Serious incident review guidance

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Serious incident review guidance

1. Overview of serious incident reviews

1.1 Reviewing serious incidents is the responsibility of the local authorities[1], often in consultation with partner agencies. This ensures relevant learning is identified in situations where someone subject to a statutory order or licence supervised by justice social work services has caused or been subject to serious harm. Serious incident reviews (SIRs) provide a consistent framework to enable local authorities to examine the quality of practice and adherence to legislation and guidance. The reviews should focus on learning and reflection around day-to-day practices and processes, and the systems within which they operate. They should identify strengths as well as areas for improvement and are intended to contribute to a culture of continuous learning to strengthen future practice.

1.2 This guidance applies to the reporting of serious incidents involving people who are subject to a statutory social work order or throughcare licence following a final disposal by a court, namely:

- people subject to all and any requirements of a community payback order (including a stand-alone unpaid work requirement)
- people subject to a drug treatment and testing order
- people released from custody who are subject to the conditions of a throughcare licence (including a supervised release order and an order for lifelong restriction).

1.3 The Care Inspectorate collates all submitted serious incident reviews on behalf of the Scottish Government. This function is underpinned by the Care Inspectorate's statutory duty to further improvement in the quality of social services, under section 44(1)(a) of the Public Service Reform (Scotland) Act 2010. To support effective practice, the Care Inspectorate reviews the effectiveness of the processes by which the serious incident review was conducted and provides feedback to local authorities.

1.4 To support continuous learning at a national level, the Care Inspectorate produces regular reports and a biennial report identifying strengths in practice and areas for improvement identified within the submitted reviews.

2. Criteria for identifying whether an incident is serious

2.1 A serious incident is defined as an incident involving:

'…harmful behaviour, of a violent or sexual nature, which is life threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible.' (Framework for Risk Assessment Management and Evaluation, RMA (2011)

[1] In most areas, justice social work services are delivered and overseen by the local authority, however in some areas, justice services are integrated within the health and social care partnership, overseen by the integration joint board. For the purposes of this guidance, when we use the term 'local authority', this also covers justice services, which are delivered as part of an integrated service.

2.2 A serious incident review (SIR) should always be carried out when:

- a person on a statutory order (see 1.2) or licence is charged with and/or recalled to custody on suspicion of a further 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 (see 1.2) has died or been seriously injured in circumstances which indicate the need for public assurance.

2.3 Appendix 1 lists examples of the kind of offences that may contribute to a seriously harmful incident. These are examples only. Some offences noted may not result in serious harm and other offences not listed should not be excluded if they meet the criteria for risk of serious harm. Appendix 2 offers illustrations of the kind of circumstances when a serious incident review should be considered.

2.4 When a person on a statutory order or licence dies or is seriously injured, the circumstances of the person's death or injury may result in a need for services to provide assurance. This may be in relation to public safety and/or the effective provision of public services. Local authorities use several processes to record and report when a person receiving a justice social work service has died. A serious incident review submission to the Care Inspectorate is required when circumstances indicate there is a need to capture relevant learning to improve practice and/or provide assurance regarding public safety.

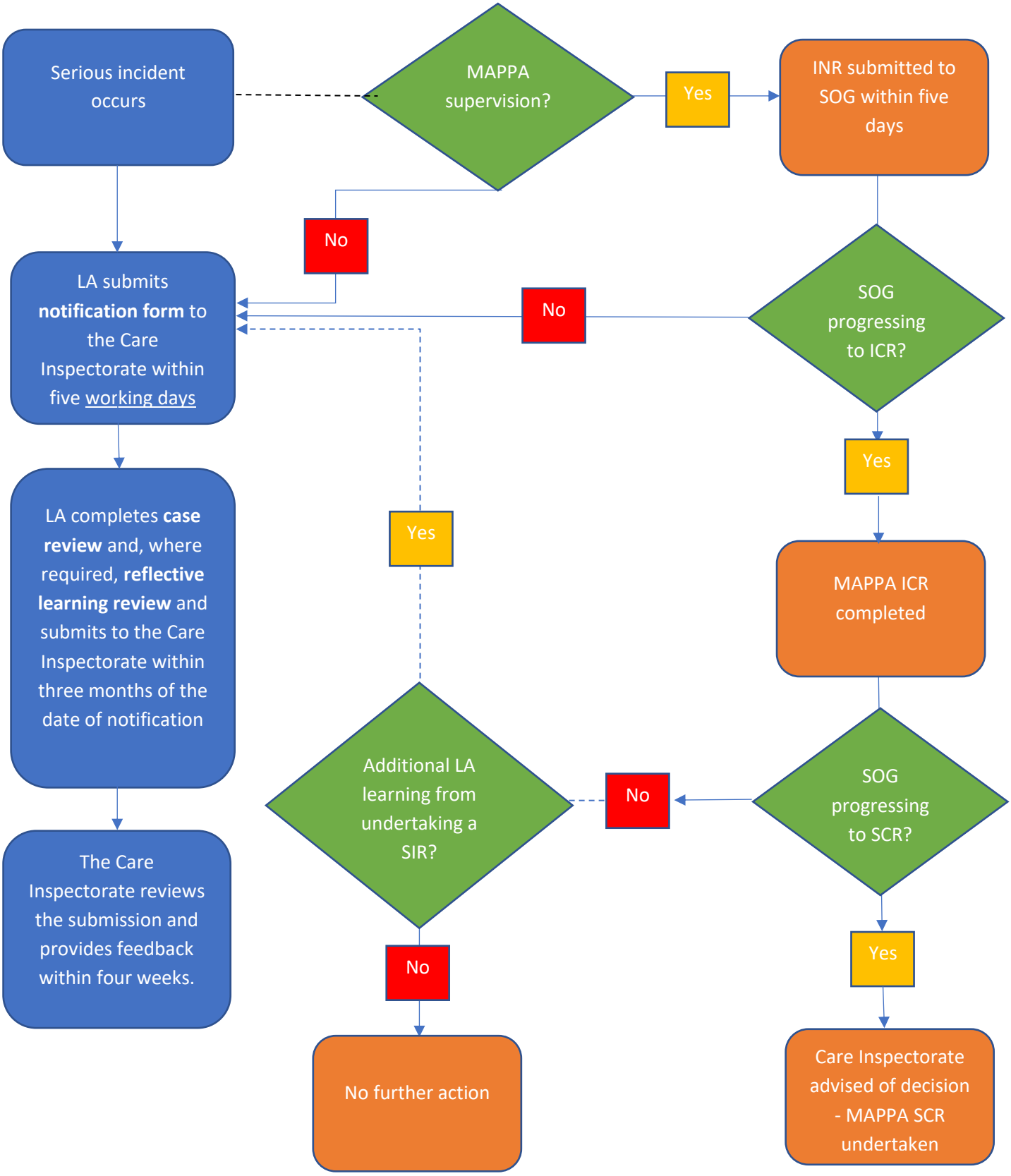
2.5 Responsibility for completing a serious incident review sits with local authority justice social work services. It differs in focus from a significant case review (SCR) relating to incidents involving people managed under MAPPA (Multi-Agency Public Protection Arrangements). The purpose of the latter is to examine whether agencies effectively applied MAPPA arrangements and whether the agencies worked together effectively. In these circumstances, the chair of the MAPPA strategic oversight group (SOG) is responsible for commissioning the significant case review. The process map in section 3 provides detail on what action is required when the SOG decides there will be **no** significant case review.

2.6 This guidance does not affect the existing arrangements for notifying the community licence team within the Scottish Government of incidents involving persons subject to statutory supervision following release from custody.

2.7 Where the nature or seriousness of an incident is likely to generate high levels of public, media, or parliamentary attention, the local authority should consider developing a communications strategy. In exceptional cases, particularly where interest is anticipated at a national level, it may be advisable to notify the Scottish Government's community justice division and other key local and national partners as appropriate. This may include sharing the communications strategy and any prepared statements with the Scottish Government to enable it to provide an informed response if necessary. It may also be appropriate to share an anonymised version of the serious incident review, though this should be discussed with the Scottish Government on a case-by-case basis. Consideration should also be given to the impact on staff and people involved in the case to ensure they are offered appropriate advice and support to deal with any resulting enquiries.

3. Serious incident review process and guidance

The flowchart shows the process to be followed when a serious incident occurs:



3.1 Within five working days of becoming aware that a serious incident has occurred, the responsible local authority should submit a **notification** to the Care Inspectorate using the email address cistrategicteamnotification@careinspectorate.gov.scot

3.2 The purpose of the notification is to enable the Care Inspectorate to determine whether the criteria for a serious incident review are met. In line with the General Data Protection Regulation (GDPR) principles, the local authority should provide the minimum amount of personal information required to enable the Care Inspectorate to reach that decision. Appendix 3 provides a template and guidance for the notification and Appendix 5 offers an illustration of a completed notification template. The notification should be signed by the member of staff who completed the form. It should be counter-signed by the justice service manager or chief social work officer to demonstrate that there is oversight and accountability within the service.

3.3 Where a justice service is supervising an order/licence on behalf of another local authority, the notification and subsequent review should ordinarily be submitted by the local authority that has supervised the bulk of the order/licence unless it is not appropriate for them to do so. In either event, the local authorities should work in partnership to prepare the review.

3.4 Where the person to whom the serious incident relates is subject to an order that has been transferred to or from another jurisdiction within the UK, the responsible authorities should negotiate and agree who will undertake the review and which procedures should be followed. In general terms, it is envisaged that where the serious incident relates to a person being supervised on an order/licence held by the probation service, the Procedure for Serious Further Offences should be followed. Where the person is subject to an order or licence in Scotland but the bulk of supervision has been undertaken by the probation service, it may also be appropriate to follow the probation service procedure, but this should be discussed and agreed by the relevant authorities. In either event, best practice suggests that the review should be undertaken collaboratively to ensure all partners are able to contribute to and learn from the process. Further details on cross-border issues are outlined in the Scottish Government guidance on Cross Border Transfer of Orders – Criminal Justice Act 2003

3.5 Where the criteria for a serious incident review are met, the local authority must carry out a **case review (part 1)** to consider the extent to which practice was delivered in compliance with national standards and best practice. Where the case review identifies practice or service-related issues, the local authority should go on to prepare a **reflective learning review (part 2)** to identify the contributing factors and develop an action plan outlining how the identified issues will be addressed.

3.6 A case review should be undertaken by someone who can develop an objective view regarding the management of the order/licence and who has sufficient seniority (such as a manager) to make recommendations about any actions that the service may need to take in response to the findings.

For very serious incidents and/or where an initial review of the evidence highlights major concerns, local authorities may wish to consider appointing an independent person(s) to carry out the review or to provide additional quality assurance.

Alternatively, it may be appropriate to ask another local authority to act as a critical friend.

3.7 People involved in serious incidents may receive support from a wide range of agencies to address their risks and needs and in many instances, partnership working will be integral to the case/risk management plan. In such instances it would be good practice for local authorities to seek the views of their partners when conducting a serious incident review, particularly where the need to complete a reflective learning review is identified. Partners may include police, social work, drug and alcohol services, mental health, the third sector, domestic abuse and/or housing services.

3.8 While it is not within the scope of a serious incident review to identify areas for improvement for another agency, this should not prevent partner agencies conducting a multi-agency review where the circumstances justify a joint approach. In these circumstances, the local authority must make it clear to their partners that they are required to submit the outcome of the review to the Care Inspectorate.

Consideration should also be given to the interface between serious incident reviews and other inter-related notification, investigative and learning review processes. For example, initial case reviews (ICRs), significant case reviews (SCRs), death of a person living in a regulated care service or death of a looked after young person (extended to include young people in continuing care and after care).

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

3.10 The local authority should submit the outcome of the case review (and where relevant, the reflective learning review) to the Care Inspectorate within three months of the date of initial notification. All submissions must be signed by the member of staff who completed the review and counter-signed by the local authority's justice service manager or chief social work officer to demonstrate that there is oversight and accountability for identified learning and actions. The designation of signatories should also be noted. Guidance on the completion of Part 1 and 2 are provided in Appendix 4.

3.11 Following receipt of a case review (and, where relevant, a reflective learning review) the Care Inspectorate will provide the local authority with comments on the review within four weeks. In instances where further information or clarification is required, we will contact the local authority directly.

Comments are copied to the local authority's Care Inspectorate link inspector to enable them to monitor and support the progress of any identified actions. Where the local authority has questions or concerns regarding the response, arrangements can be made for the Care Inspectorate to meet with relevant senior managers within the local authority to discuss the matter.

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

Process - MAPPA

3.13 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. Serious incident reviews and MAPPA review processes serve similar but distinctive purposes. Serious incident reviews support local authorities to identify learning about the quality and effective delivery of social work 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 is to examine whether responsible authorities have applied MAPPA arrangements and effectively worked together. In most cases, a serious incident review and MAPPA initial case review will consider many of the same issues, therefore, to minimise duplication, the process is outlined in the process map above.

3.14 Where a person subject to MAPPA is involved in a serious incident, MAPPA review processes take precedence. A serious incident involving a person subject to MAPPA should be reported to the strategic oversight group (SOG) using the MAPPA SCR Form 1: Stage 1 SCR initial notification report form, following the MAPPA guidance. Where the SOG decides that the matter will not proceed to an initial case review, and the criterion for a serious incident review is met, the local authority should submit a serious incident review notification to the Care Inspectorate within five working days of receiving the SOG decision. The notification form is shown at Appendix 3.

3.15 Where a MAPPA initial case review is undertaken, the review will address the majority of questions that are considered as part of the serious incident review process. In most cases, this should remove the need for the local authority to complete a serious incident review. However, given that the MAPPA and serious incident reviews serve a distinct purpose, there may be instances where the circumstances of the case indicate that the social work service would gain additional or valuable learning from undertaking a serious incident review. The decision about whether a serious incident review is required should be taken by the justice service manager. In such instances, the serious incident review notification should be submitted to the Care Inspectorate within five working days of the initial case review being concluded by the SOG.

3.16 Where a MAPPA significant case review is to be undertaken, there is **no** requirement for the local authority to undertake a serious incident review.

Process – order for lifelong restriction

3.17 Where the person concerned is subject to an order for lifelong restriction, the Risk Management Authority undertakes an additional evaluation of the implementation of the risk management plan where there has been a death or serious harm caused. This is separate from the serious incident review process.

4. Approach

4.1 As indicated above, the primary purpose of serious incident reviews is to support local and national learning about practice. Reviews should seek to identify areas of good practice and determine if there are any lessons to be learned about how to better support and manage people who have been involved in offending behaviour. Local authorities have a responsibility to victims, the general public and to people who are subject to statutory orders and licences to provide a high-quality service and to effectively assess and manage the risks presented by people who commit offences.

4.2 Local authorities also have a duty to ensure that staff are confident and competent to fulfil their statutory responsibilities. In some instances, the review will conclude that the quality of the service provided was not as good as it could have been. In such instances, the review should seek to identify the actions that will be taken to address any professional shortcomings so the service can demonstrate accountability and provide public assurance. Although it is accepted that in some instances, actions arising from a review may include staff disciplinary measures, the focus of the review should not be on apportioning blame. Staff should be given appropriate opportunities and support to participate in the review and consideration should be given to how the learning from the review will be disseminated locally.

4.3 Where a person is receiving another justice social work service not covered by this guidance (for example, bail supervision, a structured deferred sentence, or diversion from prosecution) is alleged to have committed, or is subsequently convicted of, an offence which meets the FRAME definition of serious harm, the case review and reflective learning review guidance and templates can be used by justice social work services to support learning and continuous improvement without the expectation of submitting a notification to the Care Inspectorate.

Appendix 1 – examples of offences

In determining whether an offence constitutes a serious incident, the primary consideration is whether the circumstances of the offence reflect '…harmful behaviour, of a violent or sexual nature, which is life `threatening and/or traumatic and from which recovery, whether physical or psychological, may reasonably be expected to be difficult or impossible.' (Framework for Risk Assessment Management and Evaluation, Risk Management Authority (2011).

The seriousness of any incident will be determined by the specific nature and circumstances of the offence rather than the type of offence. However, offences that could contribute to serious harm may include, but are not limited to the following.

Violent offences
Murder or culpable homicide
Attempted murder
Serious assault (including severe injury, permanent disfigurement and/or danger to life)
Robbery (aggravated by use of a weapon)
Abduction
Fire-raising
Possession of a weapon (e.g., firearm)
Terrorism
Sexual offences
Rape or sexual assault
Other contact offence
Non-contact offence – taking or distributing indecent images of children
Domestic abuse offences
Including physical, sexual, and/or psychological abuse
Coercive control
Course of abusive behaviour
Other offences
Stalking
Child neglect or cruelty

Appendix 2 - Examples of when a serious incident review may be required

- John is subject to a community payback order having been convicted of domestic assault and is engaging with the Caledonian programme. He has been charged with a serious assault against his current partner.

- Bill is on a throughcare licence having served a sentence for assault to severe injury and permanent disfigurement. He has recently been charged with a similar offence.

- Geoff is subject to a community payback order following conviction for lewd and libidinous behaviour. He is subject to multi-agency public protection arrangements (MAPPA). He has been charged with a sexual assault. The MAPPA strategic oversight group instructed an initial case review but decided not to progress to a serious case review. The justice social work manager believes there may be specific additional learning for the service and value in undertaking a serious incident review.

- Paul was subject to a throughcare licence following release from custody and was murdered by an associate.

- Michelle is subject to a community payback order unpaid work requirement and has been seriously assaulted by another person who attends unpaid work on the same day.

- Gill was subject to a drug treatment and testing order and died following a suspected drug overdose. An initial case review indicated that she had not been complying with the conditions of her order and that staff had failed to follow up on her repeated failure to attend scheduled appointments.

- Jo, who is on a community payback order with supervision, unpaid work and drug treatment requirement has died of a suspected drug overdose. While practice has been in accordance with national outcomes and standards, three other people have died in similar circumstances in the past year. This may indicate a concerning pattern worthy of further consideration.

- Karl is subject to a community payback order with an unpaid work and other activity requirement. He has appeared in court charged with attempted murder.

- Cameron is subject to a community payback order supervision requirement. In recent months he has been charged with several offences that individually do not meet the definition of a serious incident. However, considered collectively there is a concerning pattern of abusive behaviour toward his current partner. This includes intimidating, controlling and threatening behaviour.

Appendix 3 - serious incident review: notification

1	Person's initials			
2	Age			
3	Gender	☐ Male	☐ Female	☐ Other
4	Name of responsible local authority			
5	Reason for referral (tick one)			
	☐ A person subject to a statutory order or licence is charged with and/or recalled to custody on suspicion of a further offence that has resulted in the death or serious harm of another person. ☐ An incident or accumulation of incidents, gives rise to significant concerns about service involvement/lack of involvement ☐ A person subject to a statutory order or licence has died or been seriously injured in circumstances which indicate the need for public assurance.			
6	Date of incident (DD/YY/MMMM)			
7	Date service became aware of the incident (if different)			
8	Type and length of requirement/statutory order/licence			
9	Date order imposed/released on licence			
10	Current status of the person	☐ At liberty	☐ In custody	☐ Deceased
11	Brief description of incident/charge resulting in notification: • circumstances of the incident • nature and extent of harm • gender/age of victim(s) and relationship to victim(s) where known • source of information/ intelligence			

12	Category of further offence (select most serious)	☐Death of service user	☐Murder
		☐Serious violence	☐Contact sexual offence
		☐Non-contact sexual offence	☐Domestic Abuse offence
		☐ Other	Please specify:

13	Intensity of supervision at the time of the serious incident?	☐ Very high ☐ High ☐ Medium ☐ Low ☐ UPW only	
14	Are other agencies involved in providing support or supervision to this person? If yes, specify who.	☐ Yes	☐ No

15	Do any of the following criteria apply to this person?	☐Currently looked after child	☐Receiving continuing care/aftercare	☐Living in a regulated care establishment	☐ Other ongoing review process

16	Are high levels of public or media attention anticipated?	☐ Yes	☐ No	☐ Not Known
17	Where the notification relates to an alleged further offence are there charges pending against the person?	☐ Yes	☐ No	☐ Not Known
18	What level of MAPPA review has been completed?	☐ INR	☐ ICR	☐ N/A

19	**Sign-off**				
Person completing the notification:					
Name and designation		Signature		Date	
Senior manager signing off the notification:					

Name and designation		Signature		Date	

Serious incident review: notification guidance

Q1. Person's initials: Provide **only** the initials. To ensure compliance with data protection regulations, only initials should be used throughout the form.

Q2. Age: To ensure compliance with data protection regulations, provide age, **not** date of birth.

Q3. Gender: Identify the person's gender. Where the person consistently identifies as something other than male or female, please select 'Other'.

Q4. Name of responsible local authority: Provide the name of the local authority responsible for the order/licence. If another local authority is managing the person on behalf of the responsible authority, also provide its details.

Q5. Reason for referral: Indicate which of the following categories apply.

- A person subject to a statutory order or licence is charged with and/or recalled to custody on suspicion of a further offence that has resulted in the death or serious harm of another person.
- An incident or accumulation of incidents, gives rise to significant concerns about service involvement/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.

Q6. Date of incident: Provide the date when the incident occurred, where known.

Q7. Date service became aware of the incident (if different): Provide the date the local authority became aware of the incident. For MAPPA cases, please provide the date that the service was notified of the strategic oversight group decision not to proceed to an initial case review.

Q8. Type and length of supervision/statutory order/licence: Indicate the type of order/licence that was imposed and the duration. Include details of any requirements and/or conditions, for example 24-month community payback order with 180 hours unpaid work and a programme requirement (Caledonian). If the order or licence relates to a cross-border transfer, please make this clear.

Q9. Date order imposed/release on licence: Provide the date the order was imposed at court, or the person was released on licence/supervised release order/order for lifelong restriction.

Q10. Current status of the person: Select the relevant answer.

Q11. Brief description of incident/charge resulting in notification: Provide details of the offence of which the person has been accused or charged (for example attempted murder, contact sexual offence against a child, assault to severe injury) or the circumstances surrounding the harm caused to the person on an order/licence (for example murder victim). **Avoid the use of personal identifiers for victims, co-accused and/or members of staff.** Include a brief comment in your summary on the:

- circumstances of the incident
- nature and extent of harm
- gender/age of victim(s) and relationship to victim(s) where known
- source of information/intelligence.

Q12. Category of further offence (select most serious): Indicate which category the further offence falls within. Where there is more than one offence, select the category that relates to the most serious offence.

Q13. Intensity of supervision at the time of the serious incident: With reference to the following criteria from national outcomes and standards, indicate what level of supervision the individual was subject to at the time of the incident. If the person is subject to an unpaid work requirement only, select that option.

- **Very high intensity:** at least one, but up to seven contacts per week, arranged and unannounced home visits, three-monthly reviews.
- **High intensity:** at least one, but up to three contacts per week, planned and unannounced home visits, three-monthly reviews.
- **Medium intensity:** minimum weekly contact until three-month review with capacity to reduce to fortnightly. Should include at least one planned or unannounced home visit between reviews. Review after first three months and if circumstances remain stable, then at nine months and six-monthly thereafter.
- **Low intensity:** weekly contact for first month, reducing to monthly thereafter, review every six months.

Q14. Are other agencies involved in providing support or supervision to this person? If yes, specify who: Identify whether other agencies are providing support or supervision to the person and if so, specify the agencies involved and job role involved, for example social worker, children and families social work team, sex offender policing officer, Police Scotland. Where the case is being managed by one local authority on behalf of another, or involves cross-border transfer, please outline the agreements that are in place for the management of the order/licence. The names of individual staff members are **not** required.

Q15. Indicate if any of the following criteria apply to the person: Indicate if the person is a looked after child, is subject to continuing care or aftercare, or is living in a regulated care establishment. Note, if any other review process is ongoing such as initial case review, significant case review, death of looked after young person or young person in continuing care. Other processes such as a drug-related death may also be relevant. If none apply leave blank.

Q16. Are high levels of public or media attention anticipated?: Indicate whether there has been or is likely to be a high level of media interest or public attention associated with the incident. Such cases may require the allocation of additional resource or require the development of a specific media strategy.

Q17. Where the notification relates to an alleged further offence, are there charges pending against the person?: Indicate if any charges relating to the serious incident are pending. This relates to the service becoming aware of a serious incident (or cumulation of incidents) that causes concern but where the person has not yet been convicted.

Q18. For people subject to MAPPA what level of review has been completed?: Select the relevant answer. If the person is not subject to MAPPA, leave blank.

Q19. Sign-off: The notification should be signed and dated by both the person completing the form and the justice service manager or chief social work officer. Designation of signatories should be noted. This indicates that there is appropriate knowledge and oversight of the serious incident within the service.

Appendix 4 – Review templates and guidance

Serious incident review (SIR) part one: case review

1	Care Inspectorate SIR reference number		
2	Person's initials		
3	Age		
4	Basis of review		
	Role of reviewer		
5	Chronology prepared	☐ Yes	☐ No
6	**Case overview** Provide a brief description of the person's relevant history including: • the extent and nature of offending history • response to previous supervision • the offence(s) resulting in current order/licence • compliance with current order/licence • any discipline issues in custody (if relevant) • any additional details about the current charge/incident that were not included in the notification • MAPPA category and management level (where relevant).		
7	**Case file examination: answer each of the following questions and provide the evidence and rationale to support your conclusion.**		
7.1	Was an appropriate assessment of risk undertaken and completed?		
	☐ Yes ☐ No ☐ N/A		
	Evidence and rationale to support conclusion:		
7.2	Was the LS/CMI assessment completed within nationally agreed timescales (where relevant)?		
	☐ Yes ☐ No ☐ N/A		
	Evidence and rationale to support conclusion:		

7.3	Where risk of serious harm was indicated, was a risk of serious harm assessment completed? ☐ Yes ☐ No ☐ N/A Evidence and rationale to support conclusion:
7.4	Was the risk assessment updated in accordance with expectations and/or reviewed in light of significant change? ☐ Yes ☐ No ☐ N/A Evidence and rationale to support conclusion:
7.5	Was the risk assessment of an appropriate quality? ☐ Yes ☐ No ☐ N/A Evidence and rationale to support conclusion:
7.6	Was a case/risk management plan completed within nationally agreed timescales? ☐ Yes ☐ No ☐ N/A Evidence and rationale to support conclusion:
7.7	Did the case/risk management plan correlate to the identified risks/needs? ☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A Evidence and rationale to support conclusion:
7.8	Were the actions in the case/risk management plan appropriately implemented? ☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A Evidence and rationale to support conclusion:

7.9	Was the case/risk management plan reviewed and/or updated in the course of the order/licence to reflect progress and/or change?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.10	Were statutory requirements of the order/licence appropriately delivered?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.11	Was the level of supervision proportionate to the assessed level of risk/need?
	☐ Yes ☐ No ☐ N/A
	Evidence and rationale to support conclusion:
7.12	Was non-compliance appropriately managed in line with national outcomes and standards?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.13	Were home visits undertaken in line with national outcomes and standards?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.14	Did statutory social work reviews take place in line with national outcomes and standards?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:

7.15	Did the statutory social work review(s) focus on the progress of the case/risk management plan?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.16	Was the management oversight of the order/licence sufficient?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.17	Where other internal/external professionals were involved, was partnership working and information sharing appropriate?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.18	Was practice compliant with local policies and procedures?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.19	Were early warning signs of escalating risk or imminent offending appropriately identified and addressed?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:
7.20	Were all reasonable steps taken to manage risk and need?
	☐ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A
	Evidence and rationale to support conclusion:

7.21	Is the need for further examination indicated? Where you have answered 'no', 'not at all' or 'partially' to any of the key considerations, further analysis using the ***reflective learning review*** should be considered to support learning regarding local or national practice. Where you have answered 'no', 'not at all' or 'partially' but conclude that more detailed examination is not required, a clear rationale for this decision should be provided below. Please then complete sections 10, 11 and 12 prior to submission.	☐ Yes ☐ No
	Evidence and rationale to support conclusion:	

Part 1: Case review guidance

Q1. Care Inspectorate SIR reference number: At the point of notification, the Care Inspectorate will generate a unique reference number. Please use this reference here.

Q2. Person's initial: Provide **only** the initials. Use only initials throughout the form.

Q3. Age: Provide age, **not** date of birth.

Q4. Basis of review: To evidence the extent of objectivity, indicate who led the review, their role within the organisation and any level of involvement with the person prior to the serious incident (if any). Identify any sources that were used to inform the review such as social work records, risk assessments, violent offender and sex offender register database (ViSOR), details regarding interviews/professional discussions with staff and partners.

Q5. Chronology prepared? Indicate whether a chronology was prepared to support the review and attach it to the submission where relevant (removing personal identifiers).

A chronology is a logical, methodical and systematic means of organising, merging and helping make sense of information. In the context of undertaking a serious incident review, setting out key events in sequential date order can help make sense of the person's past circumstances and the impact of service responses. It can help identify patterns in the person's behaviour and circumstances, and themes or gaps in relation to professional interventions that require further exploration, investigation, and analysis.

It is not always necessary to undertake a chronology, and professional judgement should be exercised about when one is required. A chronology may prove useful in supporting assessment and analysis where the person has been subject to supervision for a lengthy period of time, where there have been multiple orders or periods of non-compliance, and/or there is more than one agency involved in providing support to the individual.

Q6. Case overview: Provide a brief description of the person's relevant history.

The case overview should include a brief comment on:

- the pattern, nature and seriousness of the person's offending history
- response to previous supervision
- the index offence(s) resulting in the current order/licence
- compliance with the current order/licence
- any discipline issues in custody (if relevant)
- any additional details about the current charge/incident that were not available or included in the notification (this may include detail about the date of the incident, the circumstances of the offence, the profile of the victim(s), the pattern of behaviour exhibited, or action that has been taken by services in response to the incident).

Q7.1 Was an appropriate assessment of risk undertaken and completed? Indicate whether appropriate risk assessment tools were completed (for example LS/CMI, SA07, RM2000, SARA, SAPROF, START:AV, AIM2 and so on).

Q7.2 Was the LS/CMI assessment completed within nationally agreed timescales (where relevant)?: When a supervision requirement is in place a full LS/CMI assessment should be completed within 20 working days.

Q7.3 Where risk of serious harm was indicated was a risk of serious harm (RoSH) assessment completed?: Consider whether risk of serious harm was appropriately identified and, where risk of serious harm was present, whether a formal risk of serious harm assessment (RoSH) was undertaken using the LS/CMI system. Consider whether LS/CMI section 7.3.2 Evaluation and Conclusion, was appropriately scored. Where the third option is selected – 'there are significant current indicators that merit a fuller assessment of risk of serious harm' - has a risk of serious harm (RoSH) assessment been completed?

The Risk Management Authority define risk of serious harm as 'the likelihood of 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.'

Q7.4 Was the risk assessment updated in accordance with expectations and/or reviewed in light of significant change?: Consider whether the risk assessment(s) was reviewed and updated in accordance with relevant guidance to inform points of ongoing review (for example statutory social work reviews, MAPPA meetings) or in response to a significant change (for example escalating risk, breakdown in protective factors).

Q7.5 Was the risk assessment of an appropriate quality?

In evaluating the quality of the risk assessment(s) consider:

- accuracy of recorded information
- acceptable range and balance of information
- accuracy of scoring
- adequate reflection of identified risk and need
- analysis of pattern, nature, seriousness and likelihood of offending
- evaluation of the potential impact of these risks
- recognition of person's strengths where appropriate
- consideration of social and health issues
- consideration of person's characteristics and responsivity factors
- overall evaluation of how risk is to be managed and how needs are to be met is consistent with the available information

Q7.6 Was a case/risk management plan completed within nationally agreed timescales?: Case/risk management plans within LS/CMI should be completed within 20 days of the order being imposed for people subject to community supervision and released on throughcare licence. If the person is subject to MAPPA supervision the case/risk management plans must be completed within three months.

Q7.7 Did the case/risk management plan correlate to the identified risks/needs? Does the case/risk management plan incorporate appropriate actions to address the primary risk factors and needs that were identified in the risk assessment(s)? Consider the impact of any aspects that have not been addressed.

Q7.8 Were the actions in the case/risk management plan appropriately implemented? Is there evidence that the actions identified in the plan were implemented. Was action timely? Were there any gaps or delays?

Q7.9 Was the case/risk management plan reviewed and/or updated in the course of the order/licence to reflect progress and/or change?: Were actions reviewed and updated to reflect progress as the order/licence progressed? If not, what contributed to the

lack of review and updates? Best practice would suggest that the LS/CMI progress record should be used to capture updates regarding the implementation of the plan.

Q7.10 Were statutory 'requirements' of the order/licence appropriately delivered? Consider whether the statutory elements of the order/licence were appropriately implemented. This includes timely initiation of the order following sentence, implementation and monitoring of compliance with any requirements or licence conditions (for example compensation, programme, conduct, or treatment requirement, monitoring of IT equipment).

Q7.11 Was the level of supervision proportionate to the assessed level of risk/need? Consider whether the intensity of supervision is commensurate with assessed levels of risk and need and correlates to the issues identified within the case/risk management plan. National outcomes and standards outline the following expectations of contact in relation to the assessed supervision intensity level.

- **Very high intensity:** at least one, but up to seven contacts per week, arranged and unannounced home visits, three-monthly reviews.
- **High intensity:** at least one, but up to three contacts per week, planned and unannounced home visits, three-monthly reviews.
- **Medium intensity:** minimum weekly contact until three-month review with capacity to reduce to fortnightly. Should include at least one planned or unannounced home visit between reviews, review after first three months and if circumstances remain stable, then at nine months and six monthly thereafter.
- **Low intensity:** weekly contact for first month, reducing to monthly thereafter, review every six months.

Q7.12 Was non-compliance appropriately managed in line with national outcomes and standards? Consider whether appropriate and timely actions were taken to investigate any incidents of non-compliance and encourage re-engagement (where appropriate). Were decisions about the exercise of discretion appropriately taken and clearly recorded? Were warnings issued in a timely fashion and, where relevant, were breach proceedings initiated within expected timescales?

Q7.13 Were home visits undertaken in line with national outcomes and standards? The frequency of home visits should correlate to the level of supervision intensity outlined in national outcomes and standards. Where home visits were not undertaken, is there evidence that this was discussed with a manager and is a rationale for this clearly recorded in case notes?

Q7.14 Were statutory social work reviews held in line with national outcomes and standards? Consider whether gaps or delays to statutory reviews were within the control of the service. The frequency of statutory reviews should correlate to the level of supervision intensity outlined in national outcomes and standards. Any deviation from review schedule outlined in national outcomes and standards should be recorded in the case file and agreed by a manager.

Q7.15 Did the statutory social work review focus on the progress of the case/risk management plan?: National outcome and standards indicate that written information should be compiled in advance of a review outlining the person's progress or otherwise. Consider whether there is evidence that progress in implementing the case/risk management plan was considered and recorded as part of the review.

Q7.16 Was the management oversight of the order/licence sufficient? Good practice would indicate that a manager/senior social worker should chair statutory reviews to provide objective monitoring of the progress of the order/licence as well as oversight of professional

practice and decision making. Management oversight might also be evidenced through notes of supervision/case discussion or a formal record indicating that a manager has reviewed practice as part of quality assurance processes. Consider whether there is evidence from the case records or staff interviews to demonstrate appropriate levels of management oversight.

Q7.17 Where other internal/external professionals were involved, was partnership working and information sharing appropriate? External agencies and other social work services who are involved with the person and/or their family should be invited to reviews. If they are unable to attend, they should be given the opportunity to provide feedback to justice social work staff in advance of the review. Consider whether information-sharing with other professionals was pro-active, proportionate and effective. This may include third sector colleagues, health professionals, police, prison staff, treatment providers, housing, and/or other social work services (for example adult/child protection). Were referrals to other agencies appropriately considered and quickly actioned? Are there any instances where information could/should have been shared and the opportunity was missed?

Q7.18 Was practice compliant with local policies and procedures? Consider whether any local policies and procedures were appropriately followed. For example, this may include information sharing with court services to ensure the timely commencement of orders or referral procedures.

Q7.19 Were early warning signs of escalating risk or imminent offending appropriately identified and addressed? Were there any indications that risk may have been escalating? Were there any significant events in the period prior to the serious incident? Did recording or information-sharing systems effectively support early identification of concerns? Were staff appropriately alert and attentive to risk? Were concerns appropriately escalated and addressed by the service? Was information or updates about concerns shared with or sought from other partners?

Q7.20 Were all reasonable steps taken to manage risk and need? Having reviewed the incident(s) in detail, are you assured that all reasonable steps were taken to manage the person's identified risks and meet their specific needs? Consider what additional supports could have been offered and whether their provision would have affected the likelihood of further offending.

Q7.21 Is the need for further examination indicated? Where you have answered 'no', 'not at all' or 'partially' to any of the key considerations above, this might indicate that there are refinements or improvements that could be made to individual practice or to service delivery.

In such instances, consider completing **part two: reflective learning review** in order to explore the factors that contributed to the identified practice issues**.** Where you have answered 'no', 'not at all' or 'partially' to any of the key considerations but conclude that there is no additional learning to be gained from further analysis, provide an explanation for why this is the case. In all cases, questions 10 and 11 should be completed before submission.

Serious incident review part two: reflective learning review

8	**Summary of approach:** Outline who led the review, how you ensured objectivity, the documents and processes you reviewed and the initials and job role of anyone who contributed to the review.

9	**Learning summary:** Using a SMART approach, this section should capture the considerations identified in the case examination and any wider issues or learning points.				
Identified learning point	**Contributing or causal factors**	**Proposed action**	**By whom**	**By when**	**Outcome (when known)**

10	**Good practice**		
Despite a serious incident occurring, note any innovative or sector leading practice identified, over and above national outcomes and standards.	How will the good practice be highlighted and shared?	By whom	By when

11	**National learning:** In considering the issues you have identified, summarise any: • impact resulting from national justice policy or practice • implications for national justice policy and practice. Please also outline any actions that have been taken to address the issues identified.

12	**Sign-off**				
Person completing the review:					
Name and designation		**Signature**		**Date**	
Chief social work officer/ Senior manager sign-off:					
Name and designation		**Signature**		**Date**	

Part 2: Reflective learning review – guidance

Q8. Summary of approach: Provide a brief summary of how you approached the case review and analysis. For example, who led the review, how did you ensure objectivity, what documents and processes did you review, and who participated in the review? Although it is not within the scope of a serious incident review to identify areas for improvement for another agency, it is good practice for local authorities to seek the views of partners when preparing a reflective learning review. In some cases where there has been significant collaboration, partners may conclude that they wish to conduct a multi-agency review.

Q9. Learning summary: The purpose of this section is to move beyond simply describing what happened to consider why it happened in order to reduce the likelihood of a similar situation occurring in the future.

Identified learning point - The identified learning point may include (but is not limited to) any instance where you have answered 'partially', 'no', or 'not at all' to the key considerations in the case review. Provide a brief summary of the issue.

Contributing or causal factors - The central idea of a systems approach is that professional practice and decision making are a result of both the skill and knowledge of the worker and the organisational setting in which they are working. In considering the factors that caused or contributed to the issues you have identified, think about how effectively practice and systems were operating in relation to:

- the application of assessment and management frameworks
- staff and service user interactions
- professional/service level decision-making
- management supports and systems
- multi-agency communication and collaboration about on-going support/service provision
- multi-agency communication and collaboration in response to increase risk/concern.

Contributing factors may relate to individual practice and decision-making, training needs, clarity of policies and procedures, effective operation of systems, lines of communication, and/or management oversight.

Proposed action - Identify the specific, achievable and measurable actions that will be taken to address the factors you have highlighted and provide some comment on how you will know that the proposed action or improvement has been successfully achieved or implemented.

By whom - Identify who is responsible for implementing the action.

By when - Identify timescales for when the action will be delivered.

Outcome – Record the outcome when known. If this is after the serious incident review has concluded, there is no need to resubmit the template to the Care Inspectorate. This section is to support continuous improvement and to demonstrate the impact and outcome of the actions taken.

Q10. Good practice: This section offers an opportunity to capture good practice which may be worthy of wider dissemination. By good practice we mean innovative improvement initiatives and/or sector leading practice (over and above what would be expected in relation to national outcomes and standards) that has contributed to positive outcomes for service users, the service and/or partners or the wider community.

Q11. National learning - In considering the incident and your service's management of the order/licence are there any national policies or practices which impacted on practice? This may relate to legislative considerations, court or prison procedures. Consider whether the learning from the review has implications for national justice policy and practice that may require wider consideration. This data will be collated and disseminated by the Care Inspectorate to support continuous improvement.

Q12. Sign-off - The case review and where required, the reflective learning review must be signed by the member of staff who completed the review and their designation noted. The review should be counter-signed by the local authority's chief social work officer (or designated depute in their absence to avoid any unnecessary delay) to demonstrate that there is oversight and accountability for any identified learning and improvement actions within the service.

Appendix 5 – Sample templates

Serious incident review: notification

1	Person's initials	SK		
2	Age	29		
3	Gender	Male		
4	Name of responsible local authority	Anytown City Council		
5	Reason for referral (tick one) ☒ A person subject to a statutory order or licence is charged with and/or recalled to custody on suspicion of a further offence that has resulted in the death or serious harm of another person. ☐An incident or accumulation of incidents, gives rise to significant concerns about service involvement/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.			
6	Date of incident (DD/YY/MMMM)	16/02/2021		
7	Date service became aware of the incident (if different)	19/02/2021		
8	Type and length of supervision/statutory order/licence	24-month CPO. Supervision and 200 hours UPW		
9	Date order imposed/release on licence	16/04/2020		
10	Current status of the individual	☐ At liberty	☒ In custody	☐ Deceased
11	Brief description of incident/charge resulting in notification: • circumstances of the incident • nature and extent of harm • gender/age of victim(s) and relationship to victim(s) where known • source of information/ intelligence On 16/02/2021, court social workers advised that SK appeared from custody at Anytown sheriff court having been arrested for assault to severe injury and permanent disfigurement. He is alleged to have assaulted a male with a bottle, pulled him to the ground, punched and kicked his body and stamped on his head, all to his severe injury. The offence appears to have been an unprovoked attacked on an unknown male.			
12	Category of further offence (select most serious)	☐Death of service user	☐Murder	
		☐Serious violence	☐Contact sexual offence	
		☐Non-contact sexual offence	☒ Domestic Abuse offence	
		☐ Other	Please specify:	
13	Intensity of supervision according to assessed level of risk/need at time of alleged offence	☐ Very high ☒ High ☐ Medium ☐ Low ☐ UPW only		
14	Are other agencies involved in providing support or supervision to this person? If yes, specify who: Support worker, Anytown City Alcohol Service.		☒ Yes	☐ No

15	Do any of the following criteria apply to this individual	☒Looked after child	☐Receiving continuing care/aftercare	☐Living in a regulated care establishment	☐N/A
16	Are high levels of public or media attention anticipated?	☐ Yes	☒ No	☐ Not Known	
17	Where the notification relates to an alleged further offence are there charges pending against the individual?	☒ Yes	☐ No	☐ Not Known	
18	What level of MAPPA review has been completed?	☐ INR	☐ ICR	☒ N/A	

19	**Sign-off**				
Person completing the notification:					
Name and designation	Jean Brown, Justice Team Leader	**Signature**	Jean Brown	**Date**	23/02/2021
Senior manager signing off the notification:					
Name and designation	Sally Sanders, Service Manager	**Signature**	*Sally Sanders*	**Date**	23/02/2021

Serious incident review part one: case review

1	Care Inspectorate SIR reference number	732	
2	Person's initials	SK	
3	Age	28	
4	Basis of review (led by whom and their relationship to the case, records read, individuals interviewed, partners consulted etc)	The review was led by justice team leader, Bob Giles who had no direct involvement in the supervision of SK. A case file audit was undertaken including a review of case notes, risk assessments and reports. Interviews were undertaken with supervising social worker (JB), and supervising team leader (SS). Professional discussion also held with the alcohol support worker (PH). Additional information regarding the offence was gathered by the supervising social worker following a visit to see SK on remand.	
5	Chronology prepared	☐ Yes	☒No
6	**Case overview** Provide a brief description of the person's relevant history including: • the extent and nature of offending history • their response to previous supervision • the offence/s resulting in current order/licence • their compliance with current order/licence • any discipline issues in custody (if relevant) • any additional details about the current charge/incident that were not included in the notification		
	SK has a long history of offending behaviour dating from 2009 and has accrued 48 convictions. Early offending largely related to anti-social behaviour linked to his pro-criminal peer association and regular use of alcohol. However, convictions for possession of a knife (2017), assault to injury (2018) and police assault (2018) indicate an escalating pattern in terms of frequency and seriousness which culminated in the imposition of a 12-month community payback order in November 2018 for the latter two offences. While the order was successfully completed, SK's overall level of engagement was superficial, and he was issued with a first and final warning following episodes of non-compliance. On 16/04/2020, SK was made subject to a 24-month community payback order with 200 hours of unpaid work following conviction for assault to injury and robbery. The incident occurred on a night out with friends. Having consumed excessive amounts of alcohol, SK (acting with a friend) assaulted and robbed an unknown male outside a local bar. Compliance with supervision has again been superficial and progress in reducing unpaid work hours was slow. Following several warnings and an extension request, SK finally completed the unpaid work hours in February 2021. The supervising social worker reported that SK consistently presented as evasive and obstructive in interviews and was reluctant to engage in any offence focussed work. Some positive engagement was noted with alcohol services, however attendance was sporadic and deteriorated in the run up to the current offence. Significant discretion was exercised by the supervising officer and SK was issued with a first and final warning in the course of the order. A referral was made to the Anytown City alcohol support service and initially SK engaged well with the service, however his attendance declined and in December 2020 he disengaged from the service.		

	During the course of the order, SK was intermittently employed as a casual labourer on building sites but has not sustained employment for more than six months at a time. In relation to the further offence, SK reports that on the day of the incident he had been sacked from his construction job following a fight with another worker. He proceeded to go to the pub where he drank heavily until 10pm when he was ejected from the bar. The victim of the assault was a passer-by walking his dog. SK reports that the victim (who was not known to him) 'looked at me the wrong way' and that this provoked the assault. SK is currently on remand awaiting trial.
7	**Case file examination: Please answer each of the following questions and provide the evidence and rationale to support your conclusion.**
7.1	Was an appropriate assessment of risk undertaken and completed? ☒ Yes ☐ No ☐ N/A *Evidence and rationale to support conclusion:* A full LS/CMI was completed following the imposition of the most recent CPO.
7.2	Was the LS/CMI assessment completed within nationally agreed timescales (where relevant)? ☐ Yes ☒ No ☐ N/A The LS/CMI was completed on 18/06/2020, two months after the imposition of the order. The reason for delay is not clear within case notes.
7.3	Where risk of serious harm was indicated was a risk of serious harm (RoSH) assessment completed? ☐ Yes ☐ No ☒ N/A SK was assessed as presenting with a high level of risk/need but at the time there were no significant current indicators to suggest that an assessment for risk of serious harm was required.
7.4	Was the risk assessment updated in accordance with expectations and/or reviewed in light of significant change? ☐ Completely ☐Mostly ☐Partially ☒ Not at all ☐N/A The LS/CMI assessment was completed in advance of the 3-month review but was not updated for the 12-month review. The 6-month review did not take place. Due to an unexplained break-down in communication between social work and addiction services, the supervising social worker was not aware that SK had lost his job or that he had disengaged from the alcohol service in December 2020. Had this information been shared, it may have triggered a review of the risk assessment.
7.5	Was the assessment of an appropriate quality? ☒ Yes ☐ No ☐ N/A The LS/CMI was largely accurate and fully considered the pattern, nature, seriousness and likelihood of offending.
7.6	Was a case/risk management plan completed within nationally agreed timescales? ☐ Yes ☒ No ☐ N/A The case management plan was completed in time for the 3-month review on 9th July.
7.7	Did the case/risk management plan correlate to the identified risks/needs? ☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A

	The case management plan did not include any explicit actions to address alcohol use, although this was highlighted as a risk factor and in practice, a referral to addiction services was made in July 2020. Failure to update the case management plan meant that actions to address disengagement with alcohol services was not taken.
7.8	Were the actions in the case/risk management plan appropriately implemented?
	☐ Completely ☒Mostly ☐Partially ☐ Not at all ☐N/A
	There were some delays in actioning a referral to employability services – the referral was not made until August 2020, four months after the order was imposed.
7.9	Was the case/risk management plan reviewed and/or updated in the course of the order/licence to reflect progress and/or change?
	☐ Completely ☐Mostly ☐Partially ☒ Not at all ☐N/A
	The case management plan was prepared in time for the three-month review but was not updated for the 12-month review through use of the progress record within LS/CMI. It's not clear from the 12-month review paperwork whether the case management plan was explicitly discussed and contrary to expected practice no senior social worker was present at the review.
7.10	Were statutory requirements of the order/licence appropriately delivered?
	☐ Completely ☒Mostly ☐Partially ☐ Not at all ☐N/A
	Both supervision and unpaid work requirements commenced without delay and in line with national outcomes and standards. Although there were compliance issues with unpaid work, an extension request was submitted to court in good time and SK was supported to complete the hours.
7.11	Was the level of supervision proportionate to the assessed level of risk/need?
	☒ Yes ☐ No ☐ N/A
	Appointments were offered at an appropriate frequency given SK was assessed as presenting with a high level of risk and need.
7.12	Was non-compliance appropriately managed in line with national outcomes and standards?
	☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A
	Verbal warnings were issued for missed appointments on 16th and 23rd July and 6th August. A first formal warning was issued for missed appointments on 8th and 16th Sept. A final warning was issued for missed appointments on 16th and 21st October. SK then failed to attend appointments on 18th Nov and 9th Dec 2020 and 13th Jan 2021. It is not clear from case records that there was a valid excuse for these absences – SK informed his social worker that he had 'forgotten' the appointments. No disciplinary action was taken in response and the opportunity to return the order to court under breach proceedings was missed.
7.13	Were home visits undertaken in line with national outcomes and standards?
	☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A
	An announced home visit was undertaken on 11th June, however no planned or unannounced home visits were attempted thereafter.
7.14	Were statutory reviews held in line with national outcomes and standards?
	☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A

	Reviews were held at the three month and 12 month point but the six-month review was not scheduled by the service. This appears to have been a consequence of the senior social worker being off sick. The first review was chaired by the senior social worker, however the 12-month review was chaired by the social worker which offered no management oversight of practice or progress.
7.15	Is there evidence that the statutory review focused on the progress of the case/risk management plan? ☐ Yes ☒ No ☐ N/A Although the case management plan was signed off at the three-month review, there is no evidence in the review paperwork or case notes that it was reviewed or explicitly discussed at the 12-month review. The six-month review did not go ahead.
7.16	Was the management oversight of the order/licence sufficient? ☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A The senior social worker chaired the 3-month review but did not attend the 12-month review. There was no evidence from case recordings that the case was reviewed by or discussed with the senior social worker within case records thereafter. There is no evidence of quality assurance of practice by the senior social worker.
7.17	Where other internal/external professionals were involved, was partnership working and information sharing appropriate? ☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A Early in the order, case recordings show evidence of effective information sharing between the social worker and the alcohol support worker regarding the referral and engagement with appointments. However, communication between the social worker and alcohol support worker trailed off in November 2020 and there is no evidence of further discussion after that point. The alcohol support worker reports that SK disengaged from the service in December 2020 and that in the run up to this there was evidence of an escalation in his level of alcohol use, and his reported levels of anger and anxiety. Opportunities to involve UPW staff and the alcohol support worker in statutory reviews were missed.
7.18	Was practice compliant with local policies and procedures? ☒ Completely ☐Mostly ☐Partially ☐ Not at all ☐N/A No evidence that local policies were not adhered to.
7.19	Were early warning signs of escalating risk or imminent offending appropriately identified and addressed? ☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A SKs level of engagement throughout was noted to be superficial and there was a persistent pattern of non-attendance. Latterly management of non-compliance drifted and there were several missed appointments which should have resulted in a breach report being submitted. Although there was good information sharing with alcohol services at the outset, in the 4 months prior to the incident, there had been no communication between social work and addiction services. Consequently, the social worker was unaware of SKs escalating alcohol use, increased levels of anger and anxiety and his disengagement from alcohol services. In the absence of this information the risk assessment was not reviewed. In addition, there was no management oversight at the 12-month review.
7.20	Were all reasonable steps taken to manage risk and need? ☐ Completely ☐Mostly ☒Partially ☐ Not at all ☐N/A

	Although supervision was commensurate with the assessed level of risk, and records reflect efforts on the part of the supervising officer to engage SK throughout the course of the order, this was made difficult by his persistent pattern of non-engagement and non-compliance. However, there were missed opportunities relating to information sharing and the review of the risk assessment and risk management plan. National standards in relation to statutory reviews and home visits were not consistently adhered to, and non-compliance was not managed as robustly as it should have been.	
7.21	Is the need for further examination indicated? Where you have answered 'no', 'not at all' or 'partially' to any of the key considerations, further analysis using the *Reflective Learning Review* should be considered to support learning regarding local or national practice. Where you have answered 'no', 'not at all' or 'partially' but conclude that more detailed examination is not required, a clear rationale for this decision should be provided below.	☒ Yes ☐ No
	N/A	

Serious incident review part two: reflective learning review

8	**Summary of approach:** Outline who led the review, how you ensured objectivity, the documents and processes you reviewed, and the name and job role of anyone who contributed to the review.
	The review was led by Justice Service Manager, Maggie Strath who had no direct involvement in the supervision of SK. Following the completion of the case review by Bob Giles, a professional discussion was held on 23/04/2021, chaired by Ms Strath. The following people attended: supervising social worker (JB); supervising Team leader (SS); UPW manager (JM), alcohol support worker (PH), and Bob Giles, team leader. Attendees discussed the findings of the case review and agreed the following learning points.
9	**Learning summary:** Using a SMART approach, this section should capture the considerations identified in the Case Examination and any wider issues or learning points.

Identified learning point	Contributing or causal factors	Proposed action	By whom	By when	Outcome (when known)
Risk Assessment practice (7.2, 7.4, 7.19)	The delay in undertaking the LS/CMI assessment was noted by the social worker to be a time management issue. The missed review at six months and the lack of management oversight at the 12-month review meant that there was no internal scrutiny of the quality and scope of the risk assessment. The risk assessment was not updated for the 12-month review. The social worker noted that, at the time, they did not identify any particular reason to reassess SK's risk but acknowledged that had they been aware that SK had disengaged from alcohol services, they would have reviewed the risk assessment and adjusted the case/risk management plan. The	Staff to be reminded of 20-day timescale at team meeting. Follow up individually in supervision.	Team Leader Senior Social Worker	23 Jun 2021 Review Dec 21	Completed. Completed.
		Compliance with 20-day timescale to be monitored via case file QA process	Service Manager	Quarterly performance review	
		Remind staff of procedures for sharing information with statutory and third sector partners – team meeting update	Team Leader	23 Jun 2021	Completed.

	breakdown in communication between addiction and social work services related to a misunderstanding between staff. The social worker believed that addiction staff would contact them with any updates, while the alcohol support worker was expecting social work to contact them for updates. Had addiction staff been invited to contribute to statutory reviews this may have aided information sharing and helped avoid confusion. In combination, these factors meant that important information on escalating risks was not captured and opportunities to mitigate the risk were missed or not fully exploited.				
Case management planning (7.6, 7.7, 7.9)	There was a delay in completing the case management plan which was noted to be a time management issue by the social worker. As such, limited progress had been made on implementing the plan prior to the three-month review and the case management plan was not explicitly discussed at the six or 12-month review point. The progress record within LS/CMI had not been updated to reflect the actions that had been implemented. It was noted that	Service to amend the statutory review paperwork to include explicit consideration of the case management plan. Update staff via team meeting.	Team Leader Senior social workers to follow up in supervision	July 2021 Review Dec 21	
		Compliance with 20-day timescale and use of the LS/CMI progress record to be monitored via case file QA process.	Service Manager	Quarterly Performance reporting	

	the current review paperwork does not prompt for an explicit discussion of the case management plan. This does not support effective case management or robust management oversight.				
Management of non-compliance (7.12, 7.13, 7.15)	The social worker acknowledged that significant discretion was exercised in the early stages of the order in an attempt to encourage SK's engagement. He was noted to be a very difficult person to engage with. He presented as evasive, hostile and was largely mono syllabic in his presentation. The social worker acknowledged that they lacked confidence in managing these behaviours and noted that this contributed to their failure to issue warnings in the later stages of the order. This also contributed to missed home visits. It was accepted that the reasons for non-attendance were not valid and that a breach report should have been submitted. The senior social worker was off long-term sick which resulted in a lack of formal staff supervision and access to informal support. As such, the social worker did not have the opportunity to escalate concerns	Review of individual learning needs for supervising social worker within supervision. Learning case study input on management of challenging people within team L&D activities	Senior Social Worker Team Leader	Review Dec 21 July 2021	
		Review staff supervision arrangements to ensure contingencies to cover staff absence.	Service Manager	July 2021	

	via a line management route and missed the benefit of senior management support and oversight. These factors contributed to a lack of adherence to national standards regarding the management of non-compliance.				
Statutory reviews (7.9, 7.14, 7.15, 7.16, 7.17)	The six-month review did not take place. This was largely due to the long-term absence of the senior social worker. The 12-month review was chaired by the supervising officer, not the senior social worker and did not explicitly consider progress in delivering the case management plan. Staff from the UPW service and alcohol support service were not invited to attend the reviews which limited capacity for information sharing. Together, these factors contributed to a lack of focus on compliance with the order, resulting in a lack of management oversight and missed opportunities to pick up on escalating risks.	Revise and reiterate procedures for statutory reviews to ensure seniors social worker's chair reviews and that scheduled reviews are not missed through staff absence.	Service Manager	July 2021	
		Review current practice on inviting partner agencies to attend statutory reviews	Team Leader – review and updated staff via monthly team meeting.	July 2021	

10	**Good practice**		
Despite a serious incident occurring, note any innovative or sector leading practice identified, over and above National Outcomes and Standards.	How will the good practice be highlighted and shared?	By whom	By when

11	**National learning:** In considering the issues you have identified, please summarise any: • impact resulting *from* national justice policy or practice • implications *for* national justice policy and practice Please also outline any actions that have been taken to address the issues identifed.
The review highlighted that the current template for statutory reviews does not prompt for explicit consideration of progress in implementing the case/risk management plan. It is noted that there may be benefit in developing a national approach to reviews to support consistency and aid effective monitoring and measuring of individual progress and outcomes.	

12	**Sign-off**				
Person completing the review:					
Name and designation	Maggie Strath, justice service manager	**Signature**	Maggie Strath	**Date**	18/05/2021
Senior manager signing off the review:					
Name and designation	Helen Moffat, chief social work officer	**Signature**	Helen Moffat	**Date**	18/05/2021