care inspectorate

Criminal Justice Social Work

Serious Incident Reviews

Annual Report 2012-13

August 2013

OPS-0813-242

Contents

Introduction

As well as regulating care services in Scotland, the Care Inspectorate has responsibility for scrutiny of social work services, including criminal justice social work.

The purpose of this report is to update the public and professionals about Serious Incident Reviews in 2012/13, to inform policy and practice, and to support those working in social work criminal justice services.

Where an offender is on licence or some form of supervision, there is, rightly, intense public interest in how they are supervised. If things go wrong, the Care Inspectorate plays an important role in making sure local authorities and their partners learn the right lessons. Social work criminal justice services supervise a large number of offenders but, fortunately, the number of serious incidents is relatively low. Where they do occur, the responsible local authority should carry out a Serious Incident Review.

While not every serious incident can be prevented, a Serious Incident Review helps drive up standards by identifying and sharing lessons to be learned. A Serious Incident Review should therefore consider whether anything could have been done to have prevented a particular incident occurring. There are three general circumstances when a Serious Incident Review should be carried out. First, an offender on supervision or licence may be suspected of carrying out a criminal offence which results in death or serious harm to someone else. Second, there may be significant concerns about the way such an offender is being supervised. Third, it may be that an offender on supervision has died or been seriously injured in a circumstance likely to generate significant public concern.

Each time a serious incident occurs local authorities must notify us within five working days. We quickly share that information with the Scottish Government, and we require the local authority to review the incident. We then scrutinise, and comment on, the local authority review. Together with the Association of Directors of Social Work (ADSW) and the Scottish Government, we believe this is an important way of monitoring these incidents and learning from them.

We issued our guidance on Serious Incident Reviews in January 2012, which made clear that we would produce an annual report identifying good practice and areas for development. During the first year of this approach, we worked closely with representatives from ADSW criminal justice standing committee and provided them with quarterly reports. They have also been consulted in the preparation of this report.

I hope this report is helpful to you.

Annette Bruton
Chief Executive

1. Statutory supervision in Scotland

Each year around 45,000 assessment reports are prepared for courts or the Parole Board and 23,000 offenders are supervised on statutory orders by social work services. The governance arrangements for criminal justice social work services are defined under legislation, making social work services responsible for delivering a range of services for those involved in the criminal justice system[1].

A serious incident could be caused by an individual on any type of licence or order. The most relevant types of statutory license and orders are:

- community payback order
- probation
- community service order
- Section 229 probation and community service order
- parole licence
- non-parole licence
- extended sentence
- supervised release order.

2. Background

In 2010, the Scottish Government, the Association of Directors of Social Work, and the then social work scrutiny body, the Social Work Inspection Agency, agreed that it would be more appropriate if the task of assessing the quality of social work practice when offenders became involved in serious incidents was carried out by the scrutiny body rather than Scottish Government officials. A scrutiny body can more readily identify where there is a need for improvement to social work practice and we are pleased to work closely with the Association of Directors of Social Work on this new approach as a way of driving forward improvement.

At our inception in 2011, we developed a procedure with the Association of Directors of Social Work and the Scottish Government which was consulted on widely before final agreement was reached. This work was timed to fit with the Scottish Government's revision of national Multi Agency Public Protection Arrangements (MAPPA) guidance. The revised MAPPA guidance and the Serious Incident Review procedure were then published respectively by the Scottish Government and the Care Inspectorate in January 2012 and are complementary.

MAPPA guidance sets out the responsibilities of partner agencies when a registered sex offender becomes involved in a serious incident; the Serious Incident Review procedure deals with the responsibilities of local authority social work services when any other category of offender is involved in a serious incident.

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

3. Classifying serious incidents

A serious incident is defined as:

> "harmful behaviour of a violent or sexual nature, which is 'life threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible." [2]

Our guidance states a Serious Incident Review should always be carried out when:

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

To date, serious incidents have related only to the first and third categories above.

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

Offences that are likely to have caused serious harm:

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

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

4. What happens when a serious incident occurs?

When a serious incident occurs the local authority is required to notify us within five working days of the incident. The local authority then conducts an initial analysis review of the supervision of the offender. They then determine whether they need to take a closer, more detailed look by conducting a comprehensive review or conclude that an initial analysis review is sufficient. Reviews must be submitted to us for consideration within three months of notification of the incident.

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

- appropriate risk assessments and risk management plans have been carried out
- there are appropriate levels of contact between the supervising officer[3] and other agencies with the offender
- issues of non-compliance are managed appropriately.

More details of what we mean by compliance and non-compliance are discussed later in this report.

If the initial analysis review gives cause for concern or uncertainty, the local authority should carry out a comprehensive review. The senior manager signing off the review should then submit that review to us. One of our strategic inspectors will then consider the review and provide comments within one month.

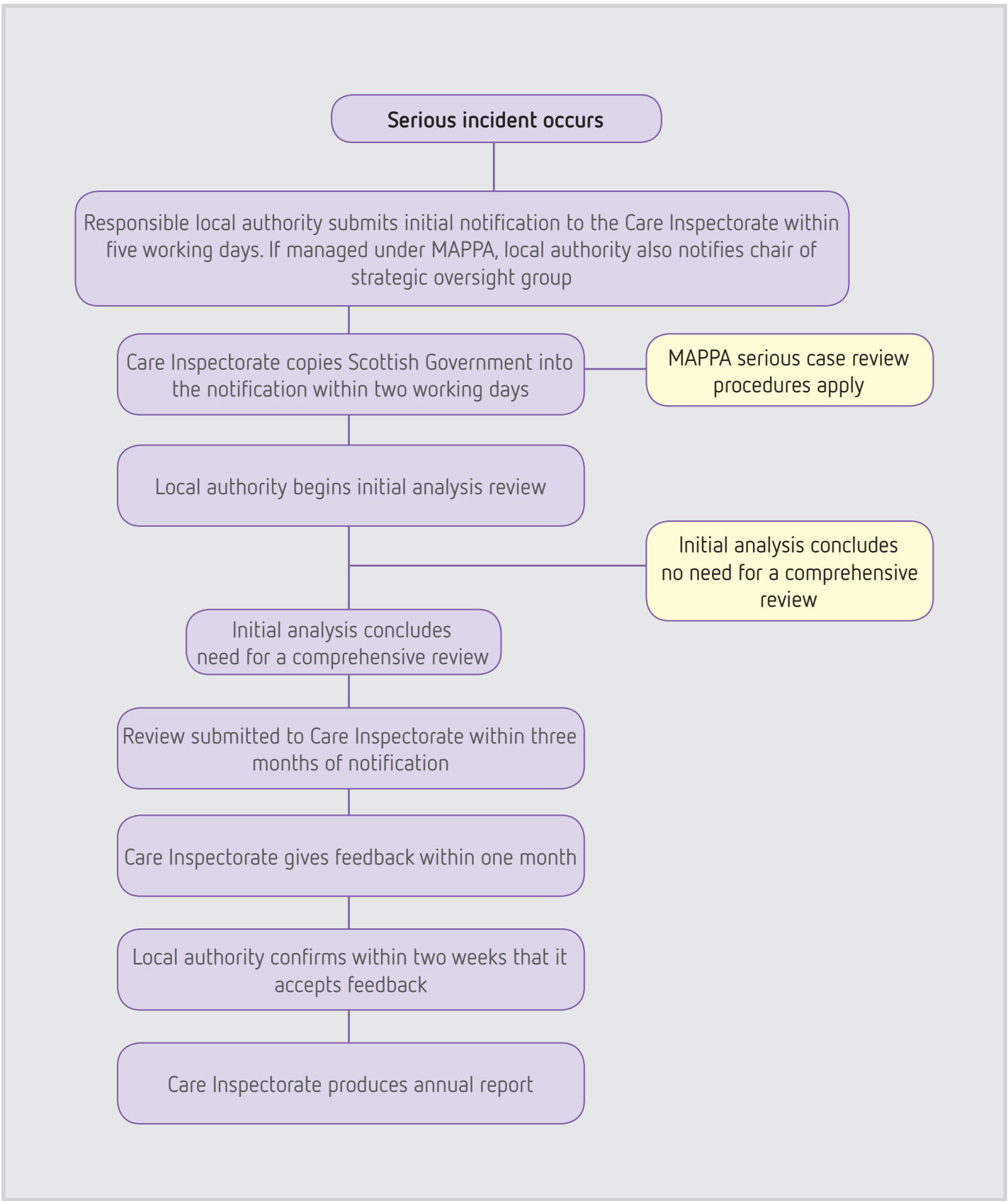
> "Responses to our reviews from the Care Inspectorate have come back recognising where we had done well, as well as identifying lessons for learning. It is important to reflect on the positive feedback as well as the areas to be reviewed, this has always been done in a constructive and supportive way. It is helpful that there is a system in place out with our own organisation that looks at near misses and significant concerns. It can provide reassurance as well as areas for improvement. Working together helps take a robust approach to this."
>
> **Head of Service, Criminal Justice**
> **Scottish Local Authority**

The Serious Incident Review guidance contains a clear process for local authorities to follow and is shown here. The full Serious Incident Review guidance is available on our website www.careinspectorate.com

The flowchart on the opposite page shows the processes to be followed when a serious incident occurs.

[3] A supervising officer is the named person from criminal justice social work who is allocated as the responsible officer for supervising the statutory licence or order.

Procedure to be followed when a serious incident occurs



5. Serious Incident Reviews

From January 2012 to May 2013, we were notified of 45 serious incidents. The table below gives a breakdown of the council areas that notified us of serious incidents. It shows that 17 of 32 local authority areas submitted at least one serious incident notification. Most local authorities submitted their notification and review on time, however nine were late by between one and six weeks.

A total of 37 reviews were completed, 28 of which were initial analysis reviews and nine were comprehensive reviews. We aim to respond and comment on reviews within one month of receipt. We responded to all but four within this timeframe; three of these were late due to staffing changes within the Care Inspectorate and one was not responded to within the timeframe.

The table on the right shows the types of incidents that have resulted in these Serious Incident Reviews.

Serious incidents notified to the Care Inspectorate, by local authority and type

Local Authority	Number of notifications received
Aberdeen	1
Angus	2
City of Edinburgh	1
East Ayrshire	3
East Renfrewshire	1
Glasgow	7
Inverclyde	2
Midlothian	1
North Ayrshire	1
North Lanarkshire	11
Perth and Kinross	1
Renfrewshire	4
Scottish Borders	2
South Ayrshire	1
South Lanarkshire	4
West Dunbartonshire	1
West Lothian	1
North Lanarkshire / Glasgow[4]	1
Total	**45**

Type of incident	Number
Murder	10
Unexplained death	10
Attempted murder	7
Suicide	4
Assault to severe injury and permanent disfigurement	3
Drug overdose	2
Culpable homicide	1
Sexual offences	8
Of which, managed under MAPPA	6
Of which, not managed under MAPPA	2

[4] North Lanarkshire Council supervised this order on behalf of Glasgow City Council

All initial analysis reviews submitted were appropriate. We asked for, and received, additional information on seven of these to help us conclude our responses to the review. All but one of the comprehensive reviews submitted were robust. We asked for, and received, additional information on three reviews. Only one council area challenged the comments we made on their review.

Of the 45 notifications we received, 31 were signed by a service manager or more senior manager, as required in the guidance. Of the 37 initial analysis and/or comprehensive reviews, 32 were signed by the local authority's head of criminal justice services or chief social work officer, as required in the guidance. All notifications and reviews were signed off by the member of staff completing them.

It is crucial that senior managers and the chief social work officer see all notifications and reviews. In nearly all reviews, the case record for the offender had been reviewed, often involving a senior manager. Staff within criminal justice services were generally interviewed as part of the review.

> "The SIR process and guidance can create a little anxiety for staff but we think it is positive. It helps us look at trends and support for other services. We are confident it allows us to look at our practice and can reassure us that we are doing well, but also lets us consider partnership issues such as addiction services, health and drug related deaths".
>
> **Justice Manager, Criminal Justice Services Scottish Local Authority**

6. Partnership working

Staff from services or agencies who were involved in providing a service to the offender were often interviewed as part of the reviews and, where they were involved, this added useful insights. We recommend this should be done more routinely.

In the majority of reviews, where staff in services other than criminal justice were not interviewed, there was clear reference to them and their involvement. This was usually sourced from the case record or IT system (where they were part of council services). Addiction service staff and staff from children's and families' services were the main groups outwith criminal justice staff that were involved in reviews.

Most reviews were able to evidence good communication and joint working between partner services.

7. Risk assessment and planning

Of the 37 completed reviews, the majority referred to risk assessments and risk management plans. The purpose of risk assessment is to better understand the risks and needs of an offender and to identify the most crucial factors in offending behaviour. Different risk assessment tools measure different factors, such as risk of re-offending, risk of harm to others, or both. Some are specifically for use with young people who offend and some with those who commit sexual offences.

Risk management plans should be informed by the findings of risk assessment. Plans should include what needs to be done to address offending behaviour and reduce the risk of offending. They should also set out what needs to be done to support the offender if they have specific needs, such as mental health issues or drug dependency. These plans should be very clear on what is to be done, how it is going to be done and who is responsible for each different part of the plan.

Nine reviews referred to the risk assessment tool used. These included: Level of Service Case Management Inventory (LSCMI), Stable & Acute 2007 (SA07), Level of Service Inventory-Revised (LSI-R), Youth Level of Service Case Management Inventory (YLSCMI) and Risk Assessment Guidance Framework (RA1-4). Of the remaining reviews, reference was either not made to the type of risk assessment tool applied or it was unknown whether a risk assessment had been done.

Around half of the reviews provided evidence that risk assessments had been updated. In the remainder, risk assessments had either not been updated or it was not clear from the review. Indeed, in the majority of instances where we requested further clarification from a local authority, this related to risk assessment. It is important when completing Serious Incident Reviews that the risk assessment process and tools used are explicitly noted and commented upon.

From the Serious Incident Reviews, it was not always clear if assessments were used to inform plans in the way that they should have been. Whilst this may not be indicative of practice, it is important a Serious Incident Review makes the links between assessment and planning more explicit.

> "Whilst there is a legitimate scrutiny and quality assurance function to the SIR process, we wanted to go a step further and use the process for a detailed case review which could teach us about practice in this case and in other cases Whilst practice is never 100% perfect, there were no real disasters in the cases we did SIRs for, but some faults and improvements needed; we took a learning approach rather than a punitive one, which meant that the staff involved were more likely to be open about the issues. Everybody involved in the cases got to have a say in the outcome. We carried out a total staff learning event in respect of the first one, facilitated by a member of Planning.
>
> Challenges were: defining acceptable practice and, if you like, "acceptable" reasons for falling below these ; staying sensitive to the staff involved in the case at the learning event; taking forward the learning and ensuring that it makes a difference."
>
> **Service Manager, Criminal Justice Services, Scottish Local Authority**

When supervising an offender on a licence/order there is an expectation that progress will be reviewed at key stages. This allows key people to come together and discuss progress or areas of concern and make changes to the risk management plan as required. In over half of the Serious Incident Reviews there was evidence that reviews had taken place.

8. Compliance

Compliance is the term used to describe whether an offender is acting in accordance with the conditions of their statutory licence/order. This may include attending appointments when instructed to, not committing further offences and fulfilling other conditions that may be part of their licence/order, such as alcohol or drug counselling. We found that compliance was referred to in nearly all reviews and was managed well. In nearly all instances where there were issues of non-compliance, these had been dealt with appropriately either by formal warning or breach applications to courts or the Parole Board.

9. Good practice

Good practice should be more than just standard practice. It should be something that is able to evidence positive outcomes for both the offender and those affected by their offending behaviour. Good practice, if shared, can improve the quality of service provided; replicated nationally, it can drive up standards.

The Serious Incident Review guidance requests that information on good practice be included where a comprehensive review has been completed. However, we found the identification of good practice was not well evidenced in reviews and as only nine comprehensive reviews had been completed the opportunity to reflect on good practice has been limited.

Following consultation with the Association of Directors of Social Work, the guidance was refreshed in February 2013. This now ensures good practice can be identified in both initial analysis reviews and comprehensive reviews and will support better recognition of good practice. However, since the guidance has been refreshed, we continue to receive limited information on good practice. We hope this report promotes the opportunity for doing this better.

Some examples of what we consider good practice include partnership working across social work services, particularly criminal justice and children and families. In these cases, close communication and joint working ensure sound oversight and management of situations to keep children safe. It ensures risks are managed effectively. In one instance, a local authority decided to use the opportunity – although it was not required – to undertake a comprehensive review. This identified different approaches taken by staff in managing compliance, and resulted in more consistent approaches being developed across staff groups carrying out different functions. In future we would like to see more examples of good practice that make a significant difference and can be shared across Scotland.

10. Areas for development

Having considered Serious Incident Reviews, we believe there is under reporting of serious incidents in some council areas across Scotland. The table on page 6 shows the breakdown of serious incident

notifications received in different local authority areas. We have had regular liaison with chief social work officers and representatives from the Association of Directors of Social Work to try and ensure all areas are notifying us of serious incidents appropriately. Local authority criminal justice senior managers and managers need to consider how they disseminate the guidance to all staff involved in criminal justice social work staff to ensure they are aware of the notification requirements and adhering to these effectively. It is important the opportunity is taken to learn lessons and identify good practice more fully.

We have identified some emerging themes. For example, high numbers of drug-related deaths of offenders in certain areas suggest services may need to take a closer look at whether alcohol and drug support provision is working effectively.

There appear to be robust approaches to managing compliance to ensure offenders are being appropriately supervised and supported in the community and held accountable if they are not fulfilling the conditions of their order/licence.

Sharing information between criminal justice social work services and other council services is mainly good, but information from health services needs to be better and given in good time. For example, in some cases psychiatric reports are not given to supervising officers at the time they need them to help inform risk assessment and planning, or to provide comprehensive reports to the court.

Those involved in delivering cross-authority supervision arrangements or shared services for those subject to licence and orders, need to be clear who is responsible for notifying us of serious incidents, progressing Serious Incident Reviews and ensuring information is shared. A national approach to these issues may help ensure consistency.

Whilst the constraints on housing, particularly on release from prison, are acknowledged, consideration needs to be given to a wider assessment of suitability and how this may present additional risk factors rather than protective factors. Too often, we heard of offenders coming out of prison and being placed in hotel or hostel accommodation.

Where action plans have resulted from the findings of comprehensive reviews, it is crucial that they are implemented and reviewed to promote improvement and prevent further incidents. Senior officers should ensure that these action plans are followed through.

11. Recommendations

A consistent approach to managing cross-authority or shared services supervision arrangements is needed where serious incidents occur. There must be clarity on who is responsible for the notification of serious incidents and how the review will be carried out.

Local authorities should take a closer look at how alcohol and drug support services are operating and whether they are providing effective enough support to those involved in the criminal justice system who have significant substance misuse issues.

Local authority and health partners should review and take appropriate action to ensure that information is shared across services in the most effective way and when required.

When completing initial analysis reviews or comprehensive reviews, those involved should take a robust approach to identifying good practice and include this in reviews more clearly.

Senior managers in criminal justice social work services should ensure that all staff working within criminal justice have access to the Serious Incident Review guidance and fully understand the expectations on them to report serious incidents.

All council areas across Scotland should ensure they closely follow the guidance on when they should notify us of a serious incident. Senior managers and the chief social work officer should ensure guidance is applied in their council areas.

12. Conclusions

Some local authorities have taken the clear opportunity to learn and improve from the Serious Incident Review process. As a result, this has led to the identification of sound practice as well as informing changes to practice such as making more robust arrangements for the transfer of orders and licences. It is important that the Serious Incident Review process provides oversight of serious incidents by senior managers and chief social work officers within the community. It should also ensure that Scottish Ministers are sighted on serious incidents involving offenders.

The process provides a key opportunity to learn about practice and recognise strengths as well as areas that need to be improved. This approach feeds into the wider self-evaluation journey for criminal justice services. We have been impressed by the way many of the local authority areas have used the Serious Incident Review process to learn and improve their services. Used well, the process provides assurance for many that criminal justice social work services are evidencing sound practice and staff are delivering services effectively.

However as we have received notifications from only 17 of the 32 local authorities, and small numbers from some areas, we remain unconvinced that all local authority areas are reporting accurately or, indeed, reporting at all. This indicates 15 local authorities – just under half – have had no serious incidents. We accept that in some areas this may be the case, but we strongly recommend that other areas ensure they follow the guidance and notify us.

We will continue to monitor notifications and Serious Incident Reviews within each local authority through the lead officer for Serious Incident Reviews, and through our strategic link inspectors who have on-going contact with senior managers in local authorities. We will report again next year and hope that it will be able to evidence increased reflections on good practice and improved reporting of serious incidents.

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

We have offices across Scotland. To find your nearest office, visit our website or call our Care Inspectorate enquiries line.

Website: www.careinspectorate.com
Email: enquiries@careinspectorate.com
Care Inspectorate Enquiries: 0845 600 9527

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Published by: Communications