HM Inspectorate of Probation

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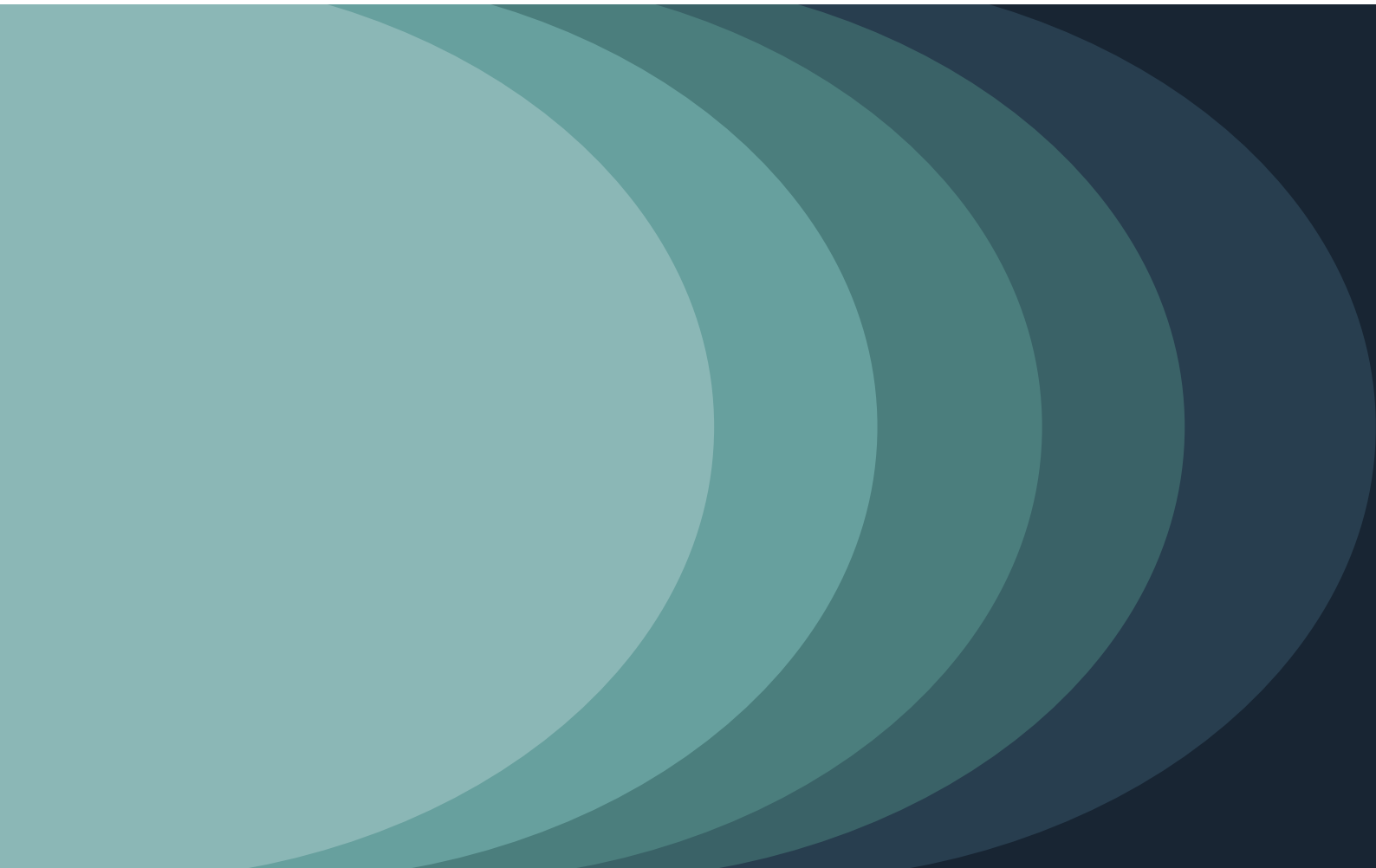
Annual report 2023:

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

Acknowledgements

This report was written by HM Inspectors Hannah Williams and Lizzie Wright.

Please note that due to rounding, not all percentages equate to 100 within our tables.

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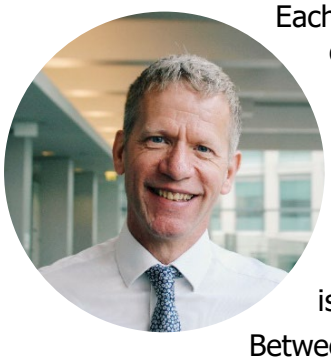
Chief Inspectors overview



Each year His Majesty's Prison and Probation Service (HMPPS) is notified of around 500 Serious Further Offences (SFOs) like murder, manslaughter and rape which are alleged to have been committed by people who are under Probation Service supervision. Following each of these incidents, the Probation Service undertakes what is called a Serious Further Offence review. In 2020, the Secretary of State for Justice asked us to start to independently quality assure a sample of these reviews. We began this role in April 2021, and this is our second annual report into this activity.

Between April 2022 and April 2023, we quality assured a total of 86 reviews – approximately 20 per cent of the total produced by the Probation Service over this period. Concerningly, we have seen the percentage of reviews we rated either 'Good' or 'Outstanding' reducing from 69 to 52 per cent compared with the previous year's findings. I was also concerned to see an increase in the proportion of reviews that relate to people on probation who had previously been assessed as high risk and who therefore should have been subject to the highest and most robust standard of supervision by the service.

More needs to be done to improve the quality of SFO reviews and the work that the service does to assess and manage the risk of serious harm to the public from people on probation. The Probation Service needs to ensure that it produces high quality SFO reviews that identify all available learning and support practitioners to improve the way they manage risk of serious harm. Our quality assurance work is demonstrating that this is not being done consistently, with notable regional differences in the quality of the SFO reviews being produced.

Last year, I raised concerns about the grade and independence of those undertaking SFO reviews, given that these reviews are carried out by middle managers from within the region in which the SFO itself occurred. Given the results of our quality assurance of reviews over the past year, my concerns have, if anything, increased and I would recommend that HMPPS give serious consideration to ensuring that reviews, certainly those involving the most serious incidents, are conducted by more senior staff from a different region to that in which the offence occurred.

Earlier this year we also published two independent reviews into the cases of Damien Bendall and Jordan McSweeney. Both identified serious concerns in relation to risk assessment, workload, management oversight, professional curiosity, case allocation and case management. These findings mirror the concerns identified within the broader range of SFO reviews we quality assure and those of our local probation inspections.

Positively, HMPPS accepted each of the 27 recommendations that we made in the Bendall[1] and McSweeney[2] reviews, many of which centre on needing to improve the assessment and management of the risks of serious harm. I hope that the recommendations in this annual report, and those from our independent reviews, will result in the urgently needed improvements that can lead to high-quality services that safeguard potential victims and keep people safe.

Justin Russell
HM Chief Inspector of Probation

[1] Independent Serious Further Offence review of Damien Bendall (justiceinspectorates.gov.uk)
[2] Independent Serious Further Offence review of Jordan McSweeney (justiceinspectorates.gov.uk)

Introduction

Following the publication of HM Inspectorate of Probation's *Thematic inspection of the Serious Further Offences (SFO) investigation and review process* in May 2020,[3] we were asked by the Secretary of State to assume a role in independently quality assuring SFO reviews completed by probation service regions. From April 2021, this has required us to:

- examine and rate approximately 20 per cent of all submitted SFO 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 overview of this work.

The Secretary of State for Justice can also ask us to complete an independent review into a specific case or aspects of a case. In January this year, we published two independent reviews into the cases of Damien Bendall and Jordan McSweeney.

As part of our routine local probation inspections, we also consider the quality of the SFO reviews being produced by a region, its analysis of the learning identified and whether this is translated into developmental action plans, and whether this activity positively impacts on practice deficits identified across the region.

This is our second SFO annual report in which we will reflect on the quality assurance findings between April 2022 and April 2023 and provide an overview of the two independent reviews published in January 2023.

[3] A thematic inspection of the Serious Further Offences (SFO) investigation and review process (justiceinspectorates.gov.uk)

What are 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 (less than 0.5 per cent),[4] and although this percentage is small, given the size of the probation caseload it still represents over 500 cases. For the victims and families affected by the SFO the impact cannot be underestimated.

The SFO review process begins when a person is charged and appears in court for a qualifying offence that was alleged to have been committed while they were under probation supervision or within 28 working days of the supervision period ending.

The SFO review is then commissioned, which is intended to be both an internal management report and a document that can be shared with the victims or their family. Therefore, it should provide a robust and transparent analysis of practice and be written in a way that is accessible to both audiences. Unlike the arrangements in the youth justice sector, where reviews are conducted in a multi-agency setting, probation SFO reviews are single agency reviews.

Each probation region has an established SFO team consisting of reviewing managers, who complete all the SFO reviews for that region. A team in HMPPS then quality assures the SFO reviews and provides feedback to the region on the quality of the completed reviews. HM Inspectorate of Probation undertake 20 per cent of this quality assurance activity.

An SFO review is mandatory when:[4]

- any eligible, supervised individual who has been charged with (including ancillary and inchoate offences such as attempt, conspiracy to commit, incitement to commit and encouraging or assisting commission): murder, manslaughter, other specified offences causing death, rape or assault by penetration, a sexual offence against a child under 13 years of age, or qualifying offences under terrorism or anti-terrorism legislation during a period of management by a probation service.
- 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 discretionary review may also be carried out 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 HMPPS has identified that it is in the public interest to conduct a review.

[4] [Notification and Review Procedures for Serious Further Offences Policy Framework] (publishing.service.gov.uk)

Contextual facts

Across England and Wales, the number of SFO notifications received by HMPPS in the 12 months to March 2022 increased by six per cent, from 498 to 529 compared to the previous year.[5] That is 23 per cent lower than the total number received in 2016 - 2017.

Table one: SFO statistics

240,431	Number of individuals under probation supervision as of 31 December2022[6]
529	Number of SFO notifications received in 2021/2022[5]
425	Number of SFO reviews completed in 2021/2022[5]
245	Number of SFO convictions from 498 notifications in 2020/2021
Less than 0.5%	Proportion of individuals under probation supervision who are charged with an SFO[5]
50%-60%	Proportion of SFO notifications that result in a conviction for an SFO in most years. In the remaining cases, charges are dropped, or the person is acquitted, or convicted of a less serious offence[5]
97 community supervision 138 determinate prison sentences 1 life licence 9 imprisonment for public protection	Number of SFO convictions in 2020/2021, broken down by index offence supervision type[6]
55	Number of the 245 SFO convictions in 2020/2021 for murder[5]
49	Number of the 245 SFO convictions in 2020/2021 for rape and other serious sexual offences[5]

Table two: SFO conviction offences by notification period as of 30 September 2022 for England and Wales[6]

SFO conviction	2020/2021	2019/2020
Murder	55	87
Attempted murder or conspiracy to commit murder	19	20
Manslaughter	27	30
Rape	49	65
Arson	22	15

[5] Ministry of Justice. (2022). Proven reoffending statistics: October to December 2020. Serious further offences annual bulletin

[6] Ministry of Justice. (2023). Offender Management Caseload Statistics as at 31st December 2022.

Kidnapping/abduction/false imprisonment	15	17
Death involving driving/vehicle-taking	8	13
Other serious sexual/violent offending	50	67
Total	**245**	**314**

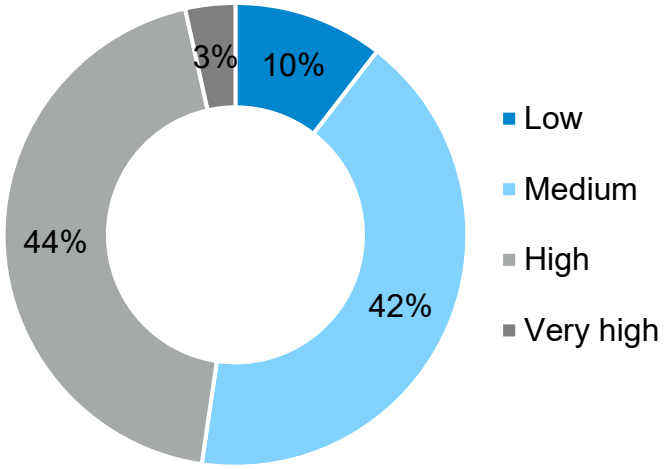
Table three: Number of SFO convictions for murder, by the type of sentence the person on probation was serving at the time as of 30 September 2022[6]

Index sentence type	2020/2021	2019/2020
Community supervision	17	37
Determinate prison sentence	38	48
Life	0	1
Imprisonment for public protection	0	1
Other	0	0
Total	**55**	**87**

What we found, April 2022 to April 2023

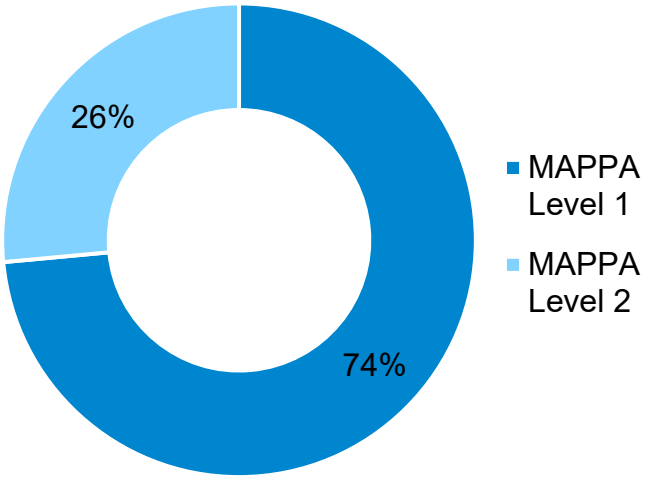
During the period April 2022 to April 2023, HM Inspectorate of Probation quality assured a random sample of 20 per cent of the SFO reviews undertaken by the Probation Service in England and Wales. This equated to 86 reviews, and it is of note that 67 per cent of these cases were for the offence of murder or rape.

Table four: Quality assurance by risk of serious harm category at the point the SFO was committed



Of the 86 SFO reviews that we quality assured, 42 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, and 44 per cent by an individual assessed as posing a high risk of serious harm. This is an increase on the 2021-2022 figures when 33 per cent were assessed as posing a high risk of serious harm. This is a significant rise and emphasises the importance of probation regions carrying out high quality and effective risk management activities. This does not include HMPPS SFO review data.

Table five: Quality assurance by MAPPA level at the point the SFO was committed



Of the 86 SFO reviews quality assured, 42 per cent were managed under Multi-Agency Public Protection Arrangements (MAPPA). The diagram shows that 74 per cent of these were managed at MAPPA level 1 at the point the SFO was committed, and 26 per cent at level 2. None of the cases quality assured were at level 3 at the point the SFO was committed, although some cases had been managed at this level during their supervision period.

Quality assurance activity

Our standards

Our quality assurance work is underpinned by standards agreed with HMPPS. These standards[7] are used consistently by our SFO inspectors and HMPPS's own quality assurance team and ensure that evidence is gathered to support the rating we apply to the SFO review. These standards set the expectation that an SFO review will:

- provide a robust and transparent analysis of practice,
- have clear and balanced judgements on the sufficiency of this practice,
- enable appropriate learning to drive practice improvements which, where relevant, will apply across all levels of the organisation,
- be suitable for sharing with the victim or their family.

The quality assurance standards are also supported by our rules and guidance and ratings characteristics.[7]

Once an SFO review being quality assured, inspectors give individual ratings for four standards:

- analysis of practice
- overall judgements
- learning
- victims and their families.

The individual ratings are then combined to contribute to a composite rating of either:

- 'Outstanding'
- 'Good'
- 'Requires improvement' or
- 'Inadequate'.

The probation region receives a feedback document that explains why each rating has been given, identifies where the review met the required standard and specifies where and how improvements to the review should be made.

If a review is deemed to be 'Inadequate,' the reviewing manager has four weeks to take account of the quality assurance feedback and make the necessary changes to the SFO review, before resubmitting it to us. If a review receives a rating of 'Requires improvement' it is expected that the reviewing manager will make the required changes within four weeks of receiving feedback. High-profile cases, and those where a victim or their family has requested access to information, are resubmitted for further assurance. However, we chose to select cases at random to verify that the required changes have been made to the expected standard, via a dip sample.

Our standards support both our quality assurance activity and that of the HMPPS central SFO team. Together, we hold quarterly interface meetings and benchmarking sessions with HMPPS colleagues to enable us to monitor how the standards are applied and to promote consistency between our teams. Combined annual data for the quality assurance teams within HM Inspectorate of Probation and HMPPS demonstrate that the teams are consistent

[7] Serious Further Offence reviews (justiceinspectorates.gov.uk)

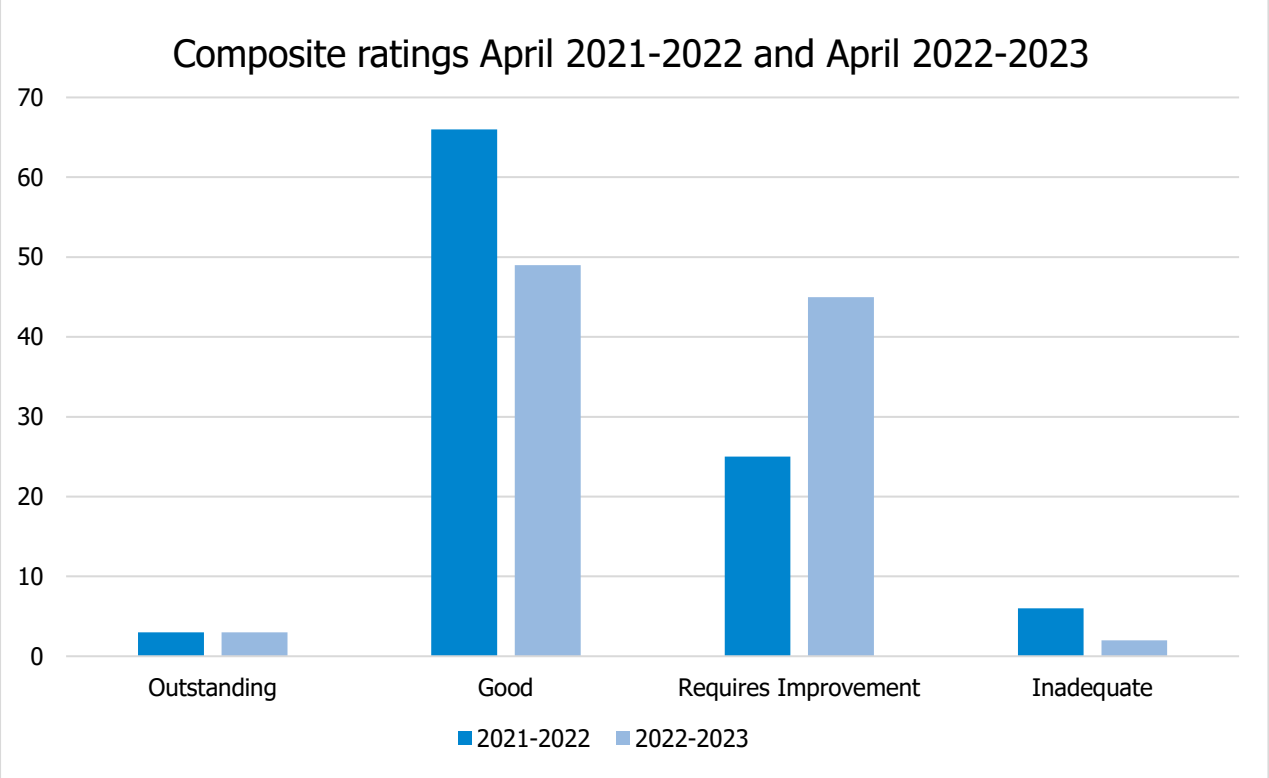
in how the standards, rules and guidance and ratings characteristics are applied to each SFO review.

Our SFO inspectors also hold an internal benchmarking session for any review where there is an initial indication that the composite rating will be 'Inadequate'. This process of continual dialogue and reflection on our standards supports inspectors in applying them robustly and consistently.

Composite ratings

We have seen a disappointing reduction in the number of SFO reviews given a composite rating of 'Good' with only 49 per cent of reviews reaching this standard in 2022-2023 compared to 66 per cent in 2021-2022.

Our most recent findings from the quality assurance activity between April 2022 and April 2023 demonstrate that probation regions have not made progress in improving the overall quality of the SFO reviews. There has been a decline in the overall quality, with a total of 47 per cent of reviews being given a composite rating of 'Requires Improvement' or 'Inadequate' against the previous year when 31 per cent were given these ratings.



We consider that this decline is due to several interconnected factors, that impact on the overall quality of the reviews:

- The resourcing of the SFO reviewing teams is not always sufficient. Several probation regions have expressed concern that the resourcing model results in high workloads which does not support them to produce high quality work. Furthermore, there is turnover among reviewing managers, resulting in teams that have inexperienced reviewing managers, or that have vacancies which are difficult to fill due to operational vacancies within regions.
- Rigorous internal countersigning should take place in the probation region before the SFO review is submitted for quality assurance. It is apparent from the quality assurance feedback and composite ratings that overall, this is not being completed to a sufficient standard. The countersigning and internal assurance process is not consistently providing the required quality of scrutiny and professional challenge, and as a result reviews are submitted for quality assurance that do not meet expected standards.

- Probation regions are continuing to complete reviews internally on themselves, which raises concerns about whether reviewing managers can be fully transparent, objective and drive notable change within their own region.
- Reviewing managers are senior probation officer (SPO) grade, which makes it difficult for them to fully consider at a senior and strategic level the systemic and procedural issues relevant to regional probation practice. This is underpinned by factors such as not feeling able to or empowered to critique the practice of senior leaders in their organisation, their own limitations and knowledge about strategic issues, and the level of engagement and response from senior leaders in the process.
- The SFO review document template does not meet the needs of all intended audiences.
- The action plan and associated process needs revision to ensure that all learning opportunities are developed into tangible actions, that contribute to identifiable learning pathways within HMPPS, and that learning has a national impact.

Regional overview

Table six: demonstrates the composite ratings awarded to SFO reviews by probation region

Code	Probation region
A	North East
B	North West
C	Yorkshire and the Humber
D	Wales
E	West Midlands
F	East Midlands
G	South West
H	South Central
I	East of England
J	London
K	Kent, Surrey and Sussex
L	Greater Manchester

Probation region	Composite rating awarded April 2022 to April 2023 (number of reviews quality assured)			
Rating	**Outstanding**	**Good**	**Requires improvement**	**Inadequate**
Yorkshire and the Humber	-	3	7	-
Greater Manchester	-	7	1	-
London	-	5	5	-
West Midlands	-	6		-
East Midlands	-	3	2	-
Wales	-	3	2	-
North West	-	4	3	-
Kent, Surrey, and Sussex	-	4	2	-
East of England	2	-	5	-
North East	-	-	4	2
South West	-	2	5	-
South Central	1	5	3	-

It is evident that the majority of the SFO reviews being completed by the probation regions are not meeting the expected standard. Engagement with the central HMPPS team has shown that they are aware of this, share our concerns and intend to review the framework that supports the delivery of SFO reviews. Although this is encouraging, we recommend that HMPPS considers this at pace and promptly revises both the operating model and SFO review document format to maximise the opportunity to produce high quality and informative SFO reviews.

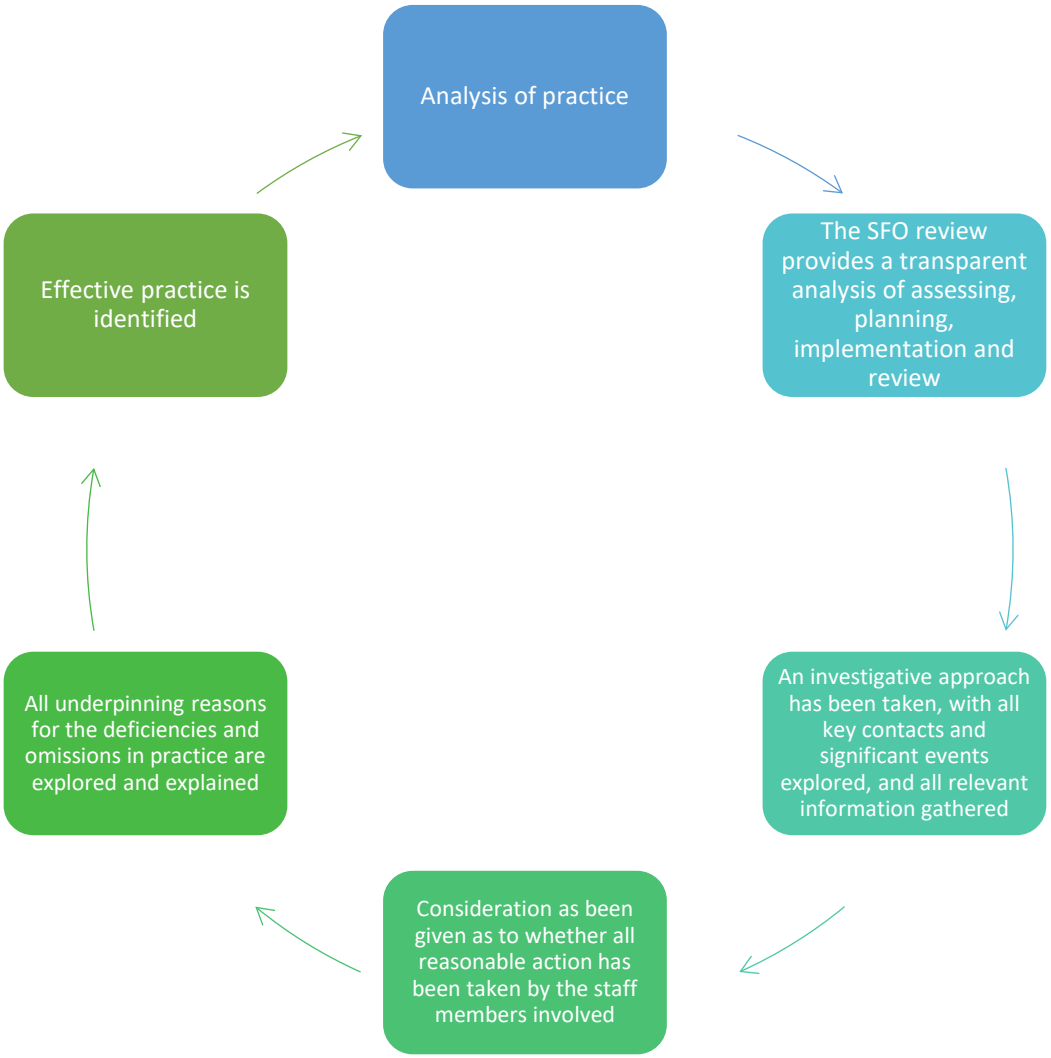
SFO reviews are completed by staff at middle manager grades within their own probation regions. We have previously raised concerns about this operating model, questioning its objectivity and whether the reviewing managers are able, at their grade, to scrutinise probation practice fully and robustly at all levels within the organisation. The quality assurance data for 2022/2023 further emphasises the need for HMPPS to revise the operating model to drive improvement in the quality of SFO reviews and to ensure these are produced to a consistently good standard.

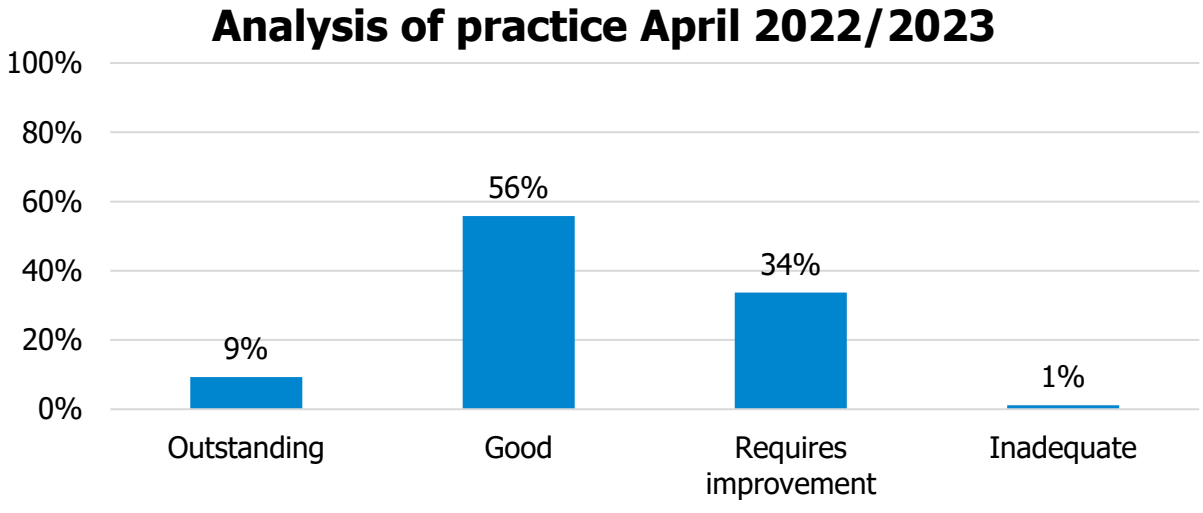
Probation regions we have spoken to have repeatedly expressed frustration at the SFO review format, emphasising that as the SFO review is both an internal document and a document for sharing with the victim or their family, it has separate audiences. As such, they say it is difficult to write a document that achieves both these aims, and that this hinders the reviewing manager in producing a high quality SFO review.

Overall, we have found that most probation regions are motivated to engage with us when receiving quality assurance feedback and are seeking to improve their quality assurance ratings. Regions have expressed concern that their SFO reviews are not reaching the required standard. To support development, we have begun to carry out regional engagement sessions which include benchmarking exercises to further encourage improvement in the quality of the SFO reviews.

Individual quality standards

Analysis of practice – what do we expect from an SFO review?





The individual ratings given show that in 65 per cent of reviews, reviewing managers were providing a 'Good' or 'Outstanding' analysis of the practice in the case considered. This meant that there was a sufficient overview of the key contacts and significant events that occurred during the supervision period, and this was supported by a sufficient level of analysis. However, often this overview of practice was at an individual level and failed to provide a holistic overview that considered practice at all levels or across all departmental areas involved in the delivery of the licence or supervision requirements. We see repeatedly that reviewing managers are not sufficiently considering the practice of approved premises, interventions teams or unpaid work supervision teams resulting in analysis that focuses predominantly on the probation practitioner and a missed opportunity to fully consider all practice in the case.

These ratings are consistent with those awarded in 2021-22 when 64 per cent of the reviews we quality assured were either 'Good' or 'Outstanding'. While it was positive to see that two thirds of SFO reviews were still meeting this standard, it is of concern that we have not seen a significant increase in the ratings awarded.

The quality assurance process enables us to identify recurring practice themes and deficits that are identified in SFO reviews across all probation regions. These include:

SFO reviews show that practitioners in the cases reviewed were not always seeking or using all available information to inform the assessment of risk of serious harm, resulting in an underestimation or inaccurate assessment of the level of risk posed.

Factors underpinning this included probation practitioners failing to undertake domestic abuse or safeguarding enquiries, specialist risk assessment tools not being used to support an informed assessment of risk, and assessments of risk of serious harm not considering the breadth and nature of the risk posed and therefore failing to identify all those potentially at risk. This poor practice was also often accompanied by a failure to respond to or recognise emerging risk issues during the supervision period, with review OASys assessments not being completed, resulting in a missed opportunity to analyse new information and behaviour to inform an updated assessment of risk and need.

Frequently practitioners were focusing their supervision appointments on 'checking in' with the person on probation or responding to their immediate needs. While addressing need is an important element to encouraging engagement and can also support desistance, it can prevent the practitioner from focusing sufficiently on managing risk of serious harm and delivering structured interventions.

A range of approved 'toolkits' are available for practitioners to work through with those subject to probation supervision, which are relevant to their offending behaviour and needs. SFO reviews showed that these toolkits were not often used. The reasons given by practitioners included workload, responding to crisis management, and lack of confidence and understanding about how to deliver the toolkits effectively

Professional curiosity encompasses all aspects of probation practice.[8] [9] It combines the need for practitioners to be actively looking, listening, and asking direct questions, supported by clarifying and reflecting on the

[8] Effective practice guide: Practitioners – professional curiosity insights (adult services) (justiceinspectorates.gov.uk)
[9] Effective practice guide: Middle managers – professional curiosity insights (adult services) (justiceinspectorates.gov.uk)

information received to analyse what it means. It is important that this is done in context for the individual person on probation.

Practitioners should embed professional curiosity as part of their core practice to support them to understand more about the individual, including their identity, motivations, capacity, resources, strengths, and risks. Seeking multiple sources of information is essential and supports the practitioner to verify and triangulate information, analyse behaviour, and make informed and evidence-based decisions.

The SFO quality assurance work has demonstrated that a lack of professional curiosity underpinned several key practice themes. These included probation practitioners:

- failing to take an inquisitive approach to managing and responding to risk of serious harm. This was apparent when working relationships had been formed with those serving long sentences (such those on life and IPP licences) which had contributed to the development of professional complacency
- having an optimism bias, which impacts on how probation practitioners view compliance and engagement and can result in superficial compliance not being recognised
- working in isolation and not using all available resources, information, tools, and interventions
- not developing their own practice and leadership skills, and not accessing or being afforded access to good quality continuous professional development. Probation practitioners are not maintaining up to date knowledge and skills, affecting the way they view and approach effective management of those subject to probation supervision
- not harnessing the power of reflection and informal conversations both with those subject to supervision and with colleagues
- not taking a lead in the management of the case and allowing other partner agencies to do so, or allowing the pace and content of the supervision sessions to be dictated by the person on probation
- not working holistically and focusing attention on one area of risk and need, failing to explore other associated, interlinked, or underlying factors
- not collaborating, sharing information, or communicating sufficiently with partner agencies.

Enforcement action was not being used consistently or in line with policy guidance, particularly with licence cases. The independent review into the case of Joseph McCann that we published in 2020 recommended improvements in the processing of recalls to custody, and a revised licence enforcement policy was issued by HMPPS in 2021. However, it is apparent that further work is needed to ensure the consistent and timely application of the policy, as is also reflected in the findings of the independent review we published into the case of Jordan McSweeney.

Opportunities to deliver responsive practice that meets the individual needs of the person on probation are being missed.

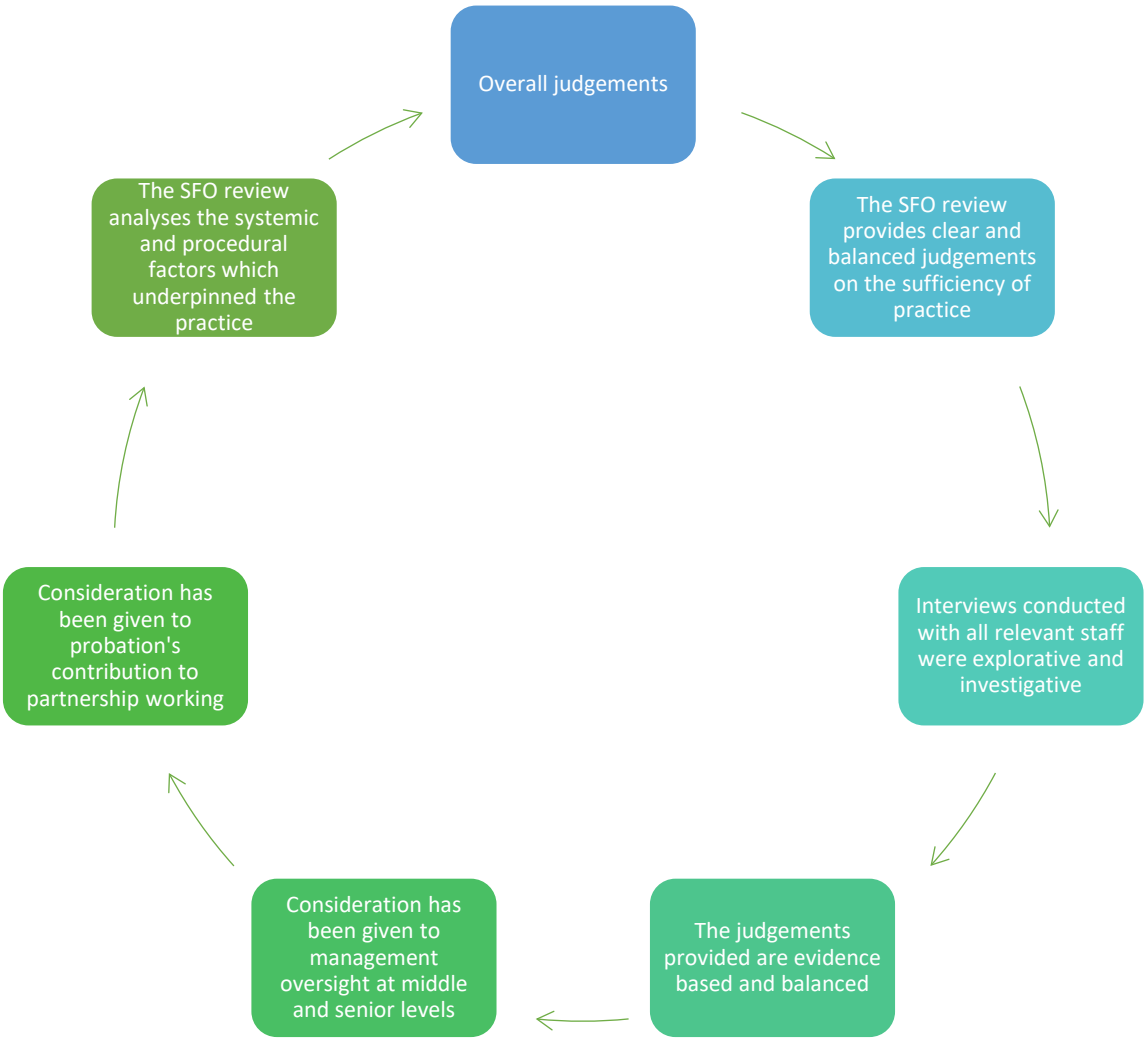
For example, those transitioning from youth to adult services should receive an informed and responsive approach, where all information is gleaned from the relevant youth offending service and any concerns regarding contextual safeguarding are used to inform the assessment of risk and need.

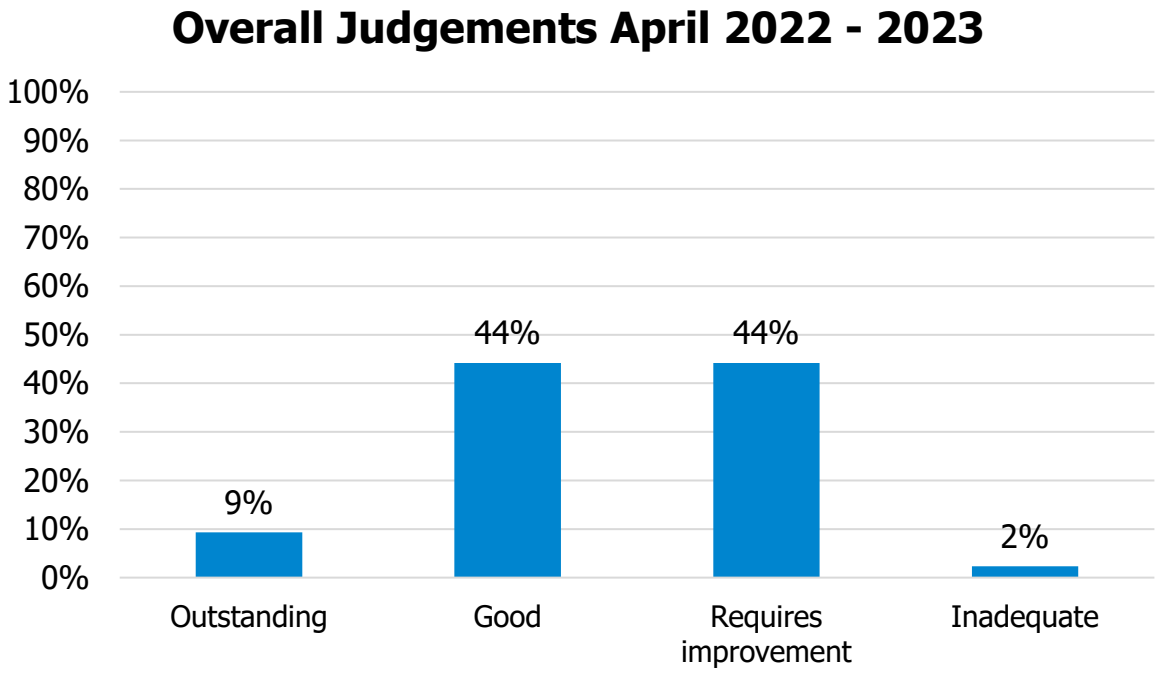
Those with diagnosed mental health, physical health or neurodiverse needs must have an approach that recognises their individual circumstances. However, for practitioners to understand the individual, they need to approach their practice in a professionally curious way. This can help the probation practitioner to gain a better understanding of the individual's identity and what motivates them, which in turn can strengthen engagement and supports the practitioner in implementing and delivering interventions to manage risk and promote change effectively.

Where approved premises (AP)[10] practice was considered in SFO reviews, there was some evidence of ineffective interfaces between AP staff and probation practitioners. We saw examples of missed opportunities to share pertinent information and to improve how relevant case information was recorded. Three-way meetings between the AP staff, probation practitioner and person on probation were not always completed. There were also examples where despite effective communication by AP staff, the community practitioner did not always act on information pertinent to risk management.

[10] Approved premises (APs) offer an enhanced level of public protection in the community and are used primarily for high and very high risk of serious harm individuals released on licence from custody

Overall judgements – what do we expect from an SFO review?





It is expected that the SFO review includes appropriate judgments both on the individual practice and on any systemic or procedural factors that impacted on how the case was managed. To do this, the reviewing manager should have scrutinised the relevant systems, policies, and procedures that influenced the practice being considered.

'Systems' relates to the objective building blocks of managing people on probation, which are often underpinned by statute, for example MAPPA. 'Procedure' is linked to policy, with the policy stating the 'what' and the procedure stating 'how'.

We have found that 53 per cent of SFO reviews, received an overall judgement of 'Good' or 'Outstanding', meaning that just under half of all reviews we assessed were not providing judgements on the sufficiency of practice to the required standard.

This year, our quality assurance findings showed that increasingly, reviewing managers were conducting interviews with senior managers to inform their SFO review. While this was positive, further work is still needed to ensure that the interview is used effectively to scrutinise any local and regional systemic and procedural issues that underpin poor practice, and that reviewing managers are providing a critique of the practice at a senior level within the SFO review.

We are finding that not all relevant staff are being interviewed to inform the SFO review. For example, staff from other parts of the Probation Service, such as unpaid work teams or approved premises staff are being omitted from the interview list and would benefit from being included. As a result, key areas of practice pertinent to the case are not being analysed at a sufficient level and therefore, the reviewing managers are unable to provide sound evidence-based judgements on these areas.

When reviewing managers are analysing how the person on probation was managed, there will often be a need to consider the involvement of partnership agencies. Reviewing managers are not expected to directly critique the practice of another agency, but they should explore and analyse the effectiveness of multi-agency working and the probation practitioner's role in this. They must have clearly identified all the partnership agencies involved in managing the case or delivering interventions and should have highlighted the quality of the referral processes, communication, and information sharing. We have found that in 62 per cent of SFO reviews, reviewing managers were not drawing sufficient conclusions on the quality of partnership working.

Where SFO reviews are effectively identifying the systemic and procedural factors relevant to the management of the case, the most common concerns are noted below. These also correlate with the findings of the independent reviews published this year and our probation local inspections:

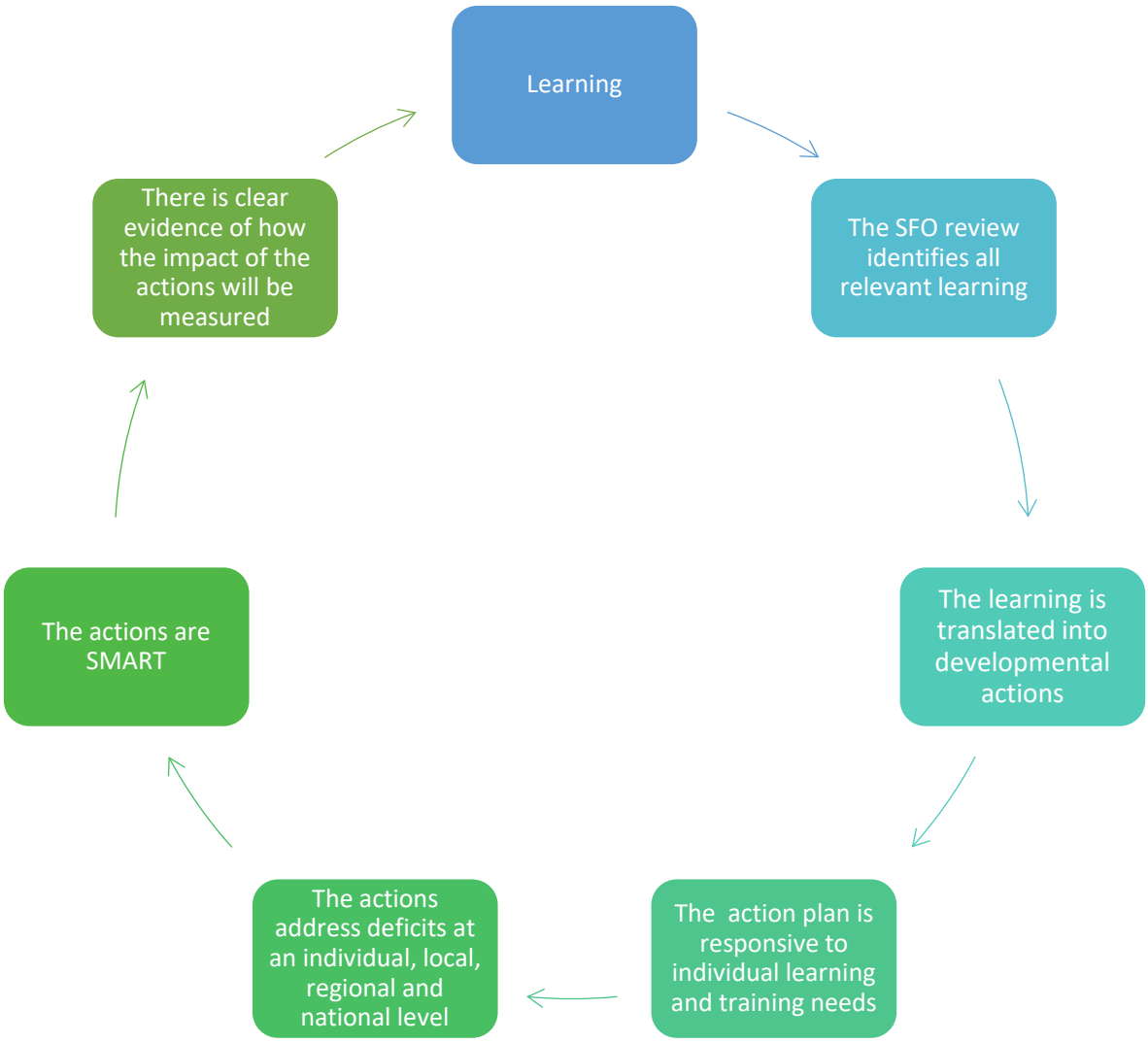
- There were continued concerns about practitioner workloads, vacancy levels, and the retention of staff. HMPPS have been actively recruiting and filling vacancies,[11] however this brings a further challenge in that it is creating a workforce which lacks the required levels of experience and training, and it will take time to develop these practitioners. This impacts on the managers' ability to allocate cases to suitably skilled and experienced practitioners, and on the practitioner's confidence and ability to manage complex cases and recognise signs of deterioration and escalating risk. We are seeing that in many teams there is an imbalance of trainee (professional qualification in probation (PQiP)) or newly qualified officers (NQO) compared with the number of more experienced staff, with further pressure on practitioners to mentor and support PQiP and NQO staff.

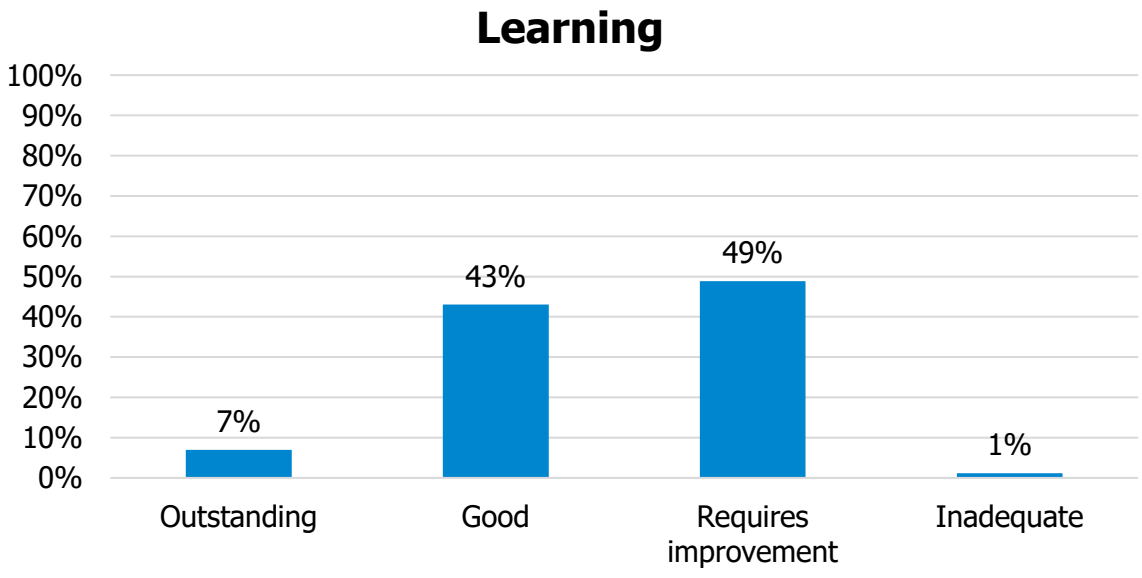
[11] Probation Workforce Strategy (2023-2025) - GOV.UK (www.gov.uk)

- Issues were raised in respect of consistent and effective management oversight, which is where managers ensure that operational expectations are met to the required standard. Management oversight can include supervision, coaching, reflective discussion, and the provision of feedback. This is an essential element of the SPO role, which in addition to operational assurance also supports the continuous professional development of probation practitioners.
- HMPPS policy guidance on the 'Touchpoints Model' sets out the expectations and principles that line managers should adhere to in providing oversight. SFO reviews are demonstrating that even if delivered at the right frequency management oversight can be formulaic and lacking quality and detail. However more often, we see that management oversight does not meet the required frequency nor the required standard. This insufficient level and quality of management oversight was attributed in part to the size and breadth of line managers' spans of control, which can include overseeing large teams of practitioners as well as managing absence, initial allocation and reallocation of cases, human resource (HR) functions, and lead specialist roles such as chairing of MAPPA level 2 meetings.
- The pace of policy and operational changes is impacting on how well they are implemented. This then translates into whether probation practitioners embed this into their practice and work to the expected policy standards. We have seen this in several key practice areas such as the expected enforcement standards not being met, and toolkits not being used in supervision appointments.
- Information was not shared between prisons and probation consistently. As a result, key information pertinent to risk of serious harm was not shared and did not inform release and resettlement plans. This included information relating to behaviour in custody, which was often viewed in isolation and as being prison-specific, rather than assessed as being relevant to a holistic risk assessment. This lack of effective information-sharing between prisons and probation can contribute to an incomplete picture of a person on probation's risk of serious harm. We explore this later in the annual report, as it was also one of the key findings of the Jordan McSweeney independent review.
- MAPPA level one[12] processes were not embedded sufficiently within probation delivery units (PDUs). Many SFO reviews did not demonstrate that management under multi-agency arrangements at this level had any added value to the management of risk of serious harm. This correlated with the findings of our joint thematic inspection into MAPPA arrangements which was published in 2022.[13]
- SFO reviews showed that in many cases OASys assessments[14] were completed in a timely manner following sentence or release from custody, which was in line with expected performance targets. However, the quality of these assessments could be limited, reflecting that they were completed to meet a deadline and were not informed by all available and relevant sources of information. Furthermore, practitioners were not reviewing OASys assessments when required to do so, for example in response to changes of circumstances, new information and evidence of escalating risk. SFO reviews emphasis the OASys tool is cumbersome and takes a long time to complete which does not support the practitioners to deliver high-quality reviews that can be completely swiftly.

[12] Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK (www.gov.uk)
[13] Twenty years on, is MAPPA achieving its objectives? A joint thematic inspection of Multi-Agency Public Protection Arrangements (justiceinspectorates.gov.uk)
[14] Offender Assessment System (OASys) is a tool used by HMPPS to assess a person on probation's risk and need.

Learning – what do we expect?





This year we have seen a decline in the number of SFO reviews receiving a rating of 'Good' for how well the required learning was identified and translated into meaningful actions. This reduced from 59 per cent in 2021/2022 to 43 per cent in 2022/23. It is of significant concern that last year this was the weakest area of the SFO reviews assured and has continued to decline further. Given the importance of SFO reviews being a learning document and supporting HMPPS to address practice deficits and identify opportunities for learning and change, this further highlights the need to revise the current operating model.

Our quality assurance data shows that in, 43 per cent of the SFO reviews, reviewing managers were not sufficiently identifying areas for improvement for staff across all levels, and 60 per cent of SFO reviews were not sufficiently identifying learning in respect of multi-agency working. Quality assurance feedback frequently emphasised the need for actions to share learning with agencies such as the police, social services, and prisons.

Repeatedly, quality assurance feedback has emphasised that more work is needed to improve the quality of the action plans attached to the SFO reviews. In 42 per cent of the reviews assured, it was deemed that the actions set did not sufficiently address the practice deficits identified at an individual or PDU level. This increased to 60 per cent when considering the sufficiency of the actions set at a regional level.

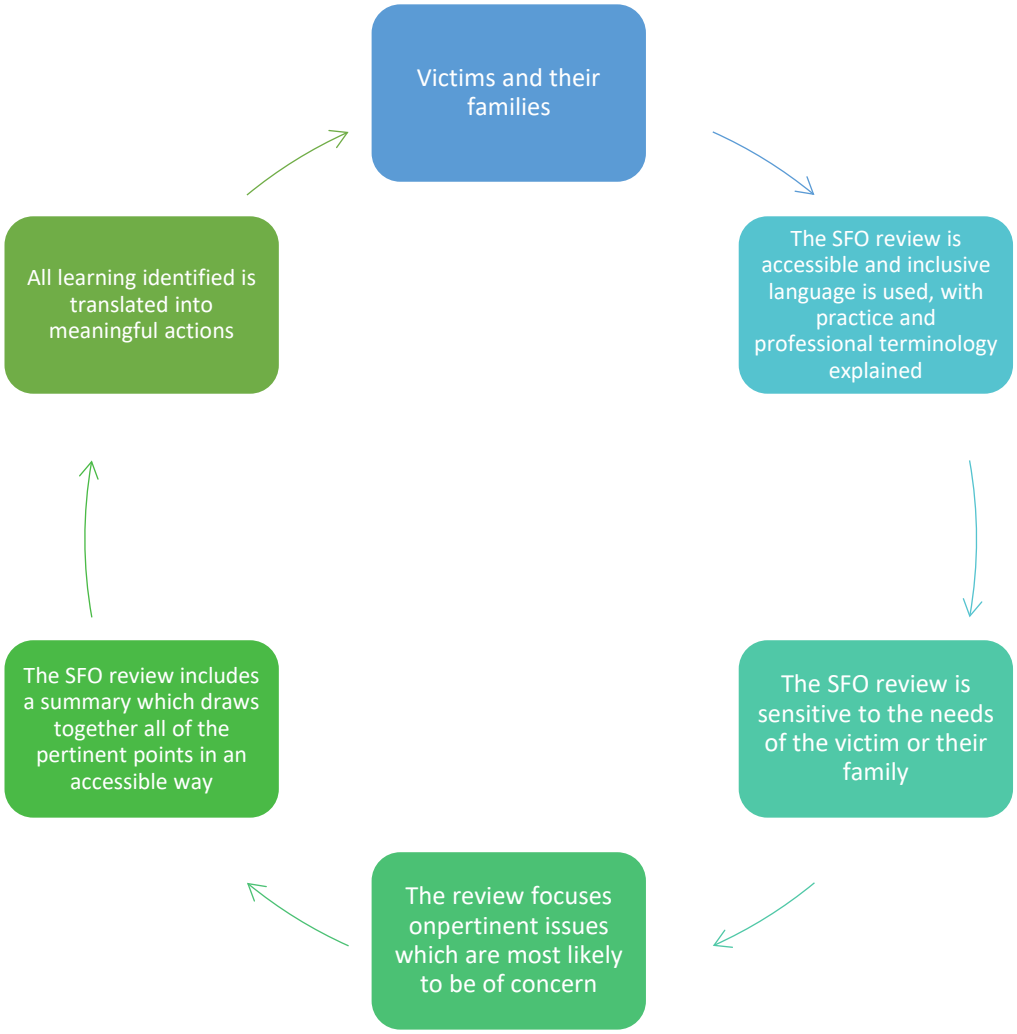
It was also found that, in 60 per cent of reviews, the actions set did not include tangible ways of monitoring their impact. Furthermore, of those which indicated multi-agency learning, 72 per cent of the action plans did not contain sufficient assurances on how the learning from the SFO review would be shared with these relevant partner agencies.

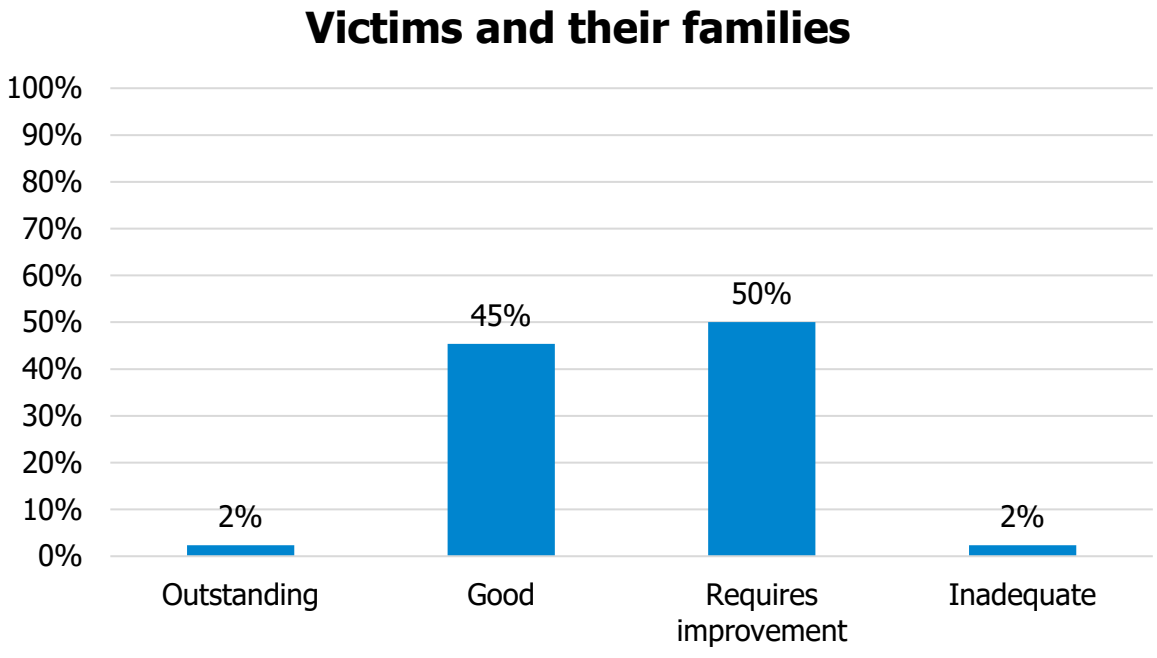
Each probation region provides an update to the central HMPPS SFO team on the progress made against the SFO review action plan six months after the review is submitted. The probation region is required to hold itself to account against the progress made, but with no additional oversight of the sufficiency of the progress made. The learning derived from SFO reviews is invaluable, and more work is needed to embed how learning is fed back into the organisation to inform and shape developments in probation regions and more widely across HMPPS.

Probation regions need to have robust processes in place to ensure that SFO action plans are implemented as expected, and that outcomes from the actions taken can be clearly demonstrated. Unless this occurs, probation regions will not be able to demonstrate that each SFO review has the required level of impact, and that practice errors will not be repeated.

From April 2023, we implemented an additional element to our quality assurance activity which includes monitoring updates to the action plan submitted by the region on the SFO reviews we quality assure, to robustly monitor their sufficiency and progress made.

Victims – what do we expect?





Concerningly, we have seen the number of SFO reviews meeting either the 'Good' or 'Outstanding' rating for this standard reduce significantly from 80 per cent to 47 per cent, and the number of those rated 'Requires improvement' and 'Inadequate' increasing from 20 to 52 per cent.

The SFO review must be an accessible and informative document for the victim of the SFO or their family. The language and tone used throughout the SFO review is an essential element to consider when assessing the review against the victim standard. Quality assurance feedback repeatedly emphasises the need for revisions to be made to reviews to ensure that they are accessible, appropriate, and easy to follow. Often, quality assurance feedback includes reference to the SFO review containing:

- an inappropriate and insensitive description of the index offence or SFO; with reviewing managers using language and terms that may be factual but are unnecessarily detailed for inclusion in the review itself
- including victims or other parties' details such as names or other identifying information
- insensitive language or comments about victims or those deemed at risk during the review period, particularly when the SFO was linked to domestic abuse and the victim of the SFO had also featured as a person at risk during the review
- repeated use of jargon and professional terminology without sufficient explanation
- opinion or assumptions made about practice that were not based on factual evidence and could therefore be misleading for the reader.

Regional SFO teams have fed back to us that in needing to be both an internal management report and an accessible document for the victim and their families, the SFO review is pulled in two different directions. They told us that the detailed review of practice required, and the length of report does not naturally lend itself to an accessible document for a victim or their family.

Of the SFO reviews we have quality assured, since April 2021, the number of victims or their families who have subsequently requested access to the review is low – at under 10 per cent – this could be linked to several factors, including court cases which had not yet concluded. However, in recent months we have seen a steady increase in such requests. We believe this may be in part because of the publication of our independent reviews and the associated publicity, which has drawn more attention to SFOs. This may also be because victims and families wish to revisit issues having had further time to reflect on their experience and require more detail of what occurred during the review period.

When a victim or their family asks to see an SFO review, the reviewer is required to re-submit it for further quality assurance, which considers how well the previous feedback has been applied and whether the document meets the expected standard and can be shared. Our inspectors are finding that often the required changes are not being made to a sufficient standard, and that not all the feedback is being actioned. This is despite probation regions being receptive to the feedback and expressing motivation to produce reviews that meet the required standard.

This leads us to further question the operating model for producing SFO reviews, and what more HMPPS can do to promote victim engagement to increase the numbers accessing the SFO review.

SFO review quality assurance - case examples

Composite rating of **'Good'**	Composite rating of **'Outstanding'**
The review provided a robust and transparent overview of practice in the case, with the key contacts and significant events made clear.	The review provided a comprehensive, highly analytical and transparent overview of the case.
It was investigative, which supported the reviewing manager in providing a detailed and transparent analysis of practice.	The review provided evidence-based judgements on missed opportunities, practice deficits and effective practice identified.
Context for the practice was explored, with a sufficient level of detail on factors that underpinned the practice, such as workload, training, experience and office culture.	The review provided an overview of the systemic and procedural issues that underpinned the practice in this case and considered management oversight at middle and senior levels.
There is consideration of middle management oversight, which includes informal and formal contact and supervision.	The reviewing manager clearly articulated the significance and impact of the practice considered, enabling the reader to understand the pertinent factors and their relevance to the overall management of the case.
Interviews were completed with relevant staff but could have been expanded further to ensure all levels and all departments were included	Staff at all grades and across all departmental areas were interviewed, including both probation and prison-based staff and national policy leads.
Consideration is given to the quality of the multi-agency working and the probation practitioner's role in this.	The review identified all learning opportunities at all levels, which were translated into meaningful and measurable actions.
The review identifies relevant learning, and actions are tangible and measurable. One area of relevant learning identified was not translated into a meaningful action	The review was concise yet emphasised all key points. It was well written and accessible. The language used was appropriate and sensitive to the needs of the victim or their family.
The review was sensitive to the needs of the victim or their family, although amendments were required to the language and terms used in the review to ensure it was fully accessible.	

Composite rating of **'Inadequate'**	Composite rating of **'Requires improvement'**
The narrative provided did not focus on all of the significant events, which resulted in gaps in the chronology.	An overview of the practice was provided which included most key contacts and significant events but was overly descriptive and not supported by a sufficient level of analysis.
The review contained incorrect information and descriptions of probation practice.	An investigative approach was not taken to explore the pertinent practice and underpinning issues.
The review was overly descriptive and lacking in analysis.	Some context was provided but more was needed to aid understanding of factors such as workload, staff experience, and management oversight.
There was a lack of clarity on the risk of serious harm and needs presented by the case.	The overly descriptive approach resulted in a lack of sufficient, evidence-based judgements and a lack of analysis of the systemic/procedural factors relevant to the management of the case.
The review failed to articulate the significance and impact of the practice deficits identified in the case.	The action plan contained some relevant actions which enabled some learning to drive improvements in practice, but not all learning was captured.
There was an over-emphasis on practice issues which were less significant and less focus on factors which needed an enhanced level of analysis and judgement.	The language used was at times not accessible and lacked sensitivity and included spelling and grammatical errors.
There were not enough judgements on the sufficiency of the practice considered, and those provided were not based on a sound evidential base.	Actions were not SMART, with feedback emphasising the need to demonstrate how the outcome of the actions will be measured.
The action plan captured some but not all of the required learning, and the actions were not SMART and did not demonstrate how the impact of the action will be measured.	The review did not fully meet the needs of the victim by virtue of the limited analysis and insufficient judgements provided.
The language used was not accessible, there were spelling errors and the review was not deemed to meet the needs of the victim or their family.	

Independent reviews – an introduction

An independent review can be commissioned when a person subject to probation supervision commits an SFO, and the Secretary of State deems it necessary to ask HM Inspectorate of Probation to conduct an independent review into the Probation Service's management of the case. Previous reviews published by the Inspectorate have included the cases of Joseph McCann 2020,[15] Leroy Campbell 2018, and Hanson and White 2006. The impact and actions resulting from independent reviews can be far-reaching and lead to significant change in probation policy and practice.

When undertaking an independent review, our SFO inspectors gather evidence on the case, engage with the relevant probation region(s), and interview staff at all levels who have been involved in managing the case. The reviews also consider wider practice issues; therefore, inspectors involve senior leaders in their interviews, to ensure any systemic or procedural issues resulting from the review are given due scrutiny. This can include analysing national policies and practices where issues have been identified in the management of the case, and interviews with any other relevant agencies such as the police and prisons.

After the key findings have been established and conclusions drawn, the review makes recommendations to the Secretary of State for Ministry of Justice (MoJ) and HMPPS to action. These can be made for individuals, teams, or regions; however, where the review has identified wider issues, the recommendations will focus on systemic and/or procedural issues to inform change on a larger scale. They will therefore be directed towards HMPPS or the MoJ at a national level. This ensures a broader approach to actioning change. Once the recommendations are submitted, HMPSS formulates and publishes an action plan to implement. We review the progress and changes made because of our independent reviews and consider how well our recommendations have been implemented when undertaking our local, regional or thematic inspections.

Since our last SFO annual report, we have published two independent reviews in January 2023, for the cases of Damien Bendall and Jordan McSweeney. It is notable that similar themes were found both these reviews and in our local PDU inspections, adding weight to the importance of implementing the recommendations we make.

[15] Inquiries and reviews (justiceinspectorates.gov.uk)

Independent review of Damien Bendall - key findings

In September 2021 Damien Bendall (DB) murdered his partner Terri Harris, her two children John and Lacey Bennett and Connie Gent, a friend of Lacey's who was at their address for a sleepover. He also raped Lacey. He was sentenced to a whole life prison sentence in December 2022. The Secretary of State commissioned the independent review on 29 September 2021, which was then published following sentence, in January 2023.[1]

DB was subject to probation supervision at the time he committed the offences having been made subject to a suspended sentence order in June 2021. He was required to attend probation appointments for supervision and rehabilitation activities, undertake unpaid work and abide by an electronically monitored curfew. The review highlighted significant failings from the outset, which began when he was assessed at court, and followed through into his sentence management.

The review highlighted the main findings from the case as follows:

Assessment of the risk of serious harm

The risk of serious harm level of 'medium' determined for DB was inaccurate and should have been 'high' given his history. However, in preparing the court report, the probation service did not obtain or analyse available information when assessing the risk of harm posed. This meant the court was missing vital information when reaching its sentencing decision. Had a more holistic risk assessment been presented to the court, (including his pattern of violent offending both inside and outside prison, an analysis of previous non-compliance and the most recent high risk of serious harm assessments) then an immediate custodial sentence may have been imposed, rather than the suspended sentence that was given to DB.

Those assessed as being high risk of serious harm are managed by a more stringent risk management plan, have increased reporting and are eligible for management under multi-agency arrangements such as interdepartmental risk management meetings (IRMM) in custody and multi-agency public protection arrangements before and on release. These options would have afforded more robust oversight of DB.

Process for recommending curfew requirements

Before his sentencing, domestic abuse enquiries were not completed in respect of DB or on the proposed curfew address. The court report stated that DB was 'suitable' for a curfew at the address. To probation practitioners, DB presented himself as a father figure to the children of Terri Harris and this was accepted without challenge. No contact was made with the children's parents to inform them of the recommendation of a curfew.

Given what was known about DB and his history, and information that was not sought by way of enquiries, this was an entirely unsuitable recommendation to make to the court.

Child safeguarding

Inspectors found that probation practitioners in this case based their risk of harm assessments on whether DB had convictions against children or for domestic abuse, or if children's services were involved with the family. The probation practitioners did not delve deeper to explore his broader attitudes and behaviours, including consideration of his potential impact on the children in his life. While he did not have any past offences against children, the review found that practitioners did not sufficiently consider whether his racist, manipulative and controlling attitudes and his violent and unpredictable behaviour would have a negative impact on the wellbeing and safety of children. Further, information

received previously from police suggesting DB might pose a sexual risk to girls was not recorded or explored effectively to inform his risk assessment and risk management plan.

DB suggested to the court report author that he played an active part in the care of John Paul and Lacey Bennett. This information was not verified or checked with Terri Harris and was therefore taken at face value. There were no enquiries to establish whether children's services were currently working with the family or had previously done so.

During his supervision period, DB continued to claim a 'father figure' status for the children, and there was no evidence of staff using professional curiosity to challenge or check these assertions. Further, they continued to make no checks with the children's parents, and did not refer to, or make enquiries with, children's services as to any involvement with the family. When DB admitted to using drugs and alcohol, the impact of this on the children he was living with was not sufficiently considered and a children's safeguarding referral was not completed. The review found that the risk of serious harm to children was inaccurately assessed and seriously underestimated.

Domestic abuse

Inspectors found that key information on risk from prison and from DB's ex-partner was not given due consideration and was not recorded appropriately. The impact of this failure was significant, as successive probation practitioners did not recognise that DB posed a risk of serious harm within relationships.

Inspectors found that the risk of serious harm to known adults, including partners, was underestimated. There was no focus on safeguarding in this case and, as a result, DB was sentenced to an inappropriate curfew requirement that may have exacerbated the risk of harm to Ms Harris and her children.

Court report

A short-format report was prepared in this case to inform sentencing. This is a shorter format than a standard delivery report and is often completed "on the day" of sentencing. The review found the use of this format was incorrect. DB's criminal history was complex and as such met the threshold for a suitable adjournment period to allow for a thorough read of his case to inform the completion of a more detailed report. This case met HMPPS's own criteria for a standard delivery report as 'additional assessment, professional discussion, and multiple enquiries [were] required to aid risk assessment' and 'liaison where medical report [was] unavailable on the day'.

Had the case been adjourned, more time would have been available to complete the necessary enquiries as outlined above, and to make a proposal to the court based on a thorough assessment of suitability, considering all available information.

Management oversight and senior probation officer workload

Inspectors found that high workloads and staff shortages impacted on the ability of probation practitioners to undertake high-quality work. Inspectors heard that this was a long-standing issue that they had experienced since the changes introduced with *Transforming Rehabilitation.*

There was insufficient oversight of a member of the probation court team, which led to a poor-quality fast delivery report being presented to the court. This was due to SPO sickness and a lack of resources to cover the absence.

The SPO who managed the probation practitioner responsible for DB after sentencing from June 2021 was unable to engage with the case fully. They managed a large number of staff, directly managing 16, but when covering for colleagues had oversight of up to 30 trainee probation officers (PQiPs).

This is far more than the line management span for SPOs recommended by HMPPS, of 10 full-time equivalent posts. This prevented the SPO from reading DB's case at the allocation stage and from providing the necessary oversight.

The review found that the SPOs were also not given meaningful, regular, and effective supervision and support.

Professional qualification in probation and probation services officer training and oversight

The probation practitioners who managed DB from June to September 2021 were inexperienced, unqualified and had insufficient support to understand and recognise the risks and needs in the case.

Inspectors heard concerns about the efficacy of online training, especially for key learning on domestic abuse and child safeguarding, from all grades of staff, not just professional qualification in probation (PQiP) and probation service officer (PSO) staff. There had been an understandable reliance on this method during the period of Covid-19 restrictions; however, some staff noted that before the pandemic there had been a trend towards self-reliant e-learning and development. Practitioners said that such self-selective training and development suffered when staff spent their hours 'firefighting' with excessive caseloads. DB's case was one of 10 being managed by a staff member who had yet to complete basic safeguarding training.

The review therefore concluded that the training available, and methods to both complete training and allow sufficient time for completion were significant issues in this case.

Independent review of Jordan McSweeney - key findings

This review was commissioned by the Secretary of State in July 2022 and published in January 2023 following sentencing.[2]

On 26 June 2022 Jordan McSweeney (JM) sexually assaulted and murdered Zara Aleena. These offences occurred as Ms Aleena walked home, alone, with JM following her, before he subjected her to a sustained physical and sexual assault. He was sentenced to life in prison in December 2022 with a minimum term of 38 years. JM was subject to prison licence at the time, having been released from custody nine days earlier, on 17 June 2022.

As with Damien Bendall, the review highlights several failings, and there are similarities in what was found in both reviews:

Risk of serious harm – inaccurate assessments and underestimation of risk

JM was managed as a 'medium risk of serious harm Integrated Offender Management (IOM) acquisitive individual' however his level of risk should have been escalated to 'high' in February 2021, based on the range of information available on his history of violence as well as acquisitive offending. There was information known about risks present in custody, such as possession of weapons, and violent and threatening behaviour. In addition, he had carried weapons in the community, and posed a risk to known adults. The risk to the public, staff, and other prisoners, should have been assessed as high risk of serious harm. The risk of serious harm to known adults should also have been high based on information related to offences against a known female, which was received in 2021 and later resulted in a restraining order being imposed.

JM's persistent poor behaviour in custody was seen in isolation and risk management in the community was not given sufficient consideration. The risk of harm posed was not viewed holistically in this case, with the focus being on acquisitive offending, and a thorough assessment of other presenting risk factors was missing.

The lack of effective information sharing between prisons and probation contributed to an incomplete picture of JM's risks and potential for violence and disruptive behaviour. The fact that he spent a significant proportion of his adult years in custody made it difficult to gather significant information about his circumstances and potential behaviour in the community.

Had he been correctly assessed as high risk of serious harm – specifically in respect of other prisoners, staff, known adults and the public – the planning for release, licence conditions, reporting instructions, and action taken when he failed to attend on release could have been significantly different and potentially more urgent (for example following his failure to attend initial probation appointments on 17 and 20 June). He may also have been eligible for joint MAPPA management, and for consideration for an approved premises (AP) placement, which would have afforded more monitoring of his risk in the community as well as opportunities for rehabilitation.

There are similarities here between DB and JM, with inaccurate risk assessments in both cases meaning opportunities were missed to undertake more robust risk management and monitoring in both cases. In each case, areas of risk were considered in isolation which meant a holistic assessment was not undertaken.

JM was managed under IOM arrangements which afforded a level of multi-agency oversight. With the correct risk assessment, it is likely that the level of monitoring through the IOM arrangements would have been enhanced, allowing timely responses to non-compliance but more importantly, contributing towards a release plan appropriate to the risk posed.

A critical omission in the case was the failure to exercise sufficient professional curiosity and management oversight to ensure all available information was analysed to assess the risk posed by JM. The review identified that a significant amount of information became known about JM's circumstances, confirming that he was in a relationship and had a stepchild, and family dynamics were deteriorating, particularly with his mother. While information was recorded, there was little evidence of this being explored in any detail or informing assessments undertaken by agencies. This led to risk factors being assessed in isolation and not building a picture of the overall risk posed.

Case allocation

There were issues with the allocation of JM's case. Although he received 16-months in custody, taking into account his time spent on remand, he only had two months left to serve in prison at the point of his sentence, and so his case should have been allocated directly to a community practitioner. The processes in place for allocating cases when a custodial sentence is imposed was found to be confusing and cumbersome in the London region, impacting significantly on pre-release planning. Had allocation taken place correctly and earlier, probation staff would have had more opportunity to consider the risks posed by this individual and to amend the risk of serious harm assessment.

Enforcement decisions and recall to custody

JM had a history of non-compliance which, on previous sentences, had not been managed effectively often meaning no action was taken. Following release, on 17 June, there were missed opportunities to recall JM following failed appointments and risk factors emerging. Recall should have been initiated following non-attendance on 20 June 2022, but a management oversight discussion did not consider recall and efforts made to locate JM were insufficient.

When the recall was initiated on 22 June, it followed an informal discussion and the probation practitioner's direct line manager was not fully included in the process. A delay to signing off the recall until 24 June, outside the 24-hour target specified in the related guidance, meant the recall was not timely and ultimately delayed the opportunity for JM to be arrested by police. The PDU was facing significant staffing issues at the time of JM's release with six staff away from work. The review found that the SPO had an excessive workload and was struggling to cope with the volume of work. This was a similar finding to that in the DB review regarding SPOs span of control and excessive workload.

Diverse needs

The review highlighted that it was well documented that JM had diverse needs. At different junctures records stated JM had attention deficit hyperactivity disorder (ADHD), Personality Disorder (PD) and had suffered from depression. He was stated to be medicated at various times for ADHD, but little analysis was undertaken of how this affected his day-to-day cognitive functioning and learning styles, and whether there were links with offending behaviour. It was judged that there was no in depth understanding of his needs, presentation, or inability to engage with supervision.

Independent review - themes and recommendations

Risk assessment

It is notable that some themes are apparent across both independent reviews we published this year. In both cases the risk of serious harm assessment was found to be inaccurate, and not all aspects of risks were considered. With DB, this was related to the risks he posed to his partner and her children as well as his previous behaviour in both custody and the community. With JM it concerned the lack of holistic risk assessment, considering his behaviour in prison, previous violent convictions, and the risks he posed to women.

The inspectorate made recommendations regarding risk assessments in both reviews. The Bendall review recommended that risk assessments should be quality-assured specifically with regards to those presented before the court, and the McSweeney review requested a review of the process that probation staff use to assess the risks of harm that people on probation may pose to others, to ensure that all staff understand and apply the correct criteria for identifying high risk of serious harm cases.

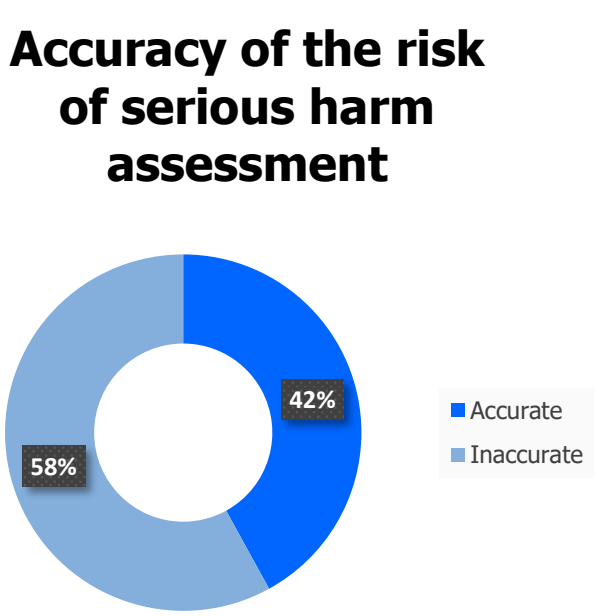
It is of note that inaccurate risk assessments have also been a feature of HM Inspectorate of Probation's local PDU inspections. Data drawn from PDU inspections in London in August 2022 shows that seven per cent of medium risk cases had an inaccurate (and too low) risk assessment. Across all our PDU inspections in England and Wales to date, we have found that risk is assessed inaccurately in 13 per cent of cases (when cases originally assessed as low risk are included too). The need for urgent action to address the quality and accuracy of risk assessments is clear.

The accuracy of risk assessments was also a concern identified through the SFO reviews we quality-assure. SFO reviewing managers are expected to analyse the risk of serious harm levels and any changes during the review period relevant to the case. They should consider whether there was an accurate assessment of risk of serious harm in place and whether there were any factors that probation practitioners should have taken account of and used to inform the assessments. These factors could include if:

- there was missing information
- relevant enquiries with partnership agencies were completed (for example, regarding child safeguarding and domestic abuse),
- risk factors were underestimated
- there was a lack of professional curiosity to understand circumstances that might increase risk.

The review should provide a judgement on the effectiveness of the risk assessment, and any changes made to this assessment during the review period.

Table seven: Percentage of SFO reviews that found the assessed level of risk of serious harm to be inaccurate Error! Bookmark not defined.



In 58 per cent of the 86 reviews quality assured, the SFO reviewing manager, or our quality assurance inspector, considered that at some point in the supervision period the assessment of risk of serious harm completed by the probation practitioner was inaccurate or did not fully consider the nature and extent of the risks presented by the individual.

Of the 86 SFO reviews quality assured by us this year, more than half (50 cases) had an inaccurate or incomplete assessment of the risk of serious harm during the period before the SFO. In many of these cases, the assigned risk level was medium, with the review concluding that it should have been assessed as high overall. Reasons for the incorrect assessments included the practitioner not using specialist risk assessment tools sufficiently and not using all available information to inform the risk assessment. There were also cases where elements of the risk assessment that did not sufficiently consider all potential victims and therefore, the probation practitioner had underestimated the full breadth and nature of the risk presented by the case.

Workload and resourcing

The issue of workload and resourcing was a significant finding in both the Bendall and McSweeney reviews. In both cases the SPO overseeing the practitioner managing the case had an excessive workload and this impacted on their practice. This issue is not confined to these teams. It is apparent that a significant number of PDUs are short staffed, have high workloads and struggle with staff retention. For example, the PDU inspections in London completed in August 2022 found a significant issue with staffing across the whole region, with 500 vacant positions in London remaining unfilled at the time of our inspections. When PDU inspections were undertaken in East Midlands in February 2023, it was found that 'staffing and workloads were a critical concern at the time of the inspection with staffing levels which were not enough to deliver services to a sufficient quality'.[16] It is recognised that HMPPS recruitment is ongoing to increase staff levels, but this will take time to have an impact, and new staff will need time to engage in effective training and gain experience in their roles.

Information sharing

Difficulties in either obtaining relevant information by probation practitioners, or sharing information with other agencies such as prisons, were apparent in both reviews, and were also a key feature of previous reviews, particularly that of Joseph McCann. It is of concern that similar themes regarding information sharing between prisons and probation were still apparent despite this being raised as a key finding previously.

[16] An inspection of probation services in Derby City PDU (justiceinspectorates.gov.uk)

In most cases, probation and prison staff have access to the NDelius system, the main recording system used by the probation service. Challenges in sharing information were seen at an individual level but also appeared prevalent with regards to sharing more sensitive information relating to security concerns.

The JM review recommended that HMPPS undertake an urgent review of processes for information and intelligence-sharing between prisons and the probation service which is to be completed by June 2023. The need for this was emphasised given the same recommendation was made following the McCann independent review published in 2020.

With regards to obtaining information in respect of child safeguarding and domestic abuse, the DB review sets out recommendations to improve this practice particularly at the sentencing stage. The review recommended that domestic abuse enquiries be carried out in respect of everyone sentenced to ensure that safe proposals are made to the court. Further, it directs that safeguarding enquiries are made in all cases where the individual lives with, is responsible for, has access to, or is likely to have a negative impact on the well-being or safety of a child.

The DB review also recommended that the MOJ should amend legislation to be more prescriptive about the information that should be obtained and considered by the court, so that the court assures itself of the safety of other household members at a proposed curfew address before they impose an electronically monitored curfew. It has been noted that this is in train and interim measures are in place in courts to ensure that enquiries are made before sentencing.

Professional curiosity

A theme prevalent in both reviews was the lack of professional curiosity to elicit, verify and explore information received in supervision sessions and from other agencies. Information was taken at face value from JM and DB and not examined further to inform the management of both cases. Again, this has been a common theme across SFO reviews and HM Inspectorate of Probation inspections. It is likely that this links with resourcing issues and staff having insufficient time to complete tasks or to spend sufficient time with the people they supervise. Similarly, staff did not always have the right amount of experience to have developed this as a key skill.

Diverse needs

Both cases in the recent independent reviews presented as complex with an entrenched history of offending behaviour. Linked with the lack of professional curiosity, there was insufficient exploration of these needs and how early experiences may have impacted on their behaviour and manifested in their presentation, as well as their likelihood and ability to engage with professionals. The JM review recommended that the London region develop an initiative on neurodiversity and invest in trauma-informed training for staff. This should enable more awareness of individual needs and result in more effective case management.

Case allocation and case management

Both reviews highlighted issues with case allocation. The McSweeney review recommends that there should be timely and accurate allocation of each case to probation practitioners in the community for supervision before and after release and a mechanism for checking this process. Given the apparent issues in overseeing the allocation in the Bendall case, that review highlights 'management oversight – allocation' entries should be completed and include evidence that the manager has considered the complexity of the case and the capabilities and capacity of the probation practitioner receiving the case.

There are other practice issues such as the inclusion of appropriate licence conditions using the correct probation tool to ensure that all are considered following the McSweeney review and there are several recommendations regarding court practice as a result of the findings in the Bendall case.

Independent reviews - impact and review

The publication of both reviews generated substantial and widespread public interest which has raised the profile of the significant issues presented in each report. Both reviews were covered extensively in the media and the McSweeney review generated a ministerial statement to Parliament in relation to our recommendations.

HM Inspectorate of Probation has engaged with the families of the victims in both cases to share the findings in advance of publication and discuss the recommendations. Whilst this will no doubt have been a difficult and traumatic experience; family members have stated that they wish to remain involved in ongoing dialogue with ministers and officials to ensure that actions are taken, and effective changes are implemented.

Since publication of the reviews in January 2023, there is evidence of changes being implemented by HMPPS. Probation regions involved in the reviews have pledged to take forward learning from both cases. Similarly, across England and Wales, there has been a significant amount of reflection, as well as a willingness to learn and improve practice based on the findings of the reviews. The impact of these reviews on the staff involved, and more widely across HMPPS cannot be underestimated.

In respect of the need for mandated enquiries before curfew orders in respect of both domestic abuse and child safeguarding, progress has been made. While the recommendation to legislate for such requirements in court remains ongoing, interim measures have been implemented to ensure legal advisors are aware of these requirements. Recent PDU inspections in Yorkshire and the Humber (YatH) found an increase in the use of domestic abuse and child safeguarding enquiries at PSR stage, ensuring more robust checks were made before sentencing. Similarly, the London probation region had reviewed all medium risk of serious harm cases, to ensure they have an appropriate risk assessment and risk management plan in place.

It is noted that changes were made to OASys, in November 2022, to ensure a more robust analysis of risks posed to children. Additionally, there will be prompts to consider any civil orders which may be in place and offences committed in a custodial setting.

HM Inspectorate of Probation will continue to review actions with HMPPS to ensure ongoing implementation and monitoring of actions.

Chief Inspector Justin Russell commented following the McSweeney review: 'This is far from the first time we have made recommendations relating to the need to improve the assessment and management of the risks of serious harm to the public posed by some people on probation. The need for us to repeat them yet again raises questions as to whether HMPPS is learning the lessons of past mistakes. It is vital that they do so in the future'. It is therefore of paramount importance that action is continually reviewed, to ensure the best possible outcomes for those subject to probation supervision, and to minimise the possibility of further serious offences being committed.

Forthcoming work

A recurring theme within SFO reviews is the need to improve partnership working. We are committed to supporting the continuing improvement of practice and strengthening of partnership working by the Probation Service at a local and regional level and are in the process of setting up two multi-agency learning panels (MALPs). These MALPs will provide an opportunity for collaborative learning for all relevant agencies involved in an SFO case and to set onward actions for each participating agency where applicable.

A pilot multi-agency learning panel was previously held in Wales, which included representatives from the Probation Service, police, and health services, as well as an independent domestic abuse charity. The feedback from this panel was positive and has supported us in developing the panels further.

We are now two years into our quality assurance work, and we will be completing a review of our standards that support this activity. This will enable us to consider where our standards can be enhanced and provide further opportunity for engagement with HMPPS who we will consult with on the proposed changes.

From April 2023 we have broadened our quality assurance activity further to include random dip sampling on those SFO reviews that receive a composite rating of 'Requires Improvement' to seek assurance as to whether the required changes have been made to a satisfactory standard. Furthermore, we will be engaging with probation regions to discuss the implementation of the action plans and monitoring the sufficiency of their action plan updates.

We will also be expanding our regional engagement and benchmarking activity to provide additional development sessions with those responsible for countersigning the SFO reviews before they are submitted for quality assurance. These sessions will be delivered in collaboration with the HMPPS quality assurance team.

We are working with representatives from the Youth Justice Board to understand how they monitor serious incidents with young people on Youth Offending Service caseloads, and how they take forward learning on a multi-agency basis.

Conclusion

This report has highlighted a decline in the overall standard of the SFO reviews quality assured this year, with the numbers rated as 'Outstanding' or 'Good' reducing from 69 per cent to 52 per cent.

We emphasised in last year's annual report that more work was needed to improve the overall quality of SFO reviews, therefore this year's findings place an even greater emphasis on this.

SFO reviewers are not sufficiently considering practice at all levels, and this failure to consider whether systemic or procedural factors underpin poor practice is also impacting on how well all learning opportunities are identified. There has been a notable decline in the quality of both the learning and victim elements of SFO reviews, both of which are key factors in meeting the overall aim of these reviews.

We published two independent reviews this year, which made a total of 27 recommendations to support HMPPS in making critical changes and improving how people on probation are managed in the community. Each of these recommendations has been accepted by HMPPS.

Recurring practice deficits are being identified through the SFO process, many of which also correlate with the findings of the local inspections and those from the two independent reviews we published. This raises further concerns that SFO reviews are not fulfilling their aim or potential in driving forward change and preventing practice deficits from reoccurring.

Our work over the forthcoming year aims to support HMPPS in driving improvements in the quality of SFOs reviews, as well as monitoring how well the action plans are implemented and effect change. It is imperative that SFO reviews meet the expected standard so that victims and their families have a transparent overview of the practice in the case and relevant learning can be taken forward effectively and drive change.

We make the following recommendations to HMPPS to improve to the quality of SFO reviews:

1. promptly review the SFO review document format to maximise the opportunity to produce high quality and informative SFO reviews that meet the needs of victims and their families
2. ensure that the learning identified is translated into meaningful and impactful actions
3. ensure that where applicable, all learning linked to the Probation partnership working is identified and shared with the relevant agencies
4. develop a process to ensure that learning from SFO reviews is fed back into the organisation to inform and shape developments within probation regions and more widely across HMPPS
5. ensure that robust and rigorous countersigning takes place on all SFO reviews before they are submitted for quality assurance
6. put robust processes in place to ensure that, following quality assurance feedback, all required changes to the SFO review document are made timely and to a sufficient standard.
7. SFO reviews, particularly those of the most serious offences, should where possible be undertaken by a separate probation region to that responsible for supervising the case at the time of the SFO. And consideration should be given to raising the grade of SFO reviewers, particularly for the most serious or complex cases.