

**Level of Service / Case Management Inventory  
(LS/CMI) Review Group**

**Report on the Review of Closed Cases**

Victims Organisations Collaboration Forum Scotland (VOCFS)  
Caledonian Programme  
Moving Forward Making Changes Programme (MFMC)



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# 1. Introduction

## 1.1 Background

The Level of Service/ Case Management Inventory (LS/CMI)<sup>1</sup> is a comprehensive general offending assessment and case management planning method. It is used by all community and prison based justice social work services in Scotland to aid decisions on the level and focus of intervention with people (aged 16+) who have been involved in offending.

### The LS/CMI in Scotland

The method has been adapted for use in Scotland to enable an evaluation of the pattern, nature, seriousness and likelihood of offending and helps structure professional decision making in a manner that is consistent and comprehensible regardless of the nature or complexity of the case.

The process for administering the LS/CMI follows a triage approach, which enables three levels of increasing assessment:

- **A scan level or initial assessment:** Applied at the pre-sentence stage to help inform the court of the suitability of community based disposals.
- **An examination level:** Applied in all cases where the disposal from court involves statutory social work intervention - via a community order; during a period of imprisonment (if the person will be subject to a release licence) and for the duration of the supervision period of the licence after release from custody. This depth of assessment is used to inform decisions about the management plan for the person whilst subject to social work intervention.
- **A scrutiny of risk** is completed for those where there are indicators of a risk of serious harm. The method follows a structured professional judgement approach to analysing the risk of serious harm in depth. The assessment informs decisions on what type of plan is required to manage the risks the person presents including a Risk Management Plan.

An LS/CMI IT system was developed in 2010 and is used by Justice Social Work (JSW) services, both community and prison based, undertaking assessments and devising management plans for those subject to supervision.

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<sup>1</sup>Andrews, D.A., Bonta, J.L., & Wormith, S.J. (2004). LS/CMI: The Level of Service/ Case Management Inventory. Toronto: Multi-Health Systems.

## Identified IT issues

In January 2022, an issue with the risk/ need level displayed within an assessment, was raised by a justice social worker, through the helpdesk provided by the IT managed service provider.

For context; as part of applying a full LS/CMI assessment, an assessor completes an actuarial, scored component which determines a risk/ need level: The score based risk/ need level.

The assessor then considers whether there are grounds to; request an override - to increase or decrease this score driven risk/ need level - or not. Any override request would be considered by a Team Leader, who would then approve or reject the request.

Next, the final risk/ need level is displayed - based either on the score or on the override.

This is where the issue presented, whereby, within some assessments, the score based risk/ need level and the final risk/ need level did not match.

In February 2022, following investigation, the IT managed service provider confirmed that the issue was connected to the IT system and affected other users.

A second issue, relating to the scoring of alcohol and drug problems was also identified at the time. Further information relating to this issue is detailed within the attached Terms of Reference document.

## 1.2 Preliminary Review of Closed Cases within the LS/CMI System

The IT managed service provider ran a test script to identify cases where a discrepancy in the score based risk/ need level and the final risk/ need level existed within the system. A total of **1032** closed cases<sup>2</sup> were identified where a discrepancy with risk/ need levels was found.

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<sup>2</sup> Where a person no longer requires to be assessed or managed by the Justice Social Work service, the service closes the record (the case) within the LS/CMI system.

## 2. LS/CMI Review Group

On 2 March 2022, the Risk Management Authority were asked by Scottish Government (SG) officials to convene an LS/CMI Review Group and a remit for this was shared.

On 3 March, 2022, the Cabinet Secretary for Justice and Veterans provided a statement to the Scottish Parliament<sup>3</sup> on the issues affecting the LS/CMI IT System and advised he had commissioned a review group, led by the Risk Management Authority to '*...make an assessment of whether these errors will have had an impact on how that case was managed in the system.*'

Following this, all members of the group met with the Chief Executive of the Risk Management Authority and the LS/CMI Review Group first met on 8 March and reviewed the proposed Terms of Reference.

The RMA would like to acknowledge the prompt reaction of all agencies in responding to this issue and request to convene, on top of demanding workloads.

This group was comprised of members from the following agencies:

- Risk Management Authority (RMA)
- Social Work Scotland (SWS)
- Scottish Prison Service (SPS)
- Parole Board for Scotland (PBS)
- The Care Inspectorate (CI)
- The Crown Office and Procurator Fiscal Service (COPFS)
- Victims Organisations Collaboration Forum Scotland (VOCFS)
- Caledonian Programme
- Moving Forward Making Changes Programme (MFMC)
- HM Inspectorate of Prisons for Scotland (HMIPS)
- Community Justice Scotland (CJS)

The objectives of the LS/CMI Review Group were agreed as follows:

- To determine which cases the LS/CMI scoring error affects. This includes initially closed cases and subsequently open cases.
- To conduct a gap analysis to determine “as was” scoring from “as should be” scoring.
- To determine for each case where such a gap exists, in the event of such a gap, and to the best that it can be determined, whether there was a material impact on how the case was subsequently dealt with in the justice system.
- To produce recommendations for each case where such a gap exists, how to amend all versions of records in the justice system so the correct scoring exists.

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<sup>3</sup> [Justice system approach to risk assessment – Ministerial statement - gov.scot \(www.gov.scot\)](#) and; [Meeting of the Parliament: 03/03/2022 | Scottish Parliament Website](#)

- To produce recommendations where there was a material impact on how the case was subsequently dealt with in the justice system what remedial action may be appropriate.
- To produce an action plan for Scottish Ministers as to how to take forward any response to the scoring issue and the analysis undertaken by the group.
- To make to Scottish Ministers any recommendations on matters of risk relevant to LS/CMI scoring which the group thinks are appropriate.

Four phases were agreed as part of the LS/CMI Review Group work:

- **Phase One:** Identification of the scope of the problem and gap analysis. Identification of decision/ communication points in the justice system.
- **Phase Two:** Material Impact. Review and report on any impact on the justice system.
- **Phase Three:** Material Impact. Validation of results.
- **Phase Four:** Report and action plan.

Since the initial meeting, the LS/CMI Review Group met on a further 12 occasions. Key decisions agreed by members during these meetings related to;

- Approval of Terms of Reference
- Review and agreement of findings from Phase One
- Review and agreement of data analysis and findings from Phase Two
- Review and agreement of First Grant of Temporary Release case evaluation
- Revised position in relation to planned deliverables surrounding alcohol & drug issue (decision explained in Limitations section of this report)
- Agreement of methodology for Phase Three validation
- Review and agreement of findings from Phase Three
- Review and agreement of the objectives within the Terms of Reference
- Review and agreement of this report and recommendations

The LS/CMI Review Group also had to extend original planned timescales for concluding each of the phases. This was necessary, in order to provide sufficient time to engage with relevant local authorities and justice agencies in relation to the significant amount of data gathering and analyses used to inform findings. All adjustments were communicated to the Cabinet Secretary for Justice and Veterans, who in turn, updated the Criminal Justice Committee.

## 2.1 Phase One: Identification of the Scope of the Problem, and Decision / Communication Points in the Justice System

As noted previously, the preliminary LS/CMI system review of closed cases by the IT service provider identified **1032** closed cases with a discrepancy in risk/ need levels. It was acknowledged at this point that the difference in levels within some of the cases, could have been where an override had been applied and not because of an error caused by the system.

Given this, each local authority JSW service was asked to undertake an immediate review of the closed cases identified as located within their part of the system in order to:

- Identify those cases where the discrepancy did appear to be an error. (These were investigated further during subsequent phases of review to evaluate the impact of this error on any decisions driven by the assessment).
- Ascertain in which (if any) of these closed cases no actual error existed with the risk/ need levels. (These cases were then removed from the list of those requiring fuller investigation from subsequent phases of review).

### Methodology

JSW service areas were provided with identifiers (LS/CMI case number and Unique Reference Number (URN)) for each of the closed cases located within their LS/CMI system, where a difference between the score based and final risk/ need level had been identified by the IT provider.

Guidance was also provided on which sections of each case to view in order to:

- Confirm there was a difference between the score driven and the final risk/ need level;
- Ascertain whether an override had been applied or not.

Returns received were collated and analysed by the RMA to provide detail, by local authority area, of those cases which could be excluded for further analysis.

The findings from this phase were agreed by the LS/CMI Review Group and were taken forward for further investigation within Phase Two.

Only cases where a difference between the score driven and final risk/ need level was confirmed and where no override had been applied were taken forward for further investigation in Phase Two.



## 2.2 Phase Two: Material Impact. Review and Report on Any Impact on the Justice System

Phase Two of the review focussed on these cases in order to ascertain:

- whether the incorrect risk/ need level was used within any reports or documents;
- whether the incorrect risk/ need level had any material impact upon decisions about/ for the person being assessed.

This phase concentrated on analysing the returns provided across key stakeholder groups: JSW, PBS, SPS and Multi-Agency Public Protection Arrangements (MAPPA) areas.

### Methodology

Phase Two was split into two steps:

#### Step One

This step involved JSW reviewing the closed cases within their LS/CMI system to identify whether they had been responsible for the case at the time the affected assessment had been completed and, if not, identify which service had been responsible for the assessment and/ or management of the case at the time.

Returns received from JSW were initially analysed by RMA to determine whether responsibility for completion of the affected assessment could be determined. For those cases where responsibility may have been with another area it was agreed by the LS/CMI Review Group that these would be redistributed to those local authority areas during this phase. Any additional returns received on the redistributed cases were included in the final collated dataset. Redistribution was an additional request of JSW areas in addition to continuing to fulfil their operational responsibilities. However, this was necessary to provide accurate case data.

Where JSW were able to ascertain the date the affected assessment was completed, that information, along with a number of identifiers<sup>4</sup>, was then provided to the remaining agencies (SPS, PBS & MAPPA areas) to determine whether the affected closed cases had; been in custody, subject to parole considerations and/ or Multi Agency Public Protection Arrangements (MAPPA) from the time of the first affected assessment onwards.

#### Step Two

The JSW service responsible for completing the affected assessment and other decision makers (if involved with the person) were asked to review documents where reference to the incorrect risk/ need level may have been used.

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<sup>4</sup> Identifying information included; Unique Reference Number (URN), LS/CMI system Case ID and Date of Birth.

These agencies were asked to evaluate what impact this may have had across decision making points within the justice system covering:

- Court Report Recommendations
- Sentencing
- Prison: Case Management, Progression, First Grant Temporary Release (FGTR) and Release
- Community Supervision and MAPPA
- Programmes
- Risk of Serious Harm Assessment and Risk Management Planning

Within the review, each agency was asked to consider the following questions related to the presence and relevance of the issue in relation to risk/ need level:

- Was the risk/ needs level referred to?
- How was this communicated?
- Did this inform any decision?
- If the reference to the risk/ need level did inform decisions, specify what decision(s).
- What was the outcome of any decision(s)?

Agencies and MAPPA regions returned all information to the RMA for analysis. For clarity of referencing, all individual JSW areas and MAPPA regions findings were grouped into single data sets. The findings from RMA analysis of: JSW, SPS, PBS and MAPPA returns were presented to the LS/CMI Review Group to provide a preliminary overview of information. During this period of analysis, additional information was gathered from SPS and PBS to provide further detail of the person's journey through the justice system. This additional information gathering caused delays, however, was necessary to provide detailed case history.

Following this, the four datasets were collated into a core master set, using URN, to provide detail of cases:

- where an incorrect risk/ need level may have been used to inform decisions;
- which could be removed from further analysis<sup>5</sup>;
- had missing/erroneous data;

The LS/CMI Review Group then agreed the findings made within this phase of work to take forward into Phase Three.

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<sup>5</sup> These cases were removed for one of the following reasons; risk/need level had not been referred to/did not inform decisions, score based risk/need level used, person not previously known to the service or where decisions made by the service preceded date of affected assessment.

## 2.3 Phase Three: Validation of Results

Phase three of the review was led by the Care Inspectorate to provide independent oversight and focussed on validating results from the previous phases, considering any evidence of possible material impact and providing further analysis to reach conclusions on specific cases.

### Methodology

This validation and assurance phase considered all cases where Phase Two concluded that the use of an incorrect risk/ need level had a possible material impact on decisions and:

- Reviewed whether and which sources of information and/ or assessment tools, other than the LS/CMI, had contributed to case decisions;
- Considered what the weighting of other information sources and/ or assessment tools was, relative to the LS/CMI.

In addition, the Care Inspectorate:

- Reviewed all cases identified where an incorrect risk/ need level had been used to inform decisions and through further analysis at Phase Two it had been concluded there was no material impact;
- Reviewed all cases from Phase Two where there was a need for clarification and further review in order to establish whether material impact was possible;
- Pursued instances where, from earlier phases, there was missing, unclear or erroneous data in order to determine whether there was a need to investigate for material impact or not;
- Reviewed a sample of cases where the conclusion within the earlier phase was that no further investigation was required<sup>6</sup>.

To assist this phase, information pertaining to earlier phases of the review<sup>7</sup> was collated by RMA and sent to Care Inspectorate.

The Care Inspectorate liaised directly with local service contacts to arrange onsite or remote access to information for assurance and validation. This was undertaken across 18 local authorities and at SPS headquarters.

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<sup>6</sup> 25% of cases were sampled.

<sup>7</sup> Information included; supporting guidance sent to agencies, datasets related to each of the recommendations from phase two of the review collated by URN and arranged by local authority area/agency.

## 2.4 First Grant Temporary Release (FGTR) Review

In addition to the review of closed cases objectives, the LS/CMI Review Group were asked by the Cabinet Secretary for Justice and Veterans to consider if there had been any material impact for affected cases (within the IT system) which related to those who were in receipt of First Grant of Temporary Release (FGTR) (defined in Rule 134(4) of [The Prisons and Young Offenders Institutions \(Scotland\) Rules 2011](#) and section 15 of the [Risk Management, Progression and Temporary Release Guidance](#)).

### Methodology

SPS were provided with identifiers from the LS/CMI system, for FGTR cases where there was an error with the risk/ need level. SPS then analysed this data against all relevant prison systems containing FGTR case information.

SPS identified all cases for further investigation and gathered all available and relevant FGTR case information. This information included all Risk Management Team (RMT) documents, FGTR applications and reports from the LS/CMI system.

SPS also took the decision to suspend any community access for these prisoners (where applicable).

SPS provided the RMA with the aforementioned case information to evaluate whether there was any material impact arising from the use of an incorrect risk/ need level caused by the IT system error.

The RMA:

- reviewed all assessments within the LS/CMI system associated with the identified FGTR cases and combined this information with all related prison system information into a single data set;
- considered all (including any differences in) risk/ need levels against dates of Ministerial consent to FGTR approval;
- analysed RMT documents and considered all relevant sections<sup>8</sup> to reach a conclusion in each case.

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<sup>8</sup> Sections included the following: Sources of Information, Analysis of Risk, Community Access Risk Assessment/Community Risk Management Plan and RMT decision.

## 3. Findings

### 3.1 Closed Cases Review

#### Phase One

This phase of work commenced on 14 March and concluded on 21 April 2022.

Of the 1032 cases identified where a difference existed in the score based risk/need level and the final risk/need level:

- **560** did not require any further investigation of which:
  - **507** had an override applied by the assessing social worker, which explained the difference in the risk/ need level;<sup>9</sup>
  - **53** no actual difference in the risk/ need levels could be found.
- No return was received in relation to **seven** cases during this phase.
- This left **465** cases where there was an error with the risk/ need level within assessments. These cases were carried forward into Phase Two for further examination.

Planned timescales for Phase One encountered a short extension due to further clarification being sought from areas, where necessary, and to enable sufficient time for JSW areas to review and respond.

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<sup>9</sup> Within the LS/CMI method, the assessor can consider whether there are grounds to request an override - to increase or decrease - this score driven risk/ need level or not. Any override request is considered by a Team Leader who would then approve or reject the request.

## Phase Two

This phase of work commenced on 20 April and concluded on 5 September 2022.

- Of the seven outstanding returns from Phase One, **two** were received and excluded due to an override being applied.
- Following analysis of the **465** cases from Phase One:
  - **293** cases did not require further investigation and were removed<sup>10</sup>;
  - **128** cases could not be analysed because of missing returns, significant errors or absence of data in returns. These were carried forward into Phase Three for further examination.
- **44** cases were identified where an incorrect risk/ need level had been used to inform decisions.
- Following detailed analysis of the 44 cases there was judged to have been:
  - No material impact within **18** cases;
  - Need for clarification and further review within **four** cases in order to establish whether material impact was possible.
  - Possible material impact within **22** cases;
- Of these 22 cases:
  - In **14**, the possible material impact was on the person being assessed;
  - In the remaining **eight**, the possible material impact was on the management of the case.

All 44 cases were carried forward to Phase Three for further examination and validation.

Planned timescales for Phase Two were extended due to the redistribution work and requirement to source additional information from agencies, notwithstanding the significant volume of data which then had to be analysed collated (as detailed within phase two methodology section of this report).

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<sup>10</sup> These cases were removed for one of the following reasons; risk/need level had not been referred to/did not inform decisions, score based risk/need level used, person not previously known to the service or where decisions made by the service preceded date of affected assessment.

## Phase Three

This phase of work commenced on 27 October and concluded on 15 December 2022.

The remaining **five** outstanding returns from phase one were located and reviewed:

- **Three** cases were removed<sup>11</sup>;
- **Two** cases were excluded due to an override being applied.

The **128** cases that could not be analysed at Phase Two were reviewed and were able to be removed.

All **44** cases, identified at Phase Two, where an incorrect risk/ need level had been used to inform decision were reviewed:

- The **18** assessed as having no material impact were validated;
- The **four** cases in need of clarification and further review were investigated and concluded upon;
- The **22** cases with possible material impact were fully analysed and concluded upon.

A 25% sample of the **293** cases removed at Phase Two were reviewed and validated during this phase.

Planned timescales for Phase Three encountered delays. These were linked to the knock-on impacts from Phase Two delay conflicting with pre-existing commitments related to scrutiny work and the volume of additional information that required to be reviewed across agencies and systems.

**Phase Three validation findings concluded that there was no evidence that incorrect LS/CMI final risk/ need levels by themselves were driving decisions that had a material impact on public safety or were detrimental to the circumstances of any person. The findings offered assurance that the approach taken to the review of closed cases had been relevant and proportionate.**

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<sup>11</sup> These cases were removed for one of the following reasons; risk/need level had not been referred to/did not inform decisions, score based risk/need level used, person not previously known to the service or where decisions made by the service preceded date of affected assessment.

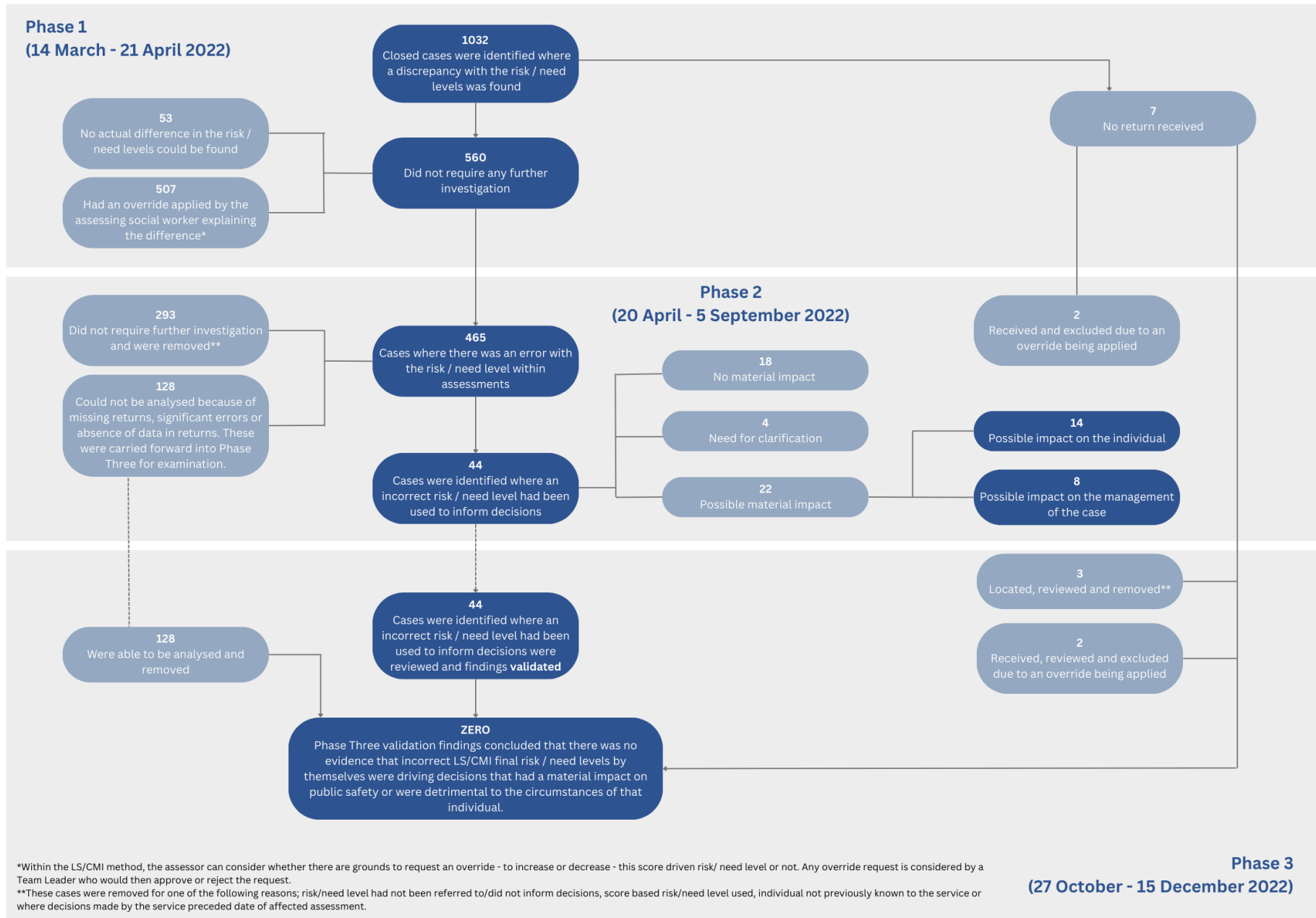
## 3.2 First Grant of Temporary Release Review

- SPS identified eight cases for further investigation.
- Of these **eight** cases, the evaluation concluded that no FGTR application, which had been approved and given consent by the Scottish Ministers, used an assessment where there was an issue with the risk/ need level related to the IT system error.
- There was evidence of incorrect risk/ need levels (but not caused by the IT system error) being used to inform other management decisions within four of these cases. However, evaluation of RMT documents evidenced there were many other factors and sources of information (for example, scrutiny level assessments), considered in reaching these decisions (see [Appendix A](#) for guidance documents that support relevant decision making).

Therefore, it is concluded there was no material impact on public safety or detrimental impact on any of these people, arising from associated management decisions.



**Figure 1: Numbers of cases and findings across the three phases of review**



## 4. Limitations

Identified limitations related to the phases of this review have informed associated recommendations, detailed below.

Within Phase One, JSW services could see no difference in risk/ need levels within 53 of the 1032 cases identified by the LS/CMI IT system provider. The LS/CMI Review Group requested, but did not receive rationale for this discrepancy through the then IT system provider.

The LS/CMI Review Group were not provided with information relating to cases affected by the alcohol & drug scoring error (Issue two within attached Terms of Reference document). The Group considered this, along with the positive findings of Phases One and Two, and agreed that they would no longer take forward the planned deliverable pertaining to 'Issue two'. This position was communicated to SG.

**Recommendation 1 (LS/CMI system):** The SG should implement and apply routine assurance checks of the LS/CMI system to ensure it is working as intended and that early detection of faults/issues are identified.

The information supplied by the IT service provider on potentially affected cases was limited and did not include key dates (such as date assessment started and completed). In the absence of this, JSW services were required to use the LS/CMI system report, to establish dates related to phase two deliverables. However, there were challenges in interpreting the system report to retrospectively ascertain assessment history information pertaining to closed cases, which led to additional work in later phases.

**Recommendation 2 (LS/CMI system):** The SG, through the IT System Provider, should ensure LS/CMI system reporting is reliable and enables self-evaluation, quality assurance measures, service planning and research.

The LS/CMI IT system permission entitled 'Global access rights, developed as part of the LS/CMI centralisation project, does not actually permit access to all records within the system nor a single, global LS/CMI system report. This limited the ability for RMA to provide information at an earlier stage to support services in carrying out review work. In addition, this lack of global access necessitated additional work for JSW services to provide information to the Care Inspectorate during phase three of the review.

**Recommendation 3 (LS/CMI system):** The SG should review and clarify the LS/CMI system permissions, as it relates to the global business support role, and global access rights (with the latter to help support any future external scrutiny).

The LS/CMI Review Group were unable to conclude objective four from its Terms of Reference, namely; to produce recommendations for each case where such a gap exists, how to amend all versions of records in the justice system so the correct scoring exists. Whilst acknowledged as a limitation within this report, the SG (who manage the IT Service contract and coordinate national JSW Service Manager meetings), were instead, best placed to progress this within the IT system.

## 5. Risk Related Issues Identified

The LS/CMI Review Group's final objective was to make to Scottish Ministers any recommendations on matters of risk relevant to LS/CMI scoring which the group considered appropriate. As such, throughout the phases of the review, the group identified areas to be addressed by justice agencies relating to:

- **Practice**
- **Policy**
- **Quality assurance**
- **Training**
- **Governance**

These have informed the recommendations within this section of the report.

During analysis of Phase Two returns from agencies and the FGTR review, there was evidence that LS/CMI risk/ need levels were frequently specified within documents being presented to decision making forums. Whilst unrelated to the IT System errors, this is a demonstrable deviation by agencies, from the agreed policy approach to risk outlined within the Framework for Risk Assessment, Management and Evaluation (FRAME)<sup>12</sup>. This policy includes standards of practice including the standard of risk assessment this outlines: *“The results of risk assessment will be communicated responsibly, in a way that is meaningful and understood by all involved. Risk will be communicated in terms of the pattern, nature, seriousness and likelihood of offending.”*(p56)

**Recommendation 4 (Policy):** The Risk Management Authority should work with all agencies to ensure awareness of and compliance with the foundations of the FRAME approach, particularly in reference to Chapter 3: Language of Risk.

**Recommendation 5 (Policy):** All agencies represented on the LS/CMI Review Group should review existing policy/ guidance/ circulars related to risk assessment & management to ensure, where applicable, they are compliant with standards of FRAME.

**Recommendation 6 (Practice):** The RMA should work with all relevant agencies to lead a review of the implementation of FRAME and its national application across assessment, management & defensible decision making.

**Recommendation 7 (Quality assurance):** The RMA should work with all relevant agencies to ensure the LS/CMI Quality Assurance Templates are embedded within audit/evaluation processes to assist decision making forums.

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<sup>12</sup> Risk Management Authority: Standards and Guidelines for Risk Assessment (2018). Standards and Guidelines for Risk Management (2016). Framework for Risk Assessment and Evaluation (2011).

**Recommendation 8 (Training):** The RMA should work with CJS and all agencies represented on the LS/CMI Review Group to analyse training needs relating to the application of FRAME approach.

During earlier phases of the review; determining when some assessments had been completed proved difficult, which led to additional work in phase three to draw conclusions. A proportion of cases had been 'overwritten' in order to update an assessment, rather than using the reassess function within the system. Some other cases were identified as having been closed and subsequently reopened in order to apply a new assessment, rather than creating a new case. Overwriting (within cases which are currently open or have been reopened) results in information from previous assessments being lost.

**Recommendation 9 (Practice):** The RMA should work with all Local Authority area JSW and CJS to reiterate the guidance in relation to reassessing and reopening cases within the LS/CMI system.

**Recommendation 10 (Training):** The SG, through the IT System provider, should work with CJS to ensure that reassessment & reopening functionality within the LS/CMI system is covered within training/user guides.

**Recommendation 11 (Training):** CJS should deliver national LS/CMI system refresher training.

The subject of LS/CMI governance was raised and discussed by Review Group members during meetings. This was in the context of varying national understanding of the associated arrangements when reviewing and agreeing the report recommendations. The LS/CMI Working Group and change control processes were acknowledged as established mechanisms, however, there was a clear need identified to clarify their purpose ahead of the LS/CMI IT System being operationalised.

**Recommendation 12 (Governance):** The SG should work with relevant agencies to review and communicate LS/CMI governance arrangement to ensure national oversight.

## 6. Conclusion

The LS/CMI Review Group was established in response to issues identified within the LS/CMI IT System. The Review Group agreed its terms of reference, seven initial key objectives and progressed deliverables through four phases of work and associated meetings.

The Review Group were initially presented with 1032 potentially affected closed cases for investigation. The methodology applied in Phases One and Two of the review first reduced this number to 465, then 44 for validation in Phase Three. Of these 44 cases, 22 were also subject to further analysis for possible material impact.

Phase Three validation findings concluded that there was no evidence that incorrect LS/CMI final risk/ need levels by themselves were driving decisions that had a material impact on public safety or were detrimental to the circumstances of any person.

The LS/CMI Review Group also considered material impact for affected cases (within the IT system) which related to those who were in receipt of FGTR. Eight cases were identified for evaluation, which concluded that no FGTR application, which had been approved and given consent by the Scottish Ministers, used an assessment where there was an issue with the risk/ need level related to the IT system error. It further concluded that there was no material impact on public safety or detrimental impact on any of these people, arising from associated management decisions.

The Review Group encountered limitations in relation to required information from the LS/CMI IT system set against what was available by the then provider. Limitations were largely overcome through additional work undertaken throughout the phases of the review. These limitations informed the first three recommendations within this report, which all concern the LS/CMI IT system.

The Review Group, as per its terms of reference, considered other matters of risk relevant to LS/CMI scoring (not related to the IT system issues). Key areas that presented within analyses of data returns included; specific references to risk/ need levels within documents, overwriting instead of reassessment being applied in cases and varying understanding of LS/CMI governance. The Review Group concludes nine report recommendations against these areas, which are categorised into; practice, policy, quality assurance, training and governance.

Whilst the LS/CMI Review Group concludes 12 recommendations, our findings confirm that there was no evidence that LS/CMI final risk/ need levels by themselves were driving management decisions.

Finally, the LS/CMI Review Group agreed that the development of an associated action plan, as originally proposed within the Terms of Reference, was no longer necessary given the outcome of the review work concluded there was no material impact. Furthermore, the recommendations outlined within this report are clear and as such, have been assigned to be taken forward by the relevant agencies or forums

e.g. SG, LS/CMI forums, FRAME implementation project. A progress update on the recommendations will be provided six months after the publication of this report.

## 7. Recommendations

### **Recommendation 1: LS/CMI system**

The SG should implement and apply routine assurance checks of the LS/CMI system to ensure it is working as intended and that early detection of faults/issues are identified.

### **Recommendation 2: LS/CMI system**

The SG, through the IT System Provider, should ensure LS/CMI system reporting is reliable and enables self-evaluation, quality assurance measures, service planning and research.

### **Recommendation 3: LS/CMI system**

The SG should review and clarify the LS/CMI system permissions, as it relates to the global business support role, and global access rights (with the latter to help support any future external scrutiny).

### **Recommendation 4: Policy**

The Risk Management Authority should work with all agencies to ensure awareness of and compliance with the foundations of the FRAME approach, particularly in reference to Chapter 3: Language of Risk.

### **Recommendation 5: Policy**

All agencies represented on the LS/CMI Review Group should review existing policy/ guidance/ circulars related to risk assessment & management to ensure, where applicable, they are compliant with standards of FRAME.

### **Recommendation 6: Practice**

The RMA should work with all relevant agencies to lead a review of the implementation of FRAME and its national application across assessment, management & defensible decision making.

### **Recommendation 7: Quality Assurance**

The RMA should work with all relevant agencies to ensure the LS/CMI Quality Assurance Templates are embedded within audit/evaluation processes to assist decision making forums.

### **Recommendation 8: Training**

The RMA should work with CJS and all agencies represented on the LS/CMI Review Group to analyse training needs relating to the application of FRAME approach.

### **Recommendation 9: Practice**

The RMA should work with all Local Authority area JSW and CJS to reiterate the guidance in relation to reassessing and reopening cases within the LS/CMI system.



**Recommendation 10: Training**

The SG, through the IT System provider, should work with CJS to ensure that reassessment & reopening functionality within the LS/CMI system is covered within training/user guides.

**Recommendation 11: Training**

CJS should deliver national LS/CMI system refresher training.

**Recommendation 12: Governance**

The SG should work with relevant agencies to review and communicate LS/CMI governance arrangement to ensure national oversight.

## 8. Appendix A - Links to Relevant Guidance

As concluded within this report; risk is considered holistically by decision makers, based on the information presented by those with functions in relation to risk assessment and management. Below are links to national guidance documents relevant to this review, which detail how information is presented and considered in reaching decisions.

[SPS Risk Management, Progression and Temporary Release Guidance](#)  
(currently under review)

[Integrated Case Management Guidance Manual](#)

[PBS Guidance for Members](#)

[Social work services in the criminal justice system: national outcomes and standards](#)

[Scottish Government Multi-Agency Public \(MAPPA\) National Guidance 2022](#)