care inspectorate

Justice Social Work

Serious Incident Reviews

National report on notifications submitted between 1 January 2022 and 31 March 2024

HAPPY TO TRANSLATE

Contents

Background

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.

This report provides details on serious incidents notified by local authority justice social work services to the Care Inspectorate during the period 1 January 2022 to 31 March 2024. The reporting period differs from previous reports. It has been changed to align with other Care Inspectorate quality assurance processes. Future reports will therefore relate to any serious incidents received during the financial year (April to March).

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

Practice standards support an increasing range of justice social work services such as bail supervision, structured deferred sentences and diversion from prosecution. As these services do not feature a conviction or final court disposal, they are not included within the serious incident review guidance at this time.

The aim of serious incident reviews is to provide assurance that incidents are thoroughly investigated when they occur. Analysis of reviews is one of the ways in which the Care Inspectorate supports improvement in justice social work services.

This report considers how well local authorities adhere to the agreed notification processes outlined within national guidance for serious incident reviews.

There are three components to a serious incident review.

- **Notification**: the local authority notifies the Care Inspectorate within five working days of becoming aware that a serious incident has occurred.
- **Case Review**: where the criteria for a serious incident review are met, the local authority has three months to carry out and submit a case review.
- **Reflective Learning Review:** where practice or service-related issues are identified within the case review, the local authority should also conduct and submit a reflective learning review. This identifies any contributing factors and includes an improvement plan outlining how the identified issues will be addressed.

Progress made from January 2018 – December 2021 report recommendations

Recommended actions

Action: The Care Inspectorate will actively support local authorities to introduce and embed the introduction of the revised serious incident review guidance, 2022 across Scotland.

Progress: Following publication of the refreshed 2022 guidance, the Care Inspectorate proactively offered follow-up sessions to interested local authorities. This was with a view to supporting use of the guidance. During this reporting period formal briefings were delivered across 13 local authorities, reaching approximately 130 justice social work staff. We also routinely responded to informal requests for clarification on various points within the guidance prior to notifications being submitted. Our commitment to delivering this support will continue.

Action: Better reference needs to be made 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.

Progress: Local authorities have made significant improvements in the attention paid to LS/CMI data within the analysis of serious incidents. This has been achieved in spite of the national LS/CMI system functionality issues experienced during this reporting period.

Feedback from local authorities confirms that the revised format of the serious incident review templates has supported this improvement.

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

Progress: Following introduction of the new guidance in May 2022 the process of the Care Inspectorate notifying the Scottish Government of every serious incident received ceased. An annual update was provided to the Scottish Government and justice social work leaders in May 2023. We aim to increase the frequency of updates to better align to our new financial year reporting structure.

Section 1 - Serious Incident Notifications

Refreshed Serious Incident Review Guidance and reporting templates were introduced during this reporting period. The guidance, published in May 2022, sets out the criteria and process for undertaking a serious incident review. The appendices include new notification, case review and reflective learning review templates for use by local authorities. These were also developed in consultation with local authority justice social work services, Social Work Scotland and the Scottish Government.

A serious incident[1] 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.'

The guidance states that the Care Inspectorate should always be notified in the following circumstances:

- a person on a statutory order 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 service involvement or lack of involvement
- a person on a statutory order or licence has died or been seriously injured in circumstances which indicate the need for public assurance.

Who is responsible for Serious Incident Reviews?

Local authority duty to notify the Care Inspectorate: Responsibility for completing a serious incident review lies with the local authority justice social work service responsible for supervision of a person's order or licence.

The process depends upon local authority justice social work services proactively undertaking reviews and sharing their analysis and learning with us. It requires a clear commitment to improving local practice and contributing to national learning.

Multi-agency partners: Where other agencies are involved in supporting the person receiving a service, it is good practice for the justice social work lead undertaking the serious incident review to consult with partner agencies. These views can then be included within the analysis. There may also be circumstances where a joint approach to undertaking a multi-agency review is required.

Where partners are involved, the local authority must make it clear that the outcome of their serious incident review will be submitted to the Care Inspectorate.

Care Inspectorate: The Care Inspectorate assures the quality of serious incident reviews. We consider how they were conducted and whether they were carried out in accordance with the serious incident review guidance. We then write to local

1 Framework for Risk Assessment, Management and Evaluation (FRAME), FRAME - RMA - Risk Management Authority

authorities with our feedback. Our comments recognise strengths in the approach to quality assurance and/or highlight where there is scope to improve the quality of a review. Supporting continuous improvement also involves us disseminating examples of good practice and identifying areas of national interest or concern.

It is not our role to comment on individual practice or staff management related issues. It is expected that local authorities report significant concerns about professional practice to the Scottish Social Services Council (SSSC).

Number of serious incident notifications

For this reporting period we received 133 new serious incident notifications. Seventy-two per cent of those notifications were submitted within five days of the justice social work service becoming aware of the incident, in accordance with the guidance. This is an area which continues to improve, and we are pleased that progress is being sustained in this regard.

The quality of notifications has also improved during this reporting period, with the general content better aligning to the national guidance. This improvement reflects the time taken by justice social work leads in pro-actively considering the relevant content for each serious incident. Informal enquiries to the Care Inspectorate also supported the reduction of inappropriate referrals, thereby avoiding unnecessary work for local authorities.

Only seven of the notifications received did not meet the criteria for a serious incident review. Where a notification does not meet the criteria, the local authority is not required to submit a case review to the Care Inspectorate.

A total of 126 notifications met the criteria and progressed to a case review. Of those, 18 are still in progress. The completed analysis presented in this report is therefore based on the 108 completed case reviews received.

Almost all notifications (94%) received were of a good quality and provided sufficiently detailed information to confirm the serious incident review criteria had been met. This greatly reduced the need to request additional information by comparison to previous reporting periods.

Notifications by area

The number of local authorities notifying the Care Inspectorate of a serious incident has remained consistent. A total of 18 local authorities submitted notifications during this reporting period.

Table 1. Notifications submitted by local authority between 1 Jan 2022 and 31 March 2024

Local Authority	1 January 2022 – 31 March 2023	1 April 2023 – 31 March 2024	Total
Aberdeen City	6	8	14
Aberdeenshire	3	2	5
Angus	2	1	3
Argyll and Bute	0	0	0
City of Edinburgh	14	11	25
Clackmannanshire	0	0	0
Comhairle nan Eilean Siar	0	0	0
Dumfries and Galloway	1	0	1
Dundee City	1	0	1
East Ayrshire	0	0	0
East Dunbartonshire	0	0	0
East Lothian	4	6	10
East Renfrewshire	0	0	0
Falkirk	1	0	1
Fife	4	0	4
Glasgow City	6	10	16
Highland	0	0	0
Inverclyde	1	2	3
Midlothian	2	0	2
Moray	1	0	1
North Ayrshire	0	0	0
North Lanarkshire	6	1	7
Orkney Islands	0	0	0
Perth and Kinross	0	0	0
Renfrewshire	4	8	12
Scottish Borders	0	0	0
Shetland	0	0	0
South Ayrshire	1	3	4
South Lanarkshire	5	2	7
Stirling	0	0	0
West Dunbartonshire	0	0	0
West Lothian	11	6	17
TOTALS	**73**	**60**	**133**

Type of serious incident resulting in notification: Local authorities advise the Care Inspectorate of the type of serious incident that resulted in a notification. During this reporting period most notifications related to alleged acts of violence such as murder, attempted murder, and serious assault.

Notifications are primarily reported under the category of the most serious offence, and therefore are listed as such in table 2.

Table 2. Type of serious incident resulting in notification

Type of Serious Incident	1 January 2022 – 31 March 2023	1 April 2023 – 31 March 2024	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	27	24	**51**
Sexual offences: contact sexual offences including rape and sexual assault	17	4	**21**
Sexual offences: non-contact sexual offences including possession of indecent images of children	0	1	**1**
Attempted murder (perpetrator)	14	19	**33**
Murder (perpetrator)	7	5	**12**
Assault	1	0	**1**
Abduction	1	3	**4**
Domestic abuse	0	1	**1**
Other offence	2	1	**3**
Murder (victim)	1	0	**1**
Deceased: includes death by natural causes, death by accident, unexplained death (often described as potentially drug related), suicide	3	2	**5**
TOTALS	**73**	**60**	**133**

MAPPA considerations: The 2022 guidance for serious incident reviews changed the process for notifying the Care Inspectorate and reviewing serious incidents in respect of people subject to Multi-Agency Public Protection Arrangements (MAPPA). The revised process is reflected within the Scottish Government Multi-Agency Public Protection Arrangements guidance published in March 2022.

The Care Inspectorate now only reviews MAPPA related serious incidents when the incident has not progressed to a MAPPA initial or significant case review. An exception to this general rule is when, following a MAPPA initial case review, the local authority determines there may be additional, service specific learning from

undertaking a serious incident review and submitting to the Care Inspectorate for additional, objective overview.

The change recognises that, while serious incident reviews and significant case reviews serve distinct purposes, they are both a means by which to scrutinise and quality assure serious incidents. Streamlining the notification process significantly reduced duplication of work for local authorities. As a result, there was an expected reduction in the number of MAPPA related notifications to the Care Inspectorate, with offences of a sexual nature (22) making up 17% of all notifications received.

Domestically aggravated offences

The updated templates within the 2022 guidance included the addition of a domestic abuse category of offence. This was done with a view to improving and refining the reporting of specific offence types. To date, this categorisation has rarely been selected. This is potentially due to the guidance asking that the most serious alleged offence is identified, such as an assault.

It is often only at the stage of a case review being submitted that the incidence of domestic abuse is fully apparent. In recognition of this issue, and to ensure the incidence of domestically aggravated offences were adequately captured, we undertook further analysis. We found that of the 108 reviews received, 23 (21%) related to domestic offences.

Local authority case reviews of these incidents confirmed that appropriate risk assessment approaches were undertaken in every instance. Most of the case reviews found risk assessments were also updated at appropriate and expected intervals. Multi-agency and responsible authority communication was considered effective in the majority of these case reviews.

The Care Inspectorate will continue to refine recording processes to capture the incidence of domestic offences.

Notifications of the death of a person receiving a justice social work service

The reporting of deaths within a justice context is complex. Local authorities use several processes to record and report the death of a person receiving a justice social work service.

These include annual statistical returns to Scottish Government, reporting suspected drug related deaths and reporting the death of a young person in continuing care. Local authorities also provide reports to inform local area suicide prevention action plans.

The third criteria of serious incident to be notified to the Care Inspectorate is when a person on a statutory order or licence has died or been seriously injured.

The wording of this category was refined in the 2022 guidance to better detail when a notification was required. The criteria requires that these notifications should be made when the incident has occurred in circumstances which indicate the need for public assurance. During this reporting period we received six such notifications.

Type of order or licence at time of notification

Local authorities also provide detail on the type of statutory social work supervision the person was subject to at the time of the serious incident notification. Of the 133 notifications received, 111 (84%) related to people subject to the various requirements of a community payback order, primarily supervision and/or unpaid work. This was proportionate, as most 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 also reflected, with 20 notifications 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	1 January 2022 – 31 March 2023	1 April 2023 – 31 March 2024	Total
Community payback order	57	54	111
Non-parole licence	1	0	1
Supervised release order	9	5	14
Drug treatment and testing order	2	0	2
Life licence	2	1	3
Parole licence	2	0	2
TOTALS	**73**	**60**	**133**

Section 2 - Serious Incident Case Reviews

Most case reviews (80%) were submitted within expected timescales. Most notably, there was significant overall improvement in the quality of serious incident case reviews. This included improved attention to detail, which reflected the revised guidance. There were only a few occasions where we needed to clarify or request additional information to conclude our quality assurance of the review.

Analysis of case reviews showed that local authority reviewers addressed the key questions within the proforma template. Responses to questions were mostly appropriately evidenced with targeted commentary and clear rationale.

Submitted case reviews reflected an improved focus on the quality of risk assessment, effectiveness of case management and consistency of quality assurance processes. Where issues were identified, proposed improvement actions were in the main appropriate and specific. This included identifying the need to progress to a full reflective learning review when required.

An area of improvement noted in the 2018 – 2021 national report on serious incident reviews required local authorities to better reference LS/CMI related data within their case review analysis. Significant improvement was also demonstrated in this regard during this reporting period. This was particularly notable, as the sector faced severe challenges in the use of the LS/CMI system during this period. The specific detail required within the revised serious incident review templates was also noted by local authority reviewers as helpfully focusing their attention to such detail.

Where chronologies were included with case review submissions, they were mostly useful and of an acceptable quality. The overall quality of chronologies would be improved by a clearer focus on historical and emerging factors about the person's circumstances and behaviour that might contribute to further offending.

For almost all (98%) of submitted case reviews, it was clear the review was undertaken by someone with an appropriate level of seniority, experience, and objectivity. A similarly high percentage of case reviews included evidence of senior management oversight with 92% of reviews co-signed by chief social work officers or other designated senior managers.

In a few instances the case reviews did not include confirmation of senior management oversight. In such circumstances this was mainly due to the relevant section of the template not being completed at the time of submission. The consistent oversight from senior leaders in local authorities is assuring and demonstrates a strong commitment to learning from each serious incident.

Reflective Learning Reviews

A reflective learning review (RLR) is undertaken when the case review identifies areas of practice that need further consideration. The RLR supports local authorities to identify the factors that contributed to areas of concern and the actions required to address them.

A reflective learning review was submitted with 21 case reviews (20%). In the main, the local authority decision to conduct an RLR was supported by evidence and an appropriate approach adopted. This indicated a focused commitment by local authorities to identify improvement actions.

The learning reflected factors identified in the course of the review and any agreed improvement actions tended to be well targeted, meaningful and within realistic timescales.

The reflective learning identified within a few of these case reviews reiterated the importance of:

- timely formal reviews
- dealing with compliance issues promptly
- being alert to escalation of risk at an early stage
- frequent and robust management oversight
- timely communication and avoidance of delays in sharing information between staff and partners.

There were a few instances where we identified issues that may have benefited from undertaking an RLR. Our responses to the local authorities highlighted how this could support identified improvements.

Section 3 - What serious incident reviews tell us about practice

Justice social work plays a crucial role in working to reduce the risk of harm a person poses to others, or to themselves, when in the community. However, risk is unpredictable and can never be completely known or eliminated.

Serious incident reviews provide a consistent framework for local authorities to examine the quality of practice and adherence to national guidance. Given the seriousness and potential impact of each occurrence, it is important to understand why an incident took place. Reviews should focus on learning and reflection around day-to-day practices and processes, and the systems within which they operate.

The detail contained within a serious incident review provides a useful indication of the effectiveness of justice social work practice. This assists in identifying relevant learning and areas for improvement.

Assessment and management

Justice social workers are trained in the use of the LS/CMI method of assessing risk and need. They are required to use the electronic LS/CMI system to record, monitor and update 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 are used by many areas to assess the risk posed by people convicted of domestic abuse offences.

Such assessments help to inform professional decision making, supporting the formulation of plans to meet identified risks and needs. Resources can then be directed accordingly when someone is subject to a court order or is preparing to be released from prison.

Our previous national reports on serious incident reviews highlighted the challenges in achieving sufficient specific reference to LS/CMI, other assessments and key stages in case management. We noted that better reference to, and analysis of, LS/CMI-related data was required within serious incident reviews.

The revision of our 2022 guidance set out specific questions to ensure attention was focused on assessment, case management and intervention proportionate to risk. This included more specific reference to the requirements of national outcomes and standards.

As noted earlier, it is encouraging to report that suitable reference was made to assessment and case management practice in almost all serious incident reviews received. This was a significant improvement from previous reporting periods.

This improvement allowed local authorities to better evaluate the quality and relevance of assessment and intervention. When local authorities identified that improvements were required, these were in the main addressed appropriately.

In the few instances where our quality assurance identified that the above areas of practice had not been analysed sufficiently, this was highlighted in our corresponding response to the relevant local authorities.

Partnership working

Effective social work practice necessitates close collaboration in the management of risk and provision of interventions to support desistance from offending. Justice social workers often maintain close links with health services, housing providers and third sector agencies. In some instances, such as the supervision of people convicted of domestic abuse or sexual offences, it is crucial for supervising social workers and their police colleagues to liaise and share information.

Our analysis of submitted case reviews highlighted that in the main, local authorities considered that relevant partner agencies worked together effectively. That said, there were important learning points identified within a few reviews relating to improving timely communication between agencies. This need was appropriately identified within reflective learning reviews and related improvement plans.

Section 4 - Embedding a learning culture

The serious incident review process is intended to contribute to a culture of continuous learning and to strengthen practice. Reviews submitted to the Care Inspectorate during this reporting period reflected a commitment from services to learning and improvement.

Good practice

The serious incident review guidance includes specific criteria for identifying innovative and sector leading practice. This relates to practice that is over and above national outcomes and standards, or what constitutes expected levels of day-to-day good practice.

A number of case reviews highlighted examples of very good standards of practice, delivered well. These included:

- additional staff resource to support people at times of transition, such as from custody to community and between young people's and adult services
- responsive internal and multi-agency case review processes implemented to address specific escalating risk or to review arising incidents.

Local authorities identified issues of national relevance in only a few reviews. These matters mainly related to the operational LS/CMI issues experienced during this reporting period. We know that this has been addressed nationally and the required solutions are in progress.

Although the issue did not feature prominently during this reporting period, the efficiency of cross-border transfer of orders remains an outstanding area of practice which would benefit from review.

Under-reporting

There are a number of local authorities who have not notified, or who report few, serious incidents. We recognise that serious incidents requiring review may not occur often in some areas. However, it remains a priority for local authorities with no or consistently low notifications to proactively assure themselves that staff are aware of the guidance and actively consider when a serious incident review may be required.

The Care Inspectorate will continue to liaise with local authorities to further strengthen the understanding of, and adherence to 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

In accordance with the guidance, the Care Inspectorate provides feedback on submitted case/reflective learning reviews within four weeks of submission. Where further information is required or where our capacity will impact on this timescale, we contact the local authority directly. During this reporting period we achieved feedback within expected timescales in almost all instances (90%). This is a slight reduction on the previous reporting period, and we are committed to improving these response times.

The revised serious incident review guidance included the introduction of a new standardised format for providing feedback to local authorities. The template supports us in delivering a consistent approach in how we convey our overall analysis of submissions. Feedback from local authorities indicates this approach is a welcome improvement.

Other review processes

The circumstances to which a serious incident review relates may also have been reported to the Care Inspectorate as part of another review process. For example, children and adult learning reviews, reporting of deaths of looked after children or incidents involving people living in regulated care establishments. This may have been identified to us within notifications or case review submissions. However, in the course of reviewing the submission we also cross-reference with other Care Inspectorate review and reporting processes.

Section 5 - Conclusion

This serious incident review reporting period reflects the impact of the changes made to the national serious incident review guidance. It also reflects the learning following the introduction of a suite of new templates. These developments have been well received and used by local authorities. The content of notifications and case reviews are more consistent, with greater attention being paid to the quality and use of risk assessment and case management.

The new reflective learning review process has also proven useful in supporting local authorities to consider issues in greater detail. This is particularly important when a need to strengthen elements of practice or partnership working is identified.

Many local authorities submit serious incident reviews of a consistently high standard. We appreciate the time and effort this involves and recognise the strength of commitment to continuous improvement and reflective learning. That said, there remain several local authorities who have yet to consistently report in accordance with local re-offending patterns. We will continue to engage with relevant local authorities with a view to identifying and removing barriers to reporting.

Key messages

- The revised guidance issued in 2022 has been well received. There is commitment from the majority of local authorities to use the new templates to structure their review and analysis of serious incidents.

- Reflective learning reviews are being used appropriately. Analysis is being used to identify areas for improvement and assign relevant, targeted actions.

- The number of local authorities recognising the need for a serious incident review, and notifying the Care Inspectorate, has remained consistent with previous years. However, there are still local authorities who have submitted no or consistently few notifications.

  Action: We recognise that incidents requiring review may not occur often in some areas. However, it remains a priority that all services are proactive in assuring themselves that staff are aware of the guidance and that submissions are proportionate to events.

  Action: The Care Inspectorate will continue to liaise with services to further strengthen the understanding of, and adherence to, the serious incident review process. This will include seeking assurance from respective services that serious incidents are being appropriately identified and reported.

- Serious incident reporting has highlighted the prevalence of domestically aggravated offences in patterns of re-offending. However, there is a need for improved categorisation at notification stage.

  Action: With a view to better identifying and reporting on domestically aggravated offences, local authority reviewers should pay particular attention to the relevant section of the notification template.

  Action: The Care Inspectorate will continue to review and refine recording processes to capture the incidence of domestically aggravated offences.

Guide to quantitative terms used in the report

Almost all	90% or more
Most	75% to 89%
Majority	50% to 74%
Less than half	35% to 49%
Some	15% to 34%
A few	14% or less

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