Her Majesty's Inspectorate of Probation

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

An inspection by HM Inspectorate of Probation

May 2020

Acknowledgements

This inspection was led by HM Inspector David Miners, supported by a team of inspectors and operations, research, communications and corporate staff. The manager responsible for this inspection programme is Helen Davies. We would like to thank all those who participated in any way in this inspection. Without their help and cooperation, the inspection would not have been possible. Please note that throughout the report the names in the practice examples have been changed to protect the individual's identity.

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This publication is available for download at:

www.justiceinspectorates.gov.uk/hmiprobation

Published by:

Her Majesty's Inspectorate of Probation
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Foreword

Serious Further Offences (SFOs) are committed by a small proportion of the probation caseload. For the victims and families involved, however, the consequences are devastating and often life changing. It is therefore essential that probation providers are accountable for the work undertaken and that the learning from such events results in improved service delivery.

This is the primary purpose of the SFO review process, which was first introduced in 2003 to ensure rigorous scrutiny when serious offences are committed by service users subject to probation supervision. A revised process was implemented in April 2018. This was the focus of our inspection.

A priority for the new process is to ensure increased transparency for victims and family members, and to some extent this has been achieved in that they now have access to the full review document. The reviews, however, are often long and complex documents that examine probation practice in detail, sometimes over many years. Although probation providers have ensured that the disclosure of reviews to victims is handled sensitively, it can still be confusing and overwhelming. Very few take up the offer of full disclosure, and further work is needed to better understand the reasons for this and to take full account of victims' individual circumstances and needs.

At the heart of the SFO review process is the aim that learning from SFO reviews should improve the management and supervision of service users. We found a mixed picture. At a national level, SFO reviews are not analysed to identify themes, inform policy and improve practice. At a local level, probation providers have procedures in place to identify learning from the reviews that they have undertaken. The fear and concern that the process provokes in operational staff, however, undermines the ability of organisations to learn from the process. Their perception is that the review focuses on individual and not organisational responsibilities, and our findings confirm this.

SFO review cases are frequently complex, with many agencies involved. Most SFO cases, however, are not the subject of multi-agency reviews and the current process focuses solely on probation practice. Valuable learning is therefore lost. A multi-agency contribution would help victims and family members to have an improved understanding of the management of the case.

The HM Prison and Probation Service (HMPPS) SFO review team is responsible for the central quality assurance of the SFO reviews and providing feedback to local areas. There have been unacceptable delays in this process, with probation providers and individual staff members waiting an average of six months for feedback on their reviews.

In contrast to the process for other serious case reviews, such as Domestic Homicide Reviews or MAPPA serious case reviews, the current SFO process lacks independent oversight and transparency. Although we don't recommend that an independent body should take on the reviews themselves, we do recommend that there should be independent oversight of the quality assurance process, by an independent body scrutinising the quality of a sample of reviews on a regular basis and reporting publicly on what they find. This would also allow the overstretched central HMPPS SFO review team to focus its efforts on drawing together the lessons learned from SFO reviews and promising practice identified across England and Wales. This in turn should be used to inform national policy and drive improvements in practice.

Significant resources are rightly invested in the SFO review process. In our view, the current arrangements are inefficient. The potential improvements to the management of service users and increased accessibility for victims and family members are not fully realised. We make a number of recommendations to improve the efficiency and the overall impact of the SFO review process.

Justin Russell
HM Chief Inspector of Probation

Contextual facts

258,157	The number of individuals under probation supervision at 30 September 2018[1]
577	The number of SFO notifications in 2018/2019[2]
495	The number of completed SFO reviews from the 2018/2019 notifications[2]
0.2%	The approximate proportion of offenders under probation supervision who were charged with an SFO in 2018/2019[3]
60% NPS, **40% CRC**	The distribution of SFO notifications across providers in 2018/2019[2]
32% sexual, **68% violent**	The proportion of SFO notifications in 2018/2019 split by offence type[2]
77%	The proportion of SFO notifications in 2018/2019 that automatically qualified for an SFO review[2]
48% high/very high, **41% medium,** **8% low,** **3% not specified/unknown**	The proportion of SFO notifications in 2018/2019 split by highest risk of serious harm assessment of offender[2]
56% post-release supervision, **38% community supervision,** **3% Imprisonment for Public Protection,** **2% life licence**	The proportion of SFO notifications in 2018/2019 split by offender supervision type[2]
41%	The proportion of SFO charges in 2017/2018 that resulted in a conviction for an eligible SFO[4]

[1] Ministry of Justice. (2019). *Offender management statistics quarterly*. Midpoint of the 2018/2019 financial year.

[2] Information provided by HMPPS.

[3] Estimate derived by dividing total number of SFO notifications by mid-year caseload figure.

[4] Calculated from Table 1 in: Ministry of Justice. (2019). *Serious Further Offences*. https://www.gov.uk/government/statistics/serious-further-offences

Executive summary

Report context

Serious Further Offences (SFOs) are qualifying violent or sexual offences (see Annexe 1) committed by individuals who are the subject of probation supervision. Mandatory notification and review procedures for probation providers were introduced in 2003 to ensure that when such an event occurs there is a comprehensive review of the management of the case.

Probation providers supervise adults who are on community orders and subject to prison licences. Since 2011, approximately 0.2 per cent of the caseload have been charged with SFOs.

In April 2018, a revised SFO review process was introduced. 'Rigorous scrutiny' remained the key objective, but the new process aimed to provide greater transparency to victims and to maintain a local and strategic focus on learning. A new narrative-style report was introduced, replacing the previous process-driven format.

The operational guidance directs that the completed SFO reviews must:

- review whether all actions had been taken, as far as could reasonably be expected, to manage the risk of harm posed to others by the individual
- identify what – if anything – could or should have been done differently
- analyse why things were done in the way they were done
- establish whether there is learning from the review of the case that requires actions at local or national levels
- ensure that areas for improvement are clearly identified.

The HMPPS SFO review team is responsible for the quality assurance of the completed SFO reviews. Its responsibilities include providing feedback to probation providers on the quality of reviews and collating SFO learning to inform practice and drive improvements in policy.

Our inspection focused on the implementation of the revised process. We visited eight probation providers and the HMPPS SFO review team. The probation providers were evenly split between National Probation Service (NPS) divisions and Community Rehabilitation Companies (CRCs). At each site we interviewed managers and operational staff. We conducted a small number of meetings with victims and family members who had received disclosures under the SFO review process. Although the remit of the SFO review process is focused on probation practice, we also interviewed managers from the police and children's services to consider their understanding of the process. We also inspected 46 SFO reviews and action plans and reviewed the quality assurance feedback provided to local areas by the HMPPS SFO review team.

Policy, strategy and leadership

The purpose of a SFO review is not consistently understood across probation organisations, with different emphases being placed on its function as an internal management review, a learning document and a report for victims. The revised process has increased transparency to victims and family members, as they now have access to a copy of the completed review document. Adherence to the operational guidance, however, has frequently resulted in long, dense reviews of probation practice that are difficult for victims and family members to digest. The number of victims and family members requesting access to the reviews is low. National figures are not recorded but, in the organisations inspected, the proportion was significantly lower than the 42 per cent of victims and family members who, nationally, opt into the victim contact scheme. There has been no analysis of the reasons for this, or of whether the process for notifying victims and family members of their entitlement to a review is effective.

The HMPPS SFO review team has focused on the considerable quality assurance backlog since April 2018. The team has issued revised guidance to ensure that the quality assurance process for high-profile and victim disclosure cases is undertaken promptly. The delay in quality assurance feedback for the majority of reviews submitted by probation providers continues to average six months.

Probation providers appropriately prioritise the completion of SFO reviews and implementing the action plans that follow. Designated SFO review teams were found to be the best working model, as they sit outside the line management of the case and develop expertise in this role. Every NPS division and two out of the four CRCs inspected operated this model.

SFO reviews begin at the point of the first court hearing, which can take anything from a few days to several months after the alleged offence. A significant number of cases do not subsequently result in an SFO conviction – in some areas up to 50 per cent. The resources invested in completing a full review in such cases are significant and are currently not justified by the learning outcomes achieved. Organisations valued the 'early look' process as immediately effective in identifying and addressing practice issues, and there is scope to make better use of this.

The experience of victims and family members

The number of victims who have requested SFO review disclosure is low, and we were only able to interview five victims and family members during the inspection. In the main, they viewed the process as open and honest about any failings identified in probation practice. They particularly appreciated being able to discuss the case with a senior manager.

Providers expressed concern at the low number of victims and family members requesting access to SFO reviews. There is currently no single process to ensure that victims and their families, including those who do not opt into the victim contact scheme (VCS), are being informed of their entitlement to reviews. London NPS has taken a proactive approach to ensuring victims and family members who have opted into the VCS are aware of their entitlement. This has resulted in more requests for access to the review. Learning from the London model will help inform nationwide change.

HMPPS Public Protection Group, in collaboration with the Effective Probation Practice division, has issued good advice to senior managers on how to disclose the review to victims. It is, however, of concern that the current process does not consider the individual circumstances of victims when making the disclosure. Providers are directed to provide victims and family members with a copy of the review if requested. There are circumstances when this causes concern in relation to self-harm and risk of serious harm but the process does not prompt the organisation to take these factors into account. Work is underway to rectify this.

Learning and quality assurance

The HMPPS SFO review team quality assure SFO reviews against the practice standards set in the operational guidance. We found that their ratings were consistent with the standards set. Overall, SFO reviews were strong in their analysis of assessment, sentence planning and implementation but weaker in their consideration of multi-agency management. Of the 46 SFO reviews we inspected, we found that around 30 per cent required some improvement in terms of their analysis of risk of harm factors or risk management plans and 22 per cent failed to give a clear judgement as to whether all reasonable steps were taken to manage the risk of serious harm. Despite guidance to the contrary, reviews were very much focused on 'what' had happened, including very detailed historical chronologies of every contact the probation service had ever had with the offender, rather than 'why', in terms of the underlying, more immediate causes of the offence and a clear conclusion on whether there were any failures of probation practice – which is likely to be the biggest priority for the victim and wider public. The action plans were overwhelmingly aimed at individual staff members and any actions for the organisation focused on the practice of local teams or units. This focus on individual practice limits the potential for wider learning from reviews.

Some high-profile cases have resulted in policy changes, but at a national level there is no systematic analysis of SFO review findings to drive policy. The themes often identified in SFO reviews are also frequently found during internal audits and HM Inspectorate of Probation inspections. These include inadequate risk management and a lack of professional curiosity. These findings are not analysed to identify why they recur and, in turn, used to drive policy and procedural changes.

Probation providers have implemented their own quality assurance approaches. The best of these are timely and systematic, with learning from SFOs disseminated to all levels of the organisation.

The SFO review is a 'top down' process, in which operational staff involved in cases are interviewed but have only partial access to the review and limited opportunities to question the findings. Staff groups view the process negatively and believe its prime focus is on attributing blame to individuals. This further limits the potential for learning.

Transparency and multi-agency learning

SFO reviews focus solely on probation practice, and external agencies such as the police and mental health services are not directly involved in the review of the case. The complexity of the probation caseload means that nearly all service users under probation supervision are also involved with other services. The lack of multi-agency involvement in the current SFO review process means that opportunities for learning and improved coordination of cases are missed.

This contrasts with other serious case review processes. Domestic Homicide Reviews (DHRs) and child safeguarding practice reviews (CSPR) take a multi-agency approach to learning. Unlike the SFO review process, the review author for DHRs and CSPRs is independent and the process and quality assurance are overseen by either the safeguarding partnership or a panel made up of representatives from the key agencies involved in the case. SFOs do not have the same statutory underpinning and were not set up to be multi-agency reviews. They are completed by probation managers from within the organisation, and there is no independent body overseeing or quality assuring the process. This lack of independence and transparency risks undermining public confidence in the process.

Effective Practice

Actions identified by inspectors to improve the SFO review process

- The disclosure of the review to victims and family members should take into account their individual circumstances.
- Learning from SFOs must be a two-way process and frontline staff should be enabled to freely feed back their experiences of the case and practice expectations.
- SFO reviews should be undertaken by probation managers located in separate SFO review teams.
- SFO reviews should analyse probation practice as well as organisational structures and procedures in order to ascertain learning. Probation providers must evidence the dissemination and embedding of changes in policy and practice.
- Information from external agencies should inform SFO reviews. This will enable both organisations and victims and family members to better understand the management of a case.

Recommendations

The Ministry of Justice should:

Commission an external agency to:

1. quality assure a proportion of completed SFO reviews each year to provide an independent view of the standard of work – with the results published on a regular basis
2. convene regional benchmarking events to spread best practice in SFO reviews and ensure consistency between probation divisions.

Her Majesty's Prison and Probation Service should:

In consultation with probation providers, review SFO policy, guidance and procedures, specifically to include the following:

3. SFO reviews should focus on the case management and significant events in the period prior to the further offence and on identifying any critical failures in probation practice or missed opportunities in the management of the case
4. SFO reviews should include an analysis of any systemic or procedural factors in relation to probation practice and decision-making
5. where indicated by the case, external agencies (for example the police and children's services) that have been involved in the case should be involved in the SFO review, with consideration given to whether this should be mandatory for all homicide cases not currently covered by domestic homicide review or MAPPA serious case review multi-agency procedures
6. there should be a requirement for SFO reviews that include findings on the actions of other agencies to be shared with those agencies
7. the victim contact scheme in each area should be responsible for contacting victims/family members
8. SFO review reports should be made easier for victims to understand, with key events and findings highlighted
9. quality assurance of SFO reviews should be conducted by local probation divisions and through a new, externally led quality assurance process
10. deliver SFO review training to local areas, with an emphasis on the narrative style and meeting the needs of victims
11. provide a redacted copy of SFO reviews to the offender managers involved in the case.

Her Majesty's Prison and Probation Service SFO team should:

12. undertake regular and detailed analysis of SFO reviews to capture all relevant themes and learning. This should inform HMPPS policy and drive improvements in practice
13. publish an annual report drawing together key trends, lessons learned and promising practice identified from SFO reviews
14. review the low take-up rate of SFO review disclosure by victims
15. ensure that the victim disclosure process takes account of the risks to, and vulnerabilities of, individuals.

1. Introduction

1.1. Why this thematic?

The impact of Serious Further Offences (SFOs) on victims and their families is profound and the level of media and public interest in such cases has increased in recent years. There is very little research evidence on the quality and effectiveness of SFO reviews, and most predates the *Transforming Rehabilitation* reforms to probation services (2014). A new SFO report format and set of documents were introduced in April 2018, leading to some important changes in practice and full transparency for victims and their families. A publication hiatus for SFO performance measures in 2018/2019 means there has been limited official information on the performance of the new process and procedures. A high-profile review of a single case by HM Inspectorate of Probation (2018) provided some evidence, but this is unlikely to be representative of all SFO reviews.

In her *Report of the Chief Inspector of Probation* (2019), Dame Glenys Stacey described the arrangements as lacking transparency. Key areas where there is very limited information include the impact of the new process and whether it is achieving its purpose; the number of victims opting to be involved in the process; and the collated learning from the reviews.

We decided to take a closer look at the implementation of the new SFO arrangements, with a specific focus on: quality assurance; how learning is identified; how probation practice is improved; and the victim and family experience.

1.2. Background

Introduction

Although SFOs are relatively rare, their impact is grave and enduring. Since 2011, 0.2 per cent of the probation caseload have been charged with SFOs (see table 1.4 below). The review of supervision following these offences has been known as an SFO review since 2003. HMPPS Probation Instructions are issued to request action and provide information and guidance on how the reviews should be undertaken. They provide a summary of the policy aim and the reason for its development or revision.

SFO Probation Instructions (PI) have gone through several revisions since 2003, but the fundamental purpose of providing rigorous scrutiny has remained largely consistent. PI 10/2011 introduced action plans as part of the process, and PI 04/2013 mandated that an overview report should be made available to victims. PI 15/2014 updated responsibilities in the light of the split of offender management between the NPS and CRCs following the implementation of *Transforming Rehabilitation*. It included reference to the *Offender Rehabilitation Act 2014* (ORA), which extended probation supervision to all individuals sentenced to more than one day in prison. It further introduced a quality assurance framework to be undertaken by the HMPPS SFO review team.

Probation Instruction PI 06/2018 was issued in August 2018, and set out instructions on the new format, including new procedures for identifying and reviewing SFOs. This included a narrative-style report with a focus on learning lessons and improving probation practice. In addition, the instruction made provision for the full report to be made available to victims and their families.

The list of offences that qualify as an SFO can be found in Annexe 1. Serious violent and sexual offences committed by a service user on supervision in the community are identified as automatic SFO review cases. Conditional SFO reviews are completed where service users have committed other violent or sexual offences and been assessed as posing a high risk of serious harm at some point during their supervision.

Key facts and data

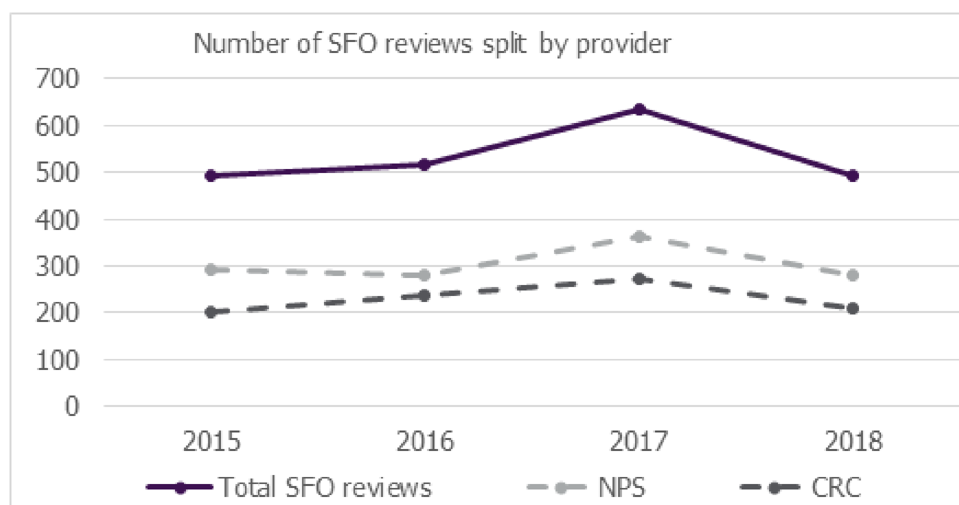
Statistical information on SFO reviews is not routinely published, but relevant information has been made public following parliamentary questions (PQs) and Freedom of Information (FOI) requests. The delay between SFO notification and completion of the review makes it difficult to accurately identify the number of notifications that result in a review during a set period. This difficulty is exacerbated by the fact that charges are frequently dropped or changed and this results in cases no longer being eligible for a review following initial notification. The information available, however, shows that the number of SFO notifications increased when post-release supervision was extended following the introduction of ORA in 2015, which increased the total caseload of offenders under supervision by the probation service by approximately 40,000 each year. The increase in the number of completed reviews resulting from this rise in notifications started to impact on the figures from 2017/2018 (see table 1.1).

Table 1.1: Number of SFO reviews, split by non-ORA and ORA-only cases.[5]

Review receipt year	Non-ORA	ORA	All
2015/2016	481	26	507
2016/2017	389	126	515
2017/2018	495	131	626

Information obtained following a parliamentary question in February 2019[6] shows that, in the calendar year 2018, the number of SFO reviews completed following the introduction of the new processes fell significantly. Probation providers initially struggled to adapt to the revised style of the review, particularly in relation to the increased accessibility of the document to victims and family members. This significantly increased the HMPPS central SFO quality assurance team's workload and there was a backlog of reviews waiting to be quality assured. The information from the parliamentary question also shows that, between 2015 and 2018, the NPS completed 57 per cent of the reviews and the CRCs 43 per cent, on average (see figure 1.1).

Figure 1.1: Number of SFO reviews by provider



[5] Information provided by HMPPS.

[6] Frazer, L. (2019). *Criminal Investigation. UK Parliament: Written answer*, 13 February 2019, HC 220995. Available at: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2019-02-13/220995/

The information released to parliament also shows that, from 2015 to 2018, the proportion of SFO reviews that were for a violent offence increased from 43 per cent to 63 per cent and the proportion for a sexual offence decreased from 57 per cent to 37 per cent. This looks to be driven both by a general increase in the number of violent SFOs and a sharp decrease in the number of reviews involving rape in 2018. There appears to have been no further analysis of the reasons for these trends in SFOs, although they do appear to be in line with wider homicide and rape trends in charge and conviction. As there are limited published statistics on the trends in SFO reviews, there is no clear evidence on whether ORA had a direct impact on offence type (see table 1.2).

Table 1.2: Number of SFO reviews in which the supervising body was (a) the NPS and (b) a CRC, completed between 01 January 2015 and 31 December 2018, by (i) murder, (ii) manslaughter, (iii) rape, (iv) violence against the person and (v) sexual assault. [7]

Probation provider	SFO offence	2015	2016	2017	2018
a) National Probation Service	(i) Murder	28	24	47	43
	(ii) Manslaughter	2	3	5	2
	(iii) Rape	124	113	124	76
	(iv) Violence against the person	95	105	149	137
	(v) Sexual assault	43	36	37	24
	Total offences	292	281	362	282
b) Community Rehabilitation Companies	(i) Murder	42	47	65	71
	(ii) Manslaughter	3	5	13	8
	(iii) Rape	101	141	132	73
	(iv) Violence against the person	44	40	49	55
	(v) Sexual assault	12	2	14	4
	Total offences	202	235	273	211
Total reviews received		494	516	635	493

SFO reviews analyse risk management practice of cases, including the assessed level of risk of serious harm. In 2018/2019, the majority of SFO notifications for murder were being managed at a medium level of risk of serious harm (see table 1.3).

Table1.3: Number and proportion of SFO reviews in which the SFO notification was for murder in 2018/2019 by risk of serious harm level. [8]

Highest risk of serious harm level	Number of SFO reviews	Proportion of SFO reviews
Low	20	14%
Medium	75	52%
High	38	27%
Very high	2	1%
Not specified	8	6%
Total	143	100%

[7] Frazer, L. (2019). Criminal Investigation. *UK Parliament: Written answer*, 13 February 2019, HC 220995. Available at: https://www.parliament.uk/business/publications/written-questions-answers-statements/written-question/Commons/2019-02-13/220995/

[8] Data supplied by HMPPS.

The ratio of SFO reviews to probation caseloads has remained relatively low since offender management was split between the NPS and the CRCs. There was an increase in the number of SFO reviews between 2013/2014 and 2015/2016, but this was in line with the increase in caseloads following the introduction of ORA in 2014 (see table 1.4).

Table 1.4: Number of SFO reviews as a percentage of caseloads.

	Financial year	SFO reviews[9]	Caseload (at end of September)[10]	SFO reviews as % of caseload[11]
Probation trusts	2011/2012	441	236,154	0.19%
	2012/2013	409	230,736	0.18%
	2013/2014	429	220,242	0.19%
	2014/2015	-	-	-
Post-ORA	2015/2016	507	234,229	0.22%
	2016/2017	515	262,388	0.20%
	2017/2018	626	265,047	0.24%
	2018/2019	495	258,157	0.19%

Performance measures

Until April 2018, the NPS divisions and CRCs were subject to the following performance measures:

CRC Assurance Metric B: Serious Further Offences Reviews:
The percentage of acceptable Serious Further Offence Action Plans conducted by the Contractor within 3 months of an Allocated Person of the Contractor being charged with a Serious Further Offence.

NPS SL017: Serious Further Offences Reviews:
The percentage of acceptable Serious Further Offence Reviews conducted by the NPS for Retained Persons within three months of notification of the SFO being submitted to NOMS.

This performance metric was suspended in April 2018 to allow for the new SFO review process to be introduced. There is currently no timescale set for re-introducing the performance measure. The HMPPS SFO team has continued to quality assure reviews since the new process was introduced and provides 'shadow' ratings to providers. We found some providers continue to use the shadow ratings to help monitor their performance.

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[9] Ministry of Justice. *Proven reoffending statistics*. https://www.gov.uk/government/collections/proven-reoffending-statistics

[10] Ministry of Justice. *Offender management statistics quarterly* https://www.gov.uk/government/collections/offender-management-statistics-quarterly

[11] Estimates derived by dividing total number of SFO notifications by mid-year caseload figure.

Qualitative evidence

There is limited information available about the quality of SFO reviews. Internally, the HMPPS SFO team provides feedback to review authors, but information is not made available externally. Similarly, there is very little research evidence available. Although the probation instructions include a mandatory obligation for the HMPPS SFO team to 'circulate key learning themes and information to support practice improvement', this sharing of lessons is not published externally (PI 06/2018). The last published lessons are from a joint analysis of full reports conducted by the National Offender Management Service's Public Protection Unit and HM Inspectorate of Probation in 2005. The four main areas for improvement identified were: (i) the quality of risk of harm assessments; (ii) domestic abuse work; (iii) enforcement; and (iv) information-sharing.

Previous inspections

As part of its core inspection programme of probation providers, HM Inspectorate of Probation receives evidence of action plan implementation and the dissemination of learning within the organisation, from recent SFO cases. This information is provided by HMPPS's SFO team six to eight weeks before the inspection fieldwork, as set out in PI 06/2018. HM Inspectorate of Probation inspectors consider how well the organisation uses learning from SFOs to drive improvement and its response to learning when things go wrong. We have found inconsistent practice across both NPS divisions and CRCs. In organisations where learning from SFOs and other serious case reviews improves performance, effective systems are in place. Managers and teams, usually with responsibilities for quality development, are responsible for improving practice. Management oversight and communication with staff are consistent and comprehensive. In weaker performing organisations, accountability is not clear and learning from SFOs is communicated inconsistently. It is left to individual managers to do this work rather than it being part of a systematic approach.

At the request of the Ministry of Justice (MoJ), HM Inspectorate of Probation undertook and subsequently published the *Independent review of the case of Leroy Campbell* (2018), a review of a high-profile case that had previously been the subject of an SFO review. HM Inspectorate of Probation examined the SFO review process and action plan, and considered whether the SFO review was sufficiently honest and reliable. It concluded that the SFO review in this case was comprehensive, accurate and robust.

Multi-agency reviews

The SFO review model is exclusively focused on probation practice and probation actions, even though there will often be other agencies involved in the case. The review is undertaken by a manager from the supervising organisation. Although the quality assurance process is undertaken centrally, it is completed by another probation manager. SFO review cases will sometimes be undertaken in parallel with other external agency reviews. In relation to SFO reviews, it is unclear what impact they have on external agencies such as the police and children's services and whether these agencies are aware of the action plans and their outcomes. Although some actions make reference to other agencies, there is no requirement for the reviews to be shared with other agencies. In sharp contrast to this, other types of serious case review are multi-agency and more likely to involve a significant independent element.

MAPPA serious case reviews, for example, of which 10 were conducted in 2018/2019,[12] are held when an offender being managed on a multi-agency basis at MAPPA level 2 or 3 commits a serious offence. The MAPPA Strategic Management Board is responsible for appointing an independent chair and a review panel made up of representatives from the key organisations involved. The key

[12] Ministry of Justice. (2019). *Multi-Agency Public Protection Arrangements – Annual Report 2018/19.* www.gov.uk/government/statistics/multi-agency-public-protection-arrangements-mappa-annual-report-2018-to-2019

organisations are required to submit internal management reviews, which contribute to the final report. Reviews are scheduled to take five months to complete but frequently take longer. The reports are internal reports for the MAPPA Strategic Management Board. They are not published, but an overview report is prepared for disclosure to victims and their family members if requested. There is no formal quality assurance, but feedback on the quality of reports is provided by the central Public Protection Group.

Domestic homicide reviews (DHR), introduced following the *Domestic Violence, Crime and Victims Act 2004*, are commissioned by local authority Community Safety Partnerships, who appoint an independent chair and report author. The review panel includes representatives from the main agencies involved. Each agency submits an internal management review for consideration by the panel, which then oversees the production of the report. The DHR remit specifically states that reviews should 'go beyond focusing on the conduct of individuals and whether procedure was followed, to evaluate whether the procedure/policy was sound.[13] The Home Office quality assurance process for DHRs is chaired by the Head of the Violent Crime Unit and involves an independent panel with representatives from the relevant statutory agencies. Between April 2018 and March 2019, 129 domestic homicides were recorded.[14]

Children's serious case reviews in England and Wales are commissioned by multi-agency panels sitting as part of the Local Safeguarding Partner arrangements. In England, following serious harm to a child, a child safeguarding practice review can be held either locally or nationally. The national reviews are approved by a national panel. The national panel is appointed by the Secretary of State for Education and comprises professionals with relevant expertise and experience. The criteria for these reviews include the implications for national policy and practice (Department for Education 2018). In Wales, child practice reviews take the form of either concise or extended reviews depending on the level of involvement of children's services. See Annexe 4 for a summary of these multi-agency reviews.

1.3. Aims and objectives

This inspection was undertaken to examine how the revised SFO review process is working some 18 months after implementation. Specifically, we wanted to know the following:

1. Does the quality assurance process for SFO reviews enable probation providers to improve learning and practice?
2. Is learning from SFO reviews used effectively to drive improvement by probation providers?
3. Is learning from SFO reviews used systematically at a national level to review and improve policies?
4. Does the SFO review process meet the expectations and needs of victims?
5. Is the SFO review model the most effective for ensuring multi-agency engagement and improved multi-agency working?
6. Are there potential improvements to the SFO review process and procedures that could improve learning outcomes and practice?

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[13] Home Office. (2016). *Multi-Agency Statutory Guidance for the conduct of Domestic Homicide Reviews*.

[14] Office for National Statistics. (2020). *Homicide in England and Wales: year ending March 2019*.

Report outline

Chapter	Content
2. Policy, strategy and leadership	National and local strategic leadership in relation to the SFO review process The role of the HMPPS SFO review team
3. The experience of victims and family members	The effectiveness of the revised SFO process in relation to victims and family members How victims and family members view the process
4. Learning and quality assurance	The effectiveness of the SFO review quality assurance process The local and national dissemination of learning from the SFO review The impact of SFO reviews on strategy and policy The impact of the SFO review process on organisational culture Multi-agency learning

2. Policy, strategy and leadership

In this chapter, we report on SFO policy and the strategic approach taken to the SFO review process at both national and local level. We comment on the stated purpose of SFO review procedures and whether or not they are achieved.

2.1. National policy and strategy

Probation providers manage complex individuals, many of whom have committed violent and sexual offences. The profile and history of service users increases the likelihood that they will be involved in SFOs. The SFO review procedures were introduced in part as recognition of this operational context.

Notification review procedures for Serious Further Offences: Probation Instruction 06/2018

PI 06/2018 was issued in August 2018 and detailed the changes in SFO review practice introduced from April 2018 (see 1.2 background). The purpose of the SFO notification and review procedures is summarised below:

'The SFO notification and review procedures are intended to ensure rigorous scrutiny of those cases where offenders under the management of the NPS or CRCs have been charged with a specified violent or sexual offence … in order that: -

- *the public may be reassured that the NPS and CRCs are committed to reviewing their practice in cases where offenders managed by them are charged with certain serious offending;*
- *areas for improvement and best practice are clearly identified, along with how and within what timescales action will be taken in respect of the former and what will be expected to improve as a result;*
- *victims and their families can be provided with relevant information on how the offender was supervised and where there were shortcomings how action to drive improvements has been, or will be, taken and;*
- *Ministers, other senior officials and managers and the wider MoJ can be informed of high-profile cases of alleged SFOs'.*

The PI identifies the responsibilities of the NPS, CRCs and HMPPS SFO team. The NPS should identify SFO cases at the first court hearing and inform the probation provider managing the case. Probation providers have 10 working days to notify the central HMPPS SFO review team of the SFO case. Following notification of an SFO, probation providers have three months to submit the SFO review and action plan to the HMPPS SFO team, who then have 20 days to quality assure the documents and give feedback to the provider. Figure 2.1 illustrates the process:

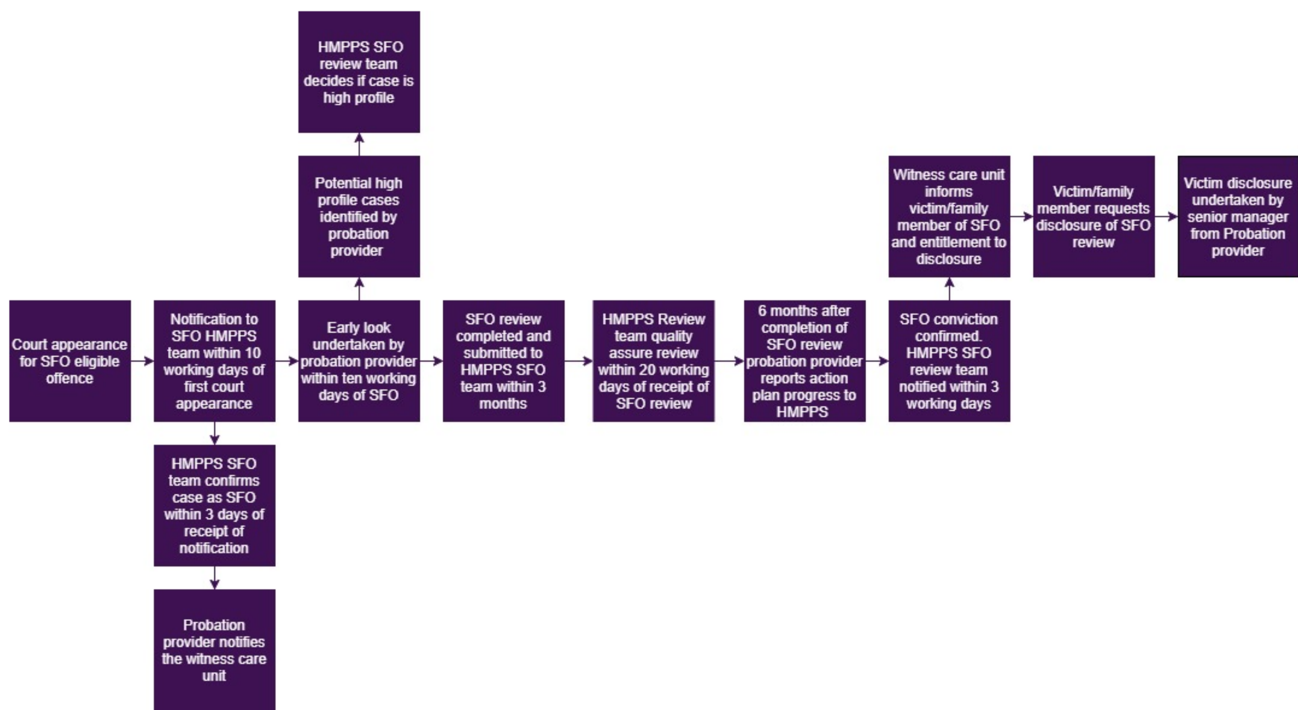

Figure 2.1. The SFO process

Alongside introductory briefings, detailed guidance on the new format was issued to staff on 29 March 2018, which largely reflected the final operational guidance issued in June 2018. During our inspection, national and local leaders acknowledged that the change in style and format of the review was more problematic for SFO reviewers than had been anticipated.

The previous SFO review format focused on specific areas of probation practice, such as risk assessment, and was viewed as repetitive and process-driven. The revised narrative format aimed to allow reviewers the flexibility to focus on significant events and to make the review accessible for victims and family members. It was not anticipated that the new format would result in an increased workload once reviewers had adjusted to the new style. We found, however, that reviewing managers were still adapting to the narrative style and, in particular, making it accessible to victims and victims' families.

To achieve its purposes, the SFO review performs different roles. It is an internal management review, a learning document and a report for disclosure to victims and their families. These areas have potentially different focuses, and we found different views on the key priorities across the organisations inspected. At national level, the view was that the SFO review is an internal management review that should be accessible to victims and their families. At local level, senior managers placed greater emphasis on the learning and improvement outcomes specified by the PI. Frontline staff viewed the process as an internal management review, with a primary focus on identifying individual responsibility for potential errors made on a case. While senior leaders do not share this view, some recognised that there had been an increasing emphasis on disciplinary and capability procedures in the 12 months before the inspection. One senior manager commented:

"Who is the audience? Internal management review, the victim or the needs of the centre? These needs are determined by organisational and political pressures… "

This confusion is underpinned by naming the process an SFO review when the details of the further offence are not directly examined. This helps confirm operational staff's belief that the process is primarily about fault and blame. Further, individual staff members do not get to see the completed review. The process requires clarification and openness for all parties involved.

The different purposes of the SFO review determine its content and focus. The operational guidance focuses the review on the sentence and supervision that the service user was subject to before the

SFO. It states that summaries can be used, but directs that the chronology should include details of 'significant events and emerging issues', and that these should be analysed in the review. Our inspection found that the strict adherence to this direction frequently resulted in long, dense reviews that focused on sometimes historical probation practice, many years before the SFO itself took place. One probation provider stated that the average length of its chronologies was 60 pages and its reviews 30 pages. Although the examination of a case must involve considering all the information known to the provider, it is unnecessary, in our view, to routinely include a detailed assessment of historical practice unless it is relevant to the management of the case in the period closer to the SFO.

PI 06/2018 directs providers to undertake an 'early look' as soon as an SFO case has been identified. Updated early look guidance issued by HMPPS in April 2019 directs providers to complete a condensed report and immediate action plan within 10 days of an SFO taking place. High-profile early look reports are submitted to the Chief Probation Officer for England and Wales. The purpose is to establish whether there are any significant concerns or practice issues that require immediate management action. In some organisations, the early look documentation is completed by SFO reviewers, and in others it is completed by operational managers outside the line management of the case. Our inspection found that this process was highly valued by senior managers, as it enabled them to take immediate action where necessary. It also enabled immediate learning to be identified and acted upon. In our view, the early look should be developed further to become an internal management review. This would ensure that a focused review of recent probation practice with an action plan was instigated immediately following an SFO charge.

The revised PI 06/2018 also continued the right of victims of automatic SFOs, and their families, to have information following a review. Since 2015, victims and family members had been entitled to a victim summary report. Following the changes in April 2018, they were entitled to the full SFO review document. It was anticipated that there would be an increase in victim and family member engagement under the new arrangements, but this has not materialised. Nationally, the proportion of victims and family members who request disclosure is not recorded. However, local providers report that the figure is much lower than, for example, the number of victims who opt into the VCS, which stands at an average of 42 per cent across NPS divisions.

2.2. HMPPS SFO review function

The central HMPPS SFO review team sits within the Public Protection Group. As well as quality assurance, it is responsible for identifying the strategic learning and improvement specified in PI 06/2018. The team consists of a team manager, a senior quality assurance reviewer and five quality assurance reviewers. At the time of the inspection, there were significant vacancies, with only 2.5 quality assurance reviewers in post. Staff shortages have been consistent since the new SFO format was introduced. This has resulted in extensive delays to the quality assurance of submitted reviews, and the team has focused primarily on addressing this backlog. This has included issuing revised guidance to probation providers in June 2019 that detailed a targeted approach to quality assurance. High-profile and victim disclosure cases are expedited and all the documentation submitted is quality assured.

Probation providers highlight cases that might attract significant national public interest to the HMPPS SFO review team, and they decide whether the case should be identified as a 'high-profile' case. The overall figure for high-profile cases as a proportion of all notifications is about 14 per cent. Once a case is confirmed as high profile, providers are expected to update the central team of the case's progress so that ministers and senior officials can be kept informed. The central team will also advise on whether the profile of the case requires it to be reviewed by another probation provider. Our inspection found that this process was effective in achieving the purpose set out in PI 06/2018.

The quality assurance of SFO reviews that are not considered high profile is targeted at the chronology, key findings and action plan. The methodology, summary of events and next steps

sections are not quality assured. The targeted approach has been applied to 67 per cent of reviews submitted to the HMPPS SFO review team since its introduction in June 2019. Only incomplete, high-profile or victim disclosure reviews are expected to be re-submitted to the central team for re-checking following the initial quality assurance feedback. For the remainder of reviews, probation providers decide whether to amend the original document following quality assurance. This is a significant change in the process and undermines the role of the central team in ensuring the quality assurance of the SFO reviews. Probation providers welcome this change, as re-submissions are no longer necessary in most cases and it allows for the immediate implementation of their action plans.

Six months after its implementation, the targeted approach had made little impact on the delay in receiving quality assurance feedback. Prioritising the quality assurance of reviews that are likely to reach the public domain is understandable and a pragmatic decision given the lack of resources available. However, the creation of a two-tier approach fails to prioritise learning and improvement in all cases. Out of 116 SFO reviews quality assured in line with the targeted approach between June and November 2019, three had to be re-submitted for full quality assurance following a victim or family member request for disclosure of the review. Should the take-up by victims increase in line with the policy intention, this unnecessary duplication in the process will increase its inefficiency.

2.3. HMPPS Effective Practice Division

The Effective Practice Division (EPD) within the Performance Directorate of HMPPS convenes a quarterly SFO review national reference group meeting. NPS divisions are represented but there is no equivalent national forum for CRCs. Its terms of reference include strategic oversight of the development of staff in relation to SFOs and facilitating a consistent approach to SFO practice and learning. The group identified a lack of understanding of the SFO review process among operational staff across NPS divisions. In response, a comprehensive briefing package has been produced for delivery within the divisions. This has been piloted in London, and there was positive feedback given about this during the inspection. Learning and the identification of good practice for dissemination are also within the remit of the group. There are some good examples, such as in relation to recall and the early look process, where this has occurred. It is evident, however, that the reference group has neither the governance nor the resources to enable it to do this in a systematic way.

2.4. Local implementation of the SFO review process

The probation providers inspected saw the primary purpose of the SFO review process as learning and practice improvement. The process was prioritised and significant levels of resources were allocated. Where specialist SFO review teams operated, 20 working days were allocated to reviewers for the completion of a review, although the complexity of the cases meant this was sometimes exceeded. Three of the NPS divisions inspected had submitted over 100 reviews since April 2018 and the CRC submissions ranged from 6 to 78.

The providers were clear about their responsibilities in relation to notification, the review and the action plans. CRCs manage smaller caseloads than NPS divisions and generally complete fewer SFO reviews. CRC operational managers complete the reviews in some organisations, and we found that this addition to their workload restricts their ability to develop their SFO review practice. Other CRCs and the NPS divisions have separate teams, staffed by senior probation officers, to undertake SFO reviews. This separation from the operational line management structure provides a degree of independence and allows reviewers to develop their practice more effectively. Reviews are countersigned by senior managers before they are submitted to the centre. In one CRC inspected, this countersigning was undertaken by senior managers in the line management structure of the case. In our view, this is not appropriate and undermines the independence of the judgements made. In both the NPS divisions and CRCs, quality assurance was undertaken before submission, in line with the guidance issued by the HMPPS SFO review team.

The SFO review process begins at the point of a first court hearing for an eligible offence, and review documents are frequently submitted to HMPPS before a final conviction. In a significant number of cases, we found that reviews were completed on cases that did not result in an SFO conviction. Of the 71 reviews London NPS completed on automatic cases between April 2018 and November 2019, 21 were of cases that did not result in SFO convictions. At the time of the inspection, 25 remained ongoing. For some providers, nearly 50 per cent of reviews completed do not result in an SFO conviction. This level of attrition is confirmed by the fact that in 2017/2018 only 49 per cent of completed SFO reviews resulted in an SFO conviction.[15] HMPPS will publish reconviction figures for 2018/2019 in October 2020. While we recognise that there is the potential for learning to be identified from all cases, this could be achieved pre-conviction by an enhanced early look process rather than a full review.

Most areas recognised that the SFO review process raised anxieties for staff. The West Midlands NPS division SFO review team were especially conscious of this. They developed a concerted approach involving team briefings and improved interview technique. Although this has not dispelled all the fears of operational staff, it has increased the understanding that learning is part of the process, and this was evident during our inspection.

2.5. Conclusions and implications

The revised SFO review process operates as an internal management review, a learning report and a document for disclosure to victims and their families. This has resulted in different understandings of its purpose within organisations. The adoption of a narrative format of review is a positive development but the accompanying operational guidance has resulted in reviews of excessive length that are not always focused on the supervision period relevant to the SFO.

A targeted approach to quality assurance has been implemented to address the significant backlog that has developed since April 2018. This has not reduced the delay in giving feedback to probation providers, who undertake their own quality assurance processes before implementing action plans.

Significant resources are invested in completing an SFO review, and a number do not subsequently result in a conviction at court. Extending the early look process so that it serves as an individual management review for probation providers would highlight immediate staffing and practice issues without delay. It could also be used to alert the centre to potentially high-profile cases and to indicate whether a full SFO review should be completed pre-conviction. A number of organisations were already making good use of the early look but are required to initiate the full SFO review irrespective of whether the individual is subsequently convicted. In the majority of cases, this is an inefficient use of resources, compounded by the delays in receiving feedback following HMPPS quality assurance.

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[15] Calculated from Table 1 in: Ministry of Justice. (2019). *Serious Further Offences*. https://www.gov.uk/government/statistics/serious-further-offences

3. The experience of victims and family members

In this chapter, we will report on the transparency and accessibility of the SFO review process for victims and family members. We will also consider whether the process meets the needs of victims and family members. Finally, we will consider the impact of disclosure.

3.1. Accessibility of the process

The principal aim of the change in SFO review format in April 2018 was to increase both the transparency and accessibility of the process to victims and family members. Under the previous arrangements, victims and family members received victim summary reports, which summarised the SFO review document. The new arrangements allowed victims and family members of automatic SFO reviews to have the full review document.

PI 06/2018 outlined a process whereby the responsibility for informing victims and families of their entitlement to an SFO review would lie with witness care units at the point of conviction. It was envisaged that this would be at the same time as they were informed of the statutory victim contact scheme (VCS).

Since April 2018, the proportion of victims or family members who have opted to be involved in the SFO review process has been relatively low and there is no tracking of the numbers who request access to SFO reviews. This is surprising given the stated purpose of the review process. It means there has been no central review or analysis of either the take-up rate or the differing trends between areas.

Locally, the victims' and families' requests for the SFO reviews are recorded by probation providers and the number requesting access to reports in the areas we inspected seemed low. Northumbria CRC has completed seven SFO reviews under the new process and none of the victims or family members have requested a copy of the report. NPS West Midlands had the highest rate of requests, but this was only 17 per cent (four cases) of the eligible SFO reviews. The providers reported that there has been no increase in victim and family requests since the introduction of the revised process.

The reason for this low request rate was of concern to the probation providers inspected. The consistency of contact from the witness care units and the timing of the communication were identified as potential issues. VCS teams routinely inform victims and family members of their entitlement to reviews if they opt into the scheme. In London NPS, this pro-active approach has resulted in five recent requests for disclosure. For those victims and family members who do not opt into the VCS team, there are no arrangements for further contact following their involvement with the witness care unit.

There is currently no certainty that all victims and family members are being informed of their entitlement to SFO reviews. In addition, there is no national system for collating and analysing the engagement of victims and family members. This is unacceptable, especially as the new process aims to increase accessibility. In London, a pilot scheme is being proposed whereby the VCS teams are responsible for contacting SFO victims and family members. We believe this is the correct approach and that NPS VCS teams should have sole responsibility for contact with SFO victims and family members.

3.2. The views of victims and family members

Due to the low number who have requested disclosure, we were only able to interview five victims and family members as part of the inspection. The individuals interviewed expressed their satisfaction with the transparency of the process and their interviews with the senior managers. A

MAPPA serious case review had also taken place on one of the cases, and this had resulted in some confusion about the difference between the two reports.

Victims and family members were positive about the narrative style of report, although some found the content dense and the reviews over-complicated. One family member commented:

"I didn't really know what to expect but didn't think the report would be as detailed as it was. I wouldn't have understood it without the meeting; it would have been baffling. I've had to read it several times since to make sense of it. I had the chance to ask questions but was overwhelmed and didn't know what to ask at the time".

Other victims and family members, however, found the content more accessible:

"The style of the report was ok. Acronyms are difficult to take in, hard to follow. We found you had to constantly reference the glossary to understand and follow the process but this interrupted the ability to take on board what it was actually telling you. It took a few reads. Some things stood out. Process and layout were fine, laid out well… we wanted to know about what the failings were and the report explained the failings".

Understandably, the focus of victims and family members was on the quality of practice and any identified shortcomings. We have concerns that, without sensitive explanation by the senior managers, the detailed examination of probation practice not directly relevant to the offence is potentially confusing.

Victims and family members interviewed felt that the process helped them to understand what had happened and viewed the process as open and honest. They particularly welcomed the opportunity to discuss the findings with probation senior managers.

3.3. Disclosure to victims and family members

PI 06/2018 is clear that victims and family members are entitled to a copy of the full review and this should be provided at a meeting with a senior manager. Probation providers have developed their own practices for disclosing reports to victims and family members. This has been helped by the production of guidance by the Effective Practice Division. This normally involves senior managers having a direct meeting with the victim or family member and a victim liaison officer also being in attendance. Senior managers expressed concern at the direction to always provide a copy of the review to victims and victim family members. Such disclosure, in their view, does not take into consideration the potential vulnerability of victims and the potential risk to staff. One manager highlighted a case where, following a disclosure, the victim had disappeared for a week before being located in a psychiatric hospital. In another, the full review was left with the victim, who was still in a relationship with the perpetrator of the SFO.

Senior managers at NPS West Midlands fill in feedback forms once the victim disclosure is complete so that learning from the meeting can be shared. Lessons learned include the need to prepare comprehensively and to ensure an assessment of the victim's vulnerability is undertaken prior to conducting the meeting. Their feedback reinforces the concern that the complexity of the reviews means that they do not always meet the needs of victims. One senior manager reported:

"The review was 29 pages long; the victim was given it at the meeting and was overwhelmed by the length and volume of words. We did pause to allow her time to read the conclusion; however, even this for someone who is not used to reading 'reports' is a big ask there and then … The current report format is really not helpful in its dual purpose; detail is too great to expect the victim to deal with at a meeting like this".

3.4. Conclusions and implications

The transparency of the disclosure process is welcomed by victims and family members. However, the content of the reviews is difficult for some victims and family members to digest, and not always relevant to the circumstances of the offence. The analysis of all aspects of probation practice is potentially confusing. It is therefore important that senior managers clearly identify the purpose and focus of the review process.

While it is important that victims and family members are allowed full disclosure, consideration must be given to their individual circumstances. This should include the potential risks entailed in a disclosure to victims, family members, staff and members of the public.

The requests for access to SFO reviews is relatively low when compared to the opt-in rate to the VCS. There has been no analysis of the effectiveness of the process and whether all victims and family members are being informed of their entitlement to disclosure of the review. In our view, responsibility for informing all victims and family members of their entitlement should be moved to probation victim liaison teams.

4. Learning and quality assurance

In this chapter, we review the quality assurance process with reference to the sample of reviews inspected. We also examine whether learning from SFO reviews informs learning at a local and national level.

4.1. Quality assurance

HMPPS SFO review teams supplied us with all the SFO reviews that had been quality assured between April 2018 and October 2019. We selected 60 reviews completed between August 2018 and January 2019, and in line with the standards set in the operational guidance (Annex B, PI 06/2018), we quality assured 46 SFO review documents submitted to HMPPS by probation providers. We inspected all the SFO review documentation, including the chronology, SFO review, action plan and any re-submissions. We compared our final ratings with the HMPPS SFO team quality assurance judgements. This aspect of the inspection did not include the reading of case management files or the interviewing of individual responsible officers and managers, and in this respect replicated the HMPPS role.

The SFO review cases

The offences which had initiated the 46 SFO reviews inspected are detailed in table 4.1.

Table 4.1 The offences initiating review in the inspected SFO reviews	No.
Murder/Attempted murder	24
Rape (Section 1 of *Sexual Offences Act 2003*)	11
Death by dangerous driving	3
Robbery	2
Sexual offences with a child under 13	3
Kidnapping	1
Offences including explosives	1
Aggravated vehicle taking which caused a death	1

The assessed risk of serious harm at the time the SFO was committed is shown in table 4.2 below.

Table 4.2 What was the assessed risk of serious harm at the time of the SFO?	No.	%
Very high	1	2
High	13	28
Medium	28	61
Low	2	4
Not clear/not assessed	2	4

Nineteen of the cases were eligible for MAPPA management at the time of the SFO and all were managed at MAPPA level one.

Inspection of SFO reviews submitted by probation providers

The operational guidance directs that the chronology should detail all significant events in the supervision of a case. The SFO review should include an analysis of this evidence in relation to the assessment, planning, implementation and review of work.

As shown in table 4.3 below, we judged that the majority of reviews had given due consideration to the assessment:

Table 4.3 Does the review consider all areas for assessment identified in the chronology?	No.	**%**
Yes	40	87%
No	6	13%

The significant events identified in the chronology and not considered in the review included potential gang affiliation; the transition from Youth Offending Teams to adult services; the management of integrated offender management licence conditions; and the reduction in the MAPPA level of management. In these reviews, the omissions contributed to a negative judgement on the analysis of risk management in the case.

The risk management of a case is central to the judgements made in SFO reviews and the review's conclusion should make a judgement as to whether reasonable steps were taken to manage the risk of serious harm. This judgement should be informed by analysing the risk of harm factors, the effectiveness of multi-agency work and the quality of the risk management plan in the case being reviewed. We found the analysis of risk of harm factors and risk management plan to be sufficient in just over two thirds of reviews, as detailed in table 4.4.

Table 4.4 Is the review's analysis of the key risk of harm factors identified in the chronology sufficient?	No.	%
Yes	31	67%
No	15	33%
Is the review's analysis of the risk management plan sufficient?		
Yes	32	70%
No	14	30%

In the 14 reviews where the risk management plan analysis was judged as insufficient, the areas highlighted by inspectors included a service user's potential involvement in organised crime, the effectiveness of joint agency actions and a failure to fully assess a previous recall of the service user. These were significant oversights with a clear potential for actions and learning points.

Poor practice example: limited analysis

Andy was the subject of a Youth Rehabilitation Order when he was convicted for an offence of murder. He was known to be vulnerable to the influence of older individuals and was involved in organised crime. He was also the father of a young child. Just under 12 months before committing the SFO, Andy was transferred from the Youth Offending Team to adult services for the management of his order.

There were significant practice errors in this case. A review of the case was not undertaken by adult services at any point following transfer, the level of contact was insufficient, enforcement action was delayed and the responsible officer was not aware of Andy's involvement in organised crime despite this information being available. Child protection safeguarding checks in relation to Andy's son were not made.

The SFO review was detailed but its analysis of the key practice issues in relation to the risk of harm posed was limited. It did not sufficiently analyse the reasons for the lack of an investigative approach, the failure to undertake safeguarding checks or the effectiveness of information exchange between agencies. In particular, the failings in the transition process between youth and adult services were not addressed.

The shortcomings of this review were identified by the HMPPS SFO team and the quality assurance rating of the review was 'requires improvement'. This was in line with the inspection assessment. The key practice gaps were addressed and the action plan included actions focused on practice issues for individuals and the probation provider. The findings from this review and others like it should be collated and used to better understand why mistakes are made and, where necessary, to inform probation policy and the relationships with external agencies.

We considered that over three-quarters of reviews included a clear judgement as to whether reasonable steps had been taken to manage the risk of serious harm. As shown in table 4.5 below, this leaves 10 reviews where a judgement was not clearly made.

Table 4.5 Does the SFO review give a clear judgement as to whether all reasonable steps were taken to manage the risk of serious harm in this case?	No.	%
Yes	36	78%
No	10	22%

This lack of clarity can be attributed in part to SFO reviewers still adapting to the narrative style of review. It is, however, a key requirement of the SFO review process that such judgements are made to ensure the appropriate learning is identified. In the deficient reviews, practice in relation to safeguarding, potential for self-harm and information-sharing was not effectively analysed in relation to the subsequent SFO. The reviews with clear conclusions on the risk management of cases provided a better picture of the effectiveness of probation practice.

Example of a good quality SFO review

Ben had a history of sexual offending and was released on licence following a long prison sentence for a serious sexual offence. He was placed in probation approved premises and initially managed at MAPPA level 2. Appropriate services were engaged in his management and the responsible officer maintained a clear focus on Ben's risk management.

Following his placement in approved premises, Ben moved to independent accommodation and this resulted in the transfer of his supervision to another responsible officer. Ben continued to meet the requirements of his licence and meet with his responsible officer. Three months after his release from prison, however, he was charged with a further sexual offence.

The review makes balanced judgements in relation to the key risk factors and the risk management plan. It is clear in its judgement that all reasonable steps had been taken to manage the case. This analysis highlights effective release planning by the responsible officer and identifies the length of approved premises placements and case transfer policy as areas for review and learning. Improved training and areas for improvement are also identified in relation to responsible officers and operational managers.

Inspectors agreed with the HMPPS SFO team's rating of 'good' for this review.

We found that all but three reviews (93 per cent) had given due consideration to the implementation and review of work undertaken in the case.

A key emphasis of the SFO process is that areas of good practice should be identified for local or national dissemination. In our sample, these were identified in only 57 per cent (26) of reviews and all were for dissemination locally. Areas identified included management oversight; information-sharing to assess risk; and incorporating prison visits into sentence planning. The HMPPS SFO review team and SFO reviewers were consistent in their view that expected practice does not constitute good practice unless it is maintained in adverse circumstances. We found some examples that should have been highlighted as good practice, including a responsible officer's management of a challenging individual, which enabled access to mental health services and accommodation.

Organisational actions were set in 70 per cent (32) of the cases, but these almost entirely refer to local team or unit practice. The majority of actions were for individuals. Areas for improvement in relation to strategy, policy or procedure were rarely identified. SFO reviewers across the eight organisations inspected were consistent in stating that recommendations on policy and procedure were difficult to make based on one case. In addition, the operational guidance and quality assurance feedback focus more on individual actions than organisational actions. As illustrated in the example below, this focus on individual actions in isolation means that wider learning for the organisation can be missed.

Poor practice example: missed opportunities for wider learning

Tim received a long prison sentence for serious violent offences, involving Class A drug use, committed when he was on licence. He had a history of reckless behaviour and his attitude, particularly to authority figures, was challenging.

Tim was released to a probation hostel and managed as an integrated offender management case, with the police actively involved. Immediately on release, he admitted Class B drug use. There were subsequently further positive tests for class A drug use. Within ten months of release, he was arrested for further violent offences, triggering an SFO review.

The SFO action plan was primarily focused on individual probation practice. The following organisational issues were not highlighted:

- Probation hostel policy. Tim was moved out after three months, in line with the policy, even though his behaviour gave no indication of stability.
- Integrated offender management. The role of integrated offender management and the police contribution to the management of the case was not analysed.
- Recall policy. The index offence involved Class A drug use, resulting in a violent crime. Positive drug tests did not result in recall, yet the organisation's approach to recall was not identified for review.
- MAPPA policy and understanding of criteria for level two management.
- Probation officer workload. Both probation officers in this case had workloads on the workload management tool of 130–150 per cent.

Quality assurance rating

Following quality assurance, the HMPPS SFO review team rates the reviews and action plans as good, satisfactory or requires improvement. The ratings provided have been considered as 'shadow ratings' since the revised process was introduced in April 2018 and they do not figure in probation provider performance measures.

Inspectors agreed with the ratings given to the local SFO review by the central HMPPS team in 83 per cent (38) of the cases, and as shown in table 4.6, the concordance between assessments was high. For instance, HMPPS SFO reviewers rated 48 per cent of reviews as requiring improvement compared with the inspectors' view of 52 per cent.

Table 4.6 Following quality assurance, what rating was given to the SFO review (by the HMPPS SFO review team)?	HMPPS rating	HM Inspectorate of Probation rating
Requires improvement	22 (48%)	24 (52%)
Satisfactory	7 (15%)	8 (18%)
Good	17 (37%)	14 (30%)

In relation to action plans, inspectors agreed with the ratings in 76 per cent (35) of cases. Of these, quality assurers identified 52 per cent as requiring improvement compared with the inspectors' figure of 54 per cent (table 4.7 below). The reasons for inspectors disagreeing with review ratings varied and no patterns emerged.

Table 4.7 Following quality assurance, what rating was given to the SFO action plan (by the HMPPS SFO review team)?	HMPPS rating	HM Inspectorate of Probation rating
Requires improvement	24 (52%)	25 (54%)
Satisfactory	11 (24%)	14 (31%)
Good	11 (24%)	7 (15%)

Probation providers are frustrated by the delays in the quality assurance feedback. Although the process is supposed to take 20 days, it is actually taking over six months for many reviews. One senior manager reported that the length of delay meant that the feedback for many cases was received "*too late to be useful*". Operational staff may be the subject of additional actions once the delayed quality feedback is received. This increases their anxiety and is, in our view, an unnecessary additional pressure on individuals and staff teams. One commented:

"It means we are left worrying about the eventual outcome of the case. There is a constant feeling of judgement held over you".

The delay also reduces the impact of any additional learning points from the quality assurance feedback. Probation providers implement the action plans on completion of the reviews and the feedback is frequently received after the plans have been implemented. With the exception of the expedited high-profile and victim disclosure reviews, all the providers we inspected experienced delays of over six months in receiving feedback. For example, NPS North East division submitted 100 SFO reviews between April 2018 and November 2019. Of the 24 cases eligible for victim disclosure, three victims had requested disclosure, for which the quality assurance process had been expedited. At the time of our inspection in November 2019, quality assurance feedback on 16 submissions, submitted before the end of May 2019, had still not been received.

Overall, probation providers described a positive relationship with the HMPPS SFO review team, although there was a shared belief that the quality assurance feedback can be inconsistent. As the feedback from the national team focuses on individual practice, often based on differing professional judgements, the process, in their view, does not routinely provide additional learning. The targeted quality assurance approach means that feedback is seen as advisory in most cases, as there is no requirement to re-submit the reviews. Probation providers already undertake their own extensive quality assurance of reviews and action plans before submitting to the HMPPS team. In the CRCs, this is undertaken by senior managers. In the NPS, the SFO review team manager quality assures the case before it is signed off by head of public protection. This local quality assurance process takes at least one day for each review. The best arrangements were timely and well informed and resulted in reviews that were consistent with the ratings of the central SFO review team.

Good practice example:

In London NPS, the local quality assurance is undertaken by the SFO review manager, who is independent from the operational structure. The completed review and action plan are quality assured against the operational guidance and the standards set by the HMPPS SFO review team. Amendments and improvements are then agreed in a meeting with the SFO reviewer and the documents are checked again by the manager before they are submitted to the central SFO review team. This normally takes between 1 and 1.5 days to complete.

In 90 per cent of reviews, feedback from the centre is now positive.

4.2. Strategic learning

PI 06/2018 identifies 'learning and improvement at a strategic as well as local level' as a key focus of the SFO review process. The operational guidance makes clear that the HMPPS SFO review team should develop national SFO policy and guidance as well as contribute to policy and practice in other areas of HMPPS.

Issues identified by the central team from high-profile cases have influenced practice. For instance, recall practice has been reviewed in relation to information exchange with the police. SFO learning points have been used by the NPS Effective Practice division to issue a seven minute briefing covering practice in relation to MAPPA, release on temporary licence, risk escalation and ViSOR.

Key data from SFO notifications and submissions is recorded. This includes information such as knife crime offences. It is shared with the Chief Probation Officer of England and Wales and NPS divisions at the SFO reference group. There is, however, no systematic analysis of this data. Similarly, themes that might emerge from SFOs, such as homelessness, lack of mental health support, workloads and the delivery of interventions, are not collated and analysed to help inform policy and practice. Staff shortages mean that the focus of the SFO team is on undertaking quality assurance to address the backlog. In our view, this absence of systematic focus on learning is a missed opportunity to inform national policy and procedure.

The probation practice often highlighted in SFO reviews is consistent with the findings of internal quality assurance audits and HM Inspectorate of Probation inspections. This includes incomplete risk management plans; poor recording; lack of management oversight; and the absence of an investigative approach. These are important findings and the fact that they continually recur, without systematic analysis of this small (approximately 0.2%) but important snapshot of the probation caseload, is of concern.

4.3. Local learning

The eight probation providers inspected had processes in place to collate and disseminate relevant learning and actions. In the West Midlands and the North East, managers from the NPS and CRC meet to share SFO learning. The most effective organisations have clear lines of accountability, with the responsibility at senior and operational levels clearly identified. All the NPS divisions and two of the inspected CRCs had separate SFO reviewing teams. We found that this was the best model for identifying, collating and disseminating key learning points.

Good practice example:

SFO reviews in Wales are completed by the Public Protection and Approved Premises team, which consists of four quality scrutiny managers (QSM) who are independent of the offender management structure. They also complete the early look process when cases are identified. QSMs adopt an inclusive approach to staff interviews. Responsible officers are encouraged to shadow them to de-mystify the SFO process.

The team systematically records all learning and actions from the 39 SFO reviews they have completed since April 2018. This is collated alongside learning from other sources, such as internal audits. Nine key learning themes from SFO reviews have been identified:

- an over-reliance on service user self-disclosure
- more robust address checks
- improved enforcement practice
- safety planning for domestic abuse cases
- improved management oversight
- improved recording quality
- improved adherence to MAPPA processes
- reviewing cases following significant events
- the quality of assessment and planning.

These inform the best practice action plans in each delivery unit and are disseminated at:

- senior leadership team meetings by the Head of Public Protection and Approved Premises
- quarterly best practice group meetings led by practitioners and attended by QSMs – these meetings for operational staff are practitioner-led
- additional briefings undertaken by team managers and QSMs
- 'Dysgu Cymru' meetings – quarterly meetings that include practitioners and examine cases in detail and can be used to ensure that action plans are achieved.

The SFO review process dictates that learning is in the main a 'top down' process. Reviews are undertaken by designated managers, internally quality assured and countersigned, and then quality assured by the central SFO team. Responsible officers and operational managers are interviewed, but the focus is predominantly on the actions taken and processes followed by the responsible officer. Operational guidance says that good practice should include ensuring that any staff (including managers) involved in the management of a case are given feedback on those outcomes of the SFO review that relate directly to them and that managers may consider providing staff with a copy of the review, subject to any appropriate redactions. However, we found that it was a top down process where operational staff do not have access to the review and are therefore unable to feed back their views on the findings of the investigation.

Responsible officers accept the need for accountability and that public protection demands that their practice meets the highest standards. The SFO review process is presented to them as a positive learning process that does not assume a causal link between probation practice and the SFO. Operational staff, however, perceive the SFO review process negatively and believe it focuses on blame and individual accountability rather than learning. Comments made included:

"It was a horrible process to go through".

"Having a SFO is a shameful experience and you feel very guilty even though the offence is often impossible to predict".

"The investigation of SFOs assumes an idealistic and controlled working environment and the expectation of practice and decision-making is unrealistic. The inspection of the case is compartmentalised and not viewed in the context of high caseloads".

"The process isn't learning; it is about blame and individual responsibility. The process focuses on detail that is not relevant to the offence".

The practice expectations identified in action plans are often viewed as unrealistic against their experience of the realities of operational culture, especially where resources are scarce. The lack of transparency for operational staff involved in the process exacerbates this negative perspective.

The culture of fear emanating from the SFO review process has contributed to defensive operational practice. Responsible officers reported taking actions "in case there is an SFO" rather than because it is good practice. This culture has also manifested itself in training events, where advice on practice is given in the event of an SFO rather than on its own merits. Probation providers recognise the negative impact that the SFO review process has on operational staff and the fear that it generates. The national briefing sessions developed by the SFO reference group are an example of organisations trying to improve the culture. In NPS London, a concerted effort has been made by the SFO review team to emphasise a positive learning focus and there is evidence that this has had some success. Operational staff who have been through the process described it as a positive experience, with the focus on learning rather than blame.

4.4. Multi-agency learning

PI 06/2018 makes clear that the remit for SFO reviews is solely probation practice, although it provides guidance for cases that are also the subject of additional external reviews. The operational guidance directs reviewers to make judgements on the multi-agency work undertaken, but they are not required to obtain the views of other agencies involved in cases. In view of the complex individuals who often commit SFOs, this potentially limits the insight into practice and learning.

The SFO review process does not have the multi-agency framework, and therefore the increased accountability, of other serious case reviews released into the public domain. SFO reviews inevitably include reference to multi-agency work, but without the input of other agencies, they cannot fully assess the effectiveness of partnership working. In our sample, only 39 per cent of reviews sufficiently addressed multi-agency working. Only 6 per cent of SFO review actions referred to external agencies. These actions were allocated to probation senior managers and included improved joint working arrangements with the police in relation to registered sex offenders and improved liaison arrangements with mental health services. The actions were appropriate within the context of the case but their achievement depended on external agencies cooperating. The remit of the current SFO process cannot mandate this.

External agencies have minimal knowledge of the SFO review process and little information is exchanged with other agencies, even those within MAPPA arrangements. We were surprised to learn that, in one NPS division, SFO findings were not shared with the local MAPPA Strategic Management Board, even where they might be relevant to the agencies attending. The absence of an external agency contribution limited the insight into case management and working relationships.

Only a small number of SFO review cases meet the criteria for multi-agency reviews such as DHRs and MAPPA serious case reviews (in our sample only 3 out of the 46 cases inspected). Since the introduction of the revised SFO process, 9 per cent of SFO reviews have also been the subject of MAPPA serious case reviews. For these external reviews, probation providers undertake an additional internal management review. These are based on the SFO review, which is completed in advance of the external review. Probation providers reported that, although the timescales for the different reviews are agreed, there is always an element of duplication in the completion of another review. For most SFOs with external agency involvement, therefore, multi-agency reviews do not

take place. Opportunities for identifying improved methods of working and models of service delivery are therefore not considered.

Poor practice example: no multi-agency perspective

Sam had been given an indeterminate sentence for several offences, including sexual activity with a child.

He was released from prison to a probation hostel before moving into independent accommodation. As would be expected, there was extensive contact between the responsible officer and the police public protection unit responsible for registered sexual offenders. Home visits were jointly undertaken. The issues discussed included child safeguarding referrals, the ability of parents to protect children, the risk to partners, class A drug relapse and decisions about the level of risk of harm that he posed.

After three years in the community, Sam appeared in court charged with the rape of his partner's adult daughter.

Despite the level of joint work between probation and police, the SFO review did not contain a multi-agency perspective. As such, the decisions taken were not scrutinised in sufficient depth and potential cross-agency learning was missed.

4.4. Conclusions and implications

The HMPPS SFO review team quality assure SFO reviews against the practice standards set in the operational guidance. We found their ratings were consistent with the standards set.

There is no national strategy to use findings from SFO reviews to inform policy and procedure. Changes have been made to policy and practice because of SFO reviews but in the main this has been a reaction to high-profile cases rather than from a systematic process for identifying learning.

The individual actions and practice issues that emerge from SFO reviews often follow established themes. The current process is consistent in identifying 'what' has happened in a case, but there is very limited scope for investigating 'why' the same issues are recurring. The HMPPS SFO review team is responsible for contributing to policy and practice development but does not have the resources to analyse findings and identify themes.

There is some evidence of NPS divisions and CRCs sharing information, but learning is not routinely shared with external agencies where they have been integral to the management of the case. Examples include those case subject to Integrated Offender Management and MAPPA.

The targeted approach now adopted by HMPPS means that the feedback provided is advisory in most cases. The significant delays mean that, with the exception of high-profile and victim disclosure cases, the quality assurance has limited impact. The wider perception is that the process is not truly independent, and risks undermining public confidence.

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Annexe 1: SFO qualifying offences

In addition to the substantive offences below, aiding, abetting, counselling, procuring or inciting the commission, or conspiring to commit, or attempting to commit any of the listed offences constitutes a Serious Further Offence.

* Automatic SFO qualifying offences are in bold.

Violent Serious Further Offences
Murder
Attempt to commit murder or a conspiracy to commit murder
Manslaughter
Kidnapping
False imprisonment
Soliciting murder (section 4 of the *Offences Against the Person Act 1861*)
Attempting to choke, suffocate or strangle in order to commit or assist in committing an indictable offence (section 21 of the *Offences Against the Person Act 1861*)
Using chloroform etc. to commit or assist in the committing of any indictable offence (section 22 of the *Offences Against the Person Act 1861*)
Causing bodily injury by explosives (section 28 of the *Offences Against the Person Act 1861*)
Using explosives etc. with intent to do grievous bodily harm (section 29 of the *Offences Against the Person Act 1861*)
Placing explosives etc. with intent to do bodily injury (section 30 of the *Offences Against the Person Act 1861*)
Endangering the safety of railway passengers (section 32 of the *Offences Against the Person Act 1861*)
Causing explosion likely to endanger life or property (section 2 of the *Explosive Substances Act 1883*)
Attempt to cause explosion, or making or keeping explosive with intent to endanger life or property (section 3 of the *Explosive Substances Act 1883*)
Child destruction (section 1 of the *Infant Life (Preservation) Act 1929*)
Infanticide (section 1 of the *Infanticide Act 1938*)
Causing or allowing the death of a child or vulnerable adult, also called 'familial homicide' (section 5 of the *Domestic Violence, Crime and Victims Act 2004*)
Possession of firearm with intent to endanger life (section 16 of the *Firearms Act 1968*)
Use of firearm to resist arrest (section 17(1) of the *Firearms Act 1968*)
Possession of firearm at time of committing or being arrested for offence specified in Schedule 1 to that Act (section 17(2) of the *Firearms Act 1968*)
Carrying a firearm with criminal intent (section 18 of the *Firearms Act 1968*)
Robbery or assault with intent to rob (section 8(1) of the *Theft Act 1968*). *[NB: only where* a *firearm/imitation firearm is used]*

Burglary with intent to inflict grievous bodily harm on a person (section 9 of the *Theft Act 1968*)
Aggravated burglary (section 10 of the *Theft Act 1968*)
Aggravated vehicle-taking involving an accident which caused the death of any person (section 12A of the *Theft Act 1968*)
Arson with intent to endanger life of another or being reckless as to whether the life of another would be thereby endangered (section 1 of the *Criminal Damage Act 1971*)
Aggravated criminal damage – destroying or damaging property other than an offence of arson (section 1(2a) of the *Criminal Damage Act 1971*) *[NB: there must be intention or recklessness as to the endangerment of life by the criminal damage]*
Hostage-taking (section 1 of the *Taking of Hostages Act 1982*)
Hijacking (section 1 of the *Aviation Security Act 1982*)
Destroying, damaging or endangering safety of aircraft (section 2 of the *Aviation Security Act 1982*)
Other acts endangering or likely to endanger safety of aircraft (section 3 of the *Aviation Security Act 1982*)
Torture (section 134 of the *Criminal Justice Act 1988*)
Causing death by dangerous driving (section 1 of the *Road Traffic Act 1988*)
Causing death by careless driving when under influence of drink or drugs (section 3A of the *Road Traffic Act 1988*)
Endangering safety at aerodromes (section 1 of the *Aviation and Maritime Security Act 1990*)
Hijacking of ships (section 9 of the *Aviation and Maritime Security Act 1990*)
Seizing or exercising control of fixed platforms (section 10 of the *Aviation and Maritime Security Act 1990*)
Destroying fixed platforms or endangering their safety (section 11 of the *Aviation and Maritime Security Act 1990*)
Other acts endangering or likely to endanger safe navigation (section 12 of the *Aviation and Maritime Security Act 1990*)
Offences involving threats (section 13 of the *Aviation and Maritime Security Act 1990*)
Offences relating to Channel Tunnel trains and the tunnel system (Part II of the *Channel Tunnel (Security) Order 1994* (S.I. 1994/570))
Genocide, crimes against humanity, war crimes and related offences, other than one involving murder (section 51 or 52 of the *International Criminal Court Act 2001*)
Female genital mutilation (section 1 of the *Female Genital Mutilation Act 2003*)
Assisting a girl to mutilate her own genitalia (section 2 of the *Female Genital Mutilation Act 2003*)
Assisting a non-UK person to mutilate overseas a girl's genitalia (section 3 of the *Female Genital Mutilation Act 2003*)

Sexual Serious Further Offences
Rape or assault by penetration (section 1 or 2 of the *Sexual Offences Act 2003*)
Intercourse with girl under 13 (section 5 of the *Sexual Offences Act 1956*)
Incest by a man with a woman whom he knows to be his grand-daughter, daughter, sister or mother (section 10(1) of the *Sexual Offences Act 1956*) **(qualifies for an automatic review if victim is aged under 13)**
Abduction of woman by force or for the sake of her property (section 17 of the *Sexual Offences Act 1956*)
Permitting girl under 13 to use premises for intercourse (section 25 of the *Sexual Offences Act 1956*)
Burglary with intent to commit rape (section 9 of the *Theft Act 1968*)
Rape (section 1 of the *Sexual Offences Act 2003*)
Assault by penetration (section 2 of the *Sexual Offences Act 2003*)
Rape of a child under 13 (section 5 of the *Sexual Offences Act 2003*)
Assault of a child under 13 by penetration (section 6 of the *Sexual Offences Act 2003*)
Sexual assault of a child under 13 (section 7 of the *Sexual Offences Act 2003*)
Causing or inciting a child under 13 to engage in sexual activity (section 8 of the *Sexual Offences Act 2003*)
Sexual activity with a child (section 9 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Causing or inciting a child to engage in sexual activity (section 10 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Arranging or facilitating commission of a child sex offence (section 14 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Sexual activity with a child family member (section 25 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Inciting a child family member to engage in sexual activity (section 26 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Sexual activity with a person with a mental disorder impeding choice (section 30 of the *Sexual Offences Act 2003*)
Causing or inciting a person with a mental disorder impeding choice to engage in sexual activity (section 31 of the *Sexual Offences Act 2003*)
Inducement, threat or deception to procure sexual activity with a person with a mental disorder (section 34 of the *Sexual Offences Act 2003*)
Causing a person with a mental disorder to engage in or agree to engage in sexual activity by inducement, threat or deception (section 35 of the *Sexual Offences Act 2003*)
Paying for sexual services of a child (section 47 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Causing or inciting child prostitution or pornography (section 48 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Controlling a child prostitute or a child involved in pornography (section 49 of the *Sexual Offences*

Act 2003) **(qualifies for an automatic review if victim is aged under 13)**
Arranging or facilitating child prostitution or pornography (section 50 of the *Sexual Offences Act 2003*) **(qualifies for an automatic review if victim is aged under 13)**
Trafficking into the UK for sexual exploitation (section 57 of the *Sexual Offences Act 2003*)
Trafficking within the UK for sexual exploitation (section 58 of the *Sexual Offences Act 2003*)
Trafficking out of the UK for sexual exploitation (section 59 of the *Sexual Offences Act 2003*)
Causing a person to engage in sexual activity without consent (section 4 of the *Sexual Offences Act 2003*) [Note: only where penetration is involved]
Care workers: sexual activity with a person with a mental disorder (section 38 of the *Sexual Offences Act 2003*) [Note: only where penetration is involved]
Care workers: causing or inciting sexual activity (section 39 of the *Sexual Offences Act 2003*) [Note: only where penetration is involved]

Annexe 2: Glossary

CRC	Community Rehabilitation Company
DHR	Domestic homicide review. A multi-agency review instigated by local authority Community Safety Partnerships in cases of domestic murder
EPD	Effective Practice Division. This division is located within the Performance Directorate of HMPPS and is responsible for developing and disseminating effective practice.
FOI	Freedom of Information request
HMPPS	Her Majesty's Prison and Probation Service (HMPPS): the single agency responsible for both prisons and probation services. See note below on NOMS.
HMPPS SFO review team	This team is located in the Public Protection Group of the NPS. It is responsible for administering the SFO review process and for quality assuring all reviews and action plans. It provides guidance to probation providers and is responsible for developing national policy and guidance relating to SFOs.
Integrated Offender Management (IOM)	Integrated Offender Management brings a cross-agency response to the crime and reoffending threats faced by local communities. The most persistent and problematic offenders are identified and managed jointly by partner agencies working together.
MAPPA	Multi-Agency Public Protection Arrangements: where probation, police, prison and other agencies work together locally to manage offenders who pose a higher risk of harm to others. Level 1 is ordinary agency management, where the risks posed by the offender can be managed by the agency responsible for the supervision or case management of the offender. This compares with levels 2 and 3, which require active multi-agency management.
MoJ	Ministry of Justice
NOMS	National Offender Management Service: until April 2017, the single agency responsible for both prisons and probation services, now known as Her Majesty's Prison and Probation Service (HMPPS).
NPS	National Probation Service: a single national service which came into being in June 2014. Its role is to deliver services to courts and to manage specific groups of offenders, including those presenting a high or very high risk of serious harm and those subject to MAPPA.
OASys	Offender assessment system currently used in England and Wales by the NPS and CRCs to measure the risks and needs

	of offenders under supervision.
Offender Rehabilitation Act 2014 **(ORA)**	Implemented in February 2015, applying to offences committed on or after that date.
PI	Probation Instruction. These are mandatory instructions issued by the HMPPS, detailing policies and guidance.
PPG	Public Protection Group. This is a group located within the NPS that is responsible for public protection strategy and policy, including the SFO review process.
Providers	Providers deliver a service or input commissioned by and provided under contract to the NPS or CRC. This includes the staff and services provided under the contract, even when they are integrated or located within the NPS or CRC.
PSR	Pre-sentence report. This refers to any report prepared for a court, whether delivered orally or in a written format.
PO	Probation officer: this is the term for a 'qualified' responsible officer who has undertaken a higher education-based course for two years. The name of the qualification and content of the training vary depending on when the course was undertaken. They manage more complex cases.
PQ	Parliamentary question
PSO	Probation services officer: this is the term for a responsible officer who was originally recruited with no qualification. They may access locally determined training to 'qualify' as a probation services officer or to build on this to qualify as a probation officer. They may manage all but the most complex cases depending on their level of training and experience. Some PSOs work within the court setting, where their duties include writing pre-sentence reports.
RO	Responsible officer. This is the officer who is responsible for supervising the case. It could be a probation officer or probation services officer. In focus groups, both grades of staff were present so we have used the generic term when referring to evidence.
SFO	Serious further offence. These are offences committed by service users that fall within the remit of PI 06/2018 Annex A.
SFO review	This the review undertaken when a service user commits an SFO eligible offence.

Annexe 3: Methodology

Pre-fieldwork

- Identification and analysis of MoJ and HMPPS policy in relation to SFOs
- A review of relevant inspection reports
- A review of information submitted in advance from the HMPPS SFO team on quality assurance standards and practice
- A review of data from the HMPPS SFO review team on the numbers of notifications, reviews submitted and reviews quality assured since 01 April 2018
- A review of information from providers detailing SFO governance arrangements, action plan monitoring and implementation
- A review of minutes from meetings, documented communication and evidence of practice implementation submitted by probation providers
- Context setting meetings with HMPPS SFO team managers
- A teleconference meeting with the Deputy Victims Commissioner
- A Skype meeting with the Head of Practice development HMPPS Effective Practice Division
- A pilot inspection hosted by NPS NW. This took place in October 2019.

Inspection fieldwork

The inspection fieldwork was undertaken in November and December 2019. It included visits to the central team and four areas where we met with both the NPS and CRCs.

Area	CRC	NPS division
North East	Northumbria	NPS North East
London	London	NPS London
Wales	Wales CRC*	NPS Wales
West Midlands	Staffordshire and West Midlands	NPS West Midlands
London		HMPPS SFO review team in the Public Protection Group

*On 01 December 2019, Wales CRC's contract ended and under the unified system NPS Wales became responsible for the management of all adult service users in Wales.

The fieldwork in each area comprised meetings with the following managers and staff:

- senior managers, NPS divisions and CRCs
- Public protection leads, NPS divisions
- CRC SFO lead manager
- Heads of SFO teams, CRCs and NPS

- middle managers, NPS divisions and CRCs.
- quality development team managers, NPS and CRC
- responsible officers, NPS and CRCs
- victim liaison managers
- victim liaison officers.

Meetings with managers from the following external agencies:

- Children's Social Care
- Police
- Community Safety Partnerships.

Meetings with victims and family members who had received disclosures under the SFO review process.

The following meetings were held with the HMPPS SFO review team:

- Deputy Director Public Protection Group
- Head of Public Protection and Partnerships
- Head of the SFO review team
- SFO senior quality assurance manager
- SFO quality assurance reviewers.

Inspection of SFO review cases

HMPPS SFO review teams supplied us with all the SFO reviews that had been quality assured between April 2018 and October 2019. We selected a sample of 60 and inspected 46.

We used the SFO operational guidance to design criteria to inspect the review documents. The documents inspected were:

- chronology
- review
- action plan
- quality assurance feedback.

The quality assurance feedback was read after a judgement had been made on the quality of the review documents.

We interviewed a senior manager from Kent, Surrey and Sussex CRC.

Annexe 4: Serious case reviews

MAPPA serious case review [16]	
Criteria	Offender charged with an SFO. As with SFO review there are mandatory and discretionary reviews. **Mandatory:** offender managed at MAPPA level 2 or 3 AND the offence is murder, attempted murder, manslaughter, rape or attempted rape. **Discretionary:** Depends on the circumstances of the case and whether there has been a significant breach of the MAPPA guidance. However, careful consideration should be given to whether any value would be gained beyond the lead agency's management review.
Review process	• MAPPA coordinator notifies Strategic Management Board (SMB) Chair of SFO charge. • SMB Chair decides whether case requires a MAPPA serious case review (SCR) and notified Public Protection Group • SMB Chair informs each agency involved that MAPPA SCR will take place. • MAPPA SCR Panel meets (consists of SCR Lead, a senior nominated person from each agency, and a lay adviser). • MAPPA SCR Lead produces report, with representation of other agencies from panel members. Report sent to SMB Chair and PPG. • MAPPA SCR Lead produces an overview report that can be shared externally.
QA process	Lay adviser on the SCR panel: • To provide an independent voice to the review. • To ensure that any community issues are addressed. • To act as a 'critical friend' to the professionals. Quality assurance of report from PPG – no further details
Timeliness	Decision to conduct MAPPA SCR within 10 days of SMB chair being notified of charge. Chair informs agencies within five days of making decision. Panel meet within one month of agencies being notified. Report produced within four months of panel first meeting. Overview report produced within 1 month of completion of report. The overall process from charge of SFO to overview report should take no longer than approximately 7–8 months unless delayed due to advice from the Crown Prosecution Service or similar.
Number	Ten MAPPA SCRs completed in 2018/2019, of which nine were MAPPA level 2 and one was MAPPA level 3.[17]

[16] MAPPA guidance 2012 version 4.5. Section 20. https://www.gov.uk/government/publications/multi-agency-public-protection-arrangements-mappa--2

[17] Ministry of Justice. (2019). *Multi-Agency Public Protection Arrangements – Annual Report 2018/19.* www.gov.uk/government/statistics/multi-agency-public-protection-arrangements-mappa-annual-report-2018-to-2019

Domestic homicide review (DHR) [18]	
Criteria	Death of a person over 16 years old which has or appears to have resulted from violence, abuse or neglect by a relative, intimate partner or member of the same household.
Review process	• Police inform the local multi-agency Community Safety Partnership (CSP) of the domestic homicide; however, any professional or agency can refer a homicide to the CSP if it believes there are important inter-agency lessons. • The CSP is responsible for establishing whether a DHR is required. It sets up a review panel involving representatives from statutory agencies and any other relevant organisations or professionals. The review panel chair is an independent, experienced individual who is not directly associated with any of the agencies involved in the review. Families should be given the opportunity to be integral to reviews and should be treated as a key stakeholder. • The review panel and chair draw up terms of reference to determine the scope, which is bespoke to each review. • Each relevant agency is commissioned to produce an individual management review (IMR) to submit to the review panel. • The overview report, executive summary and action plan, drafted by review panel chair or author, should bring together and draw overall conclusions from the information and analysis contained in the IMRs and reports or information commissioned from any other relevant interests. • The CSP agrees and signs off the overview reports, executive summaries and action plans. • All completed overview reports, executive summaries and action plans should be sent to the Home Office Quality Assurance Panel. • When signed off by QA panel, the overview report and executive summary should be suitably anonymised and made publicly available.
QA process	All completed overview reports, executive summaries and action plans should be sent to the Home Office. They will be assessed against the guidance by a Quality Assurance Panel that includes representation from all relevant statutory agencies as well as the voluntary sector. The group meets on a quarterly basis to assess report standards as well as identifying good and poor practice and training needs. Where reviews are assessed as inadequate, a summary of findings is sent to the CSP chair, who is responsible for ensuring the areas of concern are revisited and amended by the review panel.
Timeliness	Decision to commission review within one month of CSP being notified. Overview report should be complete within a further six months.
Number	Number of reviews not published. In 2018/2019, there were 129 domestic homicides (partner/ex-partner and familial homicides).[19] However, it should be noted that the threshold for conducting a DHR is lower than the criminal threshold. For example, a DHR may be conducted on an apparent suicide, where it appears the suicide was caused by abuse, but such a case would not be logged in the homicide index.

[18] Home Office. Domestic homicide reviews collection. www.gov.uk/government/collections/domestic-homicide-review.

[19] Office for National Statistics. (2020). *Homicide in England and Wales*: year ending March 2019. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/homicideinenglandandwales/yearendingmarch2019

Child safeguarding practice review, England (formerly serious case review) [20]	
Criteria	Cases in which abuse or neglect of a child is known or suspected and the child has died or been seriously harmed. Meeting the criteria does not mean that safeguarding partners must automatically carry out a local review. It is for them to determine whether a review is appropriate, considering that the overall purpose of a review is to identify improvements to practice. Some cases may not meet the definition of a 'serious child safeguarding case', but may raise issues of importance to the local area and may prompt a review.
Review process	Local authority informs local safeguarding partners and the national Child Safeguarding Practice Review Panel (the Panel) of all cases which meet the serious child safeguarding case criteria. **Rapid review:** Safeguarding partners promptly undertake a rapid review to gather facts, identify immediate actions, consider potential for identifying improvements, and decide whether a full review is required and, if so, at local or national level. **Local review:** If local level review is decided, local safeguarding partners commission and supervise a reviewer with suitable expertise and consider whether they have a conflict of interest. The safeguarding partners and reviewer agree a review method which provides a way of looking at and analysing frontline practice as well as organisational structures and learning. The final report should include recommended improvements and an analysis of systemic or underlying reasons. This should be sent to the Panel, Secretary of State and Ofsted. **National review:** The panel is responsible for overseeing and supervising national reviews, including commissioning a reviewer, and informing and discussing the scope with relevant safeguarding partners. The review should follow the same guidance on procedure as local reviews. Reports should be written in a way that is suitable to publish. Local reports should be publicly available for at least one year and national reports should be available for at least three years. The panel should send copies of published reports to the What Works Centre for Children's Social Care and relevant inspectorates, bodies or individuals as they see fit.
QA process	Safeguarding partners QA and 'sign-off' local reviews completed by commissioned reviewers and the Panel does so for national reviews. No clear national formal QA process is outlined, other than published guidance on expected quality. The Panel can suggest re-writes to remove sensitive information to enable publication.
Timeliness	Rapid review should be conducted within 15 working days of notification to the Panel. Publication of the report should be no later than six months after the decision to undertake a full review, unless publication would impact on other proceedings (for example, criminal investigations).
Number	In 2019 two national reviews were published.[21] The number of local reviews published does not appear to be published centrally by the Panel. Up to 46 local reviews may have been published in 2019.[22]

[20] Child Safeguarding Practice Review Panel. (2019). Practice guidance: www.gov.uk/government/publications/child-safeguarding-practice-review-panel-practice-guidance

[21] National reviews: https://www.gov.uk/government/organisations/child-safeguarding-practice-review-panel

[22] Local reviews (may include reviews not completed under the new guidance): https://learning.nspcc.org.uk/case-reviews/recently-published-case-reviews/

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ISBN: 978-1-84099-942-6