care inspectorate

Criminal Justice Social Work

Serious Incident Reviews

National report on notifications submitted between January 2018 and December 2021

HAPPY TO TRANSLATE

Contents

Foreword

The Care Inspectorate is the independent scrutiny body responsible for regulation, inspection and improvement of social care and social work, including justice social work. Where a person is subject to social work supervision following release from prison or subject to a community order, there is, rightly, intense public interest in the quality of the social work service they receive.

This report provides detail and highlights learning from serious incidents notified to the Care Inspectorate between January 2018 and December 2021. The purpose of the report is to update the public, inform policy and practice and to support those working in social work services.

Justice social work services supervise and support many people who have committed a wide range of offences. Fortunately, serious incidents involving people who receive a service are relatively low. When they do occur, there is an expectation that the responsible local authority notifies the Care Inspectorate and carries out a serious incident review in order to examine the circumstances and use any learning to improve practice and processes. 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 quality assures the submitted serious incident reviews and works with local authorities to ensure they are reviewed well and the important learning has occurred.

An increased number of local authorities submitted notifications during this reporting period. Nevertheless, achieving consistent and accurate reporting of serious incidents remains a challenge. We rely on local authorities following the guidance and notifying us every time a serious incident comes to their attention.

We recognise the complex and difficult circumstances that justice social work services experienced during the Covid-19 pandemic. The production of this report was also impacted by the pandemic and staffing changes within the Care Inspectorate. As a result, the biennial report was not published in 2020 as originally intended. This report therefore covers an extended reporting period.

We have developed new case review and reflective learning review tools to strengthen the serious incident review process and support continuous improvement. We are committed to working with local authorities and justice partners to embed our revised serious incident review guidance published in May 2022 to achieve consistent reporting of serious incidents nationally. This will include regular updates to local authorities and justice partners to support dissemination of learning and to highlight the value of reporting serious incidents.

We would like to take this opportunity to thank all the local authorities who undertook serious incident reviews during the period of this report.

Edith Macintosh

Interim Chief Executive

Progress made on 2018 recommendations

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

Progress made: There has been an improvement in the number of local authorities submitting notifications.

Recommendation: 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.

Progress made: There has been a consistent improvement in the overall quality and analysis of serious incidents, particularly comprehensive reviews. However, ensuring a sufficiency of relevant detail within serious incident reviews, particularly initial analysis reviews, remains an area for improvement.

Recommendation: We will explore meeting the required notification timescale with the Social Work Scotland standing committee and Scottish Government and agree further action that may be required.

Progress made: Challenges remain in notifications being made within five working days of a serious incident. This remains an area for improvement.

Note: The timescale has been reviewed. No change has been made to our revised guidance as it is important that learning takes place as soon as a serious incident occurs.

Recommendation: 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.

Progress made: The percentage of serious incident reviews submitted to the Care Inspectorate within the three-month timescale increased from 51% in 2018 to 77% in 2021.

Introduction

This report provides details on notifications of serious incidents made to the Care Inspectorate by local authority justice social work services during the period January 2018 to December 2021. It outlines our analysis of the quality of serious incident reviews. It also explores what this tells us about practice by local authority staff with responsibilities for the effective management of people on community orders or subject to supervision in the community following release from prison. It considers how well local authorities adhere to the agreed notification processes outlined within national guidance for serious incident reviews.

The aim of serious incident reviews is to provide assurance that serious incidents are thoroughly investigated when they occur and that the lessons learned inform and improve future practice. Responding to serious incident reviews is one of the ways in which the Care Inspectorate supports improvement in the quality of justice social work services.

Background to serious incident reviews

The Care Inspectorate assumed responsibility for the oversight of learning from serious incident reviews when it was established in 2011. The function is underpinned by the Care Inspectorate's statutory duties under the Public Service Reform (Scotland) Act 2010. We developed national guidance for serious incident reviews in partnership with the Scottish Government and Social Work Scotland. The guidance outlines what is expected of local authorities when a serious incident comes to their attention.

The reporting of serious incidents currently pertains to people who have received a final disposal from court following conviction. This includes people made subject to the various requirements of a community payback order or a drug treatment and testing order. It also relates to everyone released from custody subject to statutory social work supervision. Guidance on the management and delivery of these orders and licences is contained within a variety of national outcomes and standards.

Practice standards support an increasing range of justice social work services such as bail supervision, structured deferred sentences and diversion from prosecution. These services are not included within the serious incident review guidance at this time. We will review this position with justice partners as these services develop nationally.

Basis of report

The governance arrangements for justice social work services are set out in legislation[1]. In most areas, services are delivered and overseen by the local authority. However, in some areas, justice social work services are integrated within the health and social care partnership, overseen by the integration joint board (IJB). For the purposes of this report, when we use the term 'local authority', it also covers justice social work services that are delivered as part of an integrated service.

[1] Social Work (Scotland) Act 1968, Criminal Justice (Scotland) Act 2003, Community Justice and Licensing (Scotland) Act 2010, Public Bodies (Joint Working) (Scotland) Act 2014.

In 2019 – 2020[2], a total of 16,800 community payback orders and 516 drug treatment and testing orders were imposed by Scottish courts. The most recent 2020-2021 Scottish Government statistics[3] demonstrate the impact of the pandemic. As expected, there were substantial reductions for each disposal; 8,169 community payback orders and 225 drug treatment and testing orders. As at March 2021, justice social workers across Scotland were supervising 2,236 people who had been released from prison on throughcare licence. Guidance on the management and supervision of these orders and licences is contained with national outcomes and standards[4]. The Care Inspectorate refers to, and considers compliance against, these standards when analysing the overall quality of serious incident reviews submitted by local authorities.

This report relates to notifications made to the Care Inspectorate in accordance with our serious incident review guidance, May 2017[5]. This report is unlike previous reports as the period considers serious incident reviews over two pre-pandemic years – 2018 and 2019, and two years impacted by Covid-19, 2020 and 2021.

Impact of Covid-19

The pandemic resulted in significant disruption for the entire criminal justice system and impacted on the delivery of justice social work services. As can been seen in Table 1 below, there was a slight reduction in notifications during 2020 and a more significant reduction in 2021 when the lasting impact of the pandemic was more evident.

Faced with responding to national changes in legislation and local public health requirements, services managed competing demands within tight timescales. As a result, we allowed greater flexibility in the timescales for notifications and submission of serious incident reviews. It is worth noting that despite services being given greater flexibility in submission timescales during the first two years of the pandemic, in year one (2020) 64% of submitted reviews were within expected timescales. This improved further in 2021, with 77% of submissions received within the expected three months. Where local authorities required additional time to submit reviews, 78% were submitted within one month of the expected date.

This flexibility has now ceased and there is an expectation that notifications and submissions are now made in accordance with our revised serious incident review guidance, published in May 2022.

[2] Criminal justice social work statistics: 2019 to 2020 - gov.scot (www.gov.scot)
[3] Criminal Justice Social Work Statistics in Scotland: 2020-21 - gov.scot (www.gov.scot)

[4] Scottish Government collection of justice social work guidance

[5] Care Inspectorate Serious incident review guidance, May 2017

Section 1 - Serious incident notifications

A serious incident[6] is:

> '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.'

The serious incident review guidance, May 2017 informs this reporting period, stating that the Care Inspectorate should be notified in the following circumstances:

- an individual on statutory supervision or licence is charged with and/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 and/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.

Most of the notifications received during this reporting period related to the first category. A much smaller number of notifications related to the third category. As in previous reporting periods, there were no notifications for the second category. Concerns about professional and/or service involvement were routinely referenced within reviews. It is also expected that local authorities report significant concerns about professional practice to the Scottish Social Services Council (SSSC). A change in the wording of the criteria for a serious incident review to capture this position is reflected in the revised 2022 guidance.

Duty to notify the Care Inspectorate

Local authority justice social work services are expected to notify the Care Inspectorate within five working days of a serious incident occurring.

The local authority then conducts an initial analysis review (IAR). Based on the information obtained from undertaking the initial analysis review, local authorities then decide whether the initial analysis review is sufficient. If not, they undertake a more detailed comprehensive review of circumstances. Local authorities then submit the completed review of the serious incident review to the Care Inspectorate within three months from the date of the initial notification.

An initial analysis review is generally sufficient when there is clear evidence that:

- risk assessments and case management plans were up to date and implemented
- an appropriate level of contact between justice social work staff 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.

[6] Framework for Risk Assessment and Management Evaluation: FRAME, RMA (2011)

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

The Care Inspectorate assures the quality of serious incident reviews by looking at how they were conducted and whether they were carried out in a robust manner. We then write to local authorities with our comments. The feedback provided recognises strengths in the quality assurance approach and/or highlights where there is scope to improve the quality of a review.

Number of serious incident notifications

Between 1 January 2018 and 31 December 2021, the Care Inspectorate received 317 notifications that a serious incident had occurred.

There was a year-on-year increase in the two years of pre-pandemic reporting, from 72 notifications from 17 local authorities in 2017 (as reported previously) to 93 notifications from 19 local authorities in 2019. This improvement coincides with the establishment of our strategic justice team, the introduction of formal scrutiny and a higher profile to assuring justice social work practice.

This reduced to 86 notifications from 18 local authorities in 2020. The impact of the pandemic was most notable in 2021, with 62 notifications received from 17 local authorities. It is expected that as justice social work services return to more normal working, our revised serious incident review guidance published in May 2022 will be used to support improved and consistent reporting of serious incidents.

Notifications by area

Of the 32 local authorities in Scotland, 26 submitted at least one notification during the reporting period. This was a slight overall improvement in the number and geographical spread of notifications.

As can be seen in table 1 below, four local authorities submitted three or fewer notifications between 2018 and 2021. A further six areas did not submit a notification during the reporting period. Of those six areas, three have never submitted a serious incident notification.

Table 1. Notifications submitted by local authority area between 2018 and 2021

Local authority	Jan 2018 – Dec 2018	Jan 2019 – Dec 2019	Jan 2020 - Dec 2020	Jan 2021- Dec 2021	Total
Aberdeen City	3	8	6	3	20
Aberdeenshire	0	1	4	0	5
Angus	4	0	1	0	5
Argyll and Bute	0	0	0	0	0
Clackmannanshire	0	2	0	5	7
Dumfries and Galloway	4	0	0	4	8
Dundee City	1	4	3	1	9
East Ayrshire	0	0	0	0	0
East Dunbartonshire	0	0	3	1	4
East Lothian	0	4	0	0	4
East Renfrewshire	0	0	0	0	0
City of Edinburgh	10	5	9	11	35
Falkirk	1	1	0	0	2
Fife	1	1	5	1	8
Glasgow City	15	14	13	12	54
Highland	4	0	1	1	6
Inverclyde	4	2	0	2	8
Midlothian	0	7	2	2	11
Moray	0	0	0	0	0
North Ayrshire	3	3	0	2	8
North Lanarkshire	5	5	8	2	20
Orkney Islands	1	0	0	0	1
Perth and Kinross	0	3	3	0	6
Renfrewshire	8	13	4	3	28
Scottish Borders	0	2	2	0	4
Shetland Islands	0	0	0	0	0
South Ayrshire	3	1	3	0	7
South Lanarkshire	5	4	3	4	16
Stirling	1	0	0	1	2
West Dunbartonshire	0	0	3	0	3
Western Isles (Comhairle nan Eilean Siar)	0	0	0	0	0
West Lothian	3	13	13	7	36
TOTALS	**76**	**93**	**86**	**62**	**317**

Type of serious incident resulting in notification

Local authorities advise the Care Inspectorate of the type of serious incident that resulted in a notification as well as the type of order or licence the person was subject to at the time of notification.

During the reporting period (January 2018 to December 2021) most notifications related to alleged acts of violence such as murder, attempted murder and serious assault. Notifications also included instances where the person receiving a justice social work service had either been murdered or seriously harmed because of violence.

A total of 85 notifications related to sexual offences. At 27% of all notifications, this was a slight increase from the previous reporting period. This reflects national crime trends.

Table 2. Type of serious incident resulting in notification

Type of serious incident	Jan 2018 – Dec 2018	Jan 2019 – Dec 2019	Jan 2020- Dec 2020	Jan 2021 – Dec 2020	Total
Category 1					
Serious assault: includes assault to severe injury, and assault with elements of endangerment to life, carrying offensive weapon, robbery and attempt to rob	19	23	24	22	88
Sexual offences: these include different types of sexual offences including rape and sexual assault	17	24	25	17	83
Attempted murder (perpetrator)	9	12	8	11	40
Murder (perpetrator)	9	11	7	5	32
Assault	2	4	7	0	13
Abduction	0	2	0	0	2
Attempted extortion	0	1	0	0	1
Possession of Indecent Images of Children (IIOC)	0	1	1	0	2
Possession of a firearm	0	1	2	0	3
Domestic abuse	0	0	1	0	1
Terrorism offences	0	1	0	0	1
Culpable and reckless conduct	0	1	0	0	1
Other offence	0	0	0	1	1
Category 3					
Attempted murder (victim)	0	1	1	0	2
Murder (victim)	2	4	4	1	11
Deceased: includes death by natural causes, death by accident, unexplained death (often described as potentially drug related)	17	6	6	5	34
Suicide	1	1	0	0	2
TOTALS	**76**	**93**	**86**	**62**	**317**

Type of order or licence at time of notification

Of the 317 notifications received, 245 (77%) related to people subject to the various requirements of a community payback order, primarily supervision and/or unpaid work. This was proportionate when compared to the overall national figure as the majority of people subject to a statutory justice social work service in Scotland are on a community payback order. A much smaller number of people are subject to the conditions of a throughcare licence. This was reflected in the notifications, with 64 of 317 (20%) related to people subject to supervision following release from prison.

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

Type of licence/supervision at date of notification	Jan 2018 – Dec 2018	Jan 2019 – Dec 2019	Jan 2020- Dec 2020	Jan 2021 – Dec 2021	Total
Community payback order	57	68	73	47	245
Non-parole licence	2	8	3	1	14
Supervised release order	3	5	5	8	21
Extended sentence	6	4	1	1	12
Drug treatment and testing order	4	1	2	0	7
Life licence	2	3	1	1	7
Parole licence	2	1	1	0	4
Short sex offender licence	0	0	0	2	2
Other		3		2	5
TOTALS	**76**	**93**	**86**	**62**	**317**

Death of a person receiving a justice social work service

In our serious incident review guidance, May 2017, the third criteria for a serious incident review relates to a person subject to a relevant order or licence dying or being seriously injured 'in circumstances likely to generate significant public concern'. Following feedback from the sector, this wording has been amended in our revised 2022 guidance to better reflect the circumstances in which a notification may be required.

During the reporting period, a total of 49 notifications were received under the category three criteria. In 11 instances, the person receiving a service was a victim of murder. The remaining notifications related to suspected drug-related issues and suicide. The year-on-year reductions in notifications from the previous reporting period coincided with a Care Inspectorate screening process aimed at ensuring notifications met the criteria for a serious incident review. It cannot be known whether this is the sole reason for a reduction in notifications.

The reporting of deaths within a justice context is complex. Local authorities use several processes to record and report when a person receiving a justice social work service in the community has died. These include the annual statistical return to Scottish Government, reporting of suspected drug related deaths, reporting the death of a young person in continuing care and reports to inform local area suicide prevention action plans. Further research may therefore be required before any meaningful conclusions can be drawn.

Section 2 - Notifications that proceeded to a serious incident review

Local authorities are expected to notify the Care Inspectorate within five working days of a serious incident occurring. Achieving this timescale remains a challenge, with under half of notifications each year of the reporting period made within five working days. Delays in notifying were often due to the matter only coming to the attention of the service at a later date. For example, when a person receiving a service appeared in court or disclosed information to a worker.

Of the 317 notifications received by the Care Inspectorate, 300 proceeded to a serious incident review. The 17 that did not proceed did not meet the criteria. In the majority of instances (225), an initial analysis review (IAR) was considered sufficient. A comprehensive review was undertaken for the remaining 75 notifications.

Over the reporting period, there was an improving trend in the percentage of reviews submitted within the three-month timescale, increasing from 51% in 2018 to 77% in 2021. This was despite us allowing greater flexibility in reporting timescales during the Covid-19 pandemic. This was a significant improvement that demonstrated the priority afforded to serious incident reviews by local authorities.

Section 3 - What serious incident reviews tell us about practice

Justice social work services play a crucial role, often working in collaboration with others, in managing or attempting to reduce the risk of serious harm a person poses when in the community. However, risk can never be completely known or eradicated. There are therefore instances when a serious incident occurs.

While the number of notifications received by the Care Inspectorate is significant, serious incidents occur in less than 1% of the overall number of court orders and throughcare licences imposed each year. Nevertheless, given the seriousness and potential impact of each occurrence, it is important to understand why an incident took place. Serious incident reviews provide a consistent framework to enable local authorities to examine the quality of practice and adherence to legislation and national guidance. Reviews should focus on learning and reflection around day-to-day practices and processes, and the systems within which they operate. They assist in identifying relevant learning and areas for improvement. The process is intended to contribute to a culture of continuous learning to strengthen practice.

The detail contained within the serious incident reviews submitted to the Care Inspectorate by local authorities provides a useful indication of the efficiency and effectiveness of justice social work practice.

Assessment and management

Justice social workers are trained in the LS/CMI method of assessing risk and need. Such assessments help to inform decisions when someone appears in court or is preparing to be released from prison. The comprehensive assessment then informs the formation of a case management or risk management plan to meet the identified risks/needs and to direct resources accordingly. Workers are also required to use the electronic LS/CMI system to record assessments and plans. The system enables transfer of information between local authorities and prisons and supports the consistent application of the LS/CMI method.

While LS/CMI is the main method of assessment, additional, specialist assessments are also used to inform decisions and actions. Tools such as Stable and Acute 2007 and Risk Matrix 2000 are used to assess the risk posed by people convicted of sexual offences. Assessments such as the Spousal Assault Risk Assessment is used by many areas to assess the risk posed by people convicted of domestic abuse offences.

Reference was made to appropriate assessments being undertaken in almost all (91%) serious incident reviews. This was a clear strength and a significant improvement on the previous reporting period.

Specific reference to LS/CMI related information was often more challenging. For example, in almost half of serious incident reviews, there was insufficient detail on whether assessments had been completed within expected timescales[7]. Similarly, in just under half of relevant instances, detail was limited on whether the LS/CMI assessment was available to community-based social workers when someone was released from prison.

[7] We recognise the impact of two years of Covid-19 on overall justice practice and the impact on maintaining expected timescales.

Ensuring a case/risk management plan is in place and commenting on its effectiveness is an essential element of analysis within serious incident reviews. Serious incident reviews referred to case/risk management plans being in place when required in just 84% of cases. Reference to appropriate provision of interventions was made in 89% of instances.

Better reference to, and analysis of, LS/CMI-related data is required within serious incident reviews. The LS/CMI database system has recently been centralised. A national review of some aspects of the system is also ongoing. Both developments may offer opportunities to enhance the ability of local authorities to extract the necessary data from the system to support quality assurance and continuous improvement. The new templates within our revised serious incident review guidance published in May 2022 are intended to specifically address the issues noted.

Compliance

In the context of justice social work, compliance relates to whether a person fulfils the requirements of a community order or the conditions of a throughcare licence. This includes undertaking regular unpaid work and/or attending appointments with a supervising social worker. It may also involve the person working with another agency to address the issues which contributed to their offending.

In 74% of serious incident reviews, local authorities noted non-compliance as an issue. This often related to the person's failure to attend supervision appointments, statutory review meetings, to engage with drug and alcohol services or unacceptable behaviour at unpaid work. It was encouraging to note that non-compliance had either been completely or mostly addressed by the supervising social worker in the majority of instances. Where responses to non-compliance were less robust, the issue was identified within the review and appropriate actions either identified and/or taken to improve practice.

Partnership working

Effective social work practice necessitates close collaboration in the management of risk and provision of interventions to support desistance from offending. In some instances, such as the supervision of people convicted of sexual offences, it is crucial for supervising social workers and their police colleagues to liaise and share information. Justice social workers often maintain close links with health and alcohol/drug services, housing providers and third sector agencies. Similar to the previous reporting period, serious incident reviews highlighted that supervising social workers worked effectively with relevant partner agencies in most cases.

Of the 300 notifications that progressed to a serious incident review, 50 related to people managed within MAPPA (Multi-Agency Public Protection Arrangements)[8].

Serious incident reviews and MAPPA review processes serve similar but distinctive purposes. Serious incident reviews support local authorities to identify learning about

[8] Supporting documents - Multi-Agency Public Protection Arrangements (MAPPA): national guidance - gov.scot (www.gov.scot)

the quality and effective delivery of practice in situations where someone subject to a statutory order or licence has caused or been subject to serious harm.

The purpose of a MAPPA review explicitly extends beyond the local authority to examine whether responsible authorities have applied MAPPA arrangements and effectively worked together. MAPPA guidance sets out the responsibilities of partner agencies when a relevant person becomes involved in a serious incident and when a MAPPA significant case review may be required. When a serious incident occurs in respect of a person 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.

To clarify and simplify the interface of serious incident reviews and MAPPA initial case reviews (ICRs), our revised serious incident review guidance (May 2022) outlines a revised process to help avoid confusion or duplication. Serious incident reviews will only be completed where the case does not proceed to a MAPPA initial case review, or the local authority believes there may be additional learning from undertaking a serious incident review following an initial case review. No serious incident review will be required where the case progresses to a serious case review.

Contact during Covid-19

In response to emergency legislation and public health directives, justice social work services adapted service delivery. Local authorities used a risk-based approach to prioritise and inform service delivery decisions. Contact with people on orders and licences was maintained through a combination of socially distanced, office-based interviews, telephone/electronic contact and home visits. In many instances, local authorities provided people receiving a service with telephones and/or equipment to enable remote contact.

There were examples of justice social work services experiencing significant challenges in maintaining meaningful and regular contact with people receiving a service, many of whom experienced chaotic and disrupted lives. In the majority of serious incident reviews submitted during the pandemic, the type, frequency and intensity of contact was commensurate with the person's assessed risk of causing serious harm. In a small but significant minority of serious incident reviews, local authorities identified areas for improvement. These related to prioritising home visits in response to escalating concerns and ensuring sufficient staffing capacity to avoid lengthy gaps in the frequency of contact.

Section 4 - Embedding a learning culture

Performance and quality

In quality assuring all serious incident reviews submitted to the Care Inspectorate, we found that 73% of initial analysis reviews (IARs) and 87% of comprehensive reviews were appropriately analytical. In terms of overall quality, comprehensive reviews were superior with almost all (93%) being of sufficient quality compared to 68% of initial analysis reviews. This often reflected greater attention to detail within comprehensive reviews and the experience of the reviewers. Local authorities who routinely submit serious incident reviews often demonstrate excellence in the quality of analysis and critical reflection to support improvement.

Serious incident reviews were less useful in supporting learning and were of a lesser quality when they were perfunctory or overly descriptive. When key issues were not clearly identified, or insufficient detail was provided, we asked for further information or gave a reminder to include such detail in future reviews. During the reporting period, we sought additional detail on 34 occasions. Seeking additional information causes additional work for the local authority and potentially extends the process.

Almost all serious incident reviews were undertaken by a justice social work manager. All relevant staff, including the supervising social worker and first line manager, were included in almost every instance. Almost all notifications (97%) were appropriately countersigned by a justice social work manager. A similarly high percentage (93%) was appropriately countersigned by a senior manager or chief social work officer. This operational and strategic oversight provided assurance that local authorities were aware of the relevant practice and learning issues to inform continuous improvement.

National Outcomes and Standards

In most serious incident reviews, the local authority had considered and specifically analysed whether their practice was in accordance with the expectations of national outcomes and standards.

In some instances, the review concluded that the efficiency or effectiveness of the service provided was not as good as it could have been. As a result of thorough analysis and reflection within reviews, local authorities often identified key areas for improvement. These related to completing case management tasks within expected time scales, undertaking home visits and the scheduling of social work progress reviews. There was also a recognition of the importance of avoiding drift by taking timely disciplinary action or returning orders to court/taking breach action at an earlier stage.

Local authorities did not submit notifications under category two, which relates to significant concerns about standards of professional practice. Nevertheless, serious incident reviews routinely considered and commented on practice-related issues. Where relevant, managers identified issues where practice or timeliness of responses had been lacking. Improvement plans included appropriate actions to promote training for individual members of staff, teams and/or to strengthen processes.

When a person is subject to statutory social work supervision, the progress of the case management plan must be regularly reviewed by services at key stages and in

accordance with national outcomes and standards. In the previous report, almost all relevant submissions to the Care Inspectorate evidenced that progress reviews had taken place and were within required timescales. For both pre-pandemic years of this reporting period, there was a reduction, with 84% of serious incident submissions indicating that progress had been reviewed. There was a further dip during the first year of the pandemic (2020), with some recovery to the pre-pandemic level in 2021. The most common reason for a review not taking place as expected related to failure of the person to attend as required. Where the issue was within the control of the service, this was acknowledged as an area for improvement within serious incident reviews and an action plan put in place to improve practice.

Good practice

Serious incident review guidance outlines criteria and provides space within the template to highlight examples of good practice. This is defined as particularly innovative or sector-leading practice that other local authorities could learn and benefit from.

Despite a serious incident occurring, reviews can usefully reflect on strengths in practice or partnership working. While a small number of serious incident reviews noted examples of good practice, these did not always meet the criteria set out in the guidance. There was sometimes a tendency to conflate routine practice that would be expected in accordance with national outcomes and standards as an example of particularly good practice. As we work with local authorities and Social Work Scotland to embed our revised serious incident review guidance (May 2022) there will be opportunities to discuss this issue in greater detail.

Local authorities identified issues of national relevance or significance in just 9% of reviews. The consistent themes related to the complexity of cross-border supervision, sharing of information and the limitations of some legislation.

Under-reporting

The circumstances that necessitate a notification (a serious incident) are hard to predict. However, there are significant differences in notifications across local authorities, even where there are similar proportions of people subject to statutory orders and licences. The notification figures outlined in this report continue to indicate a degree of under-reporting of serious incidents. While some local authorities maintained a consistent rate of notifications and compliance with the serious incident review guidance, some areas are not reporting consistently or are not reporting serious incidents when they should. As noted in previous reports, this indicates that some local authorities are yet to implement an effective process to identify, review and learn from serious incidents. As a result, our understanding of practice across the country is incomplete.

As well as promoting adherence to guidance we support and encourage an appropriate level of notification and review of serious incidents to increase opportunities for learning and improvement. It is important that we can build a national picture of the level of serious incidents, how these are responded to and what can be learned from them to support improvements in practice.

We will continue to liaise with local authorities to further strengthen the understanding of, and compliance with, the serious incident review process. The

ongoing review of serious incident review notification data and the quality of serious incident reports will inform our deliberations and decisions regarding future scrutiny of justice social work.

Care Inspectorate performance

The previous serious incident review guidance (2017) required the Care Inspectorate to notify the Scottish Government within two days of receiving a notification. During the reporting period, this was achieved for all 300 notifications that met the criteria for a serious incident review.

In accordance with the guidance, we provided feedback on serious incident reviews to local authorities within the one-month timescale in 92% of instances. This was a significant improvement on the previous reporting period (80%). It reflects improved capacity within the Care Inspectorate team and increased ability to respond as a result of working remotely during the pandemic.

In responding to local authorities, we endeavoured to be more evaluative in our language when commenting on the quality of the review. We judged that we achieved this in most instances. Introduction of a new internal quality assurance process will further enhance our ability to produce consistent and meaningful feedback to local authorities on the robustness of their serious incident review process. In our next report, we will include specific feedback from local authorities based on their experience of embedding the revised serious incident review guidance.

The General Data Protection Regulations (GDPR) strengthens data protection for everyone. We reviewed our procedures and handling of personal data to enable the legal and proportionate sharing of information. As a result, we introduced new, anonymised templates within our revised serious incident review guidance published in May 2022.

Section 5 - Conclusion

This report informs the public and professionals by providing a national update on serious incident reviews submitted to the Care Inspectorate between 2018 and 2021. It highlights the necessity for all local authorities to follow the agreed guidance for reviewing serious incidents involving people receiving a justice social work service. When a serious incident occurs, every opportunity must be taken to review the circumstances. This includes the quality of the service provided and the level of compliance with national outcomes and standards for justice social work services.

The reflection and learning within serious incident reviews reinforced the value of national outcomes and standards. They remain important in supporting consistent practice against which performance can be measured and areas for improvement identified.

An increased number of local authorities submitted notifications during this reporting period. This indicated a willingness to use an independent review process to provide assurance that appropriate action had been taken in response to a serious incident. There are a number of local authorities that do not consistently report or have never submitted a serious incident review notification. In such instances, there is a need for local authorities to examine how well they are applying the serious incident review guidance. As we introduce and embed our revised 2022 guidance with local authorities, we will explore any potential barriers to the reporting of serious incidents.

There was a demonstrable improvement in the overall quality and analytical reflection within serious incident reviews, particularly comprehensive reviews. However, there was scope to improve the level of detail on core elements of practice. This requires local authorities to assure themselves on the timeliness of assessments, the quality of case management plans and the efficient transfer of information between prison and the community. The revised guidance and introduction of reflective learning review templates will assist local authorities in providing the necessary detail to ensure serious incident reviews are comprehensive and effectively support continuous improvement.

Key Messages

- There is an improvement in the number of local authorities that submitted a serious incident review. While this is encouraging, inconsistencies remain.

  Action: The Care Inspectorate will actively support local authorities to introduce and embed the introduction of our revised serious incident review guidance across Scotland.

- There is evidence of robust operational and strategic oversight by local authorities in almost all notifications and serious incident reviews submitted during this reporting period. This provides assurance that local authorities are aware of the practice and learning issues to inform continuous improvement.

- There is significant improvement in the percentage of serious incident reviews submitted to the Care Inspectorate within the expected three-month timescale. The timeliness of reviews enables learning to get back into the system more quickly to meaningfully support improvement.

- Local authorities reference the use of appropriate risk assessments in almost all serious incident reviews. There is a lack of specific detail in relation to some core elements of practice.

  Action: Local authorities need to make better reference to LS/CMI related data within serious incident reviews. Specifically, the timeliness of assessments, quality of case management plans and efficiency of transferring information between prison and the community. The new templates within our revised guidance ask specific questions on these elements of practice.

- A substantial number of serious incident review notifications are not made within five working days. This is often outside the control of the justice social work service.

  Action: The Care Inspectorate will actively monitor and provide regular updates to support improvement in the number of notifications submitted within expected timeframes.

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