HM Inspectorate of Probation

Serious Further Offences Annual Report 2024

10 December 2024

HM Inspectorate of Probation

Introduction

- Chief Inspector of Probation - Martin Jones

- Head of Probation Programme - Dave Argument

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About us

Our vision

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

Our purpose

HM Inspectorate of Probation is the independent inspector of probation and youth justice 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.

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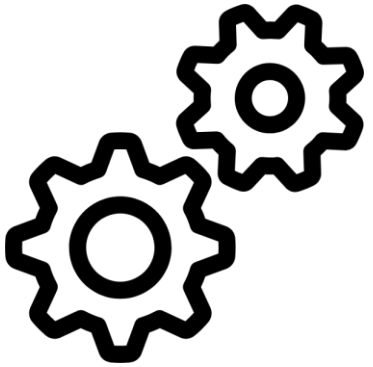

SFO Process

- The SFO review process commences when a person is charged and appears in court for a qualifying offence which was alleged to have been committed while they were under probation supervision or within 28 working days of the supervision period terminating.
- The SFO review is then commissioned, which is intended to be both an internal management report and a document which can be shared with the victim or their family. Therefore, it should provide a robust and transparent analysis of practice and be written in a way which is accessible to both audiences.
- Each probation region has an established SFO team consisting of reviewing managers, who complete all the SFO reviews for that region. A centralised HMPPS team quality assures the SFO reviews and provides feedback to the region on the quality of the completed review. HM Inspectorate of Probation undertake 20 per cent of this quality assurance activity.

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HM Inspectorate of Probation's role in SFO reviews

2020 HM Inspectorate of Probation published an SFO thematic review.

2021 In April 2021 HM Inspectorate of Probation began providing independent quality assurance and benchmarking.

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HM Inspectorate of Probation's role in quality assurance of SFOs

HM Inspectorate of Probation's approach has five specific strands:

1. Quality assurance of a sample of SFO reviews against an agreed set of independent standards.
2. SFO benchmarking events.
3. Multi-agency learning panels.
4. Publishing of annual/periodic findings.
5. Independent reviews.

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SFO Annual report

- Headlines from the report
- Feedback from staff survey
- Findings regarding quality assurance of SFO reviews
- Risk of serious harm assessments and independent reviews
- Recommendations

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Staff survey

Purpose

To understand staff's perceptions of the organisational culture in relation to SFOs, respondents were asked to comment on available support, opportunities to learn, and changes in practice resulting from SFOs.

- 245 responses.
- 88 per cent of respondents were in clearly identifiable operational roles of various grades.
- The remainder were in allied operational roles, such as specialists, senior managers, case administrators, or victim liaison workers.

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Staff survey results

- The majority (55 per cent) did not believe that there was sufficient support for staff involved in SFO reviews.
- Less than a quarter (23 per cent) believed that there were sufficient opportunities to learn from SFO reviews.
- Four in 10 (38 per cent) respondents were more confident that they had changed their professional practice in line with the findings from SFO reviews.
- Three in 10 (30 per cent) expressed satisfaction that HMPPS SFO reviews were helpful, with 33 per cent perceiving the same of HM Inspectorate of Probation independent reviews.

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Themes

- A perception of a blame and shame culture around SFOs
- The stress and anxiety of the SFO review process
- The role of SFO reviewers
- Recognition of organisational context in SFO reviews
- Management support during the SFO process
- Positive experiences of SFO reviews

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Summary of staff survey

“As an officer I feel we are made to feel more responsible for the offence than the actual perpetrator, at times, and we are left feeling guilty because we could not predict the future. When SFOs are used as 'training' examples it is always looking at what the officer did/didn't do (which is, obviously, the point) but the emphasis placed on 'blaming' the officer is clear.”

I think the best experience is with an empathic investigation officer who does not make one feel that you the practitioner are to 'blame'. Whilst we know this is not the case, the interview process can make one feel this way. I do believe there needs to be an empathic way of interviewing a practitioner, so that the process is a learning experience rather than an interrogation experience.”

“Staff feel targeted as the SFO process is shrouded in secrecy. We are not privy to any final reports or submissions. We are not privy as to whether organisational or systemic issues are addressed. We receive an action plan for ourselves only and this is fine, but it does leave us wondering what about other issues we may have raised. Are those explored and if so, how? We need to be sure of a whole systems approach to SFO reviews.”

“The interviewer was very reassuring and understanding, making me feel at ease as I was an NQO [Newly Qualified Officer]at the time of the SFO. I believe there is more support offered to staff from the outset of SFOs since my experience. I feel that regular input to CPDs [Continuing professional development] or team meetings from the SFO team is beneficial, as many new and more experienced practitioners remain fearful of the process.”

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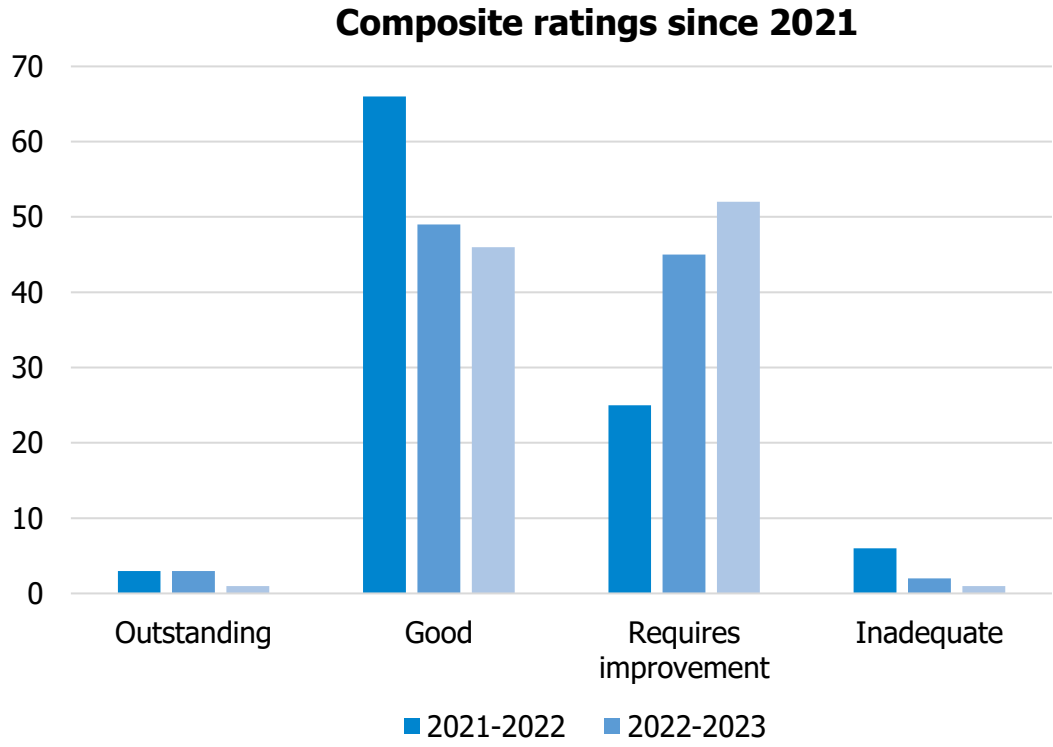
SFO review quality assurance

- We quality assured 87 SFO reviews this year, rating 46 per cent as 'Good' and 52 per cent as 'Requires improvement', with one percent rated as 'Outstanding' and one per cent as 'Inadequate'.
- The number of reviews meeting the required standard has decreased.
- The standard of SFO reviews continues to vary across probation regions with some reaching a consistently higher standard.



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SFO review quality assurance

- Probation regions requested extensions to the agreed submission deadline in 76 per cent of the 87 SFO reviews we quality assured this year.
- We have continued to hear from probation regions that the SFO review format is not conducive to writing high-quality documents.
- SFO leads have reported difficulty in consistently providing the detailed process required, particularly given the number of reviews each region is routinely producing. This has resulted in some reviews being signed off regionally as being sufficient and ready for quality assurance that, in fact, do not meet the required standard.
- Through our engagement with regional SFO teams, we have heard from many teams who feel their resourcing and workload demands are a concern.

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Regional engagement

- Benchmarking sessions with regional SFO teams.
- Band 6 benchmarking events jointly with HMPPS.
- Individual discussions regarding feedback and applying it effectively.

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Risk of serious harm (RoSH) assessments

71 per cent of the serious further offence reviews we quality assured had inaccuracies with the risk assessment. The issues were as follows:

- the overall level of risk of serious harm was inaccurate from the outset
- one or more groups were inaccurately assessed
- the risk of serious harm was accurate but did not consider the risk presented holistically, or all those who may be at risk in the different groups
- the risk of serious harm was not adequately reassessed, despite new or emerging risk factors being apparent
- the reviewing manager agreed with the overall risk assessment but the SFO inspector undertaking the quality assurance assessed it was inaccurate.

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Why was the risk underestimated or assessed inaccurately?

- Inexperienced officers completing assessments
- Lack of training, or insufficient training available
- Information not being sought from available sources, for example domestic abuse or child safeguarding enquiries not being completed
- Assessments not based on all available information, resulting in pertinent information not always being explored or used effectively to inform the risk assessment
- Information taken at face value and not followed up or verified, demonstrating a lack of professional curiosity

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Why was the risk underestimated or assessed inaccurately?

- Risk assessments not reviewed when new information about risk comes to light.
- Excessive workloads, which can result in assessments being completed quickly, late or by another practitioner who is not as familiar with the case. In some cases, review assessments are not completed.
- A narrow view of the risk of serious harm is presented, for example a practitioner may focus on the most pertinent risk factors and not consider wider issues, therefore resulting in an assessment that is not holistic and does not consider all risk factors.
- Insufficient multi-agency working to inform risk assessments.

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Independent review follow up

- The McSweeney review made nine recommendations, all of which were accepted by HMPPS. HMPPS have provided an update to their action plan, which was published on 25 January 2024.

Progress has included the following:

- A new approach to the assessment and planning of risks, needs and strengths (ARNS). The new assessment is currently being piloted and is expected to be rolled out to all staff in 2026.
- HMPPS has made changes to OASys to better capture offences committed in a custodial setting and civil and ancillary orders.
- An information-sharing form has been devised for prison offender managers to complete.
- The public protection group in HMPPS have updated the risk of harm guidance to explicitly address the need to consider all behaviour and not just criminal convictions when assessing the risk of serious harm posed.

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Independent review follow up

- The Bendall independent review made 17 recommendations, all of which were accepted by HMPPS. HMPPS have provided an update to their action plan, which was published on 09 May 2024.

Progress has included the following:

- It is now mandated that domestic abuse enquiries are undertaken for all cases where an electronically monitored curfew is proposed.
- HMPPS report that monthly recorded activity in relation to child safeguarding enquiries more than doubled between April 2022 and March 2023, and recent data indicates further continuous improvement.
- Updates to the HMPPS sections of the new *Working Together to Safeguard Children* statutory guidance aim to help strengthen the arrangements that probation delivery units have with local authority children's services, particularly in relation to exchanging information.
- HMPPS state that a new home detention curfew digital service will not allow the practitioner to progress a case unless the community offender manager has indicated that they have obtained informed consent.

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Independent reviews – Joshua Jacques

Key findings:

- Risk assessment did not cover all areas of risk.
- Inconsistent enforcement practice.
- Lack of professional curiosity and evidence of optimism bias.
- Resourcing and workload concerns.
- Insufficient management oversight.
- Missed opportunities within MAPPA oversight.
- Approved premises practice deficits.
- Mental health and substance misuse not effectively managed.

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Recommendations

Last year we made seven recommendations to HMPPS in respect of the quality of SFO reviews. There has been insufficient progress made against these recommendations; therefore, these recommendations remain, and we have set a further four;

- introduce training and development for those working in SFO teams in a way that enables reviewing managers to undertake the role in a meaningful way and supports a shared learning culture among SFO reviewing teams and across probation regions
- in conjunction with the SFO procedures being reviewed, focus specifically on the transparency of the process and how the review findings are shared with those staff members who were involved in the management of the case
- take action to ensure the resourcing of SFO reviewing teams can meet the requirements set out in the SFO policy framework, and focus specifically on addressing the backlog of SFOs and ongoing completion of SFO reviews in a timely manner
- review the effectiveness and impact of the SFO policy framework and approach to analysing practice when serious further offences occur to ensure meaningful learning is identified at the right level.

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