
While not every serious incident can be prevented, a serious incident review helps drive up standards by identifying and sharing lessons to be learned. A serious incident review should therefore consider whether anything could have been done to have prevented a particular incident occurring.

There are three general circumstances when a serious incident review should be carried out. First, an offender on supervision or licence may be charged with carrying out a criminal offence which results in death or serious harm to someone else. Second, there may be significant concerns about the way such an offender is being supervised. Third, it may be that an offender on supervision has died or been seriously injured in a circumstance likely to generate significant public concern.

Each time a serious incident occurs local authorities must notify us within five working days. We quickly share that information with the Scottish Government, and we require the local authority to review the incident. We then scrutinise, and comment on, the local authority review. 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 issued our guidance on serious incident reviews in January 2012, which was updated in February 2013. This will be reviewed and updated in Autumn 2015. We made clear that we would produce a report identifying good practice and areas for development. We continue to work closely with representatives from Social Work Scotland criminal justice standing committee and provide them with quarterly reports. They have also been consulted in the preparation of this report which will, from now, be published biennially.

I hope this report is helpful to you.



Karen Reid  
Chief Executive

## Statutory supervision in Scotland

In 2013-14, 34,590 assessment reports were prepared for courts or the Parole Board and 26,366 offenders were supervised on statutory orders by social work services<sup>1</sup>. The governance arrangements for criminal justice social work services are defined under legislation, making social work services responsible for delivering a range of services for those involved in the criminal justice system<sup>2</sup>. A serious incident could be caused by an individual on any type of licence or order. The most relevant types of statutory licence and orders are:

- Community Payback Order
- Drug Treatment and Testing Order
- parole and non-parole licence
- extended sentence
- Supervised Release Order.

## Background to serious incident reviews

In 2010, the Scottish Government, the Association of Directors of Social Work (now Social Work Scotland), and the then social work scrutiny body, the Social Work Inspection Agency, agreed that it would be more appropriate if the task of assessing the quality of social work practice when offenders became involved in serious incidents was carried out by the scrutiny body rather than Scottish Government officials. A scrutiny body can more readily identify where there is a need for improvement to social work practice and the Care Inspectorate is pleased to work closely with Social Work Scotland to drive forward improvement.

At the Care Inspectorate's inception in 2011, we developed a procedure with the then Association of Directors of Social Work and the Scottish Government that we consulted on widely before final agreement was reached. This work was timed to fit with the Scottish Government's revision of national Multi Agency Public Protection Arrangements (MAPPA) guidance. The section on conducting MAPPA significant case reviews within the MAPPA guidance and the serious incident review procedure were considered together to ensure they were streamlined as much as possible. They were then published respectively by the Scottish Government and the Care Inspectorate in January 2012 and are complementary. The process for serious incident reviews is outlined on page 5.

MAPPA guidance sets out the responsibilities of partner agencies when a registered sex offender becomes involved in a serious incident and when a significant case review may be required. This requires a multi-agency approach and is separate from a serious incident review<sup>3</sup>; the serious incident review procedure deals with the responsibilities of local authority social work services where a serious incident occurs by an offender under the supervision of criminal justice social work. This requires a single agency response by criminal justice social work only. We recognised that there were different interpretations of the guidance across the country, so in August 2014 we wrote to all chief social work officers to clarify the position. If an offender is subject to MAPPA then both the Care inspectorate and

1 Scottish Government: Criminal Justice Social Work Statistics in Scotland 2013-14

2 Social Work (Scotland) Act 1968: responsibility for reports, community sentences, post release supervision, voluntary throughcare. Criminal Justice (Scotland) Act 2003. Community Justice and Licensing Act 2010.

3 [www.scotland.gov.uk/Publications/2012/01/12094716/1](http://www.scotland.gov.uk/Publications/2012/01/12094716/1)

Strategic Oversight Group (SOG) in that area<sup>4</sup> should be notified of any serious incident. Where the SOG decides they will not conduct a significant case review under the auspices of MAPPA a serious incident review should be completed by criminal justice social work as outlined in the serious incident review guidance. This ensures a quality assurance process applies to all offenders who are under the supervision of social work services when a serious incident happens.

Work is currently underway to extend MAPPA to include different categories of offenders in the MAPPA process. This may have implications for the serious incident review process and the MAPPA significant case review process. We are currently working with Scottish Government to plan for this.

## Role of the Care Inspectorate

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 meaningful way. We then write to local authorities with our comments. This process enables us to recognise and share strengths in practice and to say where there is room for improvement. Our role is not to carry out serious incident reviews or become involved in any actions identified by local authorities. However, we can provide a 'supporting improvement' role if a local authority requests it.

## What is a serious incident?

A serious incident is defined as:

**"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'".**

(Framework for Risk Assessment and Management Evaluation: FRAME, Scottish Government, September 2011).

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

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

To date, serious incidents have related only to the first and third categories above. It is unclear why this is, but later in the report we comment on where serious incident reviews have highlighted issues of professional practice and what local authorities have done subsequently to address these.

The table below shows a list of offences that are likely to cause serious harm and result in a serious incident review. This is not an exhaustive list and other incidents may warrant a serious incident review, such as in the circumstances of suicide or death by drug overdose of an offender on a licence or order.

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<sup>4</sup> The SOG is the local strategic group that is responsible for the delivery of MAPPA. There are 9 SOGs in Scotland

# Offences likely to have caused serious harm

**Table 1**

Sexual Offences	Non-Sexual Offences
<ul style="list-style-type: none"> <li>Sexually motivated (or attempted) murder of a child</li> <li>Sexually motivated (or attempted) murder of an adult</li> <li>Rape (or attempted rape) of a child</li> <li>Rape (or attempted rape) of an adult</li> <li>Other contact sex offence against a child</li> <li>Other contact sex offence against an adult</li> <li>Non-contact sex offence - child</li> <li>Non-contact sex offence - adult</li> <li>Possession, taking or distribution of indecent images of persons under 18</li> </ul>	<ul style="list-style-type: none"> <li>Assault to severe injury and permanent disfigurement</li> <li>Assault/neglect/cruelty to children</li> <li>Robbery (aggravated by use of weapon)</li> <li>Abduction, holding hostage, terrorism</li> <li>Attempted murder</li> <li>Murder or culpable homicide</li> <li>Fire-raising with intent to cause harm</li> </ul>
Other	
<ul style="list-style-type: none"> <li>Stalking</li> </ul>	

## What happens after a serious incident?

Local authorities are required to notify us within five working days of a serious incident. They then conduct an initial analysis review, of the supervision of the offender. They then determine whether they need to carry out a closer, more detailed comprehensive review, or conclude that the initial analysis review was enough. Local authorities must submit their reviews to us for consideration within three months of notification of the incident.

An initial analysis review should be enough when there is evidence that:

- appropriate risk assessments and risk management plans have been carried out
- there are appropriate levels of contact between the supervising officer<sup>5</sup> and other agencies with the offender
- issues of non-compliance are managed appropriately.

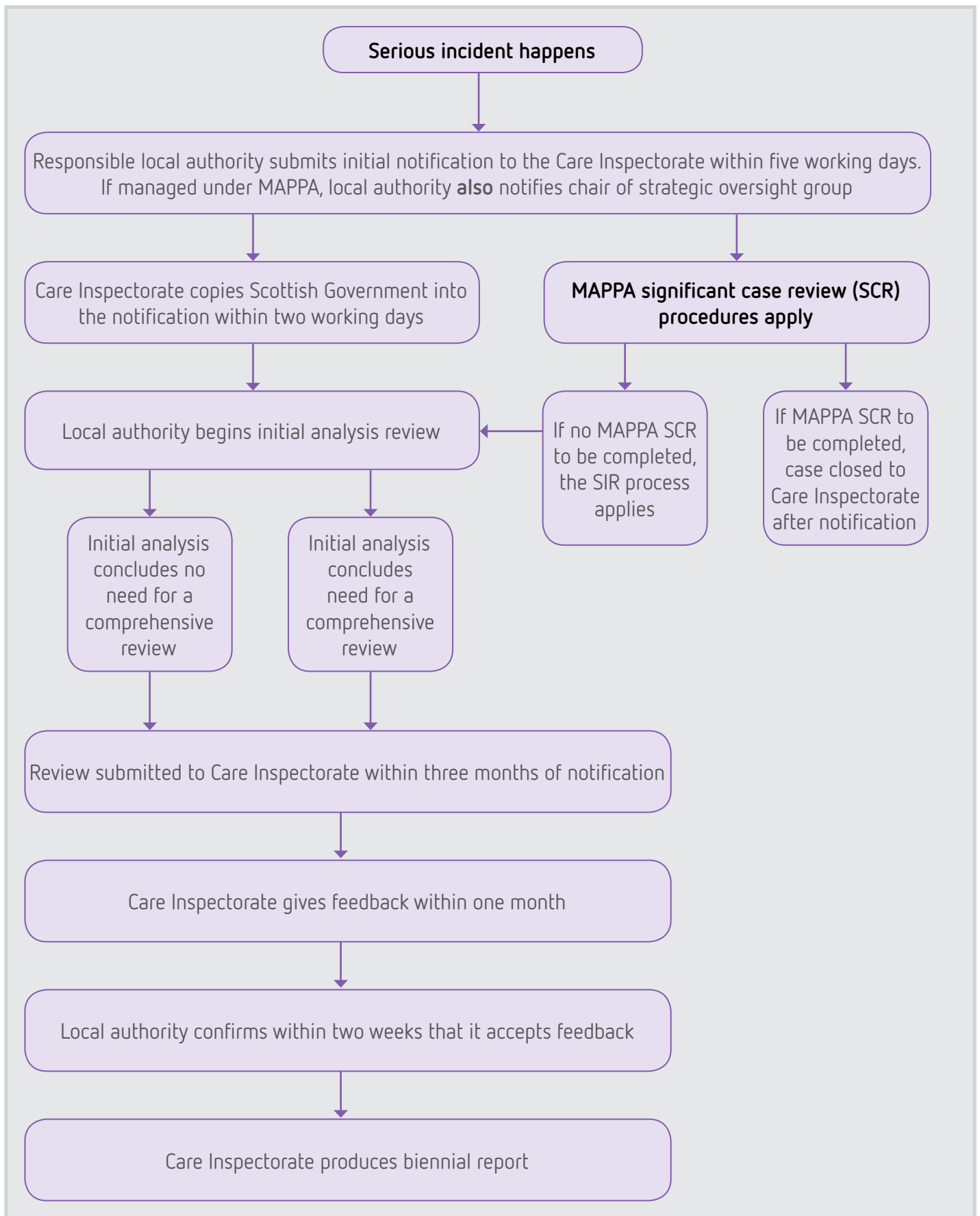
Later in this report, we discuss in more detail what we mean by compliance and non-compliance.

If the initial analysis review gives cause for concern or uncertainty, the local authority should carry out a comprehensive review. The senior manager signing off the review should then submit that review to the Care Inspectorate. One of our strategic inspectors will then consider the review in line with our quality assurance role and provide comment within one month.

The serious incident review guidance contains a clear process for local authorities to follow and is shown here. The full serious incident review guidance is available on our website [www.careinspectorate.com](http://www.careinspectorate.com)

<sup>5</sup> A supervising officer is the named person from criminal justice social work who is allocated as the responsible officer for supervising the statutory licence or order.

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



## Serious incident reviews

Since January 2012, we have received 162 notifications from 28 local authorities. Our first published serious incident review report covered the period from January 2012 to May 2013 and was published in August 2013 and can be found at [www.careinspectorate.com](http://www.careinspectorate.com)

This report focuses on the period between June 2013 and January 2015. The table below gives a breakdown of serious incidents notified to the Care Inspectorate. It shows that 24 of 32 local authority areas submitted at least one notification within this timescale. Within the reporting timescale we have received 111 notifications. This is an increase of 127% from the previous reporting period. In our last report we raised concerns that there may be under-reporting of serious incidents across the country and made a recommendation in relation to this. However, following the last report and ongoing dialogue with Social Work Scotland criminal justice social work representatives, there was recognition and acceptance that not all local authorities were being as diligent as they could be in notifying the Care Inspectorate. This has resulted in many areas undertaking a review of serious incidents that happened sometime in the past and notifying us of these retrospectively. We view this as positive and affirmative action to improve practice in this area and recognise that this slants the data somewhat. Current figures indicate a significant improvement in this area.

**Table 2**

**Serious incidents notified to the Care Inspectorate, by local authority, between June 2013 and January 2015**

Local Authority	Number of serious incidents notified
Glasgow City Council	18
West Lothian Council	12
City of Edinburgh Council	10
North Ayrshire Council	10
North Lanarkshire Council	9
South Ayrshire Council	8
Scottish Borders Council	5
Renfrewshire Council	5
Stirling Council	4
Aberdeen City Council	4
Falkirk	4
Highland Council	3
Midlothian Council	3
East Ayrshire Council	2
Inverclyde Council	2
Dumfries & Galloway Council	2
Fife Council	2
East Lothian Council	2
Dundee City Council	1



(Table 2 continued) Serious incidents notified to the Care Inspectorate, by local authority, between June 2013 and January 2015

Local Authority	Number of serious incidents notified
Angus Council	1
East Renfrewshire Council	1
Aberdeenshire Council	1
Argyll and Bute Council	1
Clackmannanshire Council	1
Orkney Islands	0
Shetland Islands	0
Eilean Siar	0
South Lanarkshire	0
Moray	0
East Dunbartonshire	0
West Dunbartonshire	0
Perth & Kinross	0
<b>Total</b>	<b>111</b>

## Notification of serious incidents

The guidance requires that we are notified within five working days of a serious incident. Local authorities achieved this in only 36% of notifications. Of the cases notified outwith the five working days these varied from six to 669 days, with the median being 11 days, and the mean being 61 days. We recognise that in some instances notifications may be outwith the timescales as criminal justice social work services may not be aware of a serious incident occurring. However, in the majority of cases they will be aware of a serious incident and need to ensure they notify us accordingly.

**Table 3**

Type of serious incident	Number	%
Murder (perpetrator)	14	13%
Sexual offences: these include different types of sexual offences including rape, sexual assault	21	19%
Unexplained death; in most instances where these have been given as the reason they are likely to be drug related deaths, in some instances at the point of notification post mortems have still to be established cause of death	22	19%
Suicide	9	8%
Assault and robbery	8	7%
Serious assault: this includes those with all or some of the components – endanger to life, permanent disfigurement and severe injury, or intent to rob element	14	13%
Attempted murder	5	5%

(Table 3 continued) Type of serious incident	Number	%
Child abuse (historical)	3	3%
Murder (victim)	4	4%
Stalking	2	2%
Assault to severe injury and attempted murder	1	1%
Burglary	1	1%
Possession of a firearm	1	1%
Terrorism offences	1	1%
Death from serious assault	1	1%
Assault, carrying an offensive weapon and breach of the peace	1	1%
Abduction	2	2%
Death by accident	1	1%
<b>Total</b>	<b>111</b>	<b>100%</b>

## Risk assessment and planning

The purpose of risk assessment is to better understand the risks and needs of an individual and to identify the crucial factors in offending behaviour. Different risk assessment tools measure different factors, such as risk of re-offending, risk of harm to others, or both. Some are specifically for use with young people and some with those who commit sexual offences.

Risk management plans should be well informed by the findings of the risk assessment. Plans should include what needs to be done to address and reduce the risk of re-offending. They should set out how the individual should be supported if they have specific needs, such as addiction, mental health or financial problems. These plans should be clear on what is going to be done, by whom and when.

Of the 111 notifications, we have received 80 serious incident reviews so far. The remainder of reviews are not yet due to be completed<sup>6</sup>. In 72.5% of the 80 reviews it was evident that risk assessments had been completed. In 54% of these it was evident that risk assessments were up to date. LSCMI (Level of Service Case Management Inventory)<sup>7</sup> is the core assessment tool that should be used when working with offenders in Scotland. In our last report, LSCMI was one tool being used along with many others. As the use of LSCMI has become increasingly embedded in practice since 2013, we would expect to see more consistent use of this tool reflected in serious incident reviews. We have found this to be the case, with the tool being used more consistently across most areas in Scotland and we see this as positive. However, these were often not completed within the 20 day timescale. In almost all reviews where the risk assessment tool was referenced, it was LSCMI. Other specialist assessment tools referred to were SA07 (Stable & Acute 2007) and SARA (Spousal Assault Risk Assessment guide).

In most serious incident reviews where the individual had been released from prison, there had been difficulty with the LSCMI either not being completed by prison based social work staff, or it not being exported from the prison to criminal justice social work in the community. This was presenting some

<sup>6</sup> This is where the completion date for the review - within three months of notification - falls outwith the reporting period of this report.

<sup>7</sup> LSCMI is the national assessment tool used by criminal justice social workers to help consider risk and needs of people who offend.

challenges for community-based social workers who did not have up-to-date risk assessments to refer to and better inform their planning for offenders on release from prison.

Of the 80 serious incident reviews, 61% referred to a risk management plan being in place, with 39% of reviews making no reference to a risk management plan. Where a risk management plan was referenced, there was supporting evidence in over half of reviews that these were informed by the risk assessment. It is crucial that risk assessment is used well to inform the risk management plans. Where this was evident, the overall quality of the review analysis was better than those that had not referred to risk assessment and planning.

When supervising someone on a statutory licence/order there is an expectation that progress will be reviewed at key stages. Only 37.5% of the 80 initial analysis or comprehensive reviews referred to statutory orders or licence reviews being held to consider progress or barriers. This does not mean they were not happening, but no reference to them in the serious incident review means it was difficult to tell if they were. Consistent reference to order or licence reviews within the serious incident review will give us better insight into practice overall. This is crucial as where local authorities were referring to order or licence reviews, in many instances they highlighted they had not happened when they should have. This gave us useful insight and some local authorities had gone on to rectify this, showing learning from the serious incident review process.

## **Compliance**

Compliance describes whether an individual on an order or licence is meeting the conditions of their statutory licence/order. This may include attending appointments when instructed, not committing further offences and fulfilling other conditions that may be part of their licence/order, such as unpaid work and alcohol or drug counselling. In our last report we stated that compliance was referred to in nearly all reviews and was managed well. This continues to be the picture, with issues of non-compliance dealt with appropriately in most instances. In a few reviews where non-compliance had not been managed as effectively as it could have been, those undertaking the review identified this and highlighted it as an area for improvement.

## **Partnership working**

In our last report, we noted that where staff from other social work services and agencies were involved in a review, they offered useful insight and enhanced the review. This involvement continues to be a strengthening feature. More complex serious incidents have been coming to our attention, with wider groups of staff and agencies being involved. These include child and family social work services, residential provision, police, specialist forensic services, housing, drug and alcohol services, mental health services and third sector providers. We would advocate these groups and agencies continue to contribute, to provide robust reviewing of serious incidents.

Staff with a case-managing role and their line managers were almost always part of the review process and individual offender records were reviewed in all instances.

Most reviews provided evidence of good partnership working in managing risk and need.

## Care Inspectorate performance on serious incident reviews

We aim to inform Scottish Government of notifications of serious incidents within two working days of receiving them. We achieved this in 97% of instances.

We aim to respond and comment on reviews within one month of receipt. We responded to 86% within this timeframe. The reasons the remainder were late were changes in our administrative processes or time constraints on our strategic inspectors. We have taken action to address this by increasing the capacity of our team.

## Local authority performance on serious incident reviews

There has been an increased level of notifications of sexual offences within the reporting timeframe. This has been influenced by improved notification reporting processes within local areas and a clearer understanding of the guidance and its relationship with the MAPPA significant case review process as referred to on page 7.

Whilst guidance states three categories where a serious incident review could occur (see page 3), the predominant category where notifications are received are for charges of further offences. Increasingly, when comprehensive reviews are taking place, local authorities are helpfully identifying some professional practice issues. These issues mainly relate to failure to adequately undertake duties in line with National Outcomes and Standards 2010<sup>8</sup>, as well as up-to-date assessments and case management plans not being completed on time or at all. In the main, senior managers undertaking the reviews have given us clear and comprehensive action plans outlining how these issues will be addressed. This can be difficult and challenging for all involved in the review process, but it is providing the opportunity to improve professional practice. We are increasingly confident that most senior managers undertaking reviews have approached this area with commitment and vigour.

A total of 80 serious incident reviews have been completed within the reporting timeframe, 60 (75%) of these were initial analysis reviews and 20 (25%) were comprehensive reviews. Local authorities are expected to submit reviews within three months of notification; this was achieved in 75% of instances.

The decision to carry out an initial analysis review was appropriate in 51 instances. In the other nine cases we concluded that an initial analysis review was not enough and a comprehensive review was necessary. We had to request additional information in 25 initial analysis reviews before these could be concluded. We are still awaiting the outcome of some which have not yet provided additional information. We continue to have dialogue with these local authority areas to ensure that action is taken.

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<sup>8</sup> National Outcomes and Standards for Social Work Services in the Criminal Justice System (2010)

In over 50% of comprehensive reviews the outcome was a high quality review being completed.. However, we had to ask for additional information in the others to allow us to conclude the reviews.

The lack of information submitted in these reviews affected their overall quality. Of the 111 notifications received, 71% were signed off by an appropriate criminal justice service manager or senior manager, as required in the guidance. Of the 80 initial analysis reviews or comprehensive reviews completed, 92.5% were signed off by the head of criminal justice social work services or chief social work officers. It is crucial that senior criminal justice managers and chief social work officers see all notifications and reviews to ensure robust oversight and quality assurance.

In some instances we found that reviews were being undertaken by the first line manager responsible for supervising the case manager. We did not find this provided enough objectivity, or was far enough removed from the case to be effective. Ultimately, this would mean staff were reviewing their own practice. In those cases we had to request additional information.

// “Serious incident reviews complement the internal and multi-agency quality assurance processes that our local authority has in place. They provide welcome external scrutiny so that we can be sure that we are doing all that we can to improve standards. Being the worker involved in a review can be a source of anxiety and it is very important that we identify examples of good practice as well as areas for improvement and make sure that we feed this back to staff. I have found that the feedback from inspectors is respectful and takes into account the complexities inherent in some cases. Credit is given where it is due and this encourages positive use of the process”.

**Service manager, local authority**

## Social trends

Social trends relate to the cultural values and practices within a society that are evident over a period of time. Over recent years, we have seen trends in certain areas, such as domestic violence and historical sexual abuse, within the realms of crime and offending behaviour. This report does not try to analyse or understand whether this is due to improved reporting of crime, better detection, prevention and early intervention approaches, or media reporting. However, this report does reflect how such societal issues have relevance to serious incidents.

In 2012/13, police in Scotland<sup>9</sup> recorded 60,080 incidents of domestic abuse. Of these, 30,259 led to the recording of a crime or offence, of which 23,606 were reported to the Procurator Fiscal. We have found an increase in notifications containing an element of domestic violence, or where the offender has had previous offences of domestic violence.

In 2013, there were 526 drug-related deaths registered in Scotland<sup>10</sup>. Within this reporting period we have received notifications in relation to 22 unexplained deaths where the cause is likely to be drug related. This is in comparison to 12 reported in the serious incident reviews report 2013.

There is increasing public awareness of cases involving historical abuse, through media reporting and recent high profile cases. Within the serious incident review process there has been an increase in notifications about serious historical incidents from the previous reporting period, but this remains a small figure.

The complexity of notifications and their circumstances appear to have increased. We have seen more child and adult protection issues, both in relation to risks the offender poses and where they may be the one in need of protection. This has meant that local authorities and partner agencies have decided to undertake significant case reviews (SCRs) using multi-agency child protection or adult protection processes when something serious has happened. We are seeing more comprehensive reviews being completed due to the complexity and issues arising from incidents and notifications. This indicates that services are taking a closer, more detailed look when things go wrong.

## National findings from serious incident reviews

Whilst we have clearly experienced an increase in notifications of serious incidents across local authority areas, we still hold the view that there is under-reporting in some areas. National crime figures vary from the pattern of reporting. For example, they show significantly greater numbers of serious assaults than murders, but our own figures for the notifications we have received show numbers for both these categories are the same (see Table 3). Working in partnership with Social Work Scotland's criminal justice standing committee and communication with chief social work officers has helped progress in this area, but we need to see further diligence and action from some local authority areas to notify us. Some local authority areas are following the process extremely well.

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<sup>9</sup> Domestic Abuse recorded by the police in Scotland 2012/13 (published October 2013, Scottish Government)

<sup>10</sup> Drug-related deaths in Scotland 2013 (NRS, August 2014)

Others have been on a steep learning curve this past year and are now following the process.

A few local authority areas need to take a closer look at how well they are applying the serious incident review guidance. This includes ensuring that the review is objective and undertaken by someone who does not have direct responsibility or management of the case, and that all senior managers are vigilant in considering the review that is being signed off by them. Overall, this should improve the quality of the reviews and avoid the need for us to ask for additional information or challenge the robustness of the review.

Our report on the use of LSCMI 'Improving assessment and case management in criminal justice social work: a report on the initial impact of LSCMI August 2014' identified the need for improvement in the use of LSCMI within prison-based social work and the exporting of this. This remains a critical feature and it is not happening as well as it should. The Scottish Prison Service and criminal justice social work are currently looking at ways to progress this with the re-establishment of the tri-partite group and a sub group to take this area forward specifically. We also recognised that LSCMI is not being completed within the timescales as routinely as it should across all local authorities. Each local authority area is aware of these issues and has an action plan in place from the LSCMI report to address this. Our link inspectors will continue to monitor local authority areas' progress on the LSCMI action plan.

Some areas highlighted staff absence, sickness or shortages as being factors where something had not been done in the review as it should have. We appreciate these challenges exist, but it is crucial that contingency planning is in place and action taken to manage these elements.

// Following an update on SIRs nationally from the Care Inspectorate, I reviewed what we were doing locally. It appeared that there may have been a degree of under reporting. The management team was tasked with undertaking a 12-month retrospective scrutiny of all supervision cases. This identified several cases that should have been considered for reporting. The process to identify the cases required a significant amount of management resource. The subsequent interrogation of the identified cases, which cumulated in a full review being undertaken and submitted for most of the cases, was a challenge however the Senior Management Team supported the process throughout. The opportunity to learn from the experience has been invaluable. Key areas identified were the lack of re-training for staff on national procedures, the limitations of LSCMI as a management tool and the need to review local policies and procedures regularly.

Whilst it was not always a welcome process, and on occasions stretched the resources of both the front line staff and the management team, it has allowed the service as a whole to revisit professional expectations and give staff an opportunity to be involved positively in the process of reviewing our professional activity."

**Service manager, local authority**

## Good practice<sup>11</sup>

### Good practice

There was a clear commitment to young people within the justice system, using the Whole Systems Approach effectively to manage risk and meet need. There was a culture of commitment across staff in children and criminal justice social work. We found evidence of robust risk assessment and planning, but also persistence and tenacity by the staff involved. The outcome was reduced drug use and improvement in mental health, better access to appropriate services to ensure people were getting the right help. Mentor support was in place and there were noticeable, positive improvements in the individual.

### Good practice

Two of the larger local authorities in Scotland have recognised potential challenges in implementing the serious incident review guidance and process consistently when there are large groups of staff involved. They have taken the guidance and developed local policy and practice to ensure both staff and managers were aware of the guidance. They have also put in place clear processes and lines of accountability to ensure it operates effectively. We have found this to be highly effective in ensuring consistency.

### Good practice

Many of those likely to come to our attention through serious incident reviews are the most difficult individuals to manage within the community. Vigilance by staff, good partnership working, robust risk management and reviewing were helping to manage the most difficult situations. Staff were using specialist resources well to seek advice. Case managers were using their skills well in being proactive and innovative to manage individuals in the community.

## Conclusion

Overall, there has been a significant improvement in reporting practice, evidenced by the volume of notifications we are receiving. It is important that the serious incident review process means senior managers and chief social work officers have oversight of serious incidents within the community. This will also ensure that Scottish Ministers know about serious incidents involving offenders on licence or order.

A serious incident review is an important opportunity to learn about practice, recognise strengths and identify areas that need to be improved and we have been impressed by the way many local authority areas have used the process to learn and improve their services. Most have been ready and open to taking a closer look at practice and management, as appropriate, when undertaking comprehensive reviews and this is hugely positive. Where these are taking place we are seeing appropriate action plans being devised to address key areas for improvement. In those local authority areas where we are

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<sup>11</sup> We have anonymised good practice examples to ensure individuals, families and victims cannot be identified.



having to challenge the robustness of the review, there is a sense that learning and action for change is less well developed. It is commendable that some areas, that recognised they may not have been following the process as they should, have taken strong, affirmative action to redress this.

Senior managers, managers and staff within criminal justice social work need to pay yet more attention to whether they are notifying us of all incidents that meet the criteria of a serious incident. More local authorities are applying the process; the next step is to make sure this is being done robustly and as effectively as it can be.

We will continue to monitor notifications and reviews within each local authority through the lead officer for serious incident reviews, and through our strategic link inspectors who have ongoing contact with senior managers in local authorities. We will report on progress again in two years.

We recognise that with the restructure of community justice and the extension of Multi Agency Public Protection Arrangements (MAPPA) there may be changes that will affect this process. We will continue to communicate with Social Work Scotland, Scottish Government and key partners within local authorities as these areas develop, to both consult and advise of any changes.

The recommendations below should be taken forward by all local authority areas. It is important that due attention continues to be given to the recommendations made in the 2013 report, as more progress on these is still needed (see Appendix A).

// In terms of the SIR reporting process, it has become evident that due to the number of SIRs we have reported that the process meets our needs quite well.

“I think that the number of reviews we have had to undertake this year has made the process feel onerous but I don’t think it actually is, it’s probably been more about volume and impact upon the service.

“My view is that reporting gives us an opportunity to critically examine and review practice and provides us with an opportunity to learn from what are often very tragic circumstances. It provides an opportunity to feedback to staff on good practice and to review any policies or procedures that are relevant to the circumstances and to adapt/amend these as required.”

**Service manager, local authority**

## Recommendations

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 LSCMI 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 Objectives 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.

# Appendix A

## Recommendations from 2013 report

1. A consistent approach to managing cross-authority or shared services supervision arrangements is needed where serious incidents occur. There must be clarity on who is responsible for the notification of serious incidents and how the review will be carried out.
2. Local authorities should take a closer look at how alcohol and drug support services are operating and whether they are providing effective enough support to those involved in the criminal justice system who have significant substance misuse issues.
3. Local authority and health partners should review and take appropriate action to ensure that information is shared across services in the most effective way and when required.
4. When completing initial analysis reviews or comprehensive reviews, those involved should take a robust approach to identifying good practice and include this in reviews more clearly.
5. Senior managers in criminal justice social work services should ensure that all staff working within criminal justice have access to the serious incident review guidance and fully understand the expectations on them to report serious incidents.
6. All council areas across Scotland should ensure they closely follow the guidance on when they should notify us of a serious incident. Senior managers and the chief social work officer should ensure guidance is applied in their council area.

## Progress made on 2013 recommendations

The strategic link inspector for each local authority has requested each local authority provide an update on progress made against the recommendations from the last report. Some areas have provided a comprehensive account of action taken and others have provided little or no information. It is important that these recommendations are taken account of and acted upon by all local authorities.

**Recommendation 1:** we found little progress had been made. Some areas identified the need for a national approach to this to ensure consistency. This would make sense and we propose this is taken forward by the Social Work Scotland criminal justice committee.

**Recommendation 2:** some local authority areas highlighted this as an integral part of their strategic planning and commissioning approaches. They recognised services for those within criminal justice services were important and many had local meetings in place where this was discussed.

**Recommendation 3:** some areas indicated this had been discussed with partners and highlighted arrangements under MAPPA supporting good information sharing. Others recognised this was still an area for further discussion and progress.

**Recommendation 4:** local authorities are still not readily identifying good practice in reviews. We are seeing good practice but this usually identified by the Care Inspectorate. Where local authorities do identify good practice, this tends to be more about staff doing their job well, as we would expect, as opposed to good practice that is innovative and others can learn from. We would like to see a more confident approach to promoting good practice that evidences positive outcomes and innovative practice that others could learn from. We appreciate this can be difficult due to the subject matter of serious incidents, but think areas could showcase what they do well better.

**Recommendations 5 and 6:** there is a sense that staff within local authorities have a better understanding of the serious incident review process and guidance. Whether staff on the ground are familiar remains uncertain. Not all senior managers appear to be aware or fully conversant with the guidance. It is important they are familiar with this and ensure managers and staff are applying this. In some areas it is evident that this is working very effectively.

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अनुरोधसापेक्षे এই प्रकाशनाटि अन्य कर्म्याटि एवं अन्यान्य भाषाय पाठ्या यय ।

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ਬੇਲੜੀ 'ਤੇ ਇਹ ਪ੍ਰਕਾਸ਼ਨ ਹੋਰ ਰੂਪਾਂ ਅਤੇ ਹੋਰਨਾਂ ਭਾਸ਼ਾਵਾਂ ਵਿਚ ਉਪਲਬਧ ਹੈ।

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