Serious incident review guidance

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Serious incident review guidance

1. Purpose of serious incident reviews

1.1 To ensure that local authorities and partner agencies identify areas for development and areas of good practice.

1.2 To provide the Scottish Government with information to enable it to respond to incidents in terms of any immediate concerns that arise and the future development of services.[1]

2. Criteria for identifying whether an incident is serious

2.1 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.' (Framework for Risk Assessment Management and Evaluation: FRAME)

2.2 A serious incident review (SIR) 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 of 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.

2.3 Appendix 1 lists examples of the kind of offences that may cause serious harm. These are examples only and other offences should not be excluded if they do not appear on this list. Appendix 1 also offers illustrations of the kind of circumstances in which a review should be carried out.

2.4 Responsibility for completing a serious incident review sits with local authority criminal justice social work services. It differs from a significant case review (SCR) relating to incidents involving offenders managed under MAPPA. The purpose of the latter is to examine whether agencies effectively applied MAPPA arrangements and whether the agencies worked together effectively. In these circumstances the chair of the MAPPA strategic oversight group is responsible for commissioning the SCR. See the section on MAPPA below for more detail on what is required when the SOG decides there will be no SCR.

[1] This guidance replaces Scottish Government circular
http://www.scotland.gov.uk/Publications/2007/06/jdcircular102007

2.5 This guidance does not affect the existing arrangements for notifying the Criminal Justice and Parole Division within the Scottish Government of incidents involving persons subject to statutory supervision following release from custody. These are separate to the procedures described in this circular. This SIR circular also carries no implications for the statutory notification of deaths of children looked after by authorities.

3. Process

3.1 Within five working days of becoming aware that a serious incident has occurred the responsible local authority must submit a **notification** to the Care Inspectorate at the e-mail address below[2]:

cistrategicteamnotification@careinspectorate.gov.scot

Appendix 2 provides a template for this notification and Appendix 4 offers an illustration of a completed notification template. The notification should be signed by the member of staff who completed it and by the criminal justice service manager or a more senior manager.

3.2 The requirement to submit a notification extends to incidents that may be subject to a MAPPA significant case review (SCR). We cover serious incidents where the individual may be subject to MAPPA in more detail in section 4 below.

3.3 Within two working days the Care Inspectorate will forward the notification to the Scottish Government Community Justice Strategy and Sponsorship Unit in order to provide an alert to Ministers. Where appropriate the Community Justice Strategy and Sponsorship Unit may make information in the initial notification available to staff working within the Scottish Government's Communications Office and to Ministers.

3.4 The local authority must carry out a **review** of the incident. It should submit the outcome of this review to the Care Inspectorate within three months of sending the initial notification to the Care Inspectorate.

3.5 The local authority should first carry out an initial analysis in order to determine whether there is a need to carry out a more comprehensive review. In the majority of situations there will be sufficient information in the **notification** to allow the local authority to reach this decision. However, in some situations the local authority may determine that it needs more information before reaching a decision. This could include an examination of case files and/or an interview with the supervising officer or first line manager. If the local authority concludes, on the basis of the initial analysis that a

[2] Where a local authority is supervising an order on behalf of another local authority the notification, and subsequent review, should be submitted by the local authority supervising the order. This should however be done in partnership with the local authority responsible for the order.

comprehensive review is unnecessary it should complete only sections one, four and six of the review report template (Appendix 3). All review reports must be signed by the member of staff who completed the review and by the local authority's head of criminal justice services or chief social work officer.

3.6 Circumstances in which an initial analysis would be sufficient include those where it is evident that the supervising officer had:

- developed an appropriate risk assessment and risk management plan,
- maintained appropriate levels of contact with the individual and other agencies involved in delivering the risk management plan,
- carried out their responsibilities in line with the risk management plan, and
- taken appropriate action within reasonable timescales in response to non-compliance or further offending by the individual involved in the serious incident.

3.7 Following the initial analysis the local authority may determine that there remain areas of sufficient concern or uncertainty that require further investigation. In these circumstances they should proceed to a more comprehensive review, completing all sections of the review report template (Appendix 3). Appendix 5 offers an illustration of a completed review.

3.8 If the local authority proceeds to a comprehensive review it should nominate a lead officer responsible for allocating tasks and co-ordinating the review. The lead should also play a quality assurance role, ensuring that the conclusions of the review are robustly evidence-based and that the resultant action plan is sufficiently SMART.

3.9 For very serious incidents and/or as a result of major concerns arising from the initial review of the evidence local authorities may need to consider independent involvement in a comprehensive review. They may choose to commission an independent person(s) to carry out the review or ask an independent person(s) to provide an additional quality assurance and challenge role. They should consider asking another local authority if it would be willing to provide this level of objectivity and challenge.

3.10 It is likely that many of those offenders involved in serious incidents will have a number of agencies involved in addressing their risks and meeting their needs. Examples include substance misuse and mental health services and, in domestic abuse situations, multi-agency approaches involving the police. In many instances partnership working will be integral to the risk management plan. In such cases it would therefore be good practice for local authorities to seek the views of their partners when conducting a comprehensive serious incident review. However, it is not within the scope of a SIR to identify areas for development for another agency. This should not prevent partner agencies agreeing, in some situations, that they wish to conduct a multi-agency review. In these circumstances the local authority must make it clear to their partners that they are required to submit the outcome of the review to the Care Inspectorate.

3.11 In carrying out the review it is important that local authorities (and partners where relevant) recognise that criminal proceedings must take precedence. This means that they should not question people who are potential witnesses in criminal proceedings. If such proceedings are underway (or if a fatal accident inquiry is underway or anticipated) the local authority should establish good communication with the Procurator Fiscal. The Procurator Fiscal can offer guidance on what elements of the review might be carried out.

3.12 Following receipt of a review report the Care Inspectorate will, within one month, provide the local authority with comments on the review. The local authority should provide confirmation within two weeks that it accepts these comments. In the event of disagreement the Care Inspectorate will meet with relevant senior managers within the local authority to discuss its comments further.

3.13 It is important that local authorities do not delay implementing any necessary actions while the above processes are underway.

3.14 The Care Inspectorate will produce an annual report identifying good practice and areas for development emerging from the reviews submitted.

4. MAPPA

4.1.1 When a serious incident occurs in respect of an individual subject to MAPPA it is important that quality assurance processes are in place to ensure local authorities review these instances as they would for any other serious incident. We want to ensure that whilst such quality assurance processes are in place we minimise and avoid any duplication of activity on behalf of the local authority. For this reason the following should help avoid any duplication of action whilst ensuring robust processes are in place.

4.1.2 Where an individual is subject to MAPPA and is also subject to statutory measures from social work then the Care Inspectorate must be notified by the local authority. However to avoid unnecessary duplication, when a MAPPA SCR Form 1: Stage 1 –SCR initial notification report is completed in order to be submitted to the strategic oversight group (SOG), this can also be used as the notification to the Care Inspectorate. In such instances appendix 2 in this guidance, serious incident review: initial notification would not be required and would be replaced by MAPPA SCR Form 1. It is the decision of the notifying local authority to decide which one they wish to use.

4.1.3 Following this if a MAPPA SCR is to be completed, this replaces the need for the notifying authority to submit a serious incident review, either initial analysis or comprehensive, to the Care Inspectorate. In such cases the local authority and partner agencies should follow the processes set out in MAPPA guidance (www.gov.scot/Publications/2016/03/6905)

4.1.4 If following initial notification the SOG decide there is to be no MAPPA SCR, then a review must be completed under the Care Inspectorate serious incident review process (Appendix 3 below). This can either be an initial analysis or comprehensive review, depending on what is most appropriate to the circumstances.

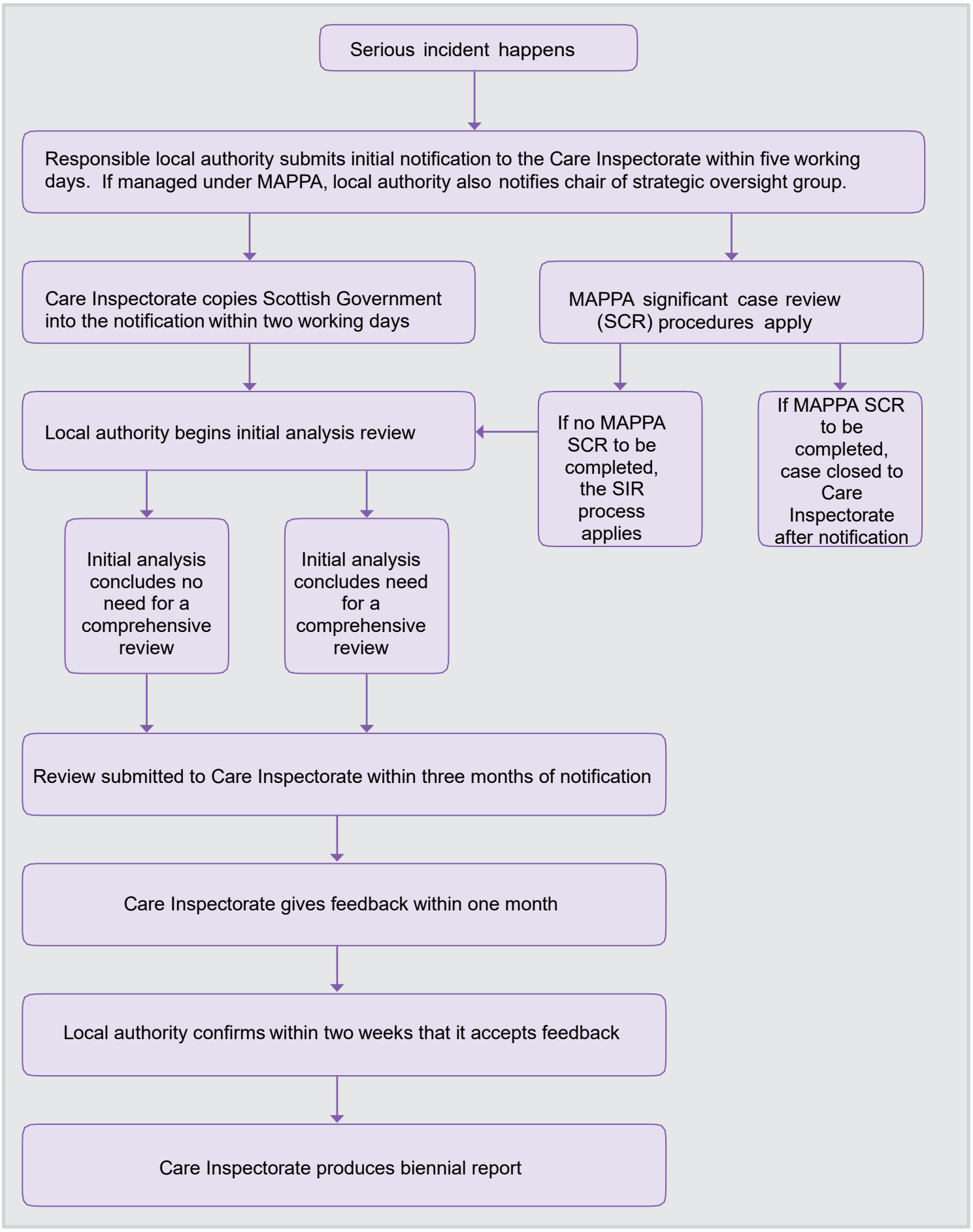
4.1.5 If a MAPPA ICR is requested and completed, again to avoid duplication this can be submitted to the Care Inspectorate as the serious incident review instead of completing Appendix 3- Serious incident reviews: review report. If this is the case local authorities must ensure all areas in appendix 3 are covered as appropriate.

4. Employee care

4.1 Local authorities have a responsibility to victims, the general public and to offenders themselves to provide a high quality service and to effectively assess and manage the risks presented by offenders. In some instances the review will conclude that the service provided was not of as good a quality as it should have been. In some instances it may even have fallen below acceptable standards of professional competence and result in disciplinary action.

4.2 Local authorities also have a duty of care to those they employ. They should give due recognition to the complexities and demands of assessing and managing the risks presented by offenders. They should also be mindful that staff responsible for supervising those offenders involved in serious incidents are likely to feel additional stress and, in some cases, trauma. It is incumbent on local authorities to make sure that those staff who need additional support at this time receive it.

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



Appendix 1

Offences that are likely to have caused serious harm
Examples include:

Sexual
Sexually motivated (or attempted) murder of a child
Sexually motivated (or attempted) murder of an adult
Rape (or attempted) of a child
Rape (or attempted) of an adult
Other contact sex offence against a child
Other contact sex offence against an adult
Non-contact sex offence child
Non-contact sex offence adult
Possession, taking or distribution of indecent images of persons under 18
Non-sexual offences
Assault to severe injury and permanent disfigurement
Assault/neglect/cruelty children
Robbery (aggravated by use of weapon)
Abduction, holding hostage, terrorism
Attempted murder
Murder or culpable homicide
Fire-raising with intent to cause harm
Other
Stalking

Illustrations of serious incidents
Examples include:

- John was on licence having served a sentence for an assault to severe injury and permanent disfigurement. He has just been charged with a similar offence.

- Tony was subject to a community payback order following his conviction for theft offences. He had a previous conviction for lewd and libidinous behaviour. He was homeless and had been placed in a hostel. He had learning disabilities. He was attacked and seriously injured by another resident.

- Anne was on a drug treatment and testing order (DTTO) when she died after receiving a heroin injection from an acquaintance who attended the same DTTO group work programme

- Bill has recently been released on life licence and has been placed in accommodation in the same village as his victim's family. A couple of articles about this have appeared in the local press. As a result Bill has been subject to threats from the local community.

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Appendix 2

Serious incident reviews: Initial Notification

Name of offender	
Offender d.o.b.	
Name of responsible local authority	
Date of incident	
Type of supervision/statutory order offender subject to	
Date statutory order imposed/date of release from custody on statutory supervision	
Current whereabouts of the offender	At liberty/in custody/deceased
Brief description of incident (nature and extent of harm/gender and age of victim where appropriate)	
Brief description of the offender's relevant history (extent and nature of offending; compliance with supervision; discipline issues in custody)	
Is the incident is likely to attract local or national media interest? If yes, state why	Yes/No
Might this incident be subject to a MAPPA significant case review?	Yes/No/Not known
Are there charges pending against the offender or, if deceased, against alleged perpetrator?	Yes/No/Not known
Date of submission of completed review. If the review cannot be submitted within 3 months state why (not relevant for incidents subject to a MAPPA significant case review)	
Name and designation of person submitting initial report	
Date signed	
Name and designation of senior manager signing-off notification	
Date signed	

Care Inspectorate ref. no:

Appendix 3

Serious incident reviews: review report

Section 1 – Initial analysis	
Name of offender	
Offender's d.o.b.	
Basis of review (records read/individuals interviewed/by whom)	
On the basis of the above information did you conclude that a comprehensive review of this incident was necessary? If no, state why and complete only sections 1, 4 and 6[3]	Yes/No

Section 2 - Comprehensive review	
Did you compile a chronology of key events? If no, state why. If yes, attach as an appendix.	
Is this a single agency or multi-agency chronology?	Single/multiagency/not applicable
From your review of available information what did you conclude about assessment, risk assessment and planning for this offender? Were these up-to-date and of good quality? If risk assessment tools had been used did they meaningfully inform the assessment and risk management plan?	
What did you conclude about the intervention provided for this offender? Did it deliver what the risk management plan said it would? Was the level and type of intervention what you might reasonably have expected?	
What did you conclude about management of any non-compliance by the offender?	

[3] Note – all review reports must be signed off by the local authority's head of criminal justice services or chief social work officer.

What did you conclude about the quality of partnership working to assess and manage the risks/needs of this offender? Was routine contact maintained with other relevant agencies?	

Section 3 Action plan to address areas for improvement			
Issue	Action	Timescale for completion	Lead individual

Section 4 Good practice [4]	
Did you identify any areas of good practice that could be disseminated more widely? If so, please describe	

Section 5 National issues	
Did you identify any areas for development that require a national approach? If so, please specify	

Section 6	
Name and designation of person responsible for compiling the review	
Signature of person responsible for compiling the review	
Date signed	
Name and designation of senior manager signing off the review	
Signature of senior manager signing off the review	
Date signed	

- [4] By good practice we mean:
- Sector leading practice that other local authorities could learn and benefit from
- Innovation and promote improvement
- where the practice has had a positive outcome on people who use services, staff and/or partners

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Appendix 4

Serious incident reviews: Notification

Name of offender	John Jones
Offender d.o.b.	21.07.94
Name of responsible local authority	Somewhere in Scotland
Date of incident	1 April 2016
Type of supervision/statutory order offender subject to	Community Payback Order
Date statutory order imposed/date of release from custody on statutory supervision	20 January 2016
Current whereabouts of the offender	Deceased
Brief description of incident (nature and extent of harm/gender and age of victim where appropriate)	John was found dead in his room in a hostel during a routine health and safety check. A tourniquet was tied around his arm and it was assumed he had dies of a drug overdose. A post-mortem examination has since confirmed this and police investigations indicate there were no suspicious circumstances. It is not yet clear from the Crown Office whether his death will be the subject of a Fatal Accident Inquiry.
Brief description of the offender's relevant history (extent and nature of offending; compliance with supervision; discipline issues in custody)	John first became known to the Social Work Department in 2009 and was made subject to a S.70 supervision requirement for drug misuse, which included heroin and valium. Despite support, he continued to misuse drugs and family relationships suffered. He was sentenced to a 1 year Probation Order for theft in September 2010 but breached this as a result of further theft offences and remanded in custody. He was then sentenced to his current CPO which also included a drug treatment requirement. He had missed several appointments on the current order and was issued with formal, written warnings for two but not the third. In supervision, he was ambivalent about his drug use and tried to address it but struggled to maintain motivation in the longer term. He had a network of friends who also misused drugs.
Is the incident is likely to attract local or national media interest? If yes, state why	No
Might this incident be subject to a MAPPA significant case review?	No
Are there charges pending against the offender or, if deceased, against alleged perpetrator?	No

Date of submission of completed review. If the review cannot be submitted within 3 months state why (not relevant for incidents subject to a MAPPA significant case review)	1 June 2016
Name and designation of person submitting initial report	Simon Smith, Service Manager
Date signed	2 April 2016
Name and designation of senior manager signing-off notification	Jane Jennings, Head of Service
Date signed	2 April 2016

Care Inspectorate ref. no:

Appendix 5

Serious incident reviews: review report

Section 1 – Initial analysis	
Name of offender	John Jones
Offender's d.o.b.	21.07.94
Basis of review (analysis of notification, files read/individuals interviewed)	File reading Interview with Social Worker Interview with Team Manager Liaison with Substance Misuse Services
On the basis of the above information did you conclude that a comprehensive review of this incident was necessary? If no, state why and complete only sections 1,4 and 6	Yes

Section 2 - Comprehensive review	
Did you compile a chronology of key events? If no, state why. If yes, attach as an appendix.	Yes
Is this a single agency or multi-agency chronology?	Single
From your review of available information what did you conclude about assessment, risk assessment and planning for this offender? Were these up-to-date and of good quality? If risk assessment tools had been used did they meaningfully inform the assessment and risk management plan?	There was an up-to-date and comprehensive risk assessment using an appropriate risk assessment tool and leading to a focused risk management plan addressing all identified risk factors.
What did you conclude about the intervention provided for this offender? Did it deliver what the risk management plan said it would? Was the level and type of intervention what you might reasonably have expected?	The intervention reflected the risk assessment and risk management plan, with a level of contact in accordance with National Outcomes and Standards. Supervision sessions were focused on the key issue of substance misuse and adopted motivational interviewing and harm reduction techniques. The offender had also been referred to substance misuse services and was attending appointments. Following an initial assessment, he had been prescribed methadone. However, it was also suspected that he continued to use heroin.
What did you conclude about management of any non-compliance by the offender?	He had appropriately been issued with an initial and a final written warning for two missed appointments for which he had been unable to provide a reasonable excuse. However, he had also missed a third appointment and despite there being no reasonable excuse on this occasion as well, breach proceedings had not been instigated.

What did you conclude about the quality of partnership working to assess and manage the risks/needs of this offender? Was routine contact maintained with other relevant agencies?	There was good information sharing between CJSW and substance misuse services, in terms of initial assessments and attendance at and responses to weekly appointments.

Section 3 Action plan to address areas for improvement			
Issue	**Action**	**Timescale for completion**	**Lead individual**
Enforcement	Reissue guidance to CJSW staff	April 2016	Service Manager
	Continue audits including focus on enforcement	Quarterly	Team Manager
	Provide advice to Social Worker	April 2016	Team Manager

Section 4 Good practice	
Did you identify any areas of good practice that could be disseminated more widely?[5] If so, please describe	No

Section 5 National issues	
Did you identify any areas for development that require a national approach? If so, please specify	No

Section 6	
Name and designation of person responsible for compiling the review	Simon Smith, Service Manager
Signature of person responsible for compiling the review	
Date signed	20 April 2016
Name and designation of senior manager signing off the review	Jane Jennings
Signature of senior manager signing off the review	
Date signed	20 April 2016

[5] Credible and of national relevance; validated as sector leading; capable of replication; leading to improved outcomes; still operational or have been time-limited by design, for example for a specified period to address a particular issue.

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