HM Inspectorate of Probation

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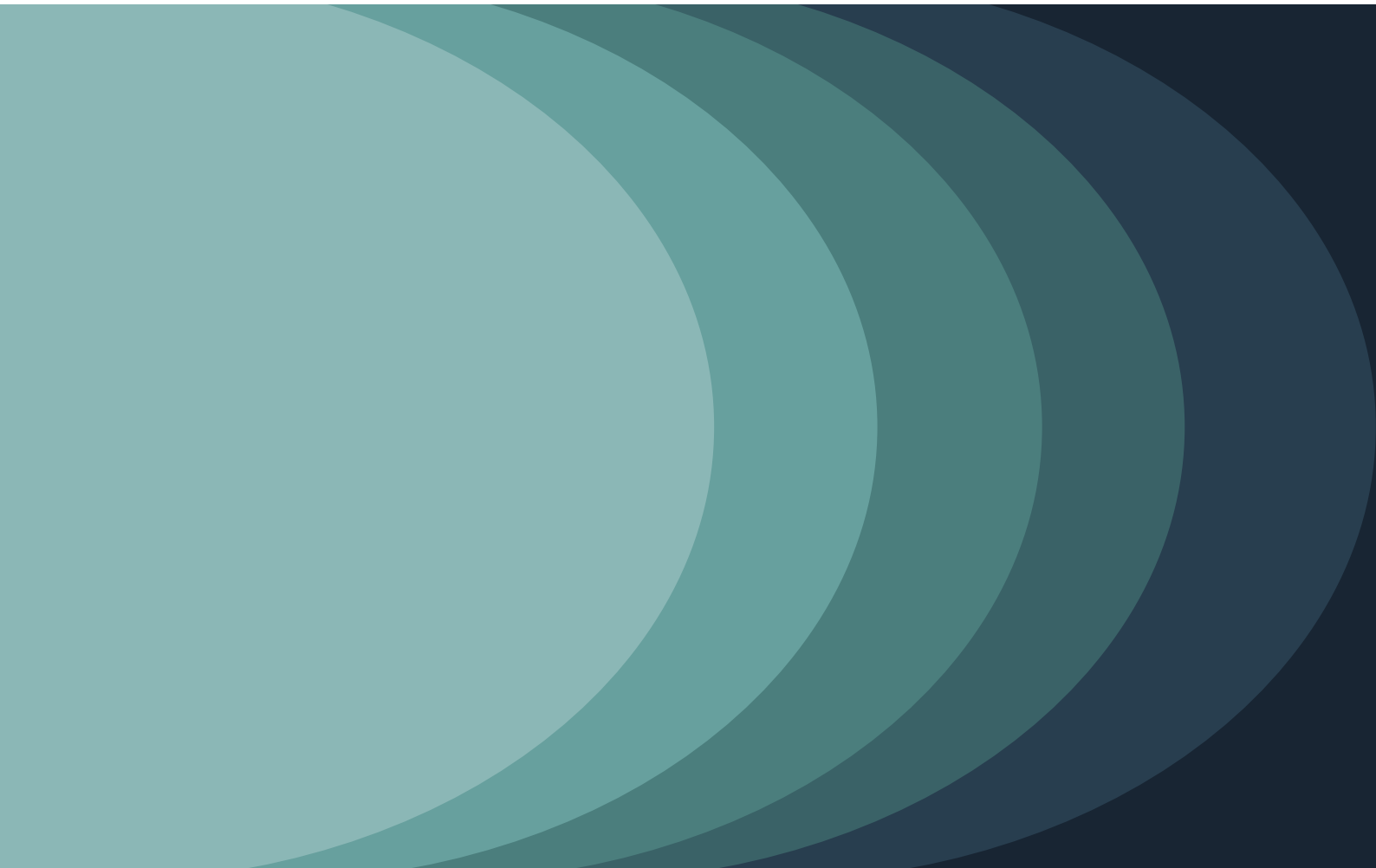
Annual report 2024:

Serious Further Offences



HM Inspectorate of Probation

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

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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Acknowledgements

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

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

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Chief Inspectors overview

This is our third Serious Further Offence (SFO) annual report[1] since we began our independent oversight of the quality assurance of SFO reviews.

The Probation Service manage a large, complex, and difficult caseload, and by its very nature those cases carry risks that need to be understood and managed but can never be fully eliminated. Thankfully, the number of SFOs committed each year remain low (at a fraction of 1%), however each of those cases have serious consequences for victims and communities and provide vital opportunities to learn lessons. Our SFO inspectors 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'. Concerningly, these ratings represent a second year where there has been a decline in the number of SFO reviews completed by probation regions that met the required standard.

This year, for the first time, we have sought reflections from probation staff on their experiences of the SFO review process, to help us understand their perceptions of the organisational culture linked to SFO reviews. Positively, we received 245 responses to our survey, which provided invaluable information that helped inform this annual report. Notably there were several recurring themes that raised concern about the SFO review policy framework, how it is applied and its outcome and impact. The key themes included the perception that there was a lack of transparency in the application of the SFO review process, and the need for staff to better understand the policy framework, and of the findings of the SFO review itself, including where they have resulted in positive changes to practice.

There was also feedback that the level of support provided to those involved in an SFO needs to be improved. A strong message in many of the responses was the high level of fear that the SFO review process generates within His Majesty's Prison and Probation Service (HMPPS). Many respondents also emphasised that they support and want a learning culture; therefore, there is a need to ensure that opportunities for learning from an SFO are maximised and result in positive changes to practice being embedded nationally.

Respondents were also concerned about a perceived culture of blame existing within HMPPS, underpinning the SFO process. Staff reported that they felt individual accountability was being sought and attributed to them. They said there was a failure to acknowledge and address the wider and procedural systemic factors that were relevant and that fundamentally underpinned how the case was managed. We will set these findings out in more detail later in this report.

This year we published our independent review into the case of Joshua Jacques.[2] The review identified concerns in relation to workload, management oversight, professional curiosity, and case management and risk assessment practice. These findings mirror many of the concerns identified in our independent reviews on Damien Bendall and Jordan McSweeney published in 2023. Concerningly, we have often found these practice concerns are reflected in the SFO reviews we quality assure and in the findings of our core inspections of probation regions.

In last year's SFO annual report we made seven recommendations to HMPPS, which focused on the quality of SFO reviews, the associated action planning, and the embedding of learning. It is of concern that we have seen little progress made nationally against these recommendations this year. As such, we repeat them and make a further four

[1] Annual report 2023: Serious Further Offences Annual report: Serious Further Offences (2022)
[2] Independent serious further offence review of Joshua Jacques

recommendations to support the improvements in SFO reviews that our quality assurance activity and engagement with staff demonstrate are required.

Martin Jones CBE, HM Chief Inspector of Probation

Introduction

Serious further offences (SFOs) are specific violent and sexual offences committed by people who were, or had very recently been, under probation supervision at the time of the offence. Each year there are usually around 500 individuals subject to probation supervision who are charged with serious further offences, however notably in 2023/2024 this number increased by 33 per cent to 770.[3] Of those charged, between fifty and sixty per cent are likely to be convicted of the SFO, with the remaining cases either being convicted of a less serious offence, acquitted or the charges are dropped.

The impact on the victims and their families affected by the SFO cannot be underestimated.

The SFO review process begins when a person on probation has been charged and appears in court for an SFO qualifying offence. This alleged offence must have been committed while the person was under probation supervision or within 28 working days of their supervision period ending. Following the initial court appearance, the SFO review is commissioned.

The SFO review is intended to provide rigorous scrutiny of cases involving people who, while under probation supervision, were charged with specified violent, sexual, or terrorist offences. The review should provide assurance to the public that the probation service is committed to reviewing practice following an arrest and charge for an SFO, and to identifying areas for improvement where required. The SFO review should also provide victims and their families with detailed information on how the person was supervised, and what action has been set following the review. It should provide ministers, and others within HMPPS and the Ministry of Justice (MOJ), with information as required, particularly if the case is identified as high profile.[4]

An SFO review is mandatory when:

- any eligible supervised individual 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 carry out a review.

An SFO review is intended to be both an internal management report and a document that can be shared with the victims of the SFO or their family. It is a single agency review that focuses on the work of the probation service.

Each of the probation regions have their own SFO reviewing team made up of reviewing managers who undertake the SFO reviews and an SFO lead manager. The team is overseen by a senior leader, and in most probation regions this is the head of performance and

[3] Serious_Further_Offences_bulletin_2024.pdf
[4] Probation Service Serious Further Offence procedures Policy Framework - GOV.UK

quality. Each regional probation director is required to ensure that the review is countersigned. This is delegated to an 'appropriate senior manager' who is independent of the line management of the case. Usually, this role sits with the senior leader for the SFO team (Head of Performance and Quality), although we now more frequently see the countersignature being completed by the SFO lead who sits within their team.

There is an option for cross-regional completion of SFO reviews; however, this is not an approach we have seen in the reviews we have quality assured since we took up this role. SFO teams complete reviews from within their own region.

Quality assurance of the completed SFO reviews is undertaken by the central SFO team within HMPPS, with HM Inspectorate of Probation completing approximately 20 per cent of this quality assurance activity. Following quality assurance, detailed feedback is provided to the probation region on the quality of the completed SFO review.

HM Inspectorate of Probation sets the standard that the quality assurance activity is delivered against. According to these standards, the SFO review will provide a robust and transparent analysis of practice, provide clear judgements on the sufficiency of that practice, and be written in an accessible way.[5]

Our role in the quality assurance of SFO reviews was established following our *Thematic inspection of the Serious Further Offences (SFO) investigation and review process*, published in May 2020.[6] We were asked by the Secretary of State to independently quality assure 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. This year, we published one independent review, into the case of Joshua Jacques.

Our core local probation inspections also consider the quality of the SFO reviews being produced by each probation region, and whether the learning and action taken following the SFO review has had a positive impact on practice deficits identified across the region.

This is our third SFO annual report, in which we will reflect on the quality assurance findings between April 2023 and April 2024. We will also provide an overview of the findings of our engagement survey with probation staff. We received 245 individual probation staff responses, which focused on the experiences of SFOs. This annual report will also share the findings of our independent review on the case of Joshua Jacques, which was published on 07 March 2024.

[5] HM Inspectorate of Probation SFO webpage Serious Further Offence reviews

[6] A thematic inspection of the Serious Further Offences (SFO) investigation and review process

Recommendations

In our previous SFO annual report, we set seven recommendations for HMPPS. These recommendations, and HMPPS's response to them, are set out in the table below.

Previous recommendation		Action taken and impact	Categorisation	Improvement still required?
		Summary of action taken and impact	*Sufficient progress/Some progress/No progress*	*Yes/no – If yes, consider repeating the recommendation*
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.	HMPPS advised that a 'more streamlined approach' has been introduced, requiring reviewing managers to focus on the most recent practice and learning opportunities. HMPPS will review the impact of these changes on the timeliness and quality of SFO reviews 'later this year' (2024), and at that point will consider whether changes are required.	Some progress.	Yes, the implementation and impact still need to be demonstrated.
2	Ensure that the learning identified is translated into meaningful and impactful actions.	No specific update received to outline the action taken.	No progress detailed.	Yes, recommendation repeated.
3	Ensure that where applicable, all learning linked to the probation partnership working is identified and shared with the relevant agencies.	No specific update received to outline the action taken.	No progress detailed.	Yes, recommendation repeated.

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.	HMPPS advised that they are developing an action plan tracker to 'track and monitor' all SFO action plans. This was due to be rolled out 'later this summer' (2024).HM Inspectorate of Probation have not received any further updates in respect of this at the time of writing. HMPPS have advised that the Chief Probation Officer holds meetings quarterly to review the progress and impact of actions taken following SFOs flagged as high profile and links these to wider improvement activity required.	Some progress.	Yes, the implementation and impact still need to be demonstrated.
5	Ensure that robust and rigorous countersigning takes place on all SFO reviews before they are submitted for quality assurance.	Collectively with HMPPS, benchmarking sessions are delivered which focus on the role of the SFO lead in undertaking the first line of quality assurance, which will inform countersignature if the SFO leads are fulfilling this role. The SFO policy framework sets out the expectations for countersigning and the central SFO team have provided a countersigning check list to support managers undertaking this role.	Some progress.	Yes, recommendation repeated.
6	Put robust processes in place to ensure that, following quality assurance feedback, all required changes to the SFO review document are timely and made to a sufficient standard.	HMPPS advised regional accountability is via the 'AED operational line', and existing guidance has been maintained where changes are required to the review following quality assurance.	Some progress.	Yes, the implementation and impact still need to be demonstrated.

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.	HMPPS advised the have considered the HMIP recommendation and are not proposing to raise the grade of SFO reviewers. This is based on experience that a more senior grade of reviewer does not necessarily improve the quality of a review. Additionally, to do so would take additional resource which was considered better targeted at front line operational delivery.	Some progress.	Yes, the implementation and impact still need to be demonstrated

In response to the recommendations set in the previous annual report, HMPPS have informed us that they recognise that there are challenges for regional SFO reviewing teams in meeting the SFO review procedures as they currently stand. They have told us that, even with extended deadlines for the completion of SFO reviews, regional teams are not completing all reviews within the expected timeframes, or to the required standard.

Last year, HMPPS conducted a workforce planning review, which identified that additional resource was needed to support SFO review teams to complete the required reviews. HMPPS have advised us that following this review, they have recruited additional reviewing managers, but this has not been fully implemented due to priority being given to front line operational posts. The numbers of additional reviewing managers recruited have not been shared therefore it is unclear what impact this has had on SFO reviewing team resourcing overall.

Revisions to the SFO template were introduced in January 2024, reducing the scope of the analysed period to the six months before the SFO was committed. HMPPS have emphasised to us that introducing this format will support them to best use the SFO team resource available. They anticipate this will have a positive impact on the quality of the documents and reduce the backlog of reviews that has formed within probation regions. HMPPS have reported that they are encouraged by some of the reviews being submitted under this format. However, our data is not yet showing an increase in quality, although we acknowledge that the number of reviews we have seen completed in this format was small during this reporting period.

In response to the recommendation that robust assurances are required that quality assurance feedback is being applied to SFO reviews, HMPPS have advised that no changes have been made to the existing policy framework. While we acknowledge that regional accountability is set out in this framework, our quality assurance work is showing that this has not provided the robust oversight required and that the amendments outlined in quality assurance feedback have not always been applied.

HMPPS have provided assurance that they are developing an action plan tracker. This will monitor all SFO action plans, with the aim of supporting their implementation, and will provide an overview of the regional and national learning set as part of the SFO review. This is due to be introduced to probation regions, and we are interested to see how it is rolled out and its impact.

To support reviewing managers, the HMPPS central SFO team introduced developmental sessions with those who have received two consecutive composite ratings of 'Requires improvement'. This is a positive developmental opportunity for reviewing managers, and we look forward to seeing how these sessions impact on the quality of reviews being written by reviewing managers.

HMPPS have confirmed that the existing SFO delivery model is being maintained; however, they will review the impact of the revised template and intend to consult on any future proposed revisions introduced following this. We look forward to receiving further information in respect of this.

As the information above demonstrates, the recommendations made in our previous SFO annual report were not taken forward fully by HMPPS; therefore, we repeat last year's recommendations and make the following additional recommendations:

1. 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
2. in conjunction with the SFO procedures being reviewed, focus specifically on the transparency of the process and how the review findings are shared with the staff members who were involved in managing the case
3. 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 SFO reviews and their ongoing completion in a timely manner

4. 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.

Contextual facts

Between 2023 and 2024 there were 770 SFO notification received by HMPPS, which represents an increase of 33 per cent on the previous year and the highest level in the reporting series by the Ministry of Justice (MOJ).[7]

Table one: SFO statistics

238,646	Number of individuals under probation supervision as of 30 June 2024.[7]
579	Number of SFO notifications received in 2022/2023, which is an increase from 529 in 2021/2022.
770	Total number of SFO notifications received in 2023/2024. This represents a 33 per cent increase in the number of SFO notifications compared to the previous year.
478	By 30 September 2024, 478 reviews had been completed on the 770 notifications received.
287	Number of SFO convictions from the 579 notifications received in 2022/2023.
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.
• **128 community supervision** • **148 determinate prison sentences** • **3 life licence** • **8 imprisonment for public protection**	Number of SFO convictions in 2022/2023 broken down by index offence supervision type.
60	Number of the 287 SFO conviction in 2022/2023 for murder, an increase from 59 from the previous year.
98	Number of the 287 SFO convictions in 2022/2023 for rape and other serious sexual offences, an increase from 75 from the previous year.

[7] Proven reoffending statistics: October to December 2022 - GOV.UK

Table two: SFO conviction offences by notification period as of 30 September 2024 for England and Wales

SFO conviction	2021/2022	2022/2023
Murder	64	60
Attempted murder or conspiracy to commit murder	16	11
Manslaughter	20	21
Rape/Assault by penetration of a child under 13/Attempted rape/Rape of a child under 13	77	98
Arson with intent to endanger life	20	21
Kidnapping/abduction/false imprisonment	22	18
Death involving driving/vehicle-taking	10	14
Other serious sexual/violent offending	67	44
Total	**296**	**287**

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 2024

Index sentence type	2021/2022	2022/2023
Community supervision	27	30
Prison sentence	35	28
Life sentence	2	1
Imprisonment for public protection	0	1
Total	**64**	**60**

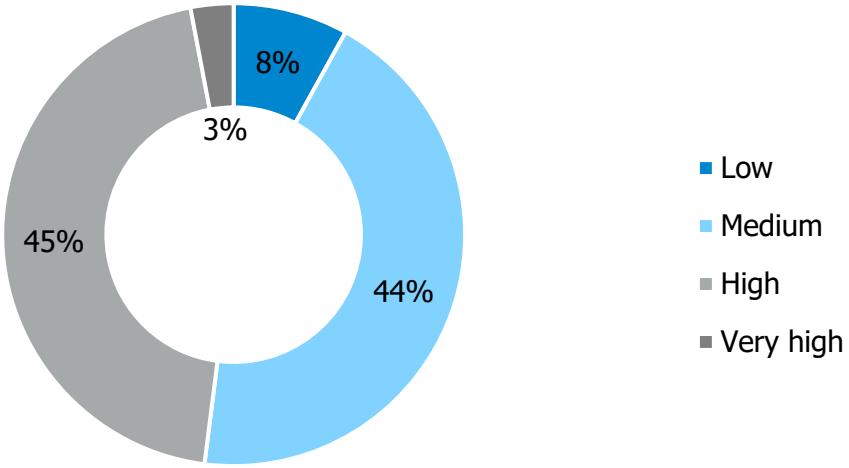
What we found, April 2023 to April 2024

During the period April 2023 to April 2024, we quality assured a random sample of 20 per cent of the SFO reviews undertaken by the Probation Service in England and Wales, which equated to 87 reviews.

Table four: SFO reviews quality assured by HM Inspectorate of Probation, by offence type

Number	SFO offence
21	Murder
2	Attempted murder
2	Manslaughter
2	Conspiracy to murder
28	Rape
3	Attempted rape
2	Assault by penetration
4	Sexual assault of a child under 13
4	Arson with intent to endanger life
1	Arranging/facilitating the commission of a child sexual offence
1	Attempting to cause/incite a child under 13 to engage in sexual activity
5	Death by dangerous driving
3	False imprisonment
3	Kidnapping
1	Sexual activity with a child under 13
4	Causing or inciting a child to engage in sexual activity
1	Burglary with intent to inflict GBH
Total 87	

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



Of the 87 SFO reviews that we quality assured this year, 45 per cent were committed by people on probation who had been assessed as posing a high risk of serious harm before the SFO was committed, and 44 per cent were assessed as posing a medium risk of serious harm. This is consistent with the previous year, when 44 per cent of the SFO reviews quality assured were assessed as high risk of serious harm and 42 per cent were medium.

Quality assurance activity

Our standards

The quality assurance of SFO reviews is underpinned by HM Inspectorate of Probation standards. This year, these standards have been updated, and we hosted an online event for those involved in SFO reviews to raise awareness of the standards and the revisions made.

The changes made in the revised standards are outlined in Annex A. The revisions were introduced in November 2023, therefore this resulted in some of the information collected following quality assurance being split across two data sets. At points within this report, and where appropriate, the data sets have been merged to inform this annual report.

The standards are supported by our rules and guidance, and our ratings characteristics. All these documents are available on our website for reviewing managers and SFO leads to utilise to support their writing and countersigning of SFO reviews.[5]

Our standards support both our quality assurance activity and that of the HMPPS central SFO team.

Embedded in our quality assurance activity is a process of continual dialogue and reflection on our standards, which supports our inspectors in applying them robustly and consistently.

Collectively with HMPPS, we hold quarterly interface meetings and benchmarking sessions. This helps us to jointly monitor how the standards are applied, and to ensure they are applied consistently.

We also hold benchmarking sessions with our SFO inspectors on a quarterly basis to provide internal assurance on the application of the standards. We recognise the impact that a composite rating of 'Inadequate' can have on reviewing managers and SFO teams. When there is an initial indication during the quality assurance process that this rating is likely, our SFO inspectors hold a benchmarking exercise to collectively assure the SFO review against the standards.

An SFO review is quality assured against four standards: analysis of practice, sufficient judgements, learning and victims and their families. These standards set out our expectations that an SFO review will have a robust and transparent analysis of practice, use an evidence base to provide clear and balanced judgements on the sufficiency of practice, identify learning opportunities to drive practice improvements across all levels of the organisation, and be written in a sensitive and accessible way so that the review can be shared with the victim or their family.

Each individual standard is given a rating, and these are then combined to produce a composite rating of:

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

We provide quality assurance feedback to the probation region. This explains why each rating was given, where the review met the required standard, and, if improvements are required, how these should be made.

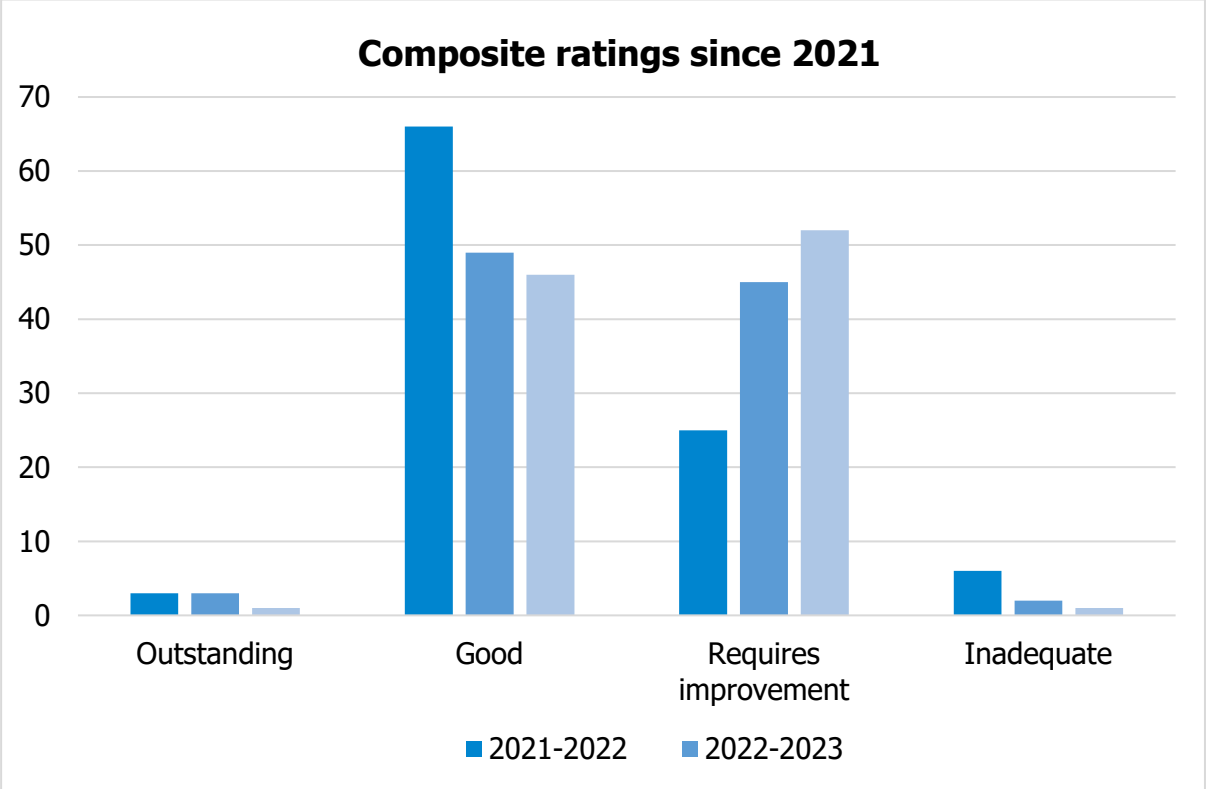
Composite ratings

Of the 87 SFO reviews quality assured this year, 52 per cent have received a composite rating of 'Requires improvement', and 46 per cent a rating of 'Good'.

Compared with the findings in previous years, we have continued to see a disappointing reduction in the number of SFO reviews that have met the required standard and been given a composite rating of 'Good'. As such, there was a comparative increase in the number of SFO reviews rated 'Requires improvement'.

The table below shows the composite ratings of all the SFO reviews we have quality assured since 2021.

Table six: Composite ratings since 2021



Regional overview

HM Inspectorate of Probation quality assures approximately 20 per cent of the SFO reviews submitted across all probation regions. The SFO reviews are allocated to us randomly, although the HMPPS central SFO team do aim to provide a fair distribution, where possible, to ensure each probation region is represented. However, this can be affected by the number of SFO reviews submitted by each probation region, the timing of submissions and the extent of the region's backlog.

Table seven: Composite ratings awarded to SFO reviews by each probation region between 2022-2023 and 2023-2024

Probation region	Composite ratings 2023-2024 / Composite ratings 2022- 2023			
	Outstanding	Good	Requires improvement	Inadequate
Yorkshire and the Humber		3	8	1
		3	7	
Greater Manchester		3	4	
		7	1	
London		3	6	
		5	5	
West Midlands		6	4	
		6		
East Midlands		1	1	
		3	2	
Wales		4	2	
		3	2	
North West		3	3	
		4	3	
Kent, Surrey, and Sussex		1	5	
		4	2	
East of England	1	6	1	
	2		5	
North East		3	4	
			4	2
South West		4	5	
		2	5	
South Central		3	2	
	1	5	3	

Table seven shows the regional breakdown of the composite ratings in the most recent reporting period, compared with the previous year. It shows that the standard of SFO reviews continues to vary across probation regions.

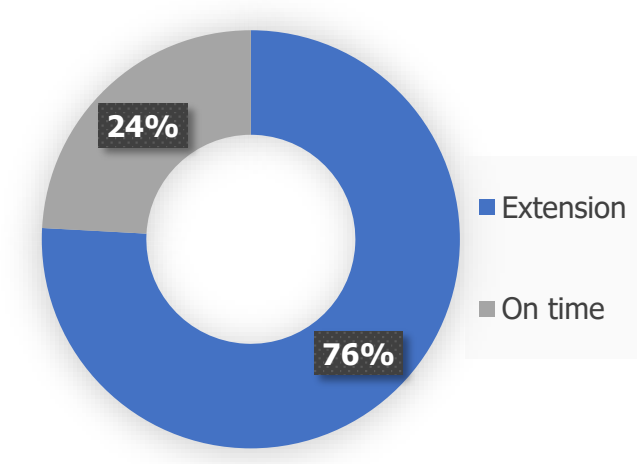
We have previously noted the factors that we deemed as having an impact on the quality of the SFO reviews completed. These factors remain of concern today.

Central to the completion of SFO reviews is a need to ensure that SFO reviewing teams are sufficiently resourced. Through our engagement with regional SFO teams, we have heard from many teams who feel their resourcing and workload demands are a concern.

In addition to their impact on the quality of reviews, resourcing concerns have contributed to a backlog of SFO reviews due for completion across probation regions. Currently, the expectation is that reviews will be completed within five months of the SFO notification being submitted to the HMPPS central SFO team. This is an amendment to the policy framework under an exceptional delivery model (EDM), which was introduced in April 2020 in response to Covid-19. The EDM sets a three-month deadline and enables probation regions to complete a reduced overview in the form of an 'enhanced early look' instead of an SFO review, in certain circumstances. An SFO review is still required in respect of the following: where the case is deemed to be high profile; where the SFO has resulted in the loss of life; where the SFO is a serious sexual offence or rape against a child under 13; or where significant practice concerns that require further examination have been identified.

It is of concern that, despite the EDM being implemented and remaining in force for a considerable period, there continues to be a delay in completing SFO reviews. Many regions have a backlog of SFO reviews due.

Table eight: the number of reviews quality assured that were submitted within expected timeframes



Probation regions requested extensions to the agreed submission deadline in 76 per cent of the 87 SFO reviews we quality assured this year.

When reviews are delayed, it takes longer for the probation service to identify and implement the required learning, and to share the findings with the victim or their family.

The SFO lead in the probation region provides management oversight of the reviewing managers and the first level of oversight of the SFO review before formal countersignature. This internal countersignature process is important. It demonstrates that the probation region has approved the quality and content of the review and determined that it is ready for quality assurance. We have heard through our regional engagement that SFO leads have 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.

Our revised quality standards emphasise the importance of the HMPPS countersignature process in supporting SFO reviews to reach the required quality at the earliest juncture in the review process. This is because robust countersignature will avoid the need for any additional developmental work to the review following quality assurance.

The quality of management oversight is also a common theme identified in our core inspection findings,[8] which showed that, of the inspections completed to date, only 19 per cent of cases demonstrated effective management oversight.

[8] Core inspection data 2024 HM Inspectorate of Probation.

The HMPPS central team has a role in supporting regional SFO teams and has regular interactions via induction meetings with new reviewing managers, and forums, and individual meetings with reviewing managers and SFO leads. However, repeatedly, we have been informed that the separate centralised training available for reviewing managers is not sufficient to equip them to complete high-quality SFO reviews. Regions have reported that this training is centred on some of the required elements of the role, such as interviewing techniques and promoting an understanding of the SFO review procedures. Although these are important, the training does not extend to helping SFO reviewing managers to develop their knowledge and understanding of how to write a review that meets the expected standard. There is also inconsistency in when the training is delivered to reviewing managers; some had been in post for a notable period before receiving the training. More is needed to develop and support reviewing managers, alongside more transparency and the sharing of high-quality data and good practice across regions to support a collective developmental approach. This is why we have recommended that HMPPS develop the training and support available for reviewing managers.

Over the course of this year, we have continued to hear from probation regions that the SFO review format is not conducive to writing high-quality documents. While our quality assurance ratings for this year show that 47 per cent have met the required standard, we do share the concerns that the current SFO review format, and the requirement to meet the expectations of two differing audiences, do have a bearing on quality.

We noted in our previous annual report the HMPPS central team agreed with the concerns about the quality of reviews being completed and that the team intended to review the framework that supports the delivery of SFO reviews. However, this year the same SFO policy framework remains in place, although the template has been revised to reduce the supervision period analysed in the review. This change was introduced towards the end of this reporting period, in January 2024, and during this reporting period we therefore quality assured just seven reviews completed in the new format.

HMPPS have reported that the revised format will help regions to manage the pace and demand of workload, and that they have started to see an increase in the number of reviews being completed by regions that were part of a backlog. HMPPS have also reported that they are 'encouraged' by the quality of some of the reviews submitted under this revised format. However, our data does not currently demonstrate that this revision has had a positive impact on quality. Of the seven SFO reviews that we quality assured, three were rated 'Good' and four 'Requires improvement'. Three of the seven were submitted within expected timeframes without an extension having been requested. However, it must be emphasised that this number is small. The forthcoming reporting year will provide more comprehensive data on this.

Previously we reported that SFO reviews were completed by staff at middle manager grades in their own probation regions. We 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. HMPPS have told us that they do not intend to change this operating model. Positively, compared with previous years, we are seeing a more consistent approach to interviewing senior leaders to inform the review. However, this is not always being reflected in the analysis and judgements provided in the SFO review. This means that learning from the review is not always being set at the correct level within the organisation. We also continue to hear from some reviewing managers that, although they have interviewed senior leaders, their ability to robustly challenge and critique practice at this level is still compromised due to their differing grades and roles within the organisation.

To support regions to deliver SFO reviews that meet the expected standard, we have continued to roll out regional benchmarking sessions with the SFO review teams. These sessions, aimed at reviewing managers and SFO leads, are designed to improve understanding on how to apply

the standards when writing SFO reviews. We will continue to roll these out further over the next reporting year.

For each of these sessions we collate anonymised feedback from the participants. This has been overwhelmingly positive, emphasising that there is a need for these in-person discussions that promote a better understanding of the SFO standards and how they should inform the reviewing manager's practice.

Some of the feedback on the benchmarking sessions is as follows:

> *'It allowed time to sit and reflect which is often difficult given the pace we are working at. I have taken a step back and reviewed all the documents which is helping me on my current review. I admit at times I lose sight of what is expected of me.'*

> *'It was really helpful to examine the thinking behind the marking and feedback. It will have an impact on the practice within the team.'*

> *'The session was really useful to better understand expectations when writing reviews, how things should be structured and what HMIP are looking for in order for a well-rounded review – this of course is within the paperwork, but the benchmarking example and discussing it face to face brought it to life. The session allowed for plenty of time to discuss any areas we (are) unsure about or wanted further clarity on, which was really helpful. I would welcome more regular sessions like this in the future.'*

To prepare for the regional benchmarking sessions, reviewing managers are required to read and prepare notes in advance. When providing feedback on the sessions, they have suggested giving them more time to prepare, reflecting that meaningful preparation can be difficult alongside their workload. Some reviewing managers have also suggested more time should be allocated to the benchmarking session itself, to allow for more discussion, reflection, and questions. This constructive feedback demonstrates how receptive reviewing managers are to face-to-face sessions focused specifically on SFO review quality and application of the standards. We will use it to develop the sessions as we roll them out further.

This engagement with probation regions demonstrates our ongoing commitment to and focus on developing the quality of SFO reviews and supporting SFO reviewing teams to fully understand and continually embed the SFO standards into their work.

Collectively with the HMPPS central SFO team we have also started this year to deliver additional benchmarking sessions specifically for the regional SFO leads who undertake the first level of countersignature. These sessions focus on quality countersigning. These sessions have been positively received, and will continue over the forthcoming year, to ensure we reach each probation region, and to encourage and support the improvement in the quality of SFO reviews.

Overall, this year, we have continued to find that most SFO reviewing teams are receptive to quality assurance feedback and motivated to engage with offers of benchmarking development sessions. However, this has not been consistent across all probation regions. Some regional SFO teams have expressed frustration to us. On occasion, this has been directed at the quality assurance composite rating or some elements of the feedback. Additionally, where reviews do not meet the required standard, regions have expressed frustration that the quality assurance feedback has generated further work, as this increases their existing workload and capacity concerns.

While we recognise that the quality assurance process will generate discussions on these points, our commitment remains to the quality of SFO reviews and to driving improvement. We encourage probation regions to focus on ensuring that the review meets the quality standard at the point it is submitted for assurance, and therefore also ensuring that it achieves its intended purpose.

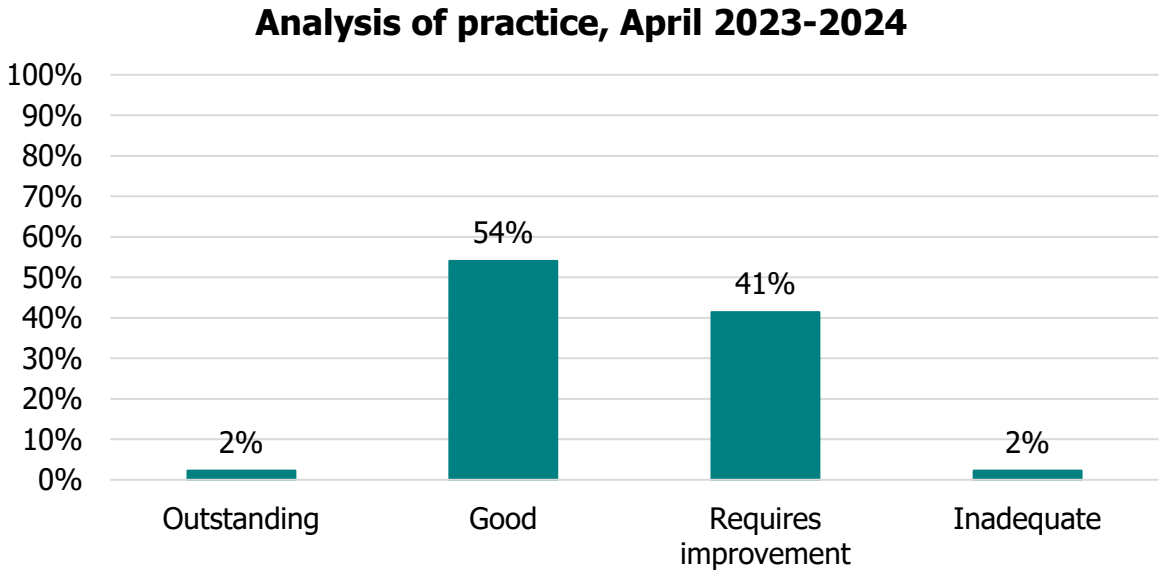
Positively, many reviewing managers do individually reach out to our SFO inspectors to discuss how they can improve their reviews and are evidently keen to develop the standard of their work. We welcome this engagement as it supports our commitment to ongoing learning and driving improvement and quality.

However, despite our engagement with probation regions, this year 53 per cent of SFO reviews were rated either 'Requires improvement' or 'Inadequate', and therefore did not meet the required standard. While we acknowledge that the HMPPS central team supports the SFO teams within probation regions via a range of activities, our quality assurance ratings emphasise the need for HMPPS to respond proactively and promptly to the concerns identified through our SFO quality assurance work and take forward the recommendations made to support the regional SFO reviewing teams to work consistently to the required standard.

Individual quality standards

Analysis of practice

Analysis of practice				
Transparent analysis of assessing, planning, implementation and review.	Investigative in its approach.	Analyses whether all reasonable action was taken across all levels.	Underpinning reasons for omissions in practice are explored and explained.	Effective practice is identified where relevant.



Please note the data set has been merged from two data sets collected over the reporting year.

The quality assurance data for this standard shows that, in 56 per cent of SFO reviews, the quality of analysis of the practice was either 'Good' or 'Outstanding'. While it is positive to see that just over half of the SFO reviews received these ratings for this standard, this is in fact lower than the previous year's figure of 65 per cent. In turn, there has been an increase in the proportion rated 'Requires improvement', and a slight increase from one to two per cent in the reviews that received a rating of 'Inadequate' for this standard.

It is a concern that in this reporting year we have seen a decline in the ratings given for analysis of practice: 43 per cent of reviews provided an insufficient analysis of the key contacts and significant events that occurred in the management of the case in the period before the SFO occurred.

Reviewing managers need to explore probation practice at all levels. This will ensure that they give due consideration to practice at an individual, probation delivery unit, regional and national level where applicable.

Importantly, SFO reviews need to explore the 'why' that underpinned the practice during the management of the case. This supports the reviewing manager to analyse all relevant factors and target learning effectively across all levels of the organisation where applicable.

The analysis provided in an SFO review focuses solely on probation practice and it is not expected that this will include the practice of other agencies. However, reviewing managers should consider the interface with agencies also involved in the management of the case and the probation service's role in this.

The recent amendment of the SFO review template by HMPPS requires reviewing managers to focus their analysis on the practice in the six-month period immediately before the SFO. They will not analyse the earlier period of supervision, providing a contextual overview only. While the expectation is that the reviewing manager will have scrutinised the earlier period, and determined the need for any learning, this analysis is not set out in the review. The impact of this will be seen as the forthcoming reporting year progresses; however, we have raised initial concerns that important elements of the early practice will not be sufficiently explored. This includes the work of the probation court team, custody and pre-release planning and engagement, placements in approved premises, and the initial period of sentence management. Ultimately this could impact on how well these critical elements of practice are understood and could limit opportunities for learning to be identified and shared, particularly at a national level.

This builds further on existing concerns from our quality assurance activity that the analysis in SFO reviews has often focused on individual practice and has not provided a sufficiently holistic overview of all key areas of practice, and across all levels within the organisation.

SFO review case example: analysis of practice standard rated as 'Good'

The SFO review provided an analysis of a complex and lengthy custodial sentence, in a concise manner that enabled the chronological history and progressive journey through the sentence and period of release to be understood.

The reviewing manager analysed the assessment, planning, implementation and reviewing practice in the case, which provided an understanding of how the probation service managed the licence. The key contacts and significant events were outlined, supported by an analysis of what occurred against expected practice.

Threaded through the review was a narrative on the risk of serious harm assessment. The manager analysed whether this assessment adequately reflected all the risks and needs of the case. This then informed the reviewing manager's analysis of how the relevant practitioners translated this into the management of the release licence.

The reviewing manager was investigative in their approach, which enabled them to explore all the information that was available on the case. This included background and risk information, prison and parole records, and specialist assessments. The review analysed how this information was used by those involved in managing the case to inform the assessment and delivery of practice.

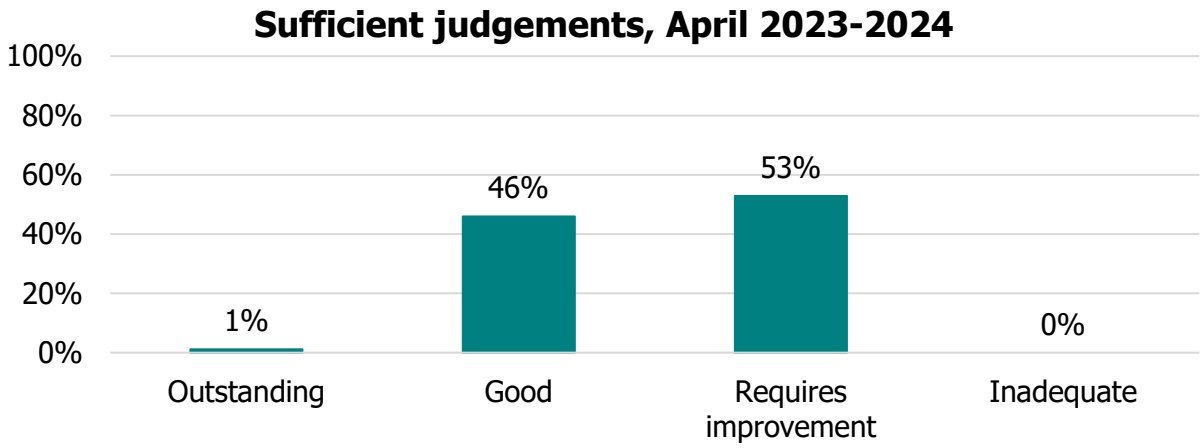
Importantly, in addition to considering how the case was managed, the reviewing manager explored and analysed the contextual factors that were relevant to the management of the case. For example, the reviewing manager considered the relevance of the manageability of workload, staff experience and training, and management oversight and support. The manager also considered how practitioners approached their work which changed from active management of risk of serious harm to a more passive oversight of the licence. This contextual analysis was also informed by relevant policy and practice guidance.

The analysis was supported by interviews with all relevant staff members within HMPPS. In addition to the core probation staff, this also included prison-based staff and the specialist polygraph examiner.

This standard was rated as 'Good', reflecting the breadth and depth of analysis provided within the review. We gave detailed feedback to the reviewing manager on the areas of analysis that were well explored. It also suggested how the review could have been developed further for this standard to achieve a rating of 'Outstanding'. For example, it provided feedback on where some further analysis was required, and on how additional information could have been gathered to inform the review from the ViSOR records.

Sufficient judgements

Sufficient judgements of practice				
Clear and balanced judgements on the sufficiency of practice which have a clear evidence base.	Explorative, investigative and all relevant interviews completed.	Provides judgements on systemic and procedural factors which underpinned practice.	Judgements provided on management oversight at all levels.	Judgements provided on probations contribution to partnership working.



Please note the data set has been merged from two data sets collected over the reporting year.

The quality assurance data for this reporting year shows that 47 per cent of SFO reviews reached the required standard of 'Good' or 'Outstanding'. This is a decrease from the previous year, when 53 per cent received this rating. There were no reviews where the sufficient judgements standard was rated as 'Inadequate'.

The reviewing manager's voice should be evident in an SFO review, providing unequivocal judgements on how well the case was managed. The reviewing manager should be clear about where the practice met expected standards, and where practice did not meet expected standards, the evidence gathered should make it clear why this judgement was reached.

It is essential that reviewing managers consider practice at an individual level, to draw conclusions on how well the case was managed against expected practice standards. However, we also expect that the review will provide clear judgements on the wider systemic and procedural factors that impacted on this practice. This standard also requires reviewing managers to be clear in emphasising the significance and impact of the practice deficits, and to be balanced and proportionate.

We reported last year that reviewing managers were increasingly interviewing senior leaders to inform the SFO review. It is positive that we have continued to see more breadth of interviews being completed this year. Our quality assurance data shows that 77 per cent of reviews were informed by relevant staff interviews.

However, what needs to be strengthened is how this evidence is then used by the reviewing manager to inform the judgements in the review. We found that in 32 per cent of the SFO reviews, judgements were focused on an individual level. The reviewing managers should have used the information gathered from all the interviews to provide judgements on the practice of staff at all levels within the organisation. This will also support reviewing managers to consistently provide judgements on the prevalence of systemic and procedural issues in the

management of the case. This was done in 57 per cent of reviews quality assured this year. Improving the quality and scope of judgements provides assurance that the review was sufficiently explorative, and that learning is being targeted at the appropriate level.

SFO review example – sufficient judgements standard rated as 'Good'

The reviewing manager's voice was clear throughout the SFO review, providing judgement on the sufficiency of practice, underpinned by detailed analysis. The judgements were balanced, emphasising where practice did or did not meet expected standards.

The reviewing manager drew conclusions on critical areas of practice and maintained an appropriate focus on the contextual factors that underpinned this. This resulted in clear judgements on the impact of workload on the individual practitioners and on the quality of management oversight across middle and senior levels. This was of particular importance in this review, as the case required senior leader oversight, which had been well analysed by the reviewing manager. This enabled the reviewing manager to draw conclusions on how well the practice at this level met expectations, and what impact it had on the management of the case.

The judgements were supported by an evidence base, including information gathered from the interviews completed, and the additional sources of information the reviewing manager had accessed.

The reviewing manager emphasised where the practice findings were deemed to be significant to the management of the case in the context of the risk of serious harm presented, and the circumstances of the SFO.

Examples of where the reviewing manager demonstrated an investigative approach that helped to inform judgements are as follows:

> *'At no stage within this release period is there any recorded management oversight from any SPO [senior probation officer] about the decision to keep the case with the probation practitioner, despite most managers in this probation delivery unit (PDU) being aware of issues, which the probation practitioner continued to flag for several months. During this period, there is evidence that the managers in this probation delivery unit did not always work as cohesively as they could and could have done more joint management to help each other, which would have helped staff wellbeing. Actions have therefore been set around this.'*

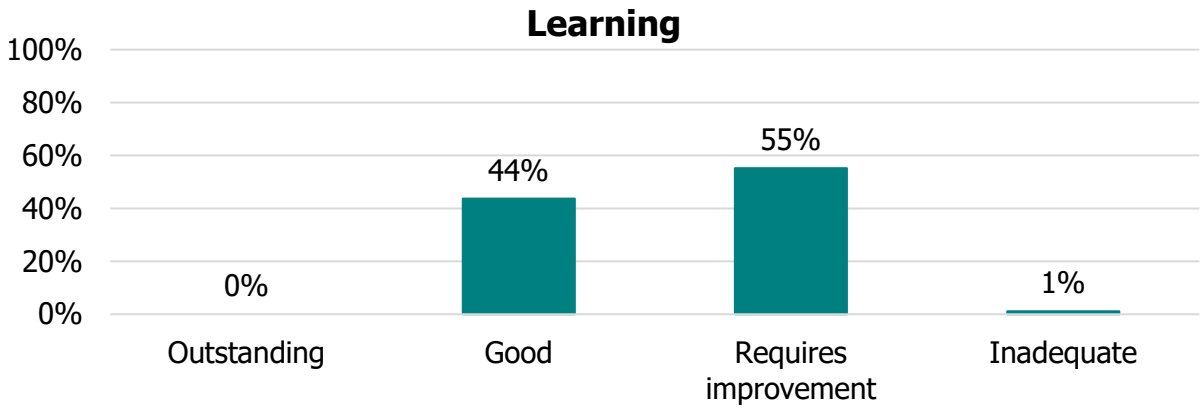
> *'The PDU Head did not provide evidence of the current process in place for delivery of MAPPA[9] Level 1 reviews in the PDU and as such, I am not confident that there is one in place. I have sourced data around current delivery of MAPPA Level 1 reviews in the area and there is a high level of Level 1 reviews overdue in the PDU. This area has been impacted by the lack of formal cover for sickness leave and the staffing situation generally however, there is a lack of consistency and organisation around the tracking and delivery of MAPPA Level 1 reviews in the PDU. I am aware that MAPPA Level 1 reviews are being revisited regionally to improve the delivery of such and therefore an action has been set specifically for the PDU to consider how they work alongside this process and implement a consistent and robust application of the policy.'*

[9] Multi-Agency Public Protection Arrangements support the management of those convicted of violent and sexual offences. MAPPA has three categories and three levels for managing offenders, with level 3 being the highest management level. Multi-agency public protection arrangements (MAPPA): Guidance - GOV.UK

To have further developed this standard to 'Outstanding', judgements could also have been provided on the approved premises and the importance of their role in observing and recording when a person on probation is living there. Also, in line with the feedback under the analysis of practice, exploration of the use of ViSOR would have also supported the reviewing manager to provide judgement on this area of practice.

Learning

Learning				
All relevant learning is identified.	The learning is translated into developmental actions.	The action plan addresses practice deficits at all levels where relevant.	SMART actions with clarity on how the impact of the actions will be measured.	Effective countersigning ensuring the review identifies all learning opportunities.



Please note the data set has been merged from two data sets collected over the reporting year.

The learning standard focuses on how well learning opportunities are identified and translated into tangible and developmental actions once the reviewing manager has analysed and judged the standard of practice in the case. Reviewing managers must ensure that the action plan details clearly how to measure the impact of the actions.

The quality assurance ratings for this reporting year showed that 44 per cent of reviews were rated 'Good' against this standard. The proportion is the same as the previous year; however, the number rated 'Outstanding' has declined. This means, overall, there has been an increase in the number not meeting the required standard, with 55 per cent rated 'Requires improvement' and one per cent rated 'Inadequate'.

Our quality assurance activity shows that reviewing managers need to strengthen how well they identify learning across all levels within HMPPS, with 41 per cent of reviews requiring further work in this area.

Our quality assurance feedback has often emphasised the need for actions to be developed further so that they are sufficiently developmental to effect change. They should also set out effective measurements so that the progress and outcomes achieved because of the action can be evidenced. We found that, in 61 per cent of reviews, this was not done sufficiently.

Often, we find actions are set at an individual level. While this is important to support learning and improvements in probation delivery, there are missed opportunities to share wider learning and drive positive change at a regional or national level. This also links to the findings from our engagement with staff who have experienced an SFO. Many of these staff felt there was a

culture of blame within HMPPS, and the focus on individual accountability and action-setting exacerbated these feelings. This emphasises further the importance of SFO reviews maximising learning and development to ensure that the practice deficits that we repeatedly see in SFO reviews, and in our core inspections, are addressed. Staff need to feel that they can positively engage in the process so that they also access all learning and development opportunities at an individual level.

Regional SFO review teams are expected to compile an update on the progress made against the action plan six months after the review is submitted for quality assurance. Each probation region is responsible for monitoring the progress made against the actions, determining both the sufficiency of the work completed and its impact.

In the forthcoming reporting year, we will begin an additional element of our quality assurance activity to monitor the sufficiency of the action plan update submitted. Each quarter, we will dip sample the action plan updates to consider the quality of the update provided, whether it demonstrates that the actions have been achieved, and what their impact has been. We will report on this assurance activity in the next SFO annual report.

Key areas of practice often identified as part of SFO learning have also been evident in cases inspected through our core inspection activity. As such, it is apparent that there are missed opportunities to put in practice the learning and actions set at a wider level to ensure repeated concerns are addressed.

We have found that learning and actions set because of our independent reviews have had an impact across all probation regions. However, we have also found that the progress made in these critical practice areas is not always sustained. We continue to emphasise the previous recommendations we made to HMPPS on the importance of ensuring that the learning identified as a result of an SFO is translated into meaningful and impactful actions, and that a process is developed to ensure that learning is fed back into the organisation to inform and shape developments within probation regions and more widely across HMPPS.

SFO review example – learning standard rated as 'Good'

The SFO review identified learning at an individual, PDU and regional probation service level.

The breadth of analysis provided by the reviewing manager enabled them to articulate where the practice deficits identified needed to be addressed by learning set at a wider level. An example of this was where MAPPA Level 1 practice had not met expected standards. The analysis looked beyond the work of the individual practitioner and identified that the practice was in fact linked to insufficient processes at a PDU level. As such, this resulted in PDU-wide actions to support staff and drive practice improvement.

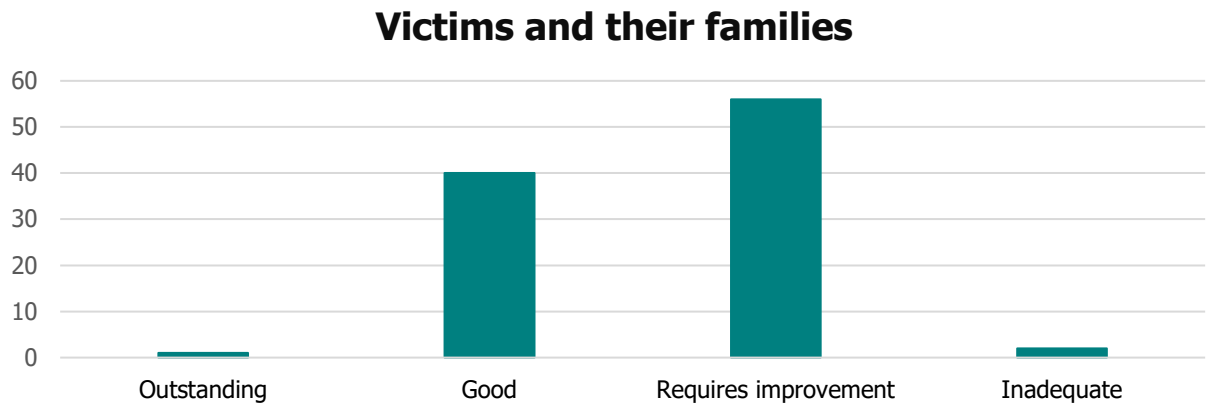
The action plan translated the learning identified into tangible actions and was detailed and comprehensive. The actions took into consideration the individual staff members and their roles, appropriately including amendments to ensure that they were relevant where roles and responsibilities had subsequently changed.

The action plan included a wide range of measurements. These are important so that it can be demonstrated whether the action has had the positive impact intended. For example, in this case, the reviewing manager specified measurements that used a variety of performance data, as well as dip sampling activity to monitor the impact of the actions on practice, and the use of an external team to support a review of how well cultural changes implemented were developing.

The quality assurance feedback also emphasised where the action points could be further developed. For example, it identified where some elements of the action required could be more specific. Additionally, in relation to the areas of analysis and judgement that could be explored further, such as ViSOR, the feedback noted that this would help the reviewing manager to identify whether more learning and action were required.

Victims and their families

Victims and their families				
The SFO review is accessible and inclusive with professional terminology explained.	It is sensitive to the needs of the victim or their family.	It is transparent and provides balanced judgements.	The review focuses on pertinent issues which are most likely to be of concern.	Assurance is provided that all required learning has been identified and is translated into tangible actions.



In the updated victim and their families standard the overarching statement posed was revised from 'the SFO review is accessible to victims and meets their needs' to 'the SFO review is appropriate to share with victims and their families and meets their needs'. The data collected against these questions has been combined to produce the data shown above.

An SFO review should be written in a way that is accessible to all readers, is transparent and presents a balanced overview of the key practice and how the case was managed. It is also sensitive to the impact the findings of the review will have on the victim and their family. The quality assurance ratings for this standard show that work is still required to improve the quality of reviews to ensure that they meet the needs of the victim or their family members.

This year we have seen a slight increase in the proportion of reviews rated 'Good' against this standard from 44 to 49 per cent. However, the number rated 'Outstanding' has reduced from nine to one per cent. Those rated 'Requires improvement' have increased from 44 to 56 per cent, and the number rated 'Inadequate' remains the same at 2 per cent.

As we have noted previously, the format of the SFO review is often cited as an issue by reviewing managers. They have expressed concerns that producing a document that acts as an internal management report but needs to be written in a way that it can be shared with victims and their families is complex. Although our quality assurance ratings show that this can be achieved, it is evident that reviews are often not meeting this standard, which further emphasises the need for HMPPS to review the format of the SFO review.

Over this reporting year it is positive to see that many victims and their family members have requested access to the SFO review. We believe that there are several factors contributing to this. One is the publication of our independent reviews in 2023 and 2024, which have further raised the profile of SFO reviews. When a request for access to the review is made, if the

quality assurance has deemed that further work is necessary to the review, it will be resubmitted for further assurance before being shared more widely.

When SFO reviews have been resubmitted to us before sharing with victims and their families, our inspectors often found that not all the changes set out in the original quality assurance feedback had been made, or where changes had been made, they were not comprehensive and were not to a sufficient standard. In these circumstances, further quality assurance feedback is provided on the areas of the review that require further development. There is an expectation that these changes will be completed before the review is shared with the victim or their family.

To further monitor how well changes are made following quality assurance feedback, each quarter we dip sample SFO reviews that received a composite rating of 'Requires improvement'. Our data has shown that, of these cases, some changes had been made following quality assurance feedback. However, frequently, not all the required changes had been made, and most often this was specifically in respect of the learning and victim standards.

This shows that, despite the quality assurance feedback detailing how the review should be amended and improved, this work has not been taken forward in the way it should. This is not in line with the requirements that amendments will be completed within four weeks of the feedback being provided, and that the probation regions will monitor and oversee this to ensure that the amendments are completed promptly and to a sufficient standard.

Concerningly, this demonstrates that probation regions have not applied learning from quality assurance feedback in a robust and timely manner. This in turn means the probation region is less responsive to the victim or their family member. Furthermore, the continued increase in the number of requests from victims or their family members emphasises the importance of timely SFO reviews. HMPPS needs to reduce the number of SFO reviews awaiting completion to ensure there are no unnecessary delays in sharing review findings.

SFO review example – victims and their families standard rated as 'Good'

The review was accessible to the lay reader and was underpinned by a clear and informative approach. A specific strength identified was the reviewing manager's explanation of complex processes and terminology that were specific to this case's lengthy sentence. The review focused on the risk of serious harm presented by the case, which was relevant to the circumstances of the SFO, and was sensitive in its approach.

The provision of robust analysis and judgement resulted in an SFO review that was transparent in its findings and maintained an appropriate focus on practice at all levels. The inclusion of relevant contextual factors was important. This provided balance to the review and supported the reviewing manager to identify learning and actions at different levels across the organisation.

The review feedback provided developmental points for the reviewing manager to consider in relation to some areas of language and grammar and minor errors that could be easily remedied.

Serious Further Offences – developing a learning culture

An organisational culture of learning is essential for promoting and supporting continuous professional development, resilience, adaptability, and psychological safety[10]. These are all factors that drive organisational success.

This year a staff survey was issued to all probation regions to help inform this annual report and a proposed research project on developing a culture of learning from SFOs. This was devised jointly by SFO inspectors and an HM Inspectorate of Probation research team. Representations were received from all the probation regions in the 245 completed survey responses.

The target audience was operational probation practitioners, and 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. Almost half (49 per cent) had been in post for five or more years and 10 per cent had been in post for 12 months or less.

Key findings

- The large majority (80 per cent) of the respondents had direct experience of an SFO, whether as the probation practitioner managing the case (44 per cent), their line manager (14 per cent), or as a colleague (7 per cent).
- Four in 10 practitioners and managers involved in an SFO review reported that the SFO review process (38 per cent) and roles of all those involved (39 per cent) were not properly explained.
- One in four (26 per cent) of all those surveyed did not believe the probation service encouraged staff members to report problems and issues that affect public protection, though 43 per cent were confident that it did.
- 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.

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.

The recurring themes of concern revealed from these testimonies were:

- fear about the prospect of an SFO occurring within their caseload
- anxiety and stress about the process and implications of an SFO review

[10] Psychological safety is a shared belief that people can take appropriate risks without fear of punishment or humiliation. It's a key aspect of a healthy team culture and can have a positive impact on a team's performance, creativity, and innovation.

- perceived attribution of individual rather than organisational accountability; failing to address wider procedural and systemic issues
- the emotional impact of what is perceived as an interrogative approach to SFO interviews that focuses on blame rather than learning
- concerns about a lack of transparency in SFO reviews, a need for a better explanation of the process, and an opportunity to see the full review
- frustration about the lack of emotional and practical support from managers and senior leaders during the SFO process
- perceptions of a negative impact on team morale and increased workload for colleagues resulting from the SFO review actions
- frustration that SFO reviews are perceived to focus on minor omissions that are not directly relevant to the SFO, with related action planning failing to address contextual issues such as caseload, staffing and management oversight issues.

There were, however, clear examples of positive experiences in the SFO review process. These included:

- supportive managers, leaders, and colleagues during the SFO review process and afterwards
- practitioners learning from SFOs and improving their professional practice following SFO reviews
- practitioners receiving empathy, support and encouragement from SFO reviewing managers.

Key themes

In asking respondents to provide their reflections on the SFO review process, including the opportunities for learning as well as what could be improved, several key themes were identified, as illustrated by the following quotes.

A perception of a blame and shame culture around SFOs

Although the HMPPS SFO review operational guidance (Annex B) stipulates that the review process is not about apportioning blame, many respondents gave detailed accounts of their experiences of feeling that blame was attributed to them as individuals, with organisational factors such as training and workload perceived as ignored by SFO reviewing managers and senior leaders during the investigation.

> *"I was interviewed for a day and a half about my case, at all times I was led to believe that my practice was at fault, and it was my fault that the SFO happened. I stated from the outset that the SFO was due to inappropriate accommodation offered to the offender at the time."*

> *"I have seen a colleague, already devastated by the SFO itself, torn to shreds by the SFO process, to the extent they left the service. SFO carries a heavy emotional weight and whilst I agree that practice needs to be looked at and cases reviewed, so much blame is apportioned that it feels toxic and terrifying. The message appears not to be 'this person committed X crime, how can we work to reduce the risk of this happening?' but rather 'person committed X crime, let's see how many ways we can blame the practitioner for this'."*

"I felt very unsupported and blamed for the SFO. I came from the CRC[11] and stayed with a big workload that I went with into PQiP[12] training. I wasn't given any training when I joined the service and the issues raised in the SFO were things I wasn't told to look for in a case due to lack of training and high caseloads, yet this was not considered or acknowledged during the SFO interviews."

"When I have been involved in SFO reviews they have been very blame focussed, with little appreciation of positive actions and with an attitude of 'if we can pin this on that person, then the issue lays with them' which is absolutely not the case."

"Staff should not be expected to take on board the SFO as if they caused it, which appears to be a lot of staff members' experiences when discussing SFOs and the interview process."

"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."

The stress and anxiety of the SFO review process

A strong theme expressed by respondents was the undermining of psychological safety* associated with their involvement in a SFO review, and a perception of negligence in the role.

"The SFO process caused a lot of work-related stress and anxiety which led to me taking several months on sick leave. I felt unable to put my learning into practice due to the high number of cases that I had which in turn caused more anxiety as I wanted to evidence my learning from the SFO. I also did not feel supported or understood throughout the process which led to further issues around work related anxiety. I felt that I was being seen as being over-dramatic about my response to the SFO and the impact that this had on me as a practitioner and in relation to my personal life. This impact was significant, and I don't think that I was supported well enough throughout the process. I was referred to trauma counselling following this. However, I felt that the trauma counsellor (via PAM Assist)[13] wasn't listening to me and the sessions were short and unhelpful."

"Receiving a letter through my front door stating I could be taken to court for gross negligence is itself negligent to staff … not once was I asked how I felt that someone I was working with committed a horrific offence (he still hasn't actually been convicted). Prior to the SFO I was very pro probation, an enthusiastic positive member of the team. I have recently been diagnosed with PTSD, anxiety, and depression as a direct result of the SFO process. I feel it's the unfairness of it all that really impacts me the most."

"SFO reviews feel like you are being investigated and that it is your fault. There is no support, and you are supposed to carry on as normal with what feels like an axe hanging over your head. There appears to be no empathy from senior managers and no

[11] Community rehabilitation company (CRC) was the term given to private sector suppliers of probation services.
[12] Professional qualification in Probation (PQiP) is the trainee probation officer programme.
[13] PAM Assist is an employee assistance programme within HMPPS.

support put in place. I know colleagues who have taken early retirement rather than go through the SFO process."

"We can only work with the information provided and the time allocated. However, the question is always "why did you not do more?" Honestly, if I could, I would go to great lengths to prevent an SFO and the impact on victims, but factors that are not considered during the SFO review are not considered and this leaves staff (not just me, we all feel it) feeling responsible for the SFO, anxious, guilty, worried about the process, concerned they have not done enough, lacking in self-esteem, and wanting to work anywhere but for the service."

The role of SFO reviewers

Respondents offered mixed views on the role of SFO reviewers based on their approach and the perception that they were seeking to apportion blame rather than identify learning points.

"I found the SFO reviewers extraordinary in the job that they do and the support they offered to me and my team during a time of great distress to them following the commission of a death by a person on probation. It is only the follow up afterwards that requires improvement."

"I have been involved in several SFO reviews and I think the experience can be linked directly to the approach of the person undertaking the review. I have been interviewed by an empathic SPO not long redeployed to the SFO team, and I have been interviewed by someone who seemed determined to highlight personal poor practice and undermine my experience or qualification."

"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."

Learning from SFOs

Another strong theme was disappointment that the opportunity to learn and improve practice was not considered to be maximised in the SFO review process. For some, this related to a perceived lack of transparency stemming from the SFO review not being shared and for others, the related action planning was considered process driven and difficult to apply without the context of the review.

"We get lists of actions but not enough information as to what these relate to which is not constructive and don't take into account what already has been done since the SFO such as training attended…it might need to be repeated again just for the purpose of achieving the action."

"We have created an over-bureaucratic reporting system that does not easily invite opportunities for learning. The reports are very long and complex and trying to appeal to too many audiences. I think the reports may meet the needs of the HMPPS central team, but I don't think they facilitate learning for practitioners as well as they might, e.g., because the staff are not allowed to read them, they just get a disjointed and cumbersome list of actions that lose meaning when they are asking for mechanistic responses."

"I think that it is unconscionable that practitioners and their managers do not have access to SFO reports. the method of feedback is unacceptable and disjointed. I have had to implement an action plan with staff when I have had no clear understanding of why or the context of it."

"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."

"Having experienced two SFOs during my career (one over a decade ago) and one last year, they remain a harrowing experience. My most recent experience was as someone who had managed the client (but did not hold at the time of the offence). I was advised that there were "a number" of actions for me to complete and learning points to review. These have never been shared with me despite my frequent requests."

Recognition of organisational context in SFO reviews

A strong theme identified by respondents was that both HMPPS reviewing managers and HM Inspectorate of Probation inspectors lacked understanding about the current context in the probation service (understaffing, high caseloads, and workloads). In addition, reviewers were perceived as often focused on irrelevant and minor document omissions and errors that were not relevant to the SFO, with little recognition of the good work that had been done.

"The learning points feel irrelevant to the nature of people's work when they move into new positions in the business and are too narrow – focussing on those involved in the case management rather than themes of poor practice that exist across the business."

"Actions are set for the sake of setting actions which is demoralising to the team. For example, if on this one occasion a form was missed, or a box was not ticked, then without any further exploration to see if this is a wider problem or a one off, an action is set. SFOs tend to steer towards blaming practitioners, not policies, guidance, or heads of service or above."

"National cases have had a visible impact on practice. There is however no local response or resolution to issues which will always be picked up in such reviews – information sharing, checks and communication."

"I think all learning from SFO reviews is vital. However, the process and blame culture is the scary and anxiety provoking part. I feel that the SFO review process is a means of trying to find evidence to pin on individuals rather than looking at the failures of the service as a whole, such as workload capacity and other demands."

"Resource is a major factor in the delivery of risk management. The impact of SFOs on frontline staff who have responsibility for case management should not be underestimated and has resulted in staff exiting the service. Practice in some cases will have been poor but needs to be set in the context of their own workload and their ability and training to deliver risk management to high-risk cases."

"I was also judged on the practice of risk assessments that had changed significantly since the SFO. Targeting OASys practice of supervising officers should focus on the SPO

countersigning. If it is countersigned, then it is the SPO at fault for not ensuring it was sufficient. If all my OASys are being countersigned over a period of 4 years without being rolled back, then I do not know there is a problem. The review process needs to be more timely, and use of peer led panel reviews would be much more helpful and look at what we as a team can achieve rather than a witch hunt on an individual."

Management support during the SFO process

Some respondents were disappointed by the support afforded to them, particularly by senior managers, who were not considered supportive or empathetic during the SFO review process.

"They couldn't distance themselves fast enough from my colleagues when they had an SFO. There was no support offered to them, one of them was suspended and it was the biggest botch job you've ever seen. Our entire team fell apart and we were just left to get on with it. When someone told a very senior manager it felt like they didn't care about us, they just became angry and defensive and shut us down. I know at least one member of staff seriously thought about killing themselves because of how isolated they had been left. Senior management tell people to contact PAM Assist and then walk away like 'job done'. There's absolutely no care at all for staff."

"My action plan was poorly delivered – no set time for this was scheduled, instead I was pulled into a room without notice by a manager and this was read out to me. During delivery of the action plan, incorrect information and actions were given – this was not corrected until several weeks later. Overall, it was a disappointing and unsupportive process."

"My workload was also not accounted for in a review I was involved in, which at the time was 165% on the workload management tool yet some of my practice was criticised. I was also under occupational health at the time, suffering with anxiety and again despite advising this, it was not acknowledged that my SPO at the time failed to support me in line with guidance. Once I completed the plan, I heard nothing back from either my SPO or the SFO team."

"There was no mental health support before and after the interviews despite the management being aware that I was struggling with mental health issues. It left me very vulnerable."

"The threat of an SFO is used in my office to create a culture of punishment and fear amongst staff which managers cause and perpetuate. I see no attempt to make staff feel understood or supported and we have lost experienced staff members as a result of how they feel treated."

Positive experiences of SFO reviews

Respondents reported some positive experiences during the SFO review process. They told us that receiving support and empathy at a difficult time from colleagues, managers and senior leaders contributed to this experience. Learning from SFO reviews, reflecting with colleagues and improving professional practice was also discussed by several respondents.

"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."

"The interviewing officer during my SFO was very understanding and reassured me that I had not done anything wrong. The interview, thanks to her, was nowhere near as traumatic as I imagined it to be. I found the lead up to the interview very stressful; however, I had the support of my manager and colleagues."

"Overall SFOs are really stressful events, and I don't feel that the service does enough to support staff at this time based on my experiences to date. I do not put my line manager in this bracket, he does everything he can to offer support, but things are out of his control."

"The most recent SFO review was conducted in a manner that helped me to develop my practice further especially in the area of multi-agency collaboration."

"I found my recent involvement a positive experience. I felt supported throughout and have since put learning into practice."

"My area seems very good at sharing learning from HM Inspectorate of Probation reviews and embedding them into training and practice in a really helpful way."

"The HMPPS and HM Inspectorate of Probation reports into SFOs are really helpful and I always spend time reading the published reviews on the Inspectorate website which I find really useful and have applied their recommendations in my own and my team's practice."

Summary

The fear of SFOs among probation professionals was highlighted in our recent thematic inspection of the role of the SPO,[14] where it was stated that: 'In the inspected English regions, we were told that a culture of fear was becoming embedded. This is driven primarily by the fear of SFOs and the consequent need to evidence management oversight activity'. This fear was driving inappropriate behaviour, for example a probation professional commented, 'Fear of SFOs makes me request management oversight. It makes decisions defensible – it is the back-up you need, reassurance; it's not that I am not confident to make decisions, I just want that back-up so I can make sure we're all on Panorama together'.

Our survey sought to explore the organisational culture associated with SFOs and the factors that impact on organisational learning. This attracted 245 respondents, who shared their perceptions on various elements of the review process, the support that is offered, and the wider learning environment.

The experiences shared caused concern about the impact on staff welfare and their ability to understand and apply learning. Respondents indicated a pervasive culture of blame within HMPPS, which was perceived as narrowly focused on individual accountability, with limited recognition of the organisational factors that influence the quality of operational practice. The findings of the survey indicated that the current organisational culture, perceived as being characterised by punishment, absent management support and a lack of transparency, both inhibits the ability to understand and apply learning, which respondents recognise is needed, and has emotional and psychological consequences for staff, who are fearful of the outcomes of the process.

Addressing these issues is therefore imperative if a culture of organisation-led learning is to be developed and recognised by HMPPS staff.

[14] The role of the senior probation officer and management oversight in the Probation Service

Risk assessment practice

A theme consistently seen in SFO reviews is that risk of serious harm is underestimated and/or inaccurately assessed.

Assessing risk of serious harm (RoSH)[15] is a fundamental part of probation practice, as this underpins the management of the case. A RoSH assessment is undertaken to ascertain the level of risk posed to different groups: the public, known adults, children, staff, and prisoners. Risk to self is also considered, but this is not given a risk level. The levels of RoSH are low, medium, high, or very high.[16]

The risk assessment tool currently used by the probation service is OASys (offender assessment system). The practitioner undertakes a risk screening, then, if certain criteria are met, completes a full analysis of the risks presented by the case. They conclude this with a risk summary and formulate a risk management plan. The risk management plan should underpin how the case is managed and include a contingency plan to consult and follow if the risk of serious harm increases.

In all SFO reviews, the RoSH assessment is scrutinised, and the reviewing manager should ascertain if the assessment was accurate. The review considers the risk of serious harm assessment at the start of the review period, and then explores any changes to risk levels. The standards require sufficient judgements to be made in respect of risk assessment at all relevant stages in the review.

As already highlighted in this report, HM Inspectorate of Probation quality assured 87 reviews from April 2023 to April 2024. Of those reviews, 62 were identified as having inaccuracies in the risk of serious harm assessment, which equates to 71 per cent. This involved a range of inaccuracies, such as:

- 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.

In some cases, more than one issue was apparent, for example the overall level was inaccurate from the outset, and there were anomalies with regard to the individual risk groups.

[15] The risk of serious harm (ROSH) is the likelihood of a life-threatening or traumatic event that could result in physical or psychological harm that is difficult or impossible to recover from.

[16] **Very high**: There is an imminent risk of serious harm. **High**: There are identifiable indicators of risk of serious harm, and the potential event could happen at any time. **Medium**: There are identifiable indicators of serious harm, but the individual is unlikely to cause harm unless there is a change in circumstances. **Low**: Current evidence does not indicate a likelihood of causing serious harm.

This is explored further below in more detail with corresponding examples.

The overall level of risk of serious harm was inaccurate from the outset
Name: Mr A.
Index offence: Supplying a class A substance, committed while on licence for section 20 wounding.
Serious further offence: Murder.
Mr A was sentenced for the index offence without pre-sentence reports. A court probation practitioner completed a risk of serious harm screening document and did not identify any areas of concern. This meant that a full analysis was not completed. This was insufficient practice and did not consider all available information, which included Mr A's previous high risk of serious harm assessment, previous approved premises placement, gang affiliation, and use of weapons. *The prison offender managers completed two OASys assessments, both of which assessed that Mr A posed a medium risk of serious harm to children and the public, and a low risk of serious harm in all other categories.* *On release from custody, the probation practitioner completed an OASys assessment, which was essentially a pulled through document, and the assessed level of risk remained unchanged.* *Clear judgements are provided throughout the review on the sufficiency of the risk of serious harm assessment, emphasising that the assessed level of risk should have been high, and that the risk assessment did not sufficiently consider the nature and breadth of risk posed.*

This demonstrates how the RoSH was inaccurately assessed from the start, and that it was not rectified in subsequent assessments. The impact of not having an accurate risk assessment was that the risk management plan formulated was then not tailored to managing a high risk of serious harm case. Reporting for high risk of serious harm cases should be carried out more frequently than for medium risk of serious harm cases. Home visits may also be more regular. Further, such cases may meet the threshold for MAPPA or for the offender personality disorder (OPD) pathway and can be considered for a place in an approved premises on release. There are also prison-related risk management strategies that are more likely to apply in a high risk of serious harm case. The impact and significance of inaccurate risk of serious harm assessments are considered in our independent reviews, which are explored further below.

One or more risk groups were inaccurately assessed
Name: Mr J.
Index offence: Assault by beating (child aged 13).
Serious further offence: Inciting sexual activity with a child under 13.
Mr J was assessed as posing a medium risk of serious harm to known adults and children. The risk was linked to domestic abuse, and the index offence. It was assessed that he posed a low risk of serious harm in all other risk categories. The reviewing manager clearly articulated that, although they agreed with the overall risk assessment, the assessed level of risk to the public (future partners) was not correct and should also have been medium. *The assessed level of risk did not change during the review period, and the reviewing manager appropriately emphasises that there were missed opportunities to review the risk assessment and risk management plan in place.*

Inaccuracies or underassessing a specific group at risk is a common theme identified in SFO reviews. Of the 62 cases with inaccurate risk assessments, 45 included specific groups that were assessed incorrectly. This can have a bearing on the management of the case. For example, it would not be apparent in this case that future partners could be at risk of serious harm from Mr J. The risk management plan would not then sufficiently consider how to safeguard any future partner, and risks posed to them effectively managed.

Risk of serious harm was assessed as accurate but did not consider risk holistically, or all those who may be at risk in the different groups
Name: Mr X.
Index offence: Criminal damage.
Serious further offence: Rape of a child under 13.
The risk of serious harm was assessed as medium to the public and known adults, and low in all other categories. The review highlights that the risk of serious harm to children should have been medium, and this was not considered effectively by the probation practitioner. There was evidence of previous domestic abuse call-outs in respect of Mr X's sister, and no action was taken when it was known that his partner was pregnant. The review does not stipulate how old his sister was. This would be helpful to add, as the reader assumes she is a child.

Assessment of individuals in this case was missed, even when the risk category was correct. This resulted in there being gaps in the risk management plan, and those managing the case not being alert to who was potentially at risk. The lack of exploration of Mr X's family circumstances and relationships meant that information about the children Mr X may have been in contact with was missing. We have seen several cases where individuals were not considered effectively in risk management plans, and therefore not all of the required safeguarding activity was considered or set out. This was also a finding in the Bendall independent review, which is considered further below.

Risk of serious harm was not adequately reassessed, despite new or emerging risk factors being apparent
Name: Mr E.
Index offence: common assault, attempted assault of an emergency worker and possession of a class A substance.
Serious further offence: Arson with intent to endanger life (the SFO victim was the same victim of the index offence of common assault – his partner).
The pre-sentence report assessed Mr E as posing a high risk of serious harm to a known adult, a medium risk of serious harm to children and a low risk of serious harm to staff and the public. The assessment completed post-sentence by the same practitioner increased the risk levels to the public and staff to medium, and the initial OASys sentence plan reflected the same levels. *There were no further risk assessment reviews completed during the review period; however, the review identifies points at which a review should have been undertaken, due to incidents and changes in behaviour intrinsically linked to the risk of serious harm towards others.* *The reviewing manager offers clear judgement throughout the review that the risk to victim 1 should have been increased to very high and that there were several missed opportunities to both consider and apply this change.*

The review also identifies that the risk of serious harm to children should have been increased to high. The quality assurance of the SFO review also considered that the risk to the public should also have been reassessed as high, based on the activation of critical risk factors intrinsically linked to risks to a known adult.

This case highlights numerous opportunities to review the risk assessment which were missed, and which then had an impact on how the case was managed. This meant the risk management plan was not updated to reflect the current situation and consider who was at risk and how this would be managed. Increasing the risk of serious harm to children would have consequences for liaison and involvement with children's services. Other safeguarding activity could have been considered to manage the very high risk of serious harm to Mr E's partner, for example by increasing monitoring and support through a multi-agency risk assessment conference (MARAC).

The reviewing manager agreed with the overall risk assessment but the SFO inspector undertaking the quality assurance assessed that it was inaccurate.
Name: Mr Z.
Index offence: Assault police.
Serious further offence: Murder.
Fundamental to this review are the repeated judgements that demonstrate the reviewing manager agrees with the risk assessment in place. These judgements contradict the evidence provided, which shows that the risk of serious harm posed by Mr Z was underestimated in both its level and breadth. Concerningly, at one point the judgement on the level of risk posed to Mr Z's ex-partner is made on the basis that there were no recorded incidents of physical violence to his ex-partner and does not recognise his domestically abusive behaviour or its impact on victims.

The inspector undertaking the quality assurance of this review disagreed with the level of risk of serious harm the case was managed at, which the reviewing manager had deemed to be accurate. When this occurs, the reviewing manager is asked to review their judgement. This should be done in consultation with their manager, who is countersigning the SFO review. Inspectors will often discuss these findings with the reviewing manager to ensure this is revisited and that the rationale for the risk assessment is sufficiently explored.

Why was the risk underestimated or assessed inaccurately?

Where SFO reviews have explored the 'why' behind practice deficits in respect of risk assessment practice, the following main themes have been identified:

- 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
- 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.

The role of management oversight

Another key finding of SFO reviews is the lack of, or limited examples of, effective management oversight of cases. Given the findings highlighted above, management oversight should play a crucial role in ensuring risk of serious harm assessments are thorough, holistic, and accurate, and are translated into meaningful risk management plans. This is part of the wider role of ensuring managers provide effective oversight at pertinent points in the management of a case, and to support the staff they manage.

There is a requirement for the OASys assessments to be countersigned in certain cases, for example for those who pose a high or very high risk of serious harm, or when the assessment has been completed by a trainee or newly qualified member of staff. Countersigning will usually be undertaken by the SPO in the team managing the case. The purpose of countersigning is to ensure the assessment is sufficient and robust enough to inform the management of the case. It is apparent that this is not always taking place in line with expected guidance; therefore, gaps, inaccuracies and insufficient assessments can often remain in place, resulting in an insufficient risk management plan with which to oversee the case. This practice concern is mirrored in our core inspection findings across probation regions.

SFO reviews, as well as our core inspections and the recent thematic report[14] into the role of the SPO, have found that the reasons why management oversight is not always sufficient are as follows:

- SPOs' span of oversight is too large
- workload does not allow for thorough countersigning process to take place
- SPOs are not using the guidance for quality assuring OASys assessments
- SPOs undertaking countersigning are not familiar with the case or are providing cover for another SPO
- insufficient assessments are being countersigned to meet performance targets.

Given that HMPPS have announced the recruitment of a further 1,000 staff[17] to manage additional workloads resulting from SDS40,[18] it is vital that the management oversight provided is sufficient and effective. The number of staff who will require robust oversight will increase; therefore, it is crucial that their development and learning are overseen effectively, and that they are given the necessary opportunities to learn and develop.

Risk assessments – next steps following independent review recommendations

Issues with the quality and accuracy of risk of serious harm assessments have been apparent in three independent reviews recently published by HM Inspectorate of Probation. The cases of Jordan McSweeney[19] and Damien Bendall[20] highlighted concerns about the assessment of risk

[17] Lord Chancellor sets out immediate action to defuse ticking prison 'time-bomb' - GOV.UK
[18] SDS40, or Standard Determinate Sentence 40, is a temporary government scheme to release prisoners early in order to ease overcrowding in prisons.
[19] Independent serious further offence review of Jordan McSweeney
[20] Independent serious further offence review of Damien Bendall

of serious harm, which had a significant impact on how both cases were managed by the Probation Service. The more recently published review of Joshua Jacques[21] also highlighted concerns with the risk of serious harm assessment and will be considered more fully later.

Jordan McSweeney sexually assaulted and murdered Zara Aleena, as she walked home in London in June 2022. He had been released from custody nine days previously and was therefore subject to probation supervision when he committed the serious further offences. He was sentenced to life imprisonment in December 2022, with a minimum tariff of 38 years. This was subsequently reduced on appeal to 33 years, in November 2023.

Our independent review found the risk of serious harm should have been raised to high in February 2021, based on the information available on his history of violence, as well as his acquisitive offending. Information was known about the risks he presented in custody, such as possession of weapons and violent and threatening behaviour. In addition, he had carried weapons in the community. The risk of serious harm to the public, staff, and other prisoners should have been assessed as high. The risk of serious harm to known adults should also have been high, based on information related to offences against a known female received in 2021, which later resulted in a restraining order being imposed. There were also further opportunities to review his risk levels; however, information about his behaviour in custody and the community was not viewed holistically.

No OASys assessment was completed after his custodial sentence was imposed in April 2022. Owing to a delay in allocating his case, the PO was not able to complete an OASys before his release in June 2022. Mr McSweeney was therefore released with no formal risk assessment having been completed since February 2021. His overall risk of serious harm level was inaccurately assessed as medium when it should have been high. He was viewed as a 'medium risk acquisitive offender'. 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. He may also have been eligible for MAPPA management, and for an approved premises (AP) placement, which would have afforded more monitoring of his risk in the community as well as opportunities for rehabilitation.

In September 2021, at their home in Derbyshire, Damien Bendall murdered Terri Harris (aged 35), her children Lacey Bennett (aged 11), and John Paul Bennett (aged 13) and Connie Gent (aged 11), who was a friend of Lacey's sleeping over at the family home. He also raped Lacey. In December 2022 he was sentenced to whole life term of imprisonment. At the time he committed these offences, he was subject to a suspended sentence order (SSO) and was under probation supervision.

In this case, the risk of serious harm was underestimated from the point of the pre-sentence report being completed for court. The review states that, had an accurate assessment been presented, he could have been sentenced to immediate custody rather than receiving an SSO. A curfew was imposed for Bendall to reside at Terri Harris's address, without relevant enquiries having been made about any domestic abuse concerns, or her view on him residing there being sought. This was therefore an entirely inappropriate recommendation.

He was subsequently assessed as posing a medium risk of serious harm when this should have been high. Had he been assessed as high risk of serious harm; he would have been allocated to a more experienced practitioner. There were subsequent failures by supervising managers and new practitioners to adequately read the case and amend the initial, incorrect assessment of 'medium risk of serious harm' to 'high risk of serious harm'. Had he been assessed as posing a high risk of serious harm, this should have informed how his case was managed. For example, it may have resulted in enforced weekly face-to-face appointments and better communication

[21] Independent serious further offence review of Joshua Jacques

with partner agencies. Assertions lacking evidence would not have been relied upon and repeated in future assessments.

Recommendations from independent reviews

The Bendall independent review made 17 recommendations, all of which were accepted by HMPPS. Ten of these focused specifically on assessing and managing different elements of risk of serious harm, including domestic abuse and child safeguarding. HMPPS have provided an update to their action plan, which was published on 09 May 2024.

It is now mandated that domestic abuse enquiries are undertaken for all cases where an electronically monitored curfew is proposed. Additional resources to carry out these commitments have been granted. Updates from HMPPS have been provided on how these resources are being used.

In response to child safeguarding enquiries, HMPPS have stated: 'The HMPPS Child Safeguarding Policy Framework mandates that child safeguarding enquiries are made to inform all reports where the person being sentenced lives with, is responsible for, has access to, or is likely to have a negative impact on the wellbeing or safety of a child'. In terms of progress with enquiries, they have stated that monthly recorded activity in relation to safeguarding enquiries more than doubled between April 2022 and March 2023, and recent data indicates further continuous improvement.

With regard to information-sharing, HMPPS report that they have worked with the Department for Education to update the HMPPS sections of the new *Working Together to Safeguard Children* statutory guidance, which was published in December 2023. The updates provide clarity for professionals across agencies and organisations about the role of HMPPS and how it can contribute to keeping children and families safe. The changes will help to strengthen the arrangements that probation delivery units have with local authority children's services, particularly in relation to exchanging information.

A court case audit tool was launched in April 2023 and will be reviewed regularly to ensure it remains aligned with current practice quality expectations and core methodology.

Following the Bendall review being completed, it was mandated that those whose address was being considered for electronic monitoring services (EMS) would be consulted. 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.

Probation regions are providing updates on the implementation and compliance with the HMPPS child safeguarding framework. They have also been reporting on campaigns such as 'Think Child', which aims to raise awareness of the probation practitioner's role in supporting children's wellbeing and safety.

Changes to OASys were made following the original action plan. The aim was to provide a better structure to prompt practitioners to consider the nature of an individual's behaviour and the impact that it may have on the children they have or may have contact with.

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.[22]

There has been a review of the risk of serious harm guidance. No concerns were found with the guidance itself; however, issues with its implementation were identified, including relating to training and IT tools. Follow-up actions include an updated RoSH activity pack to support managers in embedding the RoSH guidance in accessible format, changes to the risk of serious

[22] Jordan McSweeney Independent Review Action Plan - GOV.UK

harm training for both new and experienced practitioners, and the delivery of targeted workshops to court SPOs.

HMPPS has approved funding for a new approach to the assessment and planning of risks, needs and strengths. The project aims to change the approach to assessments, risk management and sentence planning, so that it better supports accurate assessment and sentence management, is collaborative and strengths-based, and is supported by and reflected in a new enabling digital service. The tool, called ARNS (assessment of risks, needs and strengths), was tested with a small staff cohort in August 2024. As further changes are implemented, more staff groups will be onboarded. The new assessment is expected to be rolled out to all staff in 2026.

HMPPS are continuing to undertake case audits by way of regional case audit tools and other auditing activity through the performance, assurance, and risk group.

HMPPS has made changes to OASys to better capture offences committed in a custodial setting and civil and ancillary orders. Where there are significant domestic abuse or safeguarding concerns, risk assessments are automatically sent for countersigning by an SPO. HMPPS have stated that early evidence of the impact of these changes has indicated that it has supported staff to capture information on civil orders and behaviour in custody within their risk assessment.

A PSR gatekeeping form has been implemented from January 2023. HMPPS report that compliance with this continues to rise among probation regions.

An information-sharing form has been devised for prison offender managers to complete. HMPPS state that the purpose of this is to 'ensure that necessary information is passed to the community to support ongoing risk assessment and risk management; this includes prison behaviour e.g., new offences, assaults on staff or information about Civil Orders'.

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, and to clarify the different thresholds for a civil order and a criminal conviction.

HMPPS have completed a review of the operating model for information and intelligence sharing and a review of the prison intelligence contribution to MAPPA. We note, however, that McSweeney was not managed under MAPPA. Therefore, we welcome the other initiatives to consider information-sharing that does not fall under the MAPPA remit. This includes a revised policy framework to provide enhanced guidance to prison intelligence teams and a 'tradecraft' document will be published to support 'front end' users.

We will continue to liaise with HMPPS and welcome updates on the progress of these actions. We have been involved in early discussions about the implementation of the new risk assessment tool ARNS and will continue to receive regular updates on its implementation and progress.

Summary

The assessment of risk of serious harm was found to be inaccurate and/or underestimated in the majority of SFO reviews we quality assured in the period from April 2023 to April 2024. This included overall risk being inaccurate, as well as risks to specific groups being underestimated and people at risk not being considered individually in risk assessments. We have found similar concerns on our core inspections. Two examples are:

- In the inspection of East Kent PDU,[23] Kent Surrey Sussex region, in March 2024, it was found that information about domestic abuse was only used in the assessments of 15

[23] An inspection of probation services in East Kent PDU

out of 44 relevant cases, and child safeguarding information was used in just 13 out of 46 relevant cases. This contributed to inaccurate judgements in relation to the likelihood and imminence of harm.

- In the inspection of Hertfordshire PDU,[24] East of England region, in July 2024, we found that the risk of harm assessment did not identify and clearly analyse all relevant risk of harm factors. Only 16 out of 54 cases had sufficient levels of information-sharing with the police about domestic abuse, and 19 out of 54 included sufficient information on child safeguarding. Where enquiries had been made but gaps in information remained in the responses of other agencies, this was not routinely followed up. The consequence was that 11 out of 54 cases we inspected had an inaccurate risk of harm classification.

This therefore remains a crucial element of probation practice that needs to improve. There has been a significant amount of activity regarding risk assessments following the recommendations of our independent reviews of Damien Bendall and Jordan McSweeney. We will continue to monitor progress in this area to identify the impact of these changes through both the quality assurance work of SFOs and our core inspection programme findings.

[24] An inspection of probation services in Hertfordshire PDU

Independent review of Joshua Jacques

In January 2024 we published an independent review of the case of Joshua Jacques[2].

In April 2022, Jacques was charged with the murders of four family members: Denton Burke, Dolet Hill, Tanysha Ofori-Akuffo, and Samantha Drummonds. On 21 December 2023 he was found guilty of murder following trial. He was sentenced on 01 March 2024 to life imprisonment, with a minimum term of 45 years and 301 days.

Jacques was under probation supervision when he was arrested for these offences, having been released from prison on licence in November 2021. Instead of the probation service completing an SFO review, in this case, the Secretary of State for Justice asked HM Inspectorate of Probation to complete an independent review into how the Probation Service managed Jacques.

In November 2019 Jacques was sentenced to 51 months in custody, for offences of supplying Class A drugs (heroin and crack cocaine) and possession of Class B cannabis. A criminal behaviour order (CBO)[25] was also imposed. He was released from custody on 11 November 2021, initially to reside at an AP. His case was referred to MAPPA under category 3 and one meeting had been held before his release.

The key findings of this review are set out below, and mirror some of the areas this report has already identified as being key themes in SFO reviews.

Assessment of risk of serious harm

Issues were found in the risk assessments completed in respect of Jacques.

Although the overall risk level of high was accurate, the review found that it failed to identify all factors that were linked to the risk of serious harm, such as his mental health, substance misuse and current accommodation. The other areas were assessed as low, which was considered an underestimation, based on the available information. As already highlighted, risk of serious harm assessments being inaccurate is a common theme in other SFO reviews.

An initial OASys assessment was started when he was released. However, this was never fully completed and remained an incomplete document during the period of supervision. The failure to complete an OASys assessment on release meant that there was no assessment of risk of serious harm and no risk management plan in the community to inform how the risk posed should be safely managed while Jacques was on licence. This was a similar finding to the McSweeney case, as highlighted above, where there was no up-to-date and accurate risk assessment to inform the management of the case. Additionally, there were no sentence plan objectives to support and inform the supervision appointments.

Further reviewing did not take place after the MAPPA meetings held on release, nor in response to changes of circumstances and significant events. Completing a review would have enabled the probation practitioner to consider the significance of new information, and review the sentence and risk management plans accordingly, to ensure the necessary arrangements were in place to protect the public.

Not reviewing OASys assessments following significant events or new information emerging was also a common theme in the SFO reviews we have quality assured.

Before the SFO, on 02 March 2022 Jacques appeared in court for new offences. The risk assessment was not sufficiently updated at this point to provide a holistic assessment of all known risk factors. The need for a holistic risk assessment was also a key theme highlighted in the independent review of Jordan McSweeney, as outlined above.

[25] A criminal behaviour order (CBO) is a court order that can be issued to those convicted of a criminal offence to address serious and persistent anti-social behaviour.

Although MAPPA meetings considered the level of risk of serious harm posed by Jacques, this did not negate the need for an OASys assessment to be completed. There was also no evidence of other assessment and planning in the case records, in the absence of a formal assessment. Therefore, there was no evidence of a clear understanding of how to manage the risks posed.

Professional curiosity and optimism bias

The practitioners managing Jacques focused on addressing his needs, such as accommodation and employment. We found that this focus was to the detriment of undertaking offence-focused work and managing RoSH. For example, there was no evidence of delivery of specific interventions that focused on offender behaviour. Probation practitioners took an over-optimistic view of Jacques' behaviour on licence and did not fully understand the expectations on them to be professionally curious and proactive. As a result, they did not adequately explore issues that arose linked to his RoSH, for example regarding him purchasing a vehicle, his problematic behaviour in his accommodation and the failure to inform police of a second breach of the CBO. There was a lack of experience in the PDU's probation practitioner staff group, and a lack of robust management oversight further contributed to this. Where a workforce has limited experience, they need guidance from those with a more established level of knowledge to provide support and oversight to aid their development.

A lack of experience, and inappropriate case allocation, was also apparent in both the Bendall and McSweeney reviews and is commonly found in SFO reviews. In a sample of 39 SFO review cases, inspectors judged that 41 per cent were allocated inaccurately. This demonstrates the significance of the issue and that this requires attention.

Enforcement

Enforcement practice in this case was inconsistent, with instances of non-compliance considered in isolation rather than seen in the round. Opportunities to escalate and consult with the delivery unit head were not sought. There was a failure to act on a pre-release assessment that identified that swift enforcement of the CBO and licence were required to manage the risk of serious harm that Jacques posed. Enforcement guidance issued in October 2021 was not followed. Our inspectors felt that the decision not to recall Jacques following his arrest for further offences was defensible. However, in making the decision, the SPO should have sought senior manager oversight, and the failure to do so was against expected practice. The enforcement practice in this case did not analyse Jacques' behaviour, nor did it explore whether additional supportive or restrictive measures short of recall were needed to manage his licence.

This is further evidence of the risk of serious harm and needs of the case not being considered holistically. We have seen evidence of insufficient enforcement practice across several SFO reviews.

Resourcing and workload

The PDU had been operating at 'green' status under the national Prioritising Probation Framework but had several vacancies, particularly at probation officer and probation services officer grade. Many staff in the PDU were in the early stages of their career and there were limited numbers of experienced staff available. The probation practitioners in this case lacked the required experience to respond adequately to the complexity of the case and behaviours being presented. In addition, the pace and volume of work impacted on the quality of work undertaken in this case. HMPPS's tiering framework[26] and case allocation guidance was not

[26] Tiering is way to allocate probation cases based on several factors, including the risk of serious harm, likelihood of reoffending and level of need.

followed, and Jacques' case should have been allocated to a more experienced probation practitioner.

The probation practitioner in this case was in their newly qualified probation officer (NQO) period. In allocating the case, the SPO should have been assured that the PO had the required knowledge, skills and experience to manage the case effectively. Jacques' tier increased following the initial MAPPA meeting and this should have prompted reallocation of practitioner, in line with the expected practice for NQOs.

Staffing, resources and workload are common themes highlighted as the 'why' behind practice deficits and delays in tasks being completed. This was a theme in both the Bendall and McSweeney reviews. National and regional action continues to be taken with regard to recruitment.

Management oversight

Management oversight was of an insufficient standard. Staff reported a lack of confidence in the decisions made by their line manager, which contributed to a reluctance to seek out further management oversight. When sought, decisions made by the probation practitioners would generally be approved without the necessary discussion or scrutiny needed to make sure the most appropriate course of action was being taken. Opportunities to escalate to the head of service were also missed. As in the findings from the Inspectorate's broader local inspection programme, the workload and responsibilities of line managers in this PDU were found to be concerning. SPOs were managing large teams and were expected to provide support and oversight of their staff and manage human resources issues, as well as provide oversight and scrutiny of each probation practitioner's caseload. SPOs also have additional lead responsibilities, such as MAPPA, which affects their ability to perform their role to the expected standards. Inspectors also found insufficient processes in place to manage staff absence and to support staff who were providing cover arrangements for cases. This resulted in a lack of clear ownership of this case and many other cases during this period.

Management oversight was also a theme in the Bendall and McSweeney reviews and is a common theme in our SFO work, as highlighted above.

MAPPA

Jacques' index offence (the last set of criminal convictions) meant that he was not automatically eligible for management under MAPPA[9]. t was good practice that he was referred to MAPPA as a Level 2, category 3 case; however, we found insufficient evidence that this had a positive impact on the management of the case. The MAPPA referral for Jacques was late, having been completed only one month before his release. This should have been done six months before release. Although the case was discussed promptly, the initial delay in referral resulted in little time for MAPPA to contribute effectively to the pre-release planning. Licence conditions had already been set with the prison, without a contribution from the MAPPA panel. The minutes from the four MAPPA meetings held were of an insufficient standard. They provided limited evidence that partner agencies were active in supporting the management of risk of serious harm he presented. There were missed opportunities for meaningful actions to be set in response to new information, and a lack of oversight of outstanding actions. Jacques was deregistered from MAPPA oversight without an adequate rationale, while two actions that had already been carried forward remained outstanding.

We see a mixed picture with regard to MAPPA practice in SFO reviews. We have encouraged reviewing managers to consider whether referral to MAPPA under category 3 would have been applicable, and what MAPPA oversight would have brought to the management of the case.

Approved premises

Jacques was released from custody to reside in an approved premises (AP).[27] This was an opportunity to contribute positively to the management of Jacques' risk of serious harm. AP staff held key work sessions, which were appropriately focused. They included structured sessions on Jacques' immediate needs and explored issues that supported his resettlement into the community. However, AP staff did not apply professional curiosity during their interactions with Jacques. There is no evidence that they explored his behaviour and movements, which would have helped the probation practitioner to understand how Jacques was spending his time away from the AP. AP staff should play a significant role in providing relevant risk information to the probation practitioner and contributing to effective risk management. It is essential that they understand the risk of serious harm presented, are actively involved in the delivering the risk management plan and are part of MAPPA meetings. An AP representative was not able to engage in pre-release planning due to the delayed referral, and subsequently did not attend the MAPPA meetings held. This had an impact on pre-release planning, information exchange and the effective risk management of the case.

We have seen a mixed picture in respect of how APs manage cases, in SFO reviews. While we have seen examples of effective liaison between AP staff and offender managers, there can be gaps where information is not shared sufficiently, or the offender is not robustly monitored.

Mental health

Jacques had a history of complex mental health and had previously been sectioned in 2018. He reported that feelings of anxiety and paranoia were normal for him. Before his release, Jacques' mental health was described as stable, and probation practitioners stated that there were no obvious signs of a mental health decline on release. However, he was described as presenting as 'low' on occasion, which was attributed to boredom and the need for structure in the community. Days before the SFO, Jacques was described as talkative and going off on irrelevant tangents in his conversations with probation staff.

Opportunities were not taken to explore his mental health after he had disclosed a decline when he was interviewed for the further offences committed on licence. Probation practitioners were aware of Jacques' mental health history and that he had behaved violently in prison during a period of mental instability, but they lacked any detailed information. Jacques himself had reported that random aggression could be a sign of his mental health declining. However, this was not identified as a factor linked to risk of serious harm in OASys assessments.

Information about his mental health was not shared effectively between the prison and the general practitioner.

Additionally, the correlation between Jacques' continued use of illegal substances and his mental health was not sufficiently explored or responded to. Probation practitioners stated that there was a gap in services available to support those with poor mental health, particularly if there were also substance misuse concerns. Inspectors found that staff felt ill-equipped to understand and respond to mental health concerns, with limited training and support being available.

The management of mental health has been mixed in SFO reviews. In some cases, it is apparent this is considered well, with other services involved and regular communication having taken place. However, in many cases responses to managing mental health are limited and often insufficient.

[27] Approved premises offer an enhanced level of public protection in the community and are used primarily for those assessed as posing a high and very high risk of serious harm.

Substance misuse

Jacques had used cannabis since he was a child and was described as lacking insight into the harmful effects of his substance misuse. Probation records and a psychiatrist's assessment indicate a link between Jacques' substance misuse and his mental health, and that Jacques' sectioning in 2018 had been preceded by the consumption of medication, alcohol and cannabis. Additionally, much of Jacques' offending was linked to substance misuse. Probation case records show that Jacques was routinely using cannabis while on licence. He had completed substance misuse intervention programmes in custody and his licence included a condition to engage in a drug abuse intervention on release from prison. However, this intervention was not organised by probation practitioners, and we could find no evidence of a referral to a drugs agency. Inspectors found that probation practitioners did not explore the underlying reasons for Jacques' substance misuse, and minimised and tolerated his regular use while he was on licence. This was underpinned by a failure to adequately analyse the impact of substance misuse on the risk of serious harm he posed.

This demonstrates that Jacques' risk factors were not all assessed or managed effectively, and that practitioners had not used professional curiosity to explore the reasons for his substance misuse. These are common themes in SFO reviews.

Eight recommendations were made in our review.[28] HMPPS accepted seven of these, and partly accepted an eighth, and have developed an action plan to take them forward. An update on progress is due in January 2025.

[28] Independent serious further offence review of Joshua Jacques

Forthcoming work

This year we delivered a launch event for our multi-agency learning panels (MALPs). This event was well attended, and participants responded positively to the aims and objectives of the MALP. As we have previously emphasised, the need for improvements in the probation service's partnership working is a frequent finding in SFO reviews. MALPs will assist in sharing this learning and driving improvement. In HM Inspectorate of Probation, we are committed to developing practice. A fundamental part of this is the strengthening of partnership working by the Probation Service at a local and regional level.

MALPs will provide an opportunity for collaborative learning for all relevant agencies involved in an SFO case. Where required, they will support the development of actions for each participating agency.

We will continue to undertake our random dip sampling of SFO reviews with a composite rating of 'Requires improvement'. We will expand this further to include a sample of the action plan updates provided by each region. This dip sampling will continue to support an understanding of whether the required changes have been made to a satisfactory standard following quality assurance, whether the actions set have been delivered as intended, and what impact they have had.

We will also continue our regional engagement and benchmarking activity, providing developmental sessions with reviewing managers and SFO leads, delivering against our commitment to drive practice improvements.

Conclusion

This report has shown that there has been a continued decline in the overall standard of SFO reviews. This is our third SFO annual report and each time we have emphasised that work is needed to improve the quality of SFO reviews.

It is disappointing that we are continuing to find that SFO reviews are not meeting the required standard, and that where changes were required following quality assurance feedback, these are not always being applied robustly.

Importantly, this year our annual report includes the voice of probation staff who have experienced SFOs. It is of note that 245 individuals responded to this survey providing personal experiences and reflections. There were positive examples of practice we could draw out from these responses, and while these are important to emphasise, there were also many responses that evidenced the need for the framework and delivery of the SFO review processes to be reviewed by HMPPS.

This year we published an independent review into the Probation Service's management of Joshua Jacques. As we have found through our quality assurance of SFO reviews, and our core inspection work, recurring practice deficits are being identified. This further emphasises the need to ensure that SFO reviews support a culture where learning and practice development is central, so that sustainable changes are embedded in practice.

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:

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 timely and made 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
8. 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
9. 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

10. 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
11. 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.

Annex A

Revised Serious Further Offence quality assurance standards. The changes made are denoted in **bold teal text.**

Analysis of practice

The SFO review provides a robust and transparent analysis of assessment, planning, implementation and reviewing practice at all levels.

a) Does the SFO review sufficiently consider whether all reasonable action was taken?

b) Does the SFO review sufficiently analyse crucial decisions?

c) Does the SFO review sufficiently analyse missed opportunities?

d) Does the SFO review sufficiently explore underpinning reasons for any deficiencies in practice where they existed?

e) **Does the SFO review include sufficient analysis of systemic or procedural factors in relation to probation practice and decision-making?**

f) Does the SFO review sufficiently examine the partnership work with other agencies?

g) **Does the SFO review sufficiently highlight areas of exceptional practice where they existed?**

h) **Does the SFO review sufficiently identify practice that needs to be addressed through staff performance and discipline where necessary?**

Sufficient Judgements

The SFO review provides clear and balanced judgements on the sufficiency of practice.

a) Does the SFO review include the views of all relevant staff about the case and practice expectations **to inform judgements?**

b) Does the SFO review make **sufficient judgements** on the practice of staff at all levels?

c) Does the SFO review include **sufficient judgements** on systemic or procedural factors in relation to probation practice and decision-making?

d) Does the SFO review contain sufficient judgement of probation policy?

e) **Does the SFO review sufficiently explain the significance and impact of deficiencies and missed opportunities**?

f) Does the SFO review sufficiently come to conclusions on partnership working?

g) **Does the SFO review contain sufficient judgements throughout to inform the action plan?**

Learning

The SFO review enables appropriate learning to drive improvement

Does the SFO review identify areas for learning and practice improvement?

a) Does the SFO review sufficiently identify areas for improvement for staff at all levels?

b) Does the SFO review sufficiently identify areas for improvement at a local level?

c) Does the SFO review sufficiently identify areas for improvement at a regional level?

d) Where relevant, does the SFO review sufficiently identify areas for improvement at a national level?

e) Where relevant does the SFO review sufficiently identify areas for improvement in respect of multi-agency working?

f) **Does the countersignature process ensure the review is of sufficient quality and identifies relevant learning?**

Do the planned actions sufficiently capture the learning and practice improvement?

a) **Do the planned actions sufficiently address deficiencies identified for staff at all levels in the SFO review?**

b) Do the planned actions sufficiently address deficiencies identified at a local level in the SFO review?

c) Do the planned actions sufficiently address deficiencies identified at a regional level in the SFO review?

d) Do the planned actions sufficiently address deficiencies identified at a national level in the SFO review where they existed?

e) Do the planned actions contain sufficient developmental activity to effect change?

f) Do the planned actions identify effective measures for evidencing progress/outcomes?

g) Do the planned actions include sufficient assurances about how learning will be shared with partner agencies?

Victims and their families

The SFO review is appropriate to share with victims and their families and meets their needs.

a) Is the language used in the SFO review sufficiently accessible?

b) Is the SFO review written sensitively to account for the impact on victims and their families?

c) Does the SFO review sufficiently and transparently focus on practice relevant to the circumstances of the SFO?

d) Does the SFO review present sufficient judgements, with examples used as evidence to support these?

e) **Does the review only contain information that can be shared?**

f) **Is the review concise, informative, and accurate?**