HM Inspectorate of Probation

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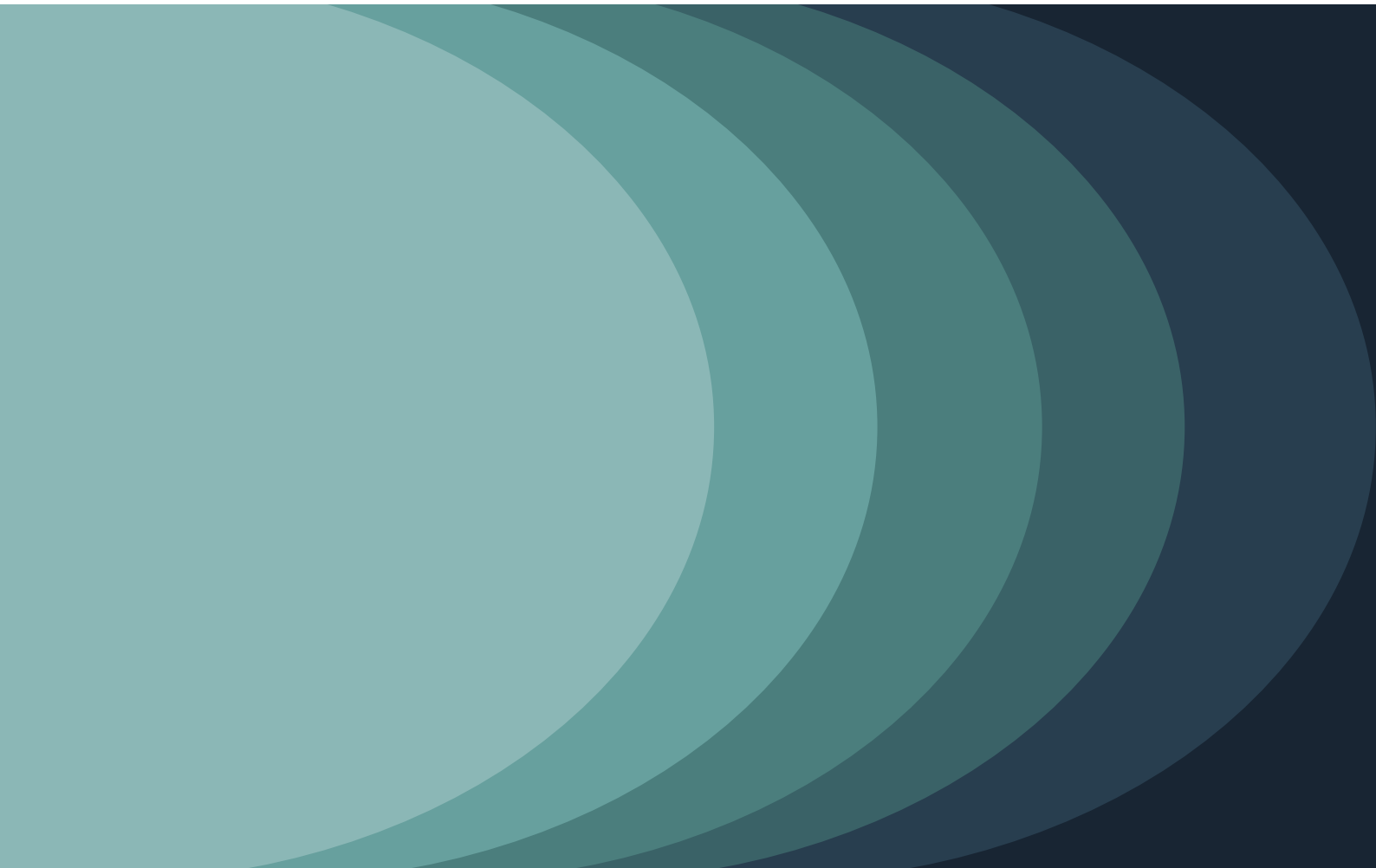
Annual report 2022:

Serious Further Offences



HM Inspectorate of Probation

High-quality probation and youth offending services that change people's lives for the better

HM Inspectorate of Probation is the independent inspector of probation and youth offending services in England and Wales. We set the standards that shine a light on the quality and impact of these services. Our inspections, reviews, research and effective practice products provide authoritative and evidence-based judgements and guidance. We use our voice to drive system change, with a focus on inclusion and diversity. Our scrutiny leads to improved outcomes for individuals and communities.

Contents

Please note that throughout the report the names in the practice examples have been changed to protect the individual's identity.

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Chief Inspector's overview

Each year, around 500 serious sexual or violent offences are committed by people who are under probation supervision. While this represents a small proportion of the total probation caseload (less than 0.5 per cent),[1] each incident will have a devastating impact on all those involved. That's why it is essential that the Probation Service learns from these awful incidents to improve the way it manages risk of harm and to support a reduction in reoffending.

Following our thematic inspection of Serious Further Offence (SFO) reviews in May 2020,[2] we were asked by the previous Secretary of State for Justice to take on a new quality assurance process. From April 2021, we have been responsible for examining and rating the quality of a sample of 20 per cent of all SFO reviews undertaken by the Probation Service in England and Wales. We also convene multi-agency learning panels to bring together agencies involved in specific cases to improve practice and strengthen partnership working. We committed to producing an annual report on this work, and this first update sets out our findings for the period April 2021 to April 2022.

During this period, we have quality-assured a total of 64 reviews. I was pleased to note that two-thirds of these were assessed as 'Good' or 'Outstanding'. However, 31 per cent were rated as either 'Requires improvement' or 'Inadequate'. This shows that further work needs to be done, in particular in relation to 'learning', which remains the weakest area of the SFO reviews inspected. On a positive note, the 'victim' standard was rated as 'Good' in 72 per cent of SFO reviews.

Some key themes that we have identified are that practitioners are underestimating the nature and level of risk of serious harm posed; diversity is not always fully considered; and there is insufficient liaison between prison and probation staff. There is sometimes a lack of professional curiosity, with practitioners not using all available resources to manage the risk of serious harm posed by people on probation in the community. There is a recurring failure to request child and adult safeguarding and domestic abuse information from the police and children's services (also evident in our local inspections). And we found themes emerging such as workloads and the frequency and quality of management oversight – another familiar finding from recent probation delivery unit (PDU) inspections.

Looking forward, over the next year we will increase our engagement with probation regions and expand our benchmarking activity to local SFO reviewing teams to further support the local SFO reviewing process. We will also continue to undertake independent SFO reviews ourselves on high-profile cases, when commissioned to do so by the Secretary of State for Justice.

Justin Russell
HM Chief Inspector of Probation

[1] Ministry of Justice and HM Prison and Probation Service. (2021). Notification and Review Procedures for Serious Further Offences Policy Framework.
[2] HM Inspectorate of Probation. (2020). A thematic inspection of the Serious Further Offences (SFO) investigation and review process.

Serious Further Offences – an introduction

Serious Further Offences (SFOs) are specific violent and sexual offences committed by people who are, or were very recently, under probation supervision at the time of the offence. They are committed by a small proportion of the probation caseload (0.5 per cent);[3] however, while this percentage is small, for the victims and families involved, the impact and consequences are devastating and cannot be underestimated.

An SFO review is triggered when a person is charged and appears in court for a qualifying offence[4] alleged to have been committed while they were under probation supervision or within 28 working days of the supervision period terminating. An internal management report, known as an SFO review, is then commissioned, which aims to provide a robust and transparent analysis of practice.

SFO reviews are mandatory when:

- any eligible person on probation has been charged with, and appears in court for, murder, manslaughter or another serious offence, such as causing death, rape, assault by penetration or a sexual offence against a child under 13 years (including attempted offences)
- any eligible person on probation has been charged with, and appears in court for, another offence on the SFO list, and they are or have been assessed as high or very high risk of serious harm during their current supervision period, or they have not been subject to a risk assessment during that period.

A review may be carried out on a discretionary basis if:

- any eligible person on probation has been charged with, and appears in court for, an offence, irrespective of whether that offence is a qualifying offence, and Her Majesty's Prison and Probation Service (HMPPS) has identified that it is in the public interest to conduct a review.

The SFO review process was first introduced in 2003. Its primary purpose is to ensure rigorous scrutiny of probation practice when serious offences are committed by a person subject to probation supervision. The process was revised in April 2018, to move from a process-driven to a descriptive format for all cases. This involves setting out the chronology of significant events and key contacts during the period when the person on probation was supervised. The aim of this revised approach is to increase transparency for victims and family members. SFO teams have been established in each probation region, made up of reviewing managers, who will carry out all SFO reviews for that region. HMPPS then quality-assures the SFO reviews and gives feedback to the Probation Service. The HMPPS SFO team must also collate learning from SFOs to inform practice and improve policy.

In May 2020, we published *A thematic inspection of the Serious Further Offences (SFO) investigation and review process*,[5] which focused on the implementation and effectiveness of this process. We found that the purpose of SFO reviews was not consistently understood, with differing emphases being placed on its function as an internal management review, a learning document and a report for victims and their families. This meant that aim of the

[3] Ministry of Justice and HM Prison and Probation Service. (2021). Notification and Review Procedures for Serious Further Offences Policy Framework.
[4] Ministry of Justice and HM Prison and Probation Service. (2021). Probation Service Serious Further Offence procedures Policy Framework.
[5] HM Inspectorate of Probation. (2020). A thematic inspection of the Serious Further Offences (SFO) investigation and review process.

SFO review was not always being met. The thematic inspection found that, at a national level, SFO reviews were not analysed sufficiently to identify themes, inform policy and support improvements in practice. At a local level, we found that procedures were in place to identify individual learning from the SFO reviews completed. However, the SFO reviews focused on 'what' had happened rather than 'why'. This meant that the underlying factors that had contributed to the practice deficits were not fully understood. Staff also expressed concern that SFO reviews focused on individual practice and did not sufficiently explore and analyse organisational responsibility. The underlying fear and concern felt by operational staff hindered HMPPS's ability to maximise learning from the SFO process at all levels.

SFO reviews focus solely on probation practice. While the operational guidance directs reviews to make judgements on the multi-agency work undertaken, reviewing managers do not have to obtain the views of other agencies involved in the case. Often the cases reviewed are complex and have involved contact with a number of other agencies; thus, there is the potential for valuable learning to be lost if the breadth and quality of the insight into the practice is limited to only that of the Probation Service.

Following our thematic inspection, the Secretary of State asked us to take on a new quality assurance process from April 2021. This role requires us to:

- examine and rate a sample of Serious Further Offence reviews (approximately 20 per cent of all submitted reviews), to drive improvement and increase public confidence in the quality of the reviews
- convene multi-agency learning panels to bring together agencies involved in specific cases to improve practice and strengthen partnership working
- provide an annual update on this work.

While we are not responsible for conducting SFO reviews ourselves, where appropriate the Secretary of State for Justice can ask us to complete an independent review of a particular case or aspects of a case.

As part of our routine local inspections, we are also focusing on regional SFO work, including the content and delivery of action plans. This includes analysing the overall quality of the SFO reviews being produced by a region; exploring the key practice findings and exploring how the learning identified in the SFO reviews is translated into developmental action plans and how learning, including effective practice, is shared across probation regions.

This is the first annual report of our findings since we began this work.

Contextual facts

Between 2014/2015 and 2016/2017 there was a marked increase in the number of SFO notifications and resulting convictions.[6] This is attributed to the implementation of the Offender Rehabilitation Act 2014 (ORA). The introduction of ORA led to a significant increase in the number subject to post-release supervision by the Probation Service.

Since then, the annual SFO notification and conviction figures have been relatively stable; however, the latest provisional figures indicate that they have fallen from the previous year. This may be because of the impact of Covid-19 on the output of the criminal courts, which has resulted in fewer sentences being imposed.

240,922	Number of individuals under probation supervision as of 31 March 2022[7]
537 **National Probation Service: 336** **Community Rehabilitation Company: 201**	Number of SFO notifications received in 2019/2020, broken down by type of supervision provider[6]
499	Number of SFO notifications received in 2020/2021[8]
473	Number of SFO reviews completed in 2019/2020[6]
271	Number SFO convictions out of 536 notifications in 2019/2020[8]
0.5%	Proportion of individuals under probation supervision charged with an SFO[9]
33% sexual **67% violent**	Proportion of SFO notifications in 2019/2020, broken down by offence type[10]
71%	Proportion of SFO notifications in 2019/2020 that automatically qualified for an SFO review[10]
52% high/very high **38% medium** **6% low** **4% not specified/unknown**	Proportion of SFO notifications in 2019/2020, broken down by highest risk of harm assessment[10]
58% post-release supervision **36% community supervision** **4% imprisonment for public protection** **2% life licence**	Proportion of SFO notifications in 2019/2020, broken down by supervision type[10]

[6] Ministry of Justice. (2020). Serious Further Offences Annual Bulletin 2020.
[7] Ministry of Justice. (2022). Offender Management Caseload Statistics as at 31 March 2022
[8] Ministry of Justice. (2021). Serious Further Offences Annual Bulletin 2021.
[9] Ministry of Justice. (2021). Notification and Review Procedures for Serious Further Offences Policy Framework

Table one: Number of SFO reviews received between 01 January 2015 and 31 December 2020, by SFO offence[10]

Offence	2015	2016	2017	2018	2019	2020
Murder	70	72	112	114	137	117
Manslaughter	5	8	18	10	11	5
Rape	225	254	256	149	110	123
Violence against the person	139	145	198	192	174	217
Sexual assault	55	37	51	28	26	47
Total	**494**	**516**	**635**	**493**	**458**	**509**

Table two: Number and proportion of SFO reviews in which the SFO notification was for murder in 2020/2021, by risk of serious harm level[10]

Original Probation Service assessment of risk of serious harm	Number of SFO murder reviews	Proportion of SFO murder reviews (%)
Low	11	11
Medium	55	57
High	26	27
Very high	0	0
Not specified	4	4
Total	**96**	**100**

Table three: SFO conviction offences 2019/2020[8]

SFO conviction	Number of offences
Murder	74
Attempted murder or conspiracy to commit murder	18
Manslaughter	25
Rape	54
Arson	14
Kidnapping/abduction/false imprisonment	13
Death involving driving/vehicle-taking	13
Other serious sexual/violent offending	60
Total	**271**

[10] Data provided by HMPPS Public Protection Group.

What we found, April 2021 to April 2022

SFO reviews quality-assured by offence type and risk of harm category

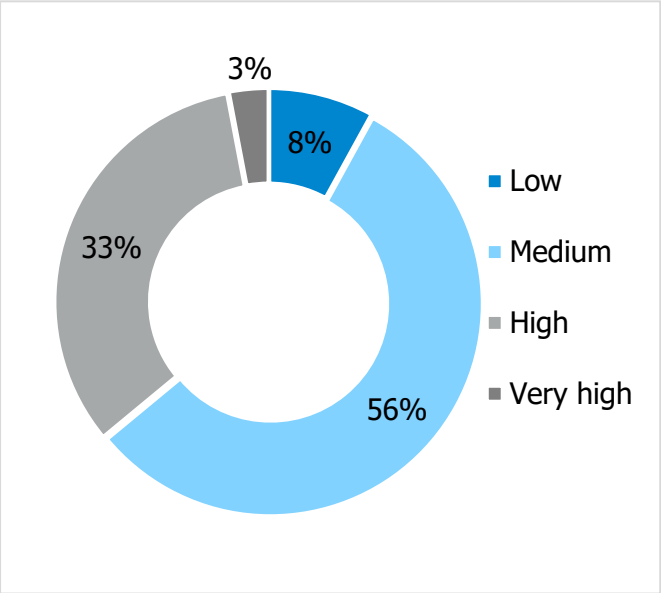
During the period April 2021 to April 2022, we quality-assured a random 20 per cent sample of the SFO reviews undertaken by the Probation Service in England and Wales (64 reviews).

Table four: SFO reviews quality-assured by HM Inspectorate of Probation, by offence type [11]

Number	SFO offence
23	Murder
3	Attempted murder
2	Conspiracy to murder
14	Rape
2	Attempted rape
2	Rape and kidnap
3	Assault of a child under 13 by penetration
2	Arson with intent to endanger life
3	False imprisonment
0	Armed robbery
1	Arranging/facilitating the commission of a child sexual offence
4	Assault by penetration
1	Death by dangerous driving
2	Kidnap
1	Robbery
1	Sexual activity with a child under 16
64	**Total**

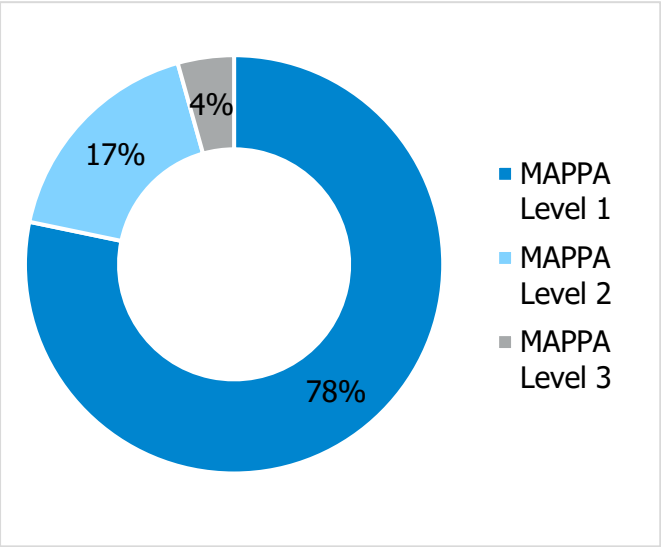
[11] HM Inspectorate of Probation data.

Table five: Quality assurance by risk of serious harm assessment at the point the SFO was committed [11]



Of the 64 SFO reviews that we quality-assured, 56 per cent of the offences had been perpetrated by an individual who had been assessed as posing a medium risk of serious harm before the offence was committed.

Table six: Quality assurance by MAPPA level at the point the SFO was committed[11]



36 per cent of the 64 SFOs were managed under Multi-Agency Public Protection Arrangements (MAPPA). The diagram shows that the majority of these were managed at MAPPA level 1 at the point the SFO was committed.

Our standards

Following the Secretary of State's request for HM Inspectorate of Probation to take on the new quality assurance process from April 2021, we devised a set of quality assurance standards.[12] The standards are used by inspectors in the quality assurance process, ensuring that we ask the right questions, and gather evidence to rate the quality of the SFO review.

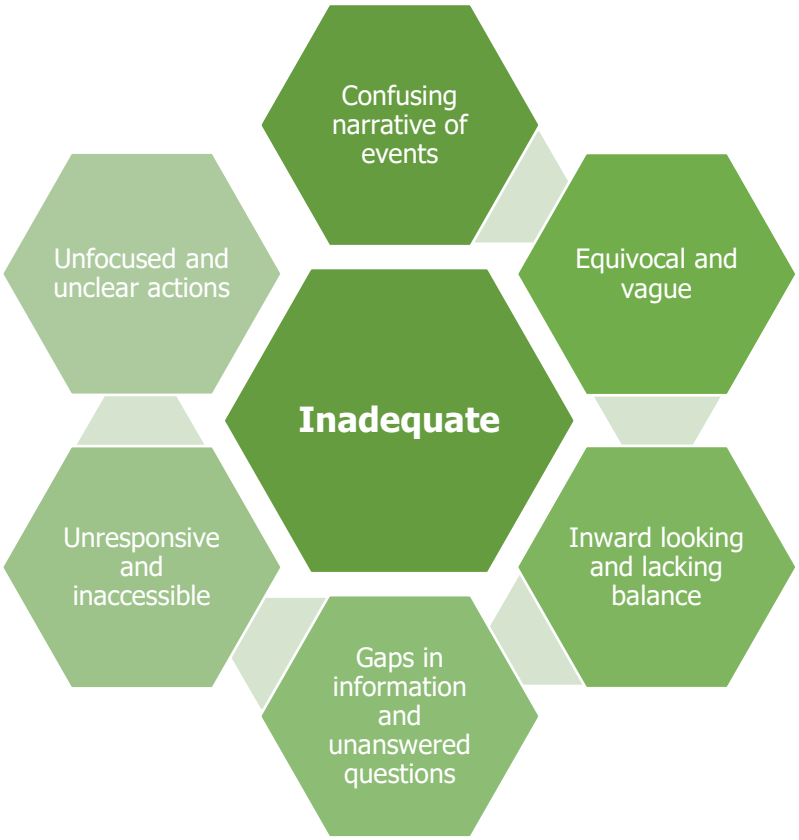
Our quality assurance standards set out the expectation that an SFO review will provide a robust and transparent analysis of practice, provide a clear and balanced judgement on the sufficiency of practice, enable appropriate learning to drive improvement and be suitable to share with victims (or their family) and meet their needs. The quality assurance standards are supported by rules and guidance,[13] and ratings characteristics.[14] Our standards also give a fresh focus to the crucial inter-agency work that probation practitioners carry out and seek to drive improvements in practice at all levels, where necessary. Inspectors give individual ratings for each of the quality standards, and these contribute to the composite rating of 'Outstanding', 'Good', 'Requires improvement' or 'Inadequate'.

The reports produced for each probation region following the quality assurance of an SFO review explain clearly why each rating has been awarded and specify where and how improvements should be made. Where a review is deemed to be 'Inadequate', the reviewer is required to resubmit it. This is to ensure that the reviewer takes account of the quality assurance feedback and makes all necessary changes to the SFO review document.

The HMPPS SFO quality assurance team has also chosen to adopt our standards, rules and guidance and ratings. We have worked closely with them to develop their understanding and confidence in applying these, by leading and facilitating a series of workshops. This approach ensures that reviews are quality-assured against the same standards by both HMPPS and HM Inspectorate of Probation and that feedback for improvement is consistent.

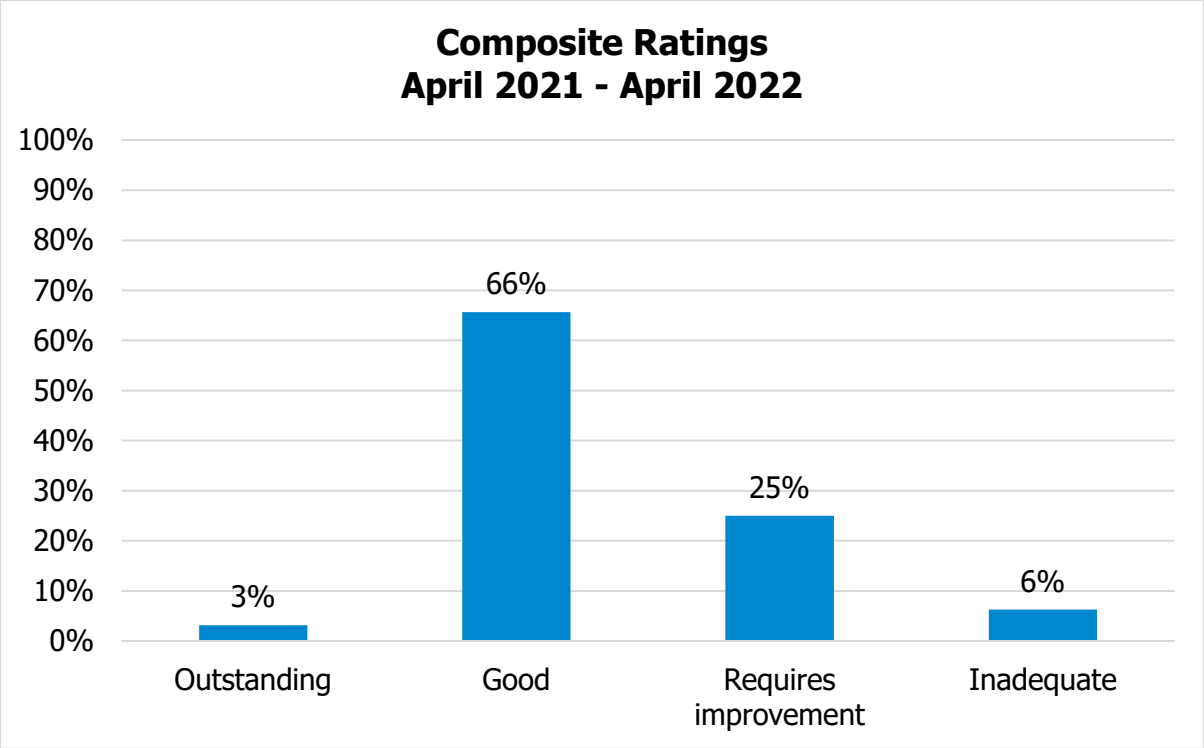
[12] HM Inspectorate of Probation and HM Prison and Probation Service. (2021). Serious Further Offence reviews. https://www.justiceinspectorates.gov.uk/hmiprobation/about-hmi-probation/about-our-work/serious-further-offence-reviews/.
[13] HM Inspectorate of Probation and HM Prison and Probation Service. (2021). Rules and guidance for the quality assurance of Serious Further Offence reviews. https://www.justiceinspectorates.gov.uk/hmiprobation/about-hmi-probation/about-our-work/serious-further-offence-reviews/.
[14] HM Inspectorate of Probation and HM Prison and Probation Service. (2021). Ratings characteristics for the quality assurance of Serious Further Offence reviews. https://www.justiceinspectorates.gov.uk/hmiprobation/about-hmi-probation/about-our-work/serious-further-offence-reviews/.

Quality assurance rating – 'Outstanding' and 'Inadequate'.



Composite ratings

We awarded the following composite ratings to the 64 SFO reviews that we quality-assured:



To achieve a composite rating of 'Good' or 'Outstanding', reviewing managers must take an analytical and investigative approach to the SFO review. The review must also provide a transparent account of the significant events during the management of the case and support all findings with evidence based on interviews with staff and additional investigation. Of particular importance is the reviewing manager's ability to articulate how they have considered practice at an individual level and explored the extent to which this practice was underpinned by PDU, national and regional-level procedural and systemic issues. This depth of analysis is essential to ensuring that SFO reviews are impactful and influence the required changes to policy and practice.

It is positive to see that two-thirds of SFO reviews achieved a composite rating of 'Good', which is where we encourage reviewing managers to pitch their work. However, a total of 31 per cent were rated as either 'Requires improvement' or 'Inadequate'. This demonstrates that HMPPS and Probation Service regional teams need to do further work to improve the quality of SFO reviews to ensure that they are sufficiently comprehensive and meet the expected standards, and that they identify the necessary learning and translate it into a meaningful action plan. In the next section of this report, we provide further information about the specific findings under each standard.

To ensure that the quality standards are applied consistently, we have held benchmarking sessions with the HMPPS SFO quality assurance team. This collaborative approach has supported the implementation of the quality standards and will continue to run on a quarterly basis. We will also continue to consult with the HMPPS SFO team when any revisions are made to the quality standards.

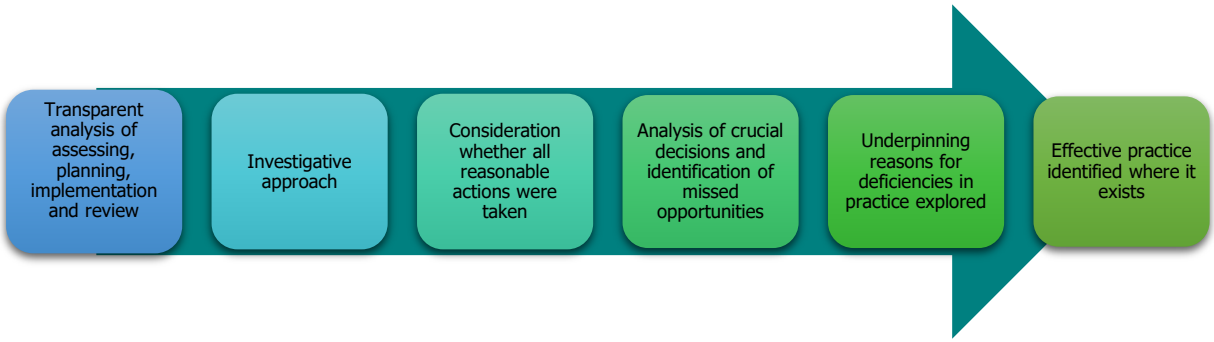
Over the next year, we will maximise opportunities to engage with the Probation Service regions and will extend the benchmarking sessions to local SFO reviewing teams in order to further develop and improve SFO reviewing practice. Feedback from probation regions has been supportive of this; the regions are keen to work with us to develop and embed high-quality SFO work.

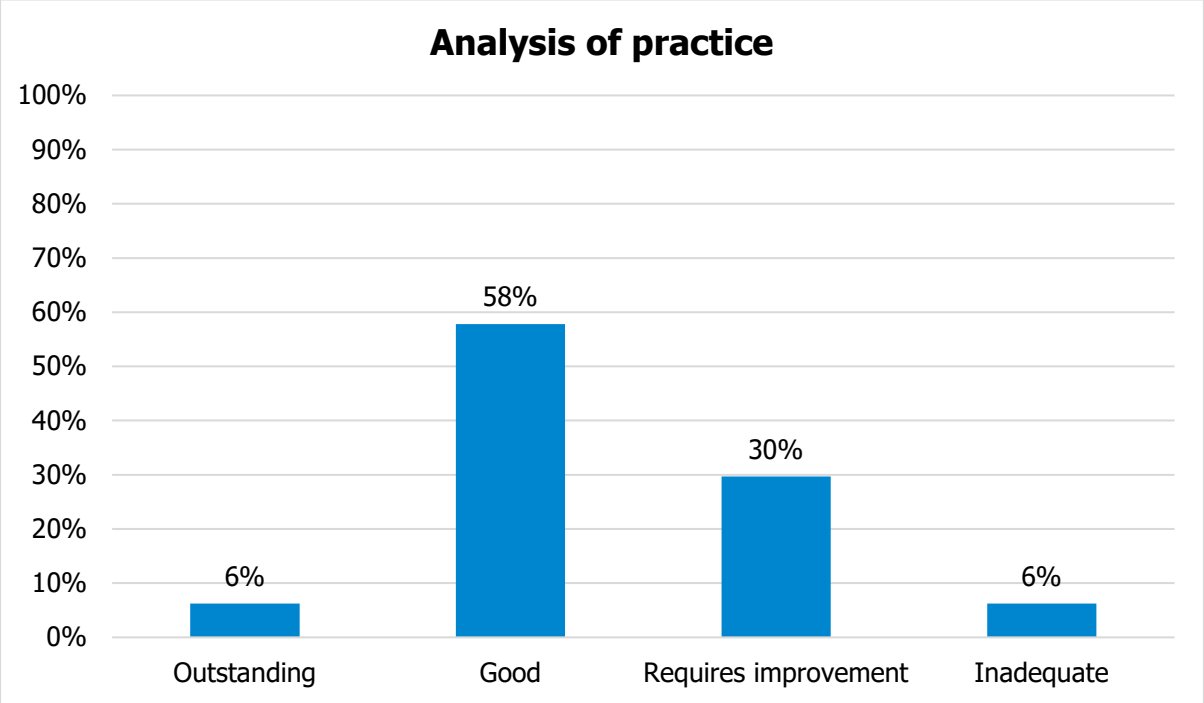
Individual quality standards

Analysis of practice

Each SFO review should provide a robust and transparent analysis of practice, exploring the assessment, planning, delivery, and reviewing practice in the management of the case.

Analysis of practice – what do we expect?





The quality assurance process has found that, while the reviewing managers are generally providing a sufficient overview and analysis of practice, they need to explore the underlying reasons for the identified practice deficiencies in more depth. Failure to do this reduces the probation region's ability to maximise learning from reviews and, where necessary, inform wider national learning.

The SFO reviews were broadly consistent in how well they considered each aspect of practice, in that assessment was sufficiently considered in 75 per cent of reviews, planning in 79 per cent, delivery in 77 per cent and reviewing in 80 per cent. This means that there is a good level of understanding of what is expected at each of these stages of sentence

management, and that reviewing managers have the skills and experience necessary to identify the deficits in practice.

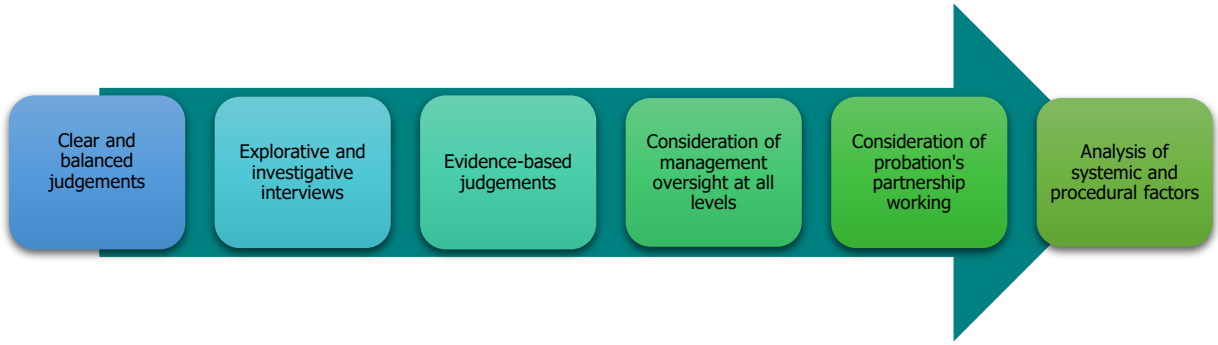
Through the quality assurance process, we identified key practice themes that occur frequently in SFO reviews:

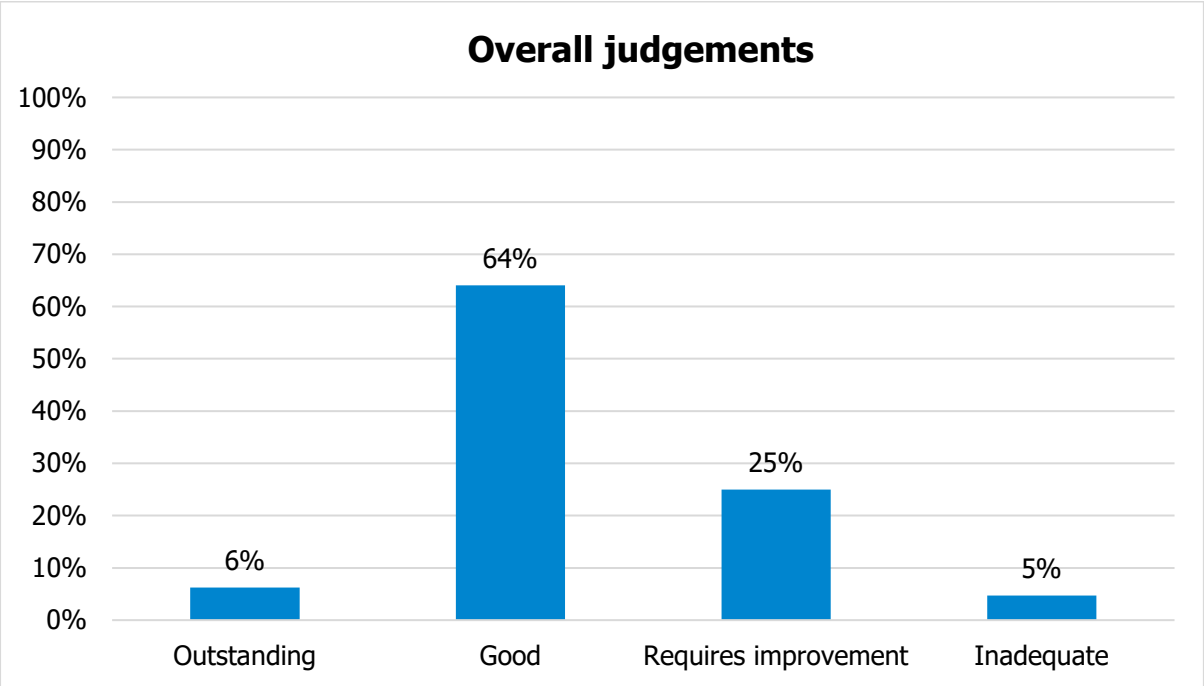
- Practitioners are underestimating the nature and level of risk of serious harm that the person on probation poses, which means they do not always recognise or respond to emerging risk factors. This is exacerbated by practitioners focusing on providing support, to the detriment of managing risk and delivering offence-focused interventions.
- Diversity, including maturity, mental health, and neurodiversity, are not always fully considered in order to understand how they impact on a person on probation.
- Many practitioners do not apply professional curiosity; they rely too much on the person on probation's own reports and tend to view progress with an optimism bias. Often, they do not take the required action in response to significant changes or new information, and do not escalate concerns to facilitate management support and oversight.
- Good management oversight should support and build practitioners' confidence, facilitate case discussions, and assurance of decisions made. SFO reviews often find that management oversight is not as robust as it needs to be, which has an impact on the quality and frequency of discussions about the case.
- Insufficient liaison between prison and probation staff, and a lack of robust pre-release planning which can impact on the person on probation's level of engagement in the community and the quality of the risk management plan.
- Practitioners are not using all available resources to support the management of risk in the community; for example, they are not using all proportionate licence conditions, and not using multi-agency working to enhance their practice.
- Practitioners frequently fail to request information relating to child and adult safeguarding and domestic abuse. This is vital to ensure that they have access to all available information, so that they can carry out a fully informed assessment of risk of serious harm.
- OASys assessments are often being completed to meet organisational performance targets at the beginning of a period of supervision. However, these assessments are not always being completed to the expected quality standard and are not being reviewed when the probation practitioner receives new information or there are significant changes to the person on probation's circumstances.
- SFO reviews have found repeatedly that practitioners are not taking enforcement action in line with policy expectations and are missing opportunities to recall to custody.

Overall judgements

SFO reviews should provide clear and balanced judgements on the sufficiency of practice. They should also analyse systemic and/or procedural factors that relate to probation practice and decision-making.

Overall judgements – what do we expect?





64 per cent of the SFO reviews we quality-assured contained judgements of 'Good'; 92 per cent included interviews with staff relevant to the management of the case, including some senior managers; and 77 per cent sufficiently analysed systemic issues.

Positively, where good practice existed, it was recognised in 98 per cent of SFO reviews, contributing to an appropriately balanced SFO review.

We also found that, in many of the judgements on the sufficiency of practice, the reviewer needed to analyse and explore in greater depth the systemic and procedural factors that may have impacted on the deficits in practice that they found. Often, they took a descriptive rather than an analytical approach to the SFO review, with judgements lacking clarity and requiring a stronger evidence base. SFO reviewers must ensure that they consider practice holistically, which includes looking at practice and decisions made at a senior level.

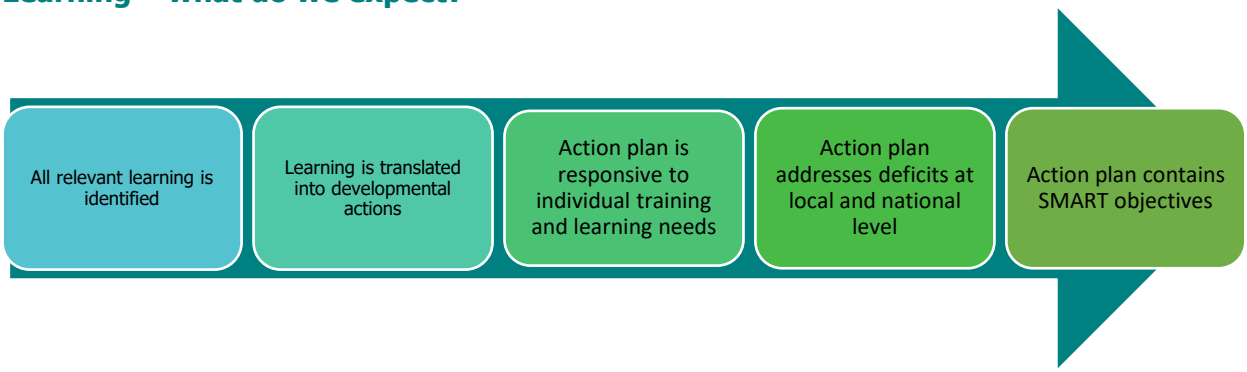
High quality SFO reviews are insightful and analytical and help the reader to understand the recurring systemic and procedural themes underpinning the practice. Some of these are outlined below:

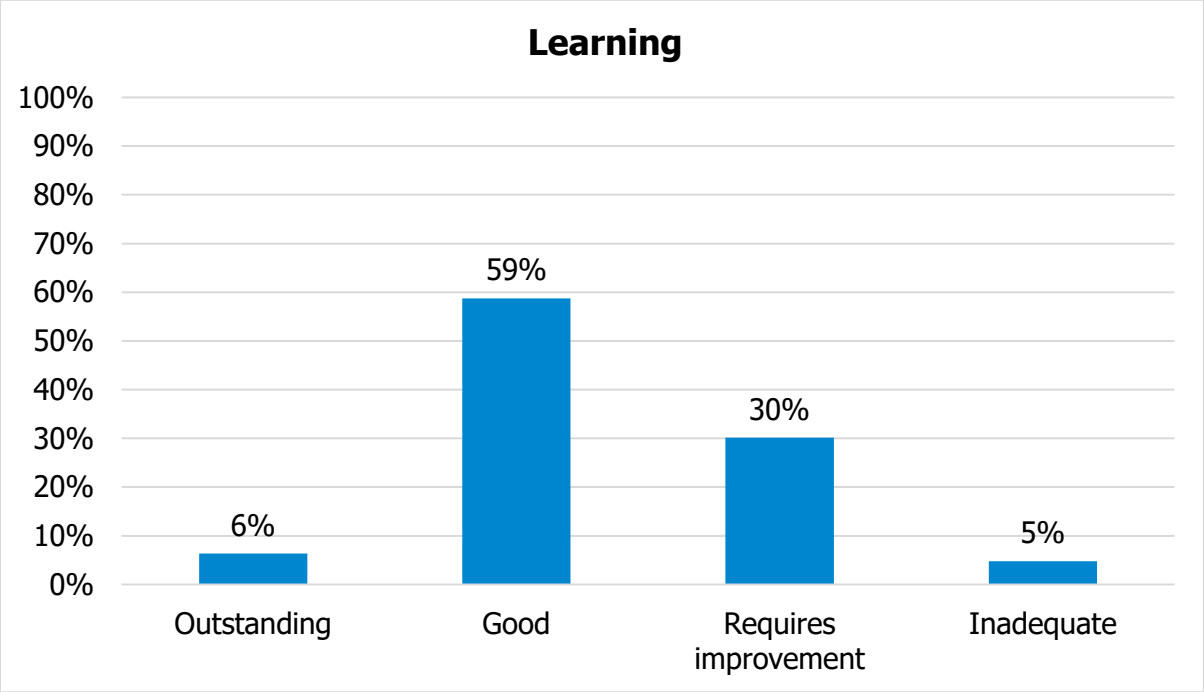
- Excessive workloads often underpin the practice deficits identified. Concerns about workload are not limited to caseload numbers but also reflect the volume and pace of change in policy and practice. High workloads can cause stress and reduce the time available for reflective and considered practice. Workload issues are exacerbated by challenges in recruitment, retention, and resourcing, particularly following the impact of *Transforming Rehabilitation*. New practitioners can feel inexperienced and can lack relevant training and development opportunities, which further reduces their confidence in working with complex or challenging cases. It is widely acknowledged that recovery from a significant change programme will take some time.
- SFO reviews have repeatedly highlighted concerns about the frequency and quality of management oversight. Too often, middle managers have a large span of control, coupled with a wide breadth of other expected roles and responsibilities. As a result, they lack opportunities to robustly oversee the management of cases and provide consistent and meaningful support to staff.
- SFO reviews have frequently found that local working arrangements have not maximised opportunities to share information between agencies, including prisons. This has resulted in missed opportunities to share valuable information and work collaboratively to support the delivery of the sentence and risk management plan. The availability of specialist services and key support services at a PDU and regional level, such as mental health treatment and access to appropriate accommodation, has also been identified as a fundamental concern.
- The impact of Covid-19 and the resultant exceptional delivery models cannot be underestimated. This affected how probation services were delivered, and SFO reviews have identified that the requirement to work at home reduced the frequency of one-to-one appointments with people on probation. It also reduced probation practitioners' opportunities to benefit from informal conversations in a team environment. These often facilitate reflective discussions and enable learning to be shared.

Learning

The SFO review should identify areas for improvement at all levels, considering learning at individual practitioner, manager, PDU, and regional and national levels. It should also be supported by an action plan, in which all the relevant learning is translated into developmental actions that can be taken and monitored to ensure similar errors are not made in the future.

Learning – what do we expect?





Our SFO quality assurance work found that reviewers identified the correct areas for learning and practice improvement in 75 per cent of SFO reviews and set out sufficient developmental activity to effect change in 79 per cent of action plans. There was a sufficient focus on regional-level learning in over three-quarters of SFO reviews. Action plans suitably included multi-agency working in 75 per cent. However, learning remains the weakest area of SFO reviews: we rated 59 per cent as 'Good', and 35 per cent as 'Requires improvement' or 'Inadequate'. This means that the probation service still has work to do to ensure that there is a coordinated and collective response to the learning identified within SFO Reviews.

Learning from the SFO reviews is not being identified at all relevant levels of the probation service and there is insufficient analysis of why the deficits in practice occurred. Reviewing

managers are better at identifying learning at practitioner level, and do not explore wider procedural and systemic issues frequently or thoroughly. As a result, action plans do not robustly address all appropriate deficiencies. Nor do they ensure that all relevant learning has been identified and translated into developmental and measurable actions.

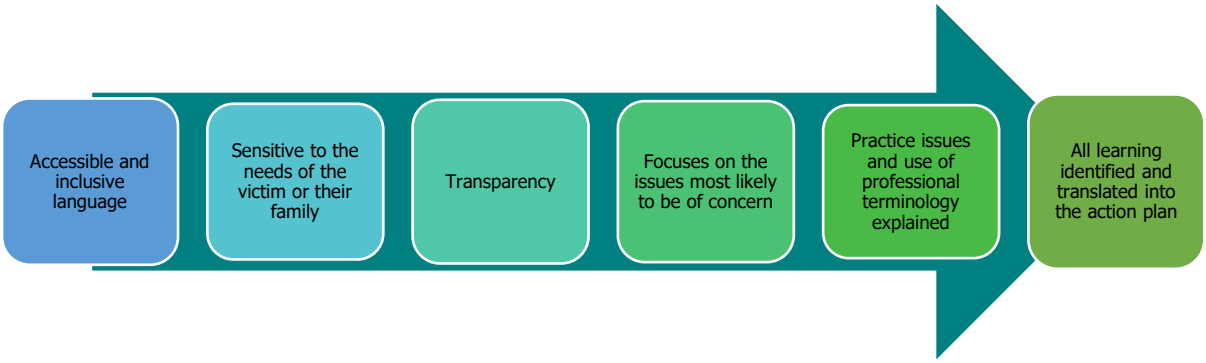
SFO reviews are completed by reviewing managers who are at middle manager grade in their probation region. Feedback from them is that, while they would like to explore issues at a senior level, they often do not feel empowered to do so. They have expressed concern that their ability to scrutinise and potentially criticise the practice of their own senior leaders can be limited by their own role, grade, and experience and by a concern doing so may impact on their future career opportunities within the region.

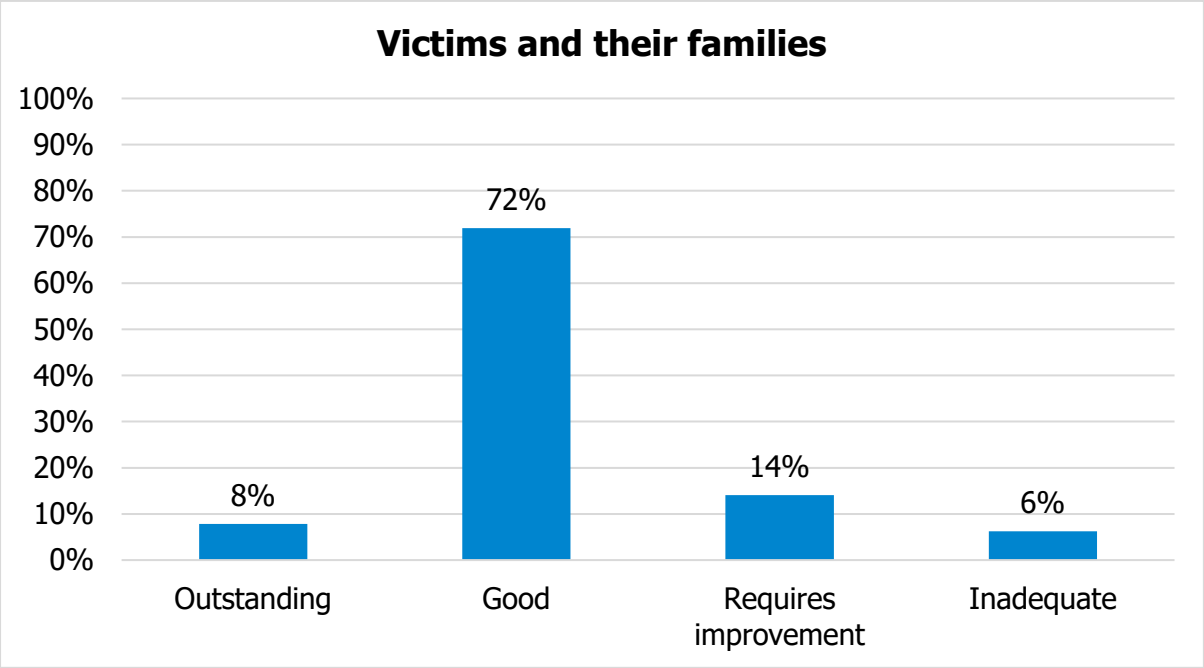
Probation regions have told us that embedding learning from SFO reviews continues to be a challenge, and that they are still establishing ways to ensure that they collate and monitor the emerging themes. Regions feel that the process of feeding back progress made against the SFO learning plan is not as effective as it could be and requires more development, particularly to foster opportunities for collective learning across probation regions.

Victims and their families

The style and language used in an SFO review should be inclusive and easy to read. Any professional jargon or acronyms should be explained, and clear explanations of any processes provided. The review should be accessible to a reader with no knowledge of the work of probation, and sensitive to the impact that the findings might have on victims

Victims and their families – what do we expect?





The victim standard was found to be 'Good' in 72 per cent of SFO reviews. We found that 89 per cent of SFO reviews were sufficiently accessible to victims or their families and, importantly, 90 per cent were written sensitively to take account of the impact on victims. However, we found that six per cent of SFO reviews were inadequate on this standard. The main reasons were that the reviews included unsuitable descriptions of the victim or included personal information where anonymity was necessary.

We found that the language used in the SFO reviews was not always accessible, inclusive, or easy to read. The review should be written in a way that is accessible to a reader with no prior knowledge of the work of the probation service, and any professional jargon or acronyms should be explained.

The probation regions have given positive feedback on the revised policy framework and SFO review template issued by HMPPS in December 2021. They felt that the revised documents will help reviewing managers to produce reviews that are more accessible to victims and their families. However, the probation regions have said that it will take time for them to fully familiarise themselves with the new framework, and that they would like more support and guidance to ensure it is implemented effectively.

SFO review quality assurance case studies

Case study - SFO review quality-assured as 'Outstanding'

Mr Stanton was sentenced to 10 weeks in custody in December 2018 for malicious communications. In May 2019, while he was subject to post-sentence supervision, he received a further sentence of 12 weeks in custody for an offence of criminal damage. His case was well known to probation services at the point when he committed the SFO of attempted murder in September 2019, while he was subject to post-sentence supervision. The SFO review covered the period of both these sentences up to the point when the SFO was committed. Mr Stanton was assessed as posing a very high risk of serious harm and was managed under MAPPA level 3 arrangements.

The SFO review, following quality assurance, was rated as 'Outstanding'. It was written to a high standard, with a highly analytical review of the work undertaken in this case. The reviewing manager's approach was investigative and well researched. There was a substantial period to consider in the review, and the reviewing manager was effective in covering the relevant information and summarising where necessary, while giving a helpful analysis of practice and identifying relevant learning points. The reviewing manager correctly identified positive professionally curious practice from the probation practitioner who worked with Mr Stanton.

The review was effective in highlighting practice deficits, an example being issues with recording. These were effectively identified and analysed, resulting in relevant actions being included in the action plan. The reviewing manager made balanced and robust judgements throughout the review, based on sound evidence, gleaned both from case records and from investigative interviews with practitioners and managers at all levels.

The action plan enabled the learning from the review improve practice at all levels. It highlighted where action and learning had already taken place following the SFO, as well as where changes to national policy and/or practice had been implemented and have driven improvements.

From the perspective of the victim and their family, the report identified the relevant areas for improvement and was written in a way that was easy to understand, taking a sensitive approach. Helpfully, the review fully explained any acronyms used and gave full descriptions of policies or practice that might not otherwise have been understood by someone not familiar with the work of the probation service.

Case study - SFO review quality-assured as 'Good'

Mr Richards was sentenced to 12 weeks' imprisonment for assault and possession of class A drugs. He was released on licence and was subsequently convicted of murder.

The SFO review set out the chronology of probation management, providing a transparent and informative overview of the management of the case. The SFO review received a composite quality assurance rating of 'Good'.

There was a sufficiently robust and transparent analysis of practice, which considered whether all reasonable actions were taken during the management of the case. The review analysed crucial decisions and missed opportunities and provided context to help support the analysis of the underpinning reasons for the deficiencies in practice. The

reviewing manager analysed the child safeguarding practice in this case, exploring Mr Richards' violent and aggressive behaviour and how practitioners had considered this.

The reviewing manager showed an appropriate level of balance in their analysis and judgement. They gave due consideration to the impact of the exceptional delivery model brought about by Covid-19. The reviewing manager analysed practice beyond that of the individual probation practitioner, exploring whether probation guidance clearly set out how to escalate concerns regarding the work of another agency.

The learning derived from the SFO review identified opportunities to make improvements. The learning points were effective yet simple, with an action plan that contained practical and achievable actions. The reviewer also focused appropriately on inter-agency work between agencies. The action plan addressed appropriate deficiencies at a local probation delivery unit level and actions contained SMART objectives.

Most of the professional jargon and acronyms used in the review were explained by the reviewing manager. However, the review was particularly lengthy and contained sensitive information about Mr Richards' previous offences, the SFO, and the probation practitioner. The quality assurance feedback highlighted the need to review this, indicating where information should be removed, amended or condensed. Undertaking the suggested changes would ensure that the review was accessible to someone unfamiliar with probation practice and sensitive to the impact that the findings may have on the victim.

Case study – SFO review quality-assured as 'Requires improvement'

Mr Key was sentenced to a suspended sentence order (SSO) comprising 24 months' imprisonment suspended for 24 months. The SSO included 60 rehabilitation activity requirement (RAR) days, an electronically monitored curfew for four months, and an exclusion zone imposed for two years. This was for an offence of sexual assault against an unknown female.

There were well-documented risks in this case relating to Mr Key's history of assaults and abusive behaviour towards current and former partners. His risk of serious harm was assessed as high to known adults and the public. The SFO offence of false imprisonment was committed while he was subject to the SSO. It was committed against an ex-partner, whom he was deemed to pose a high risk of serious harm to.

Following the quality assurance process, this review was rated as 'Requires improvement'. It was noted that, while the case details were mostly completed to a sufficient standard, information on diversity was missing. Stated facts such as Mr Key having a low IQ were not explored further, for example in relation to any impact this may have had on case management. There were gaps in the chronology, and SFO quality assurance feedback was provided on how the reviewing manager could better use the review document to enhance the quality of the review.

The review correctly highlighted deficiencies in practice relating to safeguarding and information-gathering. While there was a succinct analysis of practice, there were key areas that the reviewing manager had not considered in detail, such as the lack of professional curiosity, a lack of focus on risk, and an insufficient analysis of some of the underpinning reasons for practice deficiencies.

The SFO review often described rather than analysed systemic and/or procedural factors in probation practice. The quality assurance process identified that judgements were missing on the sufficiency of management oversight, safeguarding practice and

professional curiosity. It was of note that there was a lack of evidence from the interviews conducted, which meant that judgements on the practice of staff were missed.

The learning plan did not cover all areas of learning highlighted in the review. Therefore, actions were not set to address some of the practice deficits that were apparent. In addition, the plan did not set actions at all levels to ensure learning was widely embedded.

The SFO review did not explain all terms used and therefore did not enable victims to understand the nuances of probation jargon and acronyms. While the review gave some consideration to what may be most pertinent to the victim, it did not sufficiently explain the significance of the deficiencies and missed opportunities during the case and the impact that these had.

Case study – SFO review quality-assured as 'Inadequate'

Mr Evans was sentenced to four weeks' custody for two counts of common assault, having assaulted an unknown female and her friend in a pub. He was released on licence in April 2020. In October 2020, he was charged with murder.

The review set out a concise narrative of events which, while informative, contained no analysis. The reviewing manager had not identified the underlying factors behind the practice deficiencies and did not draw through all necessary learning into the action plan. The reviewing manager had not given due consideration to the level of management oversight, supervision and support provided to the probation practitioner.

Senior leaders had not been interviewed and there was no examination of systemic or procedural factors that may have contributed to the deficiencies in the management of this case. Judgements on the sufficiency of practice or policy were not provided, and there was no consideration of multi-agency working.

The learning identified was not sufficiently supported by evidence. The action plan identified three areas of learning; however, given the limited breadth of analysis and judgement in the review, not all opportunities for learning had been identified.

The SFO review was not deemed sufficiently accessible, particularly to victim's family who may not have any understanding of the probation service. The reviewer did not focus sufficiently on practice or on the critical risk issues presented by the case. This resulted in a review that failed to explain the significance of deficiencies and missed opportunities during the management of the case, and the impact these had.

As a result of the 'Inadequate' rating, the reviewing manager was required to make the necessary improvements to the review and to resubmit it for quality assurance.

Effective probation practice identified in SFO reviews

SFO reviewers are encouraged to identify practice deemed to be effective, where it is present, and share it within the probation region to support the wider development of probation practice.

Some examples of the effective practice identified are outlined below:

Case one

The SFO review found evidence that the probation practitioner had taken an investigative approach. They applied professional curiosity well, and this underpinned each supervision appointment. There was evidence of good multi-agency working between the probation practitioner and police, including the frequent sharing of pertinent information. The probation practitioner responded to this and used it to inform actions taken to manage the risk of serious harm posed.

Case two

The SFO review noted that there was good intelligence-gathering with partnership agencies, including effective engagement with prison staff to support effective pre-release planning.

OASys assessments completed were of a good standard. They were reviewed when new information was received, and supported by the specialist risk assessment spousal assault risk assessment (SARA).

Case three

There was a good level of consultation between the senior probation officer and the probation practitioner. Clear actions were set in response to the escalating risk of serious harm, which included increasing the frequency of contact and enhancing the supervision and risk management plan. The probation practitioner took an investigative approach, which included carrying out regular home visits.

Case four

This person was released with relevant licence conditions to support the management of risk of serious harm posed in the community. The probation practitioner demonstrated a high level of professional curiosity, which included monitoring the person on probation's social media activity. The probation practitioner was flexible and creative in their approach and used the maturity toolkit to inform their practice. There was evidence of collaborative working with partner agencies to implement the risk management plan.

Multi-agency learning panels

To improve practice and support the strengthening of partnership working by the Probation Service, we are setting up multi-agency learning panels to promote collaborative learning from SFO cases.

The Probation Service works closely with other agencies to support risk management; however, SFO reviews only focus on probation practice. Multi-agency learning panels will provide an opportunity for collaborative learning for all agencies involved in the case. We are seeking to influence improvements in the way the Probation Service works with other agencies at both a local and a regional level. This is an essential area of work, particularly because failures in partnership working are one of the recurring themes found in SFO reviews.

A pilot multi-agency learning panel was set up in Wales, and included staff from the Probation Service, the police, health services, and an independent domestic abuse charity. The panel was well received, and identified shared learning and areas for enhanced collaborative work between agencies.

We are currently working with Greater Manchester Probation Region, with a view to convening a multi-agency learning panel later this year.

Conclusion

The quality assurance work undertaken by HM Inspectorate of Probation has demonstrated that there is more work to do to improve the quality of the SFO reviews completed. SFO reviewers must explore practice at all levels, ensuring that each review fully considers whether systemic or procedural factors may have underpinned the practice.

Recurring practice deficits have been identified through our quality assurance process, many of which mirror the findings from the local inspections. This emphasises the importance of ensuring that SFO reviews maximise all opportunities for learning and development, and that the associated action plan is robust. The implementation of the action plan and its impact must be overseen at a senior level and outcomes measured to monitor and drive change across the probation regions. This will support the probation regions in ensuring that their SFO process is robust, transparent, and fulfils its purpose of providing rigorous scrutiny and meeting the needs of victims and their families.

Over the next year, we will continue our work, quality assuring SFO reviews, tracking themes that emerge and working with probation regions on benchmarking activity. We will further develop the multi-agency learning panels and identify partners local to the probation region to engage with us on this work. We will also continue to undertake independent reviews, when commissioned to do so by the Secretary of State for Justice.